

Republic of Kenya



Ministry of Health

Management of complications pregnancy, childbirth and the postpartum period in the presence of FGM/C

**A Reference Manual
for Health Service Providers**

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FOREWORD

This reference manual was prepared through multi-disciplinary consultations involving a wide range of Ministry of Health officials at national, provincial and district levels, research institutions, development partners, UN agencies, and professional bodies. This reference manual was developed because, despite the fact that there remains a high prevalence of female genital mutilation/cutting (FGM/C) in Kenya, no appropriate materials have been developed locally that can assist health providers to give optimum care to women who have undergone FGM/C. This manual is designed particularly for use by non-specialist clinicians, including nurses / midwives, Clinical Officers, District Medical Officers and other general practitioners working in isolation, postgraduate medical officers (registrars), and medical students. Medical and other health service providers at primary, secondary and tertiary levels, particularly those working in areas with high prevalence of FGM/C, will also find the manual a valuable resource.

This reference manual marks a departure from many clinical manuals in several ways. The document defines and classifies FGM/C, highlights the reasons why different communities practice FGM/C, describes the psychosocial and sexual complications of FGM/C, presents the ethical implications of FGM/C, and describes the various laws and decrees against FGM/C and the legal implications. This approach not only makes the reference manual available and relevant to other professionals concerned with this illegal act, but also recognises that FGM/C is a fundamental human rights abuse. Drawing on this breadth of content, the manual adds value to, and can be used in conjunction with, the Ministry of health's 'National Plan of Action for the Elimination of FGM in Kenya' (1999-2019).

The Government of Kenya is committed to countering the practice of FGM/C throughout the country. This will be done through mobilising resources from both internal sources and from development partners. It is anticipated that the knowledge and skills acquired from the reference manual will be put to good use in preventing the practice of FGM/C. Service providers will also develop skills to manage complications in pregnancy and childbirth strongly associated with FGM/C.



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The authors would like to acknowledge two organizations that have produced materials from which this manual drew heavily: the World Health Organisation's "Female Genital Mutilation: Integrating the prevention and the management of health complications into the curricula of nursing and midwifery" (Teachers Guide and Students' Manual), as well as its policy guidelines for nurses and midwives; and RAINB♀ for its publication "Caring for Women with Circumcision: A Technical Manual for Health Care Providers".

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The Kenya Obstetrical and Gynaecological Society (KOGS) have endorsed this manual through its Chairman Dr. Omondi Ogotu and members Professor J.G. Karanja and Dr. Nancy Kidula, to whom we extend our gratitude. Professor Karanja and Dr. Kidula were also involved in piloting the training manual. We would also like to thank the medical staff of North Eastern Province, Kenya for their inputs during the training, which enabled the materials to be made relevant and practical for health providers in Kenya.



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LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
DANIDA	Danish International Development Agency
DHMT	District Health Management Team
DRH	Division of Reproductive Health
FGC	Female Genital Cutting
FGM	Female Genital Mutilation
FIGO	International Federation of Gynaecology and Obstetrics
GTZ	German Technical Cooperation
HIV	Human Immunodeficiency Virus
KOGS	Kenya Obstetrical and Gynaecological Society
MOH	Ministry of Health
TBA	Traditional Birth Attendant
RVF	Rectovaginal Fistulae
USAID	United States Agency for International Development
UNICEF	United Nations Children's Fund
VVF	Vesicovaginal Fistulae
MWIA	Medical Women's International Association

WHO IS THE MANUAL FOR AND HOW IS IT ORGANIZED?

The manual is intended for health care providers in Kenya working among communities that have a high prevalence of female genital mutilation/cutting (FGM/C) and those who encounter women and/or girls who have undergone the practice. The manual is designed particularly for use by non-specialist clinicians, including:

- Nurses / midwives
- Clinical officers
- District medical officers and other general practitioners working in isolation
- Postgraduate medical officers (registrars)
- Medical students.

It should also be a valuable resource for medical and other health service providers at primary, secondary and tertiary levels, particularly those working in areas with high prevalence of FGM/C.

The manual can be used as a reference material for trainers of nurses and midwives during basic, post-basic or in-service training, and may also be of use in the education and training of medical students, clinical officers, public health officers, and other health care providers. The manual is intended also for those carrying out continuing medical education programmes for health service providers.

The interventions described in this manual are based on the latest available scientific evidence. It will be updated as new information becomes available but, since the evidence base for effective clinical practice is constantly evolving, readers are encouraged to consult up-to-date sources of information as they emerge.

Besides equipping health care providers with knowledge to manage complications associated with FGM/C, the manual also aims to empower them to resist requests to perform FGM/C, and to be advocates against the practice in their communities. The professional associations of various cadres of health providers can also use the manual for developing policy statements to prevent their members from performing FGM/C, and to discourage their clients and communities from sustaining the practice.

The manual consists of ten sections:

Section 1:

Introduces the practice in Kenya by defining and describing various types, its prevalence in Africa and among different communities in Kenya, reasons for the practice, and how different people are involved in undertaking the practice.

Section 2:

Reviews various complications associated with the practice of FGM/C.

Sections 3-5:

Educates health care providers in identifying complications associated with FGM/C, and in managing girls and women who present with such complications.

Section 6:

Prepares midwives and others caring for women during pregnancy, labour, delivery and the postpartum period with skills in counselling, opening up of women with infibulation, and management of other obstetric complications due to FGM/C.

Sections 7-9:

Discusses the role of health care workers in communicating with practicing communities and preparing them for behaviour change, through empowering health workers with knowledge so that they can resist requests for FGM/C, including re-infibulation after delivery. Describes the law forbidding the practice and gives policy statements discouraging the practice in Kenya, and discusses how FGM/C contravenes the reproductive and other basic rights of women and girls.

Section 10:

Provides examples of international policy statements and agreements relevant to abandonment of FGM/C.

Objectives of this manual

1. To define and classify FGM/C.
2. To describe why different communities practice FGM/C.
3. To describe the short- and long-term physical complications of FGM/C.
4. To describe the psychosocial and sexual complications of FGM/C.
5. To provide health workers with knowledge and skills in managing complications associated with FGM/C.
6. To describe the ethical implications of FGM/C.
7. To describe the laws and decrees against FGM/C and the legal implications.

Expected outcomes of training using this manual

Knowledge

By the end of the training, participants will be able to:

1. Describe the different types of FGM/C and the complications of the practice.
2. Describe problems associated with FGM/C during pregnancy, labour, delivery, and postpartum.
3. Explain the management of women with Type I, II, and IV FGM/C during pregnancy, labour, delivery and postpartum.
4. State the indications for opening up Type III FGM/C.
5. Discuss the procedure of opening up Type III FGM/C.
6. Describe the post-operative care of an opened Type III FGM/C.
7. Discuss the relevant rights of women and girls in different communities and how FGM/C violates these rights.
8. Discuss the legal instruments and declarations relevant to the abandonment of FGM/C.
9. Describe the role of professional and regulatory bodies in the abandonment of FGM/C.

Skills

By the end of the training, participants will be able to:

1. Manage the complications of FGM/C.
2. Manage the complications of FGM/C during pregnancy, labour and delivery.
3. Advocate for the rights of women and girls in different communities.
4. Involve professional and regulatory bodies in FGM/C abandonment.

SECTION 1: INTRODUCTION TO FGM/C

Definition and typology of FGM/C

What is FGM/C?

Female Genital Mutilation / Cutting (FGM/C) encompasses “all procedures involving 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.”¹ It is estimated that 100 – 140 million girls and women have experienced FGM/C, and that at least three million girls undergo some form of the procedure every year. Most of these girls and women live in 28 African countries, although some live in Asian countries. They are also found increasingly among immigrant population groups in more developed countries. Because of its devastating effects on female health and sexuality, and the specific complications it causes during pregnancy, childbirth and the postpartum period, management of the complications of FGM/C should be integrated into existing reproductive health services.

There is growing evidence that nurses and midwives are ill prepared to deal with prevention and management of FGM/C, because it has not been included as a specific topic in nursing and midwifery curricula in many countries where FGM/C is practised, including Kenya. However, nurses and midwives are well placed to handle the health consequences, and a relatively modest investment in basic undergraduate and post-graduate training could reduce the misery suffered by those who have undergone the practice and those who are at risk.

Deciphering the Terms: Circumcision, Mutilation, or Cutting?

The terminology applied to this procedure has undergone a number of important evolutions. When the practice first came to be known beyond the societies in which it was traditionally carried out, it was generally referred to as “female circumcision”. This term, however, draws a direct parallel with male circumcision and, as a result, creates confusion between these two distinct practices. In the case of girls and women, the phenomenon is a manifestation of deep-rooted gender inequality that assigns them an inferior position in society and has profound physical and social consequences. This is not the case for male circumcision, which may help to prevent the transmission of HIV/AIDS. The expression “female genital mutilation” (FGM) gained growing support in the late 1970s.

The word “mutilation” not only establishes a clear linguistic distinction with male circumcision, but also, due to its strong negative connotations, emphasizes the gravity of the act. In 1990, this term was adopted at the third conference of the Inter African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) in Addis Ababa. In 1991, WHO recommended that the United Nations adopt this terminology and subsequently, it has been widely used in UN documents. The use of the word “mutilation” reinforces the idea that this practice is a violation of girls’ and women’s human rights, and thereby helps promote national and international advocacy towards its abandonment. At the community level, however, the term can be problematic.

Local languages generally use the less judgmental “cutting” to describe the practice; parents understandably resent the suggestion that they are “mutilating” their daughters. In this spirit, in 1999, the UN Special Rapporteur on Traditional Practices called for tact and patience regarding activities in this area and drew attention to the risk of “demonizing” certain cultures, religions and communities. As a result, the term “cutting” has increasingly come to be used to avoid alienating communities. To capture the significance of the term “mutilation” at the policy level and, at the same time, in recognition of the importance of employing nonjudgmental terminology with practicing communities, the expression “female genital mutilation/cutting” (FGM/C) is used throughout this manual.

Source: Changing a Harmful Social Convention: Female Genital Mutilation/Cutting, UNICEF, 2006.

¹ WHO. 1997. *Female Genital Mutilation: A Joint WHO/UNICEF/UNFPA Consultation*, Geneva: WHO.

Though much has been achieved over the past two decades in lifting the veil of secrecy surrounding FGM/C, there is still an enormous amount to be done to provide quality services to those affected, and to prevent other girls and women from adding to their numbers. It is hoped that bringing FGM/C into mainstream education for health professionals will increase the pressure for abandonment of the practice, while at the same time throwing a lifeline to those who have felt isolated with their problems for so long.

Types and terms

FGM/C is a deeply rooted traditional practice, but has been condemned in Kenya and globally as a form of violence and discrimination against girls and women. It can also have serious physical, psychological and sexual consequences that adversely affect their health, at the time of the procedure as well as throughout their life. All four types, as categorized by WHO², are practised in Kenya:

- Type I - Removal of the prepuce, with or without cutting out of part of or the entire clitoris. Healing after the procedure can often be so complete that someone untrained in FGM/C can miss this type of cutting.
- Type II - Removal of the entire clitoris, with partial or total cutting of the labia minora. This is the most common form of FGM/C. Although no stitching takes place, deep cutting of the labia minora may result in raw surfaces that fuse together during healing, creating a false infibulation. In some places, such fusion is accidental, while elsewhere it is deliberate.
- Type III - Removal of the clitoris, the labia minora and the labia majora, followed by infibulation, that is, the stitching together of the raw surfaces to create a small opening to ensure passage of urine and menstrual blood. In a few cases, infibulation has been done over an intact clitoris, and so care needs to be taken when opening up an infibulated woman.
- Type IV - Includes pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterisation by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice or cutting of the vagina; introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purposes of tightening or narrowing it; and any other procedure that falls under the definition of FGM/C given above.

WHO FGM typology modified 2007

Type I: Partial or total excision of the clitoris and the prepuce (clitoridectomy).

Type II: Partial or total excision of the clitoris and the labia minora, with or without excision of the labia majora (excision)¹.

Type III: Narrowing of the vaginal orifice by creating a covering seal through the cutting and apposition of the labia minora and/or labia majora, with or without excision of the clitoris (infibulation).¹

OR: Excision as in Type II, but with apposition of the cut ends, resulting in narrowing the vaginal introitus.

Type IV: Unclassified: All other procedures that fall under the definition of FGM, e.g. pricking, piercing, incision, stretching, cauterization, scraping and cutting into the external genital organs or introduction of harmful substances into the vagina.

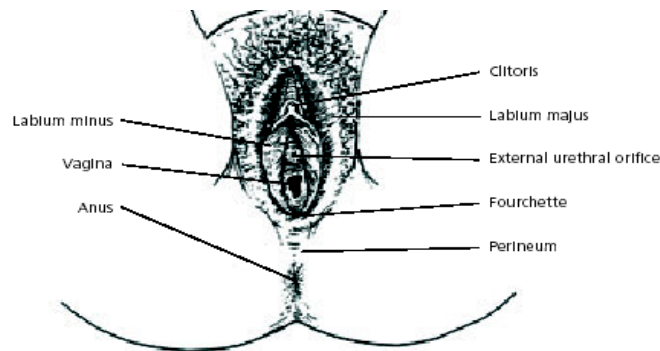
² This classification is currently under review at WHO and a revised version is anticipated in late 2007. It is expected that the four broad categories will remain but with modifications to reflect a greater understanding of the variety of types of FGM/C practiced.

The term **clitoridectomy** is an anatomical description, which refers to the removal of the clitoris (i.e. type I or II). The term **sunna** is sometimes used by Islamic cultures, with the intention to describe Type I cutting. However, this term is also used in Islam to cover a range of religious values and requirements more generally and although some communities may perceive FGM/C to be a religious obligation this is not the case, because mainstream teaching of sunna has neither commanded, prohibited nor recommended this practice. The use of this term should therefore be avoided because it has the potential to reinforce feelings of religious obligation, which are unfounded. Further, the term can be used to describe a wide range of procedures.

The term **excision** is used, and especially in West Africa, to denote cutting of the clitoris, together with all or parts of the labia minora (i.e. type II).

The term **infibulation** describes removal of the external genitalia and sewing up or gluing together the sexual opening (i.e. type III). The term **Pharaonic** is used by some Islamic cultures to describe the practice of infibulation. According to Sudanese history, the practice originated in Egypt at the time of the Pharaohs. However, in Egypt the term **Sudanic** is used for the same procedure, but infibulation is not practised in Egypt.

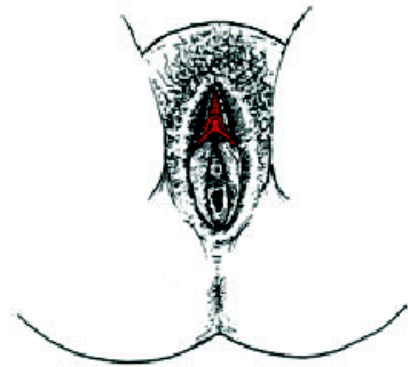
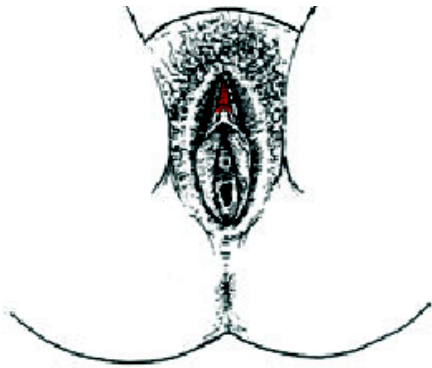
Structure and Function of Normal Female Genitalia



Source: WHO/RHR/01.16)

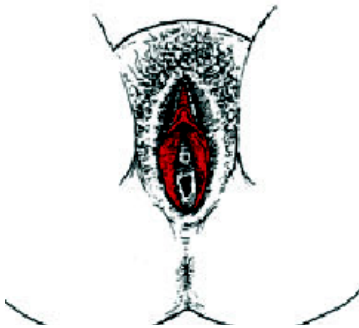
Structure	Function
Vagina	Allows escape of the menstrual flow, sexual intercourse and delivery of the baby
External urethral orifice	Allows emptying of the bladder within a few minutes
Clitoris	Assists women to achieve sexual satisfaction
Perineum	Supports the pelvic organs and separates vagina from anus
Labia minus (minora)	Protects structures and orifices
Labia majus (majora)	Protects the inner structures and orifices
Fourchette	The base of the vaginal opening

TYPE I (with or without removal of entire clitoris)



TYPE II

Removed entire clitoris, partial or total cutting of labia inora



(Source: WHO/FCH/GWHO/01.3WHO/RHR/01.16)

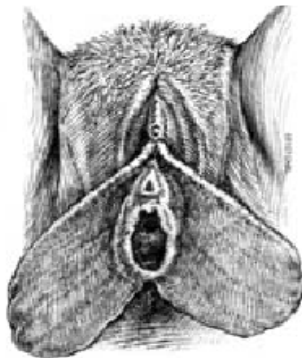
TYPE III

Removed clitoris, labia minora, labia majora and stitching together of raw surfaces (infibulations)



(Source: CNLPE, BURKINA FASO)

TYPE IV: PULLED LABIA MINORA



(Source: WHO/RHR/01.16)

FGM/C in Kenya

In Kenya, the type of procedure, the age at which it is performed, its prevalence in the community, and the factors that support its continuation vary widely across communities that practise FGM/C. FGM/C is practiced in over half of the districts of Kenya and by followers of several religions including Christians, Muslims, and Animists.

Thirty-two per cent of all women aged 15-49 years surveyed in the 2003 Kenya Demographic and Health Survey (KDHS) reported having undergone FGM/C – this marks a slight decline from 38% recorded in the 1998 KDHS. The practice appears to be declining substantially among the younger generation, however, with nearly one-half of women aged 35 years and over being cut, but only 26 percent of those age 15-19 years. This decrease among the younger age group is particularly pronounced among the Kalenjin (62% to 49%), Kikuyu (43% to 33%) and Kamba (33% to 27%).

Ethnic groups throughout the country practise FGM/C to varying degrees and for differing reasons. FGM/C is nearly universal among the Somali, Abagusii, and Maasai, but is not practised at all among the Luo and the Luhya.

Different ethnic groups also practice different types of FGM/C. While types I and II are the predominant types throughout the country, the Somali, Borana, Rendille, and Samburu practise the more severe form of type III, including infibulation. Among the Abagusii, there is evidence of a trend away from types I or II towards nicking the skin around the clitoris to draw blood without wounding the flesh (type IV)³.

Ethnic group	% of women circumcised
Somali	97
Abagusii	96
Maasai	94
Taita Taveta	62
Kalenjin	49
Embu	43
Meru	41
Kikuyu	33
Kamba	27
Other	21
Mijikenda/Swahili	5

The age at which it is performed varies greatly also, depending on the ethnic group, geographical location and rationale for the practice. For example, among the Somali and Abagusii it is undertaken pre-puberty, between 4 and 10 years; among the Meru, Embu, Kalenjin and Kikuyu it is an integral component of the rite of passage to adulthood and so is undertaken during puberty (between 11- 14 years); and because of its association with marriage, is usually undertaken prior to marriage (i.e. between ages 14 – 17 years) by the Masaai and Samburu. For some cultures, if an uncircumcised woman marries into an ethnic group that practices FGM/C, she is at risk of undergoing FGM/C upon being married or during her first pregnancy or labour.

³ Njue C. and I. Askew. 2004. *Medicalization of Female Genital Cutting Among the Abagusii in Nyanza Province, Kenya*, Nairobi, Kenya: FRONTIERS program, Population Council.

Reasons for performing FGM/C

How and why the practice began is not at all clear. It appears to have originated over 2,000 years ago in Central Africa and spread north along the Nile into Egypt. It was not until Arab Muslim armies conquered Egypt in the eighth century, however, that the practice spread systematically into sub-Saharan Africa and beyond⁴, parallel with the spread of Islam.⁵

Most Kenyan cultures that practise FGM/C are patriarchal and largely patrilineal, and so women's access to land and other resources is often only possible through marriage. Consequently, if women are considered suitable for marriage only if they have undergone FGM/C, there is a strong pressure on the girl, her family and their community, to sustain the practice. The reasons for requiring a girl to undergo FGM/C, and therefore be suitable and ready for marriage, vary between cultures.

The Kikuyu, for example, practise FGM/C with the belief that it enhances fertility, and so historically Kikuyu men have been unwilling to marry uncircumcised women as there is the fear that they may not be able to bear children⁶.

The Digo, the Masaai and Swahili also believe that FGM/C improves fertility, as well as preventing maternal and infant mortality. They also believe that practising infibulation will enhance the husband's sexual pleasure because of narrowing the vaginal opening, and for this reason the practice may be repeated after each delivery.

Among the Abagusii, FGM/C is regarded as necessary for a girl to be initiated into adulthood and therefore be eligible for marriage⁷, as well as giving the girl a cultural identity to distinguish her from the surrounding non-circumcising communities.

For the Meru, FGM/C provides an external sign of sexual maturity and therefore readiness for sexual relations and childbearing within marriage, and so it is often undertaken before first menstruation. Uncircumcised women are generally considered unclean and promiscuous because they are not able to marry⁸.

⁴ The practice reached as far as Pakistan and Indonesia, including some places on the Arabian Peninsula, and in the Buraimi Oasis in the United Arab Emirates.

⁵ Brooks, G. *Nine Parts of Desire*, London, Penguin. 1995.

⁶ Kenyatta, J. 1965. *Facing Mount Kenya*, New York, Vintage Books. 1965; Thiong'o, Ngugi. 1983. *The River Between*, Heinemann.

⁷ El Sayeed. 1982. "Reasons For and Purpose of Female Circumcision", *WHO EMRO Technical Publication No.2 Vol 2* Alexandria, Egypt; Njue C. and I. Askew. 2004. *Op cit*; Meschig R. et al. (1983). "Clitoridectomy and Excision of the Labia Minora Among the Kisii in West Kenya", *Die Medizinische Welt* 13:34(19): 579-83.

⁸ Meschig R. et al. 1983 *op cit*; Mburu R. 1992. *The knowledge, attitude and practice of FC among high school girls studying in Meru*, Mmed dissertation, University of Nairobi.

The Samburu also believe that unless a girl's clitoris is removed, she cannot become a mature woman or even be considered an adult human being⁹, and so she would have no right to associate with others of her age group, or her ancestors.

Among the Somalis living in Kenya, FGM/C is believed to ensure a girl's virginity prior to marriage, and marriage is essential to maintain her family's honour as well as the family lineage. The Somali and Boran believe that uncut girls and women have an overactive and uncontrollable sex drive that increases their likelihood of having sex before and outside of marriage. It is also believed that narrowing the vaginal opening enhances male sexual pleasure, thus reducing divorce or unfaithfulness. These communities believe also that a woman's natural external genitalia are ugly and unhygienic, and that they will continue to grow if they are not cut away. Removing the external genitalia is believed to enhance hygiene and make a female spiritually clean¹⁰.

Who cuts the girls?

In most Kenyan cultures, traditional practitioners perform the procedure; these are usually older women in the community who specialise in this task, and often include traditional birth attendants. There is growing evidence, however, that medical practitioners and other health staff in Kenya are increasingly engaging in FGM/C:

- In the 1998 KDHS, one-third of all circumcised women reported having been cut by a health worker; this proportion reached one half of all circumcised Abagusii women.
- Recent studies among the Abagusii¹¹ found that medical staff have increasingly become involved in the practice. Whereas 94% of circumcised older women reported having been cut by a traditional practitioner, 71% of girls aged 4 – 17 years reported having been cut by a nurse or other health staff. Moreover, 37% of the girls reported having been circumcised at a health facility. Wanting to make the procedure safer and financial gain by the medical staff seem to be the driving forces behind this rapid medicalization of the practice.
- A study¹² among health workers who serve the Somali community found that three of the 18 interviewed in North Eastern Province and 15 of 26 in Nairobi reported having been approached to perform FGM/C.

⁹ Jaldesa G. *Reasons for the practice and health problems associated with female genital mutilation (FGM): Evidence from four communities in northern Kenya*, Action Aid, (Unpublished Report). 2002

¹⁰ Jaldesa, G., I. Askew, C. Njue, and M. Wanjiru. 2004. *Management of FGC and its complication among the Somalis*. Nairobi, Kenya: FRONTIERS program, Population Council.

¹¹ Chege, J., I. Askew, and J. Liku. 2001. *An Assessment of the Alternative Rites Approach for Encouraging Abandonment of Female Genital Mutilation in Kenya*, Nairobi, Kenya, FRONTIERS program, Population Council; Njue C. and I. Askew *op cit.*; Christoffersen-Deb, A. 2006. "Taming Tradition': Medicalized Female Genital Practices in Western Kenya", *Medical Anthropology Quarterly*, 19(4): 402-18.

¹² Jaldesa, G *et al, op cit.*

- Recent studies by GTZ¹³ indicate that the proportions reporting being cut by health workers are still relatively low among those living in Kuria (10%), Kajiado (10%), Meru North (3%), and Tharaka (2%). However, many traditional birth attendants reported using medical supplies (surgical scalpels, antiseptic and gloves) procured from local pharmacies when cutting girls.

Medical staff working among the Somali community appear also to be involved in the practice of re-infibulating women after delivery¹⁴; many nurses and midwives reported that, following delivery, they were sometimes requested by the woman to re-stitch her vulva so as to re-create the reduced opening. Of 57 antenatal clients interviewed, 35 reported being re-infibulated following a previous pregnancy, 26 by a nurse or midwife and seven by a TBA (the other two did not specify who did it).

¹³ GTZ. *Female Genital Mutilation in Kuria District: Baseline Survey Report*. Nairobi, Kenya, GTZ/MOH Anti-FGM Project (Unpublished Report), 2005.

¹⁴ Jaldesa, G *et al*, *op cit*.

SECTION 2: FGM/C AND ITS COMPLICATIONS

Immediate physical complications due to the procedure

Most short-term complications occur because of unsanitary conditions during the cutting or lack of access to adequate medical services once a complication occurs. The amount of tissue removed and the resulting injury varies from community to community, and is influenced by the skills of the person doing the cutting as well the amount the child struggles. Although rates of mortality immediately following FGM/C are poorly documented, morbidity from haemorrhage, sepsis and shock appear to be considerable.

It is not known whether FGM/C procedures (especially where several children undergo FGM/C at the same time with the same cutting instrument) contribute significantly to the spread of HIV and hepatitis.

Some of the immediate complications can include:

- Injury to the adjacent tissue of urethra, vagina, perineum and rectum.
- Fracture or dislocation resulting from forceful holding down of girls and the girls struggle due to the resultant pain.
- Failure to heal as a result of wound sepsis.

Long-term physical complications

A study among women attending clinics for reproductive health services in Mali and Burkina Faso, who had undergone different types of FGM/C, found that five percent of women in Mali and 14 percent in Burkina Faso had an observable physical complication that could be associated with FGM/C¹⁵. The most frequent complications were keloids, and vaginal narrowing due to scarring. The likelihood of reporting experiencing difficulty during sex and at delivery increased with the severity of cutting. Conversely, a community-based study in the Gambia¹⁶ found that physical complications, such as damage to the perineum or anus, vulval tumours, and keloids, as well as painful sex, infertility, and prolapse, were no more common in women with type I or II FGM/C than in uncut women.

As well as creating a physical barrier, type III is associated with the development of epidermal cysts (implantation dermoids). These may reach a large size and may become infected and painful as a result of internal haemorrhage. They require removal if they become symptomatic, but the dissection can be tedious and difficult and should only be attempted in a hospital. During pregnancy, these cysts are best left alone, as attempted

¹⁵ Jones, H. *et al.* 1999. "Female Genital Cutting Practices in Burkina Faso and Mali and Their Negative Health Outcomes", *Studies in Family Planning*, 30 (3): 219-30.

¹⁶ Morison, L. *et al.* 2001. "The long-term reproductive health consequences of female genital cutting in rural Gambia: A community-based survey," *Tropical Medicine and International Health*, 6(7): 1-11.

removal may provoke considerable haemorrhage. If acute problems develop (e.g., abscess formation) simple remedies such as incision, with or without marsupialization (suturing so that the incision remains open) can be used.

Gynaecological complications

Reproductive tract infections: The community-based study in the Gambia¹⁷ found that women with type I or II cutting were significantly more likely to have reproductive tract infections such as bacterial vaginosis and herpes simplex virus 2, probably due to damage to tissues in the genital area.

Infertility: It is unclear whether FGM/C contributes to infertility. A review of national DHS surveys in the Central African Republic, Côte d'Ivoire and Tanzania found that women with type I or II cuts were no more likely to be infertile than uncut women¹⁸, as did a community-based survey in The Gambia¹⁹. A study in the Sudan found that women with more severe forms of cutting, i.e. with the labia majora cut rather than the minora, were much more likely to suffer primary infertility²⁰; however, infibulation in itself did not increase the likelihood of infertility.

Other gynaecological complications: The following complications may be more likely in women with FGM/C than in those without, and so should be carefully considered during consultations with women who have undergone FGM/C:

- Difficulty in passing urine as a result of partial blockage of urinary opening.
- Difficulties in menstrual flow.
- Recurrent urinary infections.
- Keloid scarring.
- Cysts and abscesses on the vulva.
- Clitoral neuroma.
- Calculus formation in the vagina.
- Vesico-vaginal fistula (VVF), recto-vaginal fistula (RVF).

Obstetric complications associated with FGM/C

Type III infibulation causes a direct mechanical barrier to delivery. However, types I, II and IV can also produce vulval and vaginal scarring and keloids that can act as an obstruction to delivery. Infection and inflammation during cutting may lead to vulval

¹⁷ Morison, L., *et al. op cit.*

¹⁸ Larsen, U. and S. Yan. 2000. "Does female circumcision affect infertility and fertility? A study of the Central African Republic, Cote D'Ivoire, and Tanzania", *Demography* 37(3): 313-321.

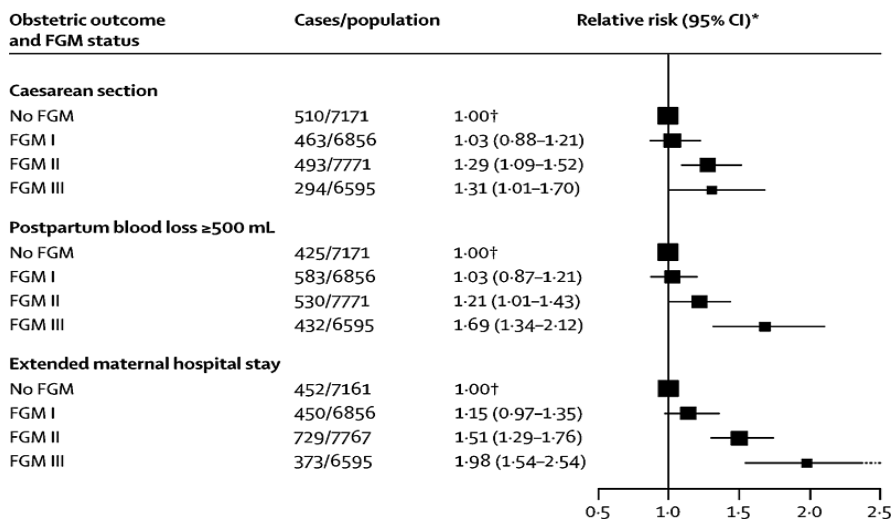
¹⁹ Morison, L. *et al, op cit.*

²⁰ Almroth, L. 2005. *et al.* "Primary infertility after genital mutilation in girlhood in Sudan: A case-control study," *The Lancet*, 366: 365-91.

adhesions, which effectively narrow or completely obliterate the vaginal opening. Some affected women may never become pregnant, and those that do may experience prolonged or obstructed labour, which can in turn lead to a fistula.

A recent six-country study (including Kenya) published by WHO²¹ in *The Lancet* has shown that women who have had FGM/C are significantly more likely to experience difficulties during childbirth, and that the likelihood of complications increases by the extent and severity of the FGM/C (see Figure 1).

Figure 1: Relative risk of adverse obstetric outcomes in women with type I, II, or III compared with women without FGM/C



Antenatal complications and complications in early labour: The reduced vaginal opening affects not only delivery, but appears to be the main factor responsible for other obstetric problems in women with FGM/C. Women with type III have, on average, 30 per cent more caesarean sections compared with those without FGM/C. FGM/C can also makes antenatal assessment, intrapartum vaginal examination or catheterisation difficult or even impossible, which may compromise the mother and foetus.

Prolonged labour and/or obstruction: Soft tissue obstructions (dystocia) can be caused by FGM/C, many of which could be easily overcome by episiotomies. Delayed labour during the second stage, a stage that cannot be easily timed unless there is obvious delay, seems to depend on the quality of obstetric care rather than the FGM/C itself. A study in Saudi Arabia that compared circumcised Sudanese immigrants with uncut Saudi women found significantly higher levels of prolonged second stage among the infibulated Sudanese

²¹ WHO study group on female genital mutilation and obstetric outcome. 2006. "Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries", *The Lancet* 367:1835-1841.

women,²² whereas a study in Sweden comparing Ethiopian and Somali immigrants with ethnic Swedes showed no difference.²³

Episiotomies and perineal tears: These are by far the commonest complications reported, with the WHO study showing that women with FGM/C suffer more perineal injury during delivery than those without FGM/C. Among primiparous women, the proportion having episiotomies ranged from 41% in women without FGM to 88% in those with FGM III; among multiparous women the proportions were 14% and 61% respectively.

Pain during and after de-infibulation (anterior episiotomy): Any extra perineal cuts necessitated by having to open a woman up can lead to further pain at the time when they are performed, as well as after delivery.



Patient with type III in prolonged labour as a result of tough scar formation on the vulva



Patient with normal external genitalia that is elastic and opens easily compared to fibrotic scar tissue in the opposite picture on the left

Postpartum haemorrhage: The WHO study found a 70 per cent increase in the proportion of women who suffer from postpartum haemorrhage among those with type III compared to women without FGM/C.

²² De Silva, S. 1989. "Obstetric sequelae of female circumcision", *European Journal of Obstetrics & Gynecology and Reproductive Biology*, 32: 233-240

²³ Essen, B. *et al.* 2005. "No association between female circumcision and prolonged labour: A case control study of immigrant women giving birth in Sweden" *European Journal of Obstetrics & Gynecology and Reproductive Biology*, 121: 182-185

Postnatal genital wound infection: Rates of infection are higher among women FGM/C Type III compared to wound from type. In a systematic literature review WHO identified seven studies where postnatal genital wound infection was found as a complication of FGM. Shandall, 1967, showed that the rates of infection are higher with the wound from FGM Type III compared to the wound from FGM Type I. It was noted that FGM was a contributory factor to puerperal infection.²⁴

Maternal death postpartum: According to the WHO study, the relative risk of maternal inpatient death was 1.59 – 5.80 times greater (but not statistically significant) for women with FGM/C compared with women without. Maternal deaths attributable to FGM/C are usually due to unattended or inappropriately treated obstructed labour caused by the vulval scarring from FGM/C.

Maternal hospital stay: According to the WHO study women with FGM were more likely than those without to have an extended hospital stay. For women with vaginal deliveries, the RRs of staying in hospital for longer than 3 days were 1.19 (1.01–1.41) for FGM I, 1.55 (1.31–1.83) for FGM II, and 2.34 (1.59–3.45), for FGM III compared with those without FGM; this pattern of risk was similar in nulliparous and parous women.

Potential Complications with the foetus or baby

Determining whether or not FGMC/ increases the likelihood of complications for the foetus or baby has been difficult. Studies among migrant populations of women with FGM/C first gave some indications that childbirth and infant survival may be complicated by FGM/C. A study in Norway found that perinatal complications (e.g., foetal distress, low Apgar scores and pre-labour deaths) were two to three times more frequent among Somali migrant women who had been infibulated than among ethnic Norwegians.²⁵ A study in Saudi Arabia, comparing Arabian women with infibulated Sudanese immigrants, also found significantly higher levels of neonatal distress.²⁶ A third study, of perinatal deaths among immigrants from Ethiopia, Eritrea, and Somalia in Sweden,²⁷ concluded that none of deaths were directly due to the woman having undergone FGM/C, but were caused by malformations, poor health-seeking behaviours, or sub-optimal care, a finding supported by research among Somali women in Norway.²⁸

²⁴ WHO. A systematic review of the health complications of female genital mutilation including sequelae in childbirth 2001

²⁵ Vangen S., C. Stoltenberg, R. Johansen, J. Sundby, and B. Stray-Pedersen. 2002. "Perinatal complication among ethnic Somalis in Norway," *Acta Obstetrica et Gynecologica Scandinavica*, 81:317-22.

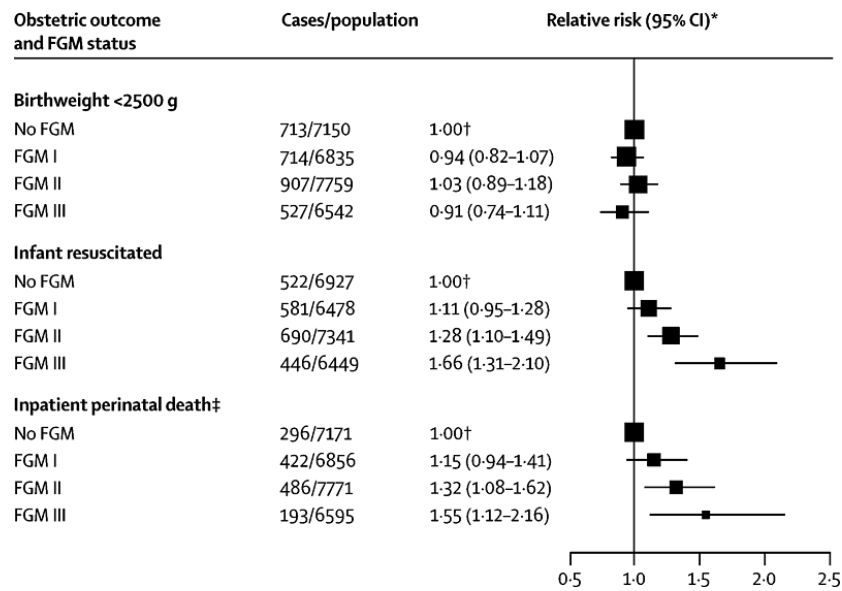
²⁶ De Silva, S. *op cit*.

²⁷ Essén, B., B. Bødker, N. Sjöberg, S. Gudmundsson, P. Östegen, and J. Langhoff-Roos. 2002. "Is there an association between female circumcision and perinatal death?" *Bulletin of the World Health Organization*, 80: 629-632.

²⁸ Vangen, S., R. Johansen, J. Sundby, B. Træen, and B. Stray-Pedersen. 2004. "Qualitative study of perinatal experiences among Somali women and local healthcare professionals in Norway," *European Journal of Obstetrics & Gynecology and Reproductive Biology*, 112: 29-35.

The WHO study on obstetric outcomes (see Figure 2 below) concluded that FGM/C does not put women's babies in substantial danger during childbirth. There was an increased need to resuscitate babies whose mother had FGM/C (66% higher in women with FGM III), and the death rate among babies during and immediately after birth was much higher for those born to mothers with FGM/C: 15% higher for those with type I, 32% higher for those with type II, and 55% higher in those with type III. WHO estimates that, in the African context, an additional 11 to 17 babies per 1,000 deliveries die as a result of the practice. FGM/C does not, however, appear to have any influence on low birth weight deliveries.

Figure 2: Relative risk of adverse infant outcomes in women with type I, II, or III compared with women without FGM/C



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FGM/C and HIV

To date, no scientific study has been undertaken to determine whether or not FGM/C is associated with an increased risk of acquiring HIV. Given the nature of the procedure and its effect on genital tissues, it is thought that FGM/C may increase the risk of HIV acquisition through two mechanisms:

- At the time of the procedure from a contaminated instrument, especially if FGM/C is practised on groups of girls;
- During sexual activity due to disruption of the epithelial surfaces in the genital area. The study in the Gambia²⁹ found increased likelihood of HSV2 in women with FGM/C, which may indicate an increased susceptibility for HIV too.
- It has been said that anal intercourse is more frequent in type III practising societies and other virginity cultures, as a way to have sex without breaking their virginity (hymen/infubilation). Anal sex is may also be practised in marriage if vaginal penetration is difficult. This might predispose to HIV infection.

Psychosocial Consequences

For some girls, FGM/C 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.³⁰ For example, a study in Senegal found that circumcised women were significantly more likely than uncut women to have symptoms of Posttraumatic Stress Disorder, other psychiatric syndromes and memory problems.³¹ FGM/C is commonly performed when girls are young and uninformed, and is often preceded by acts of deception, intimidation, and coercion by parents, relatives and friends that the girl has trusted.

Some girls and women are ready to express the inhibition and fear that have become part of their lives as a result of enduring FGM/C. 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.

Symptoms of psychological stress, due to any factor, include sleeplessness, nightmares, loss of appetite, weight loss or excessive weight gain, as well as panic attacks, instability of

²⁹ Morison, L., *et al. op cit*

³⁰ D.A. Kokonya. “Female Genital Cutting/Mutilation (FGM/C) Baseline Survey Report for Garissa District, Kenya”, UNICEF, (Unpublished Report) 2004.

³¹ Behrendt A. and S. Moritz. “Posttraumatic Stress Disorder and Memory Problems after Female Genital Mutilation”, *American Journal of Psychiatry*, 162:5, 1000-1002. 2005.

mood, and difficulties in concentration and learning. Medical practitioners should, therefore, be vigilant for these symptoms among girls and young women who have undergone FGM/C, especially shortly after the procedure. As they grow older, women may develop feelings of incompleteness, loss of self-esteem, depression, chronic anxiety, phobias, panic or even psychotic disorders, and so for women displaying these symptoms the possible association with FGM/C should be explored.

Sexual complications of FGM/C

Some women have reported that they sometimes suffer pain during sexual intercourse and menstruation that is almost as bad as the initial experience of genital mutilation.³² Reliable data are required on the impact of FGM/C on sexual activity in order to guide the management of painful scars and intercourse. Cultural attitudes to sex vary widely and in many communities where FGM/C is a traditional practice, women are reluctant to discuss sexual matters with health personnel and are shy to complain of painful intercourse or inability to consummate marriage. Health workers should take the time to find out if women are experiencing any such complications.

There is an intuitive expectation that genital cutting adversely affects a woman's sexuality, in terms of desire and sensation. Indeed, for many cultures, FGC is practised largely because of the belief that it is a mechanism for reducing a woman's sexual feelings. There is very little scientific evidence that addresses this issue, however, and especially research that compares cut with uncut women.

Women who have been cut do experience sexual desires and feelings, although the physical mechanisms for sexual stimulation may be different than for women with an intact clitoris and labia.³³ The extent to which this affects desire and pleasure is unclear. For example, a study in Nigeria comparing women with type I and II with uncut women found no significant differences in frequency of intercourse, in arousal, or in experiencing orgasm.³⁴ For infibulated women, however, there is greater tissue removal and a reduced vaginal opening that makes penetration difficult and painful. Interviews with infibulated women and with men in Sudan indicate ways in which couples adapt their sexual behaviours to allow for this,³⁵ but these and other studies³⁶ give conflicting findings as to whether desire and satisfaction are diminished or not.

³² Njoroge, G. *Female circumcision among women attending antenatal and gynaecology out patient clinics at Chogoria hospital in Tharaka-Nithi district of Kenya*. M. Med dissertation, University of Nairobi, 1996

³³ See presentations made at the International Research Seminar on "Advancing Knowledge on Psycho-Sexual Effects of FGCM/C: Assessing the Evidence" Organized by the International Network to Analyze, Communicate and Transform the Campaign Against FGM/C (INTACT) in Alexandria, Egypt, October 10-12, 2004. Website: <http://www.intact-network.net/main2/document/articles/abstracts.htm>.

³⁴ Okonofua, F., U. Larsen, F. Oronsaye, R. Snow, and T. Slanger. 2002. "The association between female genital cutting and correlates of sexual and gynaecological morbidity in Edo State, Nigeria," *British Journal of Obstetrics and Gynaecology*, 109(10): 1089-96.

³⁵ Lightfoot-Klein H. 1989. "The sexual experience and marital adjustment of genitally circumcised and infibulated females in the Sudan," *Journal of Sex Research*, 26(3): 375-392; Almroth L., V. Almroth-Berffren, O. Hassanein, S.

Women who have undergone FGM/C may experience various forms and degrees of sexual dysfunction.³⁷ They may suffer painful sexual intercourse (dyspareunia) because of scarring, narrowing of the vaginal opening, obstruction of the vagina due to elongation of labia minora and complications such as infection. With the severe forms, vaginal penetration may be difficult or even impossible without tearing or re-cutting the scar.

Vaginismus is classified as a sexual dysfunction in the subcategory of sexual pain disorders and results from injury to the vulval area and repeated vigorous sexual acts. The main diagnostic criterion is the presence of a recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with intercourse; the muscle spasm is described as readily observable and in some cases, as 'so severe or prolonged as to cause pain. Vaginismus may be associated with psychological trauma during the FGM/C procedure itself or from fear of sexual penetration. Finger dilatation along with topical application of lignocaine gel may facilitate muscle relaxation.

Complications associated with FGM/C which affect men

A study in the Sudan³⁸ found that some men who are married to infibulated women have reported complications following intercourse with an infibulated woman, including skin wounds, bleeding or inflammation of the penis, difficulties with penetration and the associated psychological problems. They also report economic problems due to the cost of seeking medical care, and decreased sexual desire and enjoyment by the woman, which can also affect sexual satisfaction for the man. Failure by the man to penetrate the vagina could lead the woman or her family to demand a divorce, and to social stigma because of his apparent inability to consummate the marriage. Medical practitioners should therefore also seek to engage with the male partner of a woman reporting sexual problems associated with FGM/C.

Al-Said, S. Hasan, U-B. Lithell, and S. Bergstrom. 2001. "Male Complications of Female Genital Mutilation," *Social Sciences and Medicine*, 53: 1455-1460; Gruenbaum, E. 2004. "Sexual response and Sudanese conceptions of the infibulated and uninfibulated vulva: research in Sudan, 2004," Paper presented at the Seminar on *Advancing Knowledge on Psycho-Sexual Effects of FGCM/C: Assessing the Evidence*. Cairo: INTACT.

³⁶ El-Defrawi M., G. Lofty, K. Dandash, A. Refaat, and M. Eyada. 2001. "Female Genital Mutilation and its Psychosexual Impact," *Journal of Sexual Marital Therapy*, 27(2): 465-473.

³⁷ Abdalla, R. *Sisters in Affliction: Circumcision and Infibulation of Women in Africa*. Zed Press, London, 1982

³⁸ Almroth L. *et al.* 2001. "Male complications of female genital mutilation", *Social Science and Medicine*, 53: 1455-1460.

SECTION 3: MANAGING IMMEDIATE AND SHORT-TERM COMPLICATIONS OF FGM/C

Bleeding

Haemorrhage is the most common and life-threatening immediate complication of FGM/C. Excision of the clitoris involves cutting the clitoral artery in which blood flows under high pressure. Cutting of the labia also causes damage to the blood vessels. Bleeding usually occurs during or immediately after the procedure. Secondary bleeding may occur after the first week due to sloughing of a clot over the artery through infection. Management of bleeding associated with excision is the same as management of bleeding in any other circumstances. Health providers should observe the following procedures:

- Inspect the site of the bleeding.
- Clean the area.
- Apply pressure at the site to stop the bleeding, or if there is an obvious vessel bleeding, ligate it to arrest the bleeding.
- Assess the seriousness of the bleeding and the condition of the girl or woman.
- If necessary replace fluid lost. If managing the client at a primary level facility, give IV fluids, monitor and transfer her immediately to a secondary level facility for blood transfusion if necessary.
- If managing the client 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, cow dung) may have been applied to the wound, and this can lead to tetanus or other infection. Therefore, give a tetanus vaccine and antibiotics in accordance with the Ministry of Health guidelines.

If the problem is not serious, clean the site with antiseptic and advise the client or attendants to keep it dry. Follow up the client by making an appointment for her to return so that you can check her progress on the wound healing.

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/C is the same as pain management under any other circumstances. Health care providers should observe the following:

- Assess the severity of pain and injury.
- Give strong analgesic and continue with it during the healing period and treat injury.
- Clean site with antiseptic and advise the client or her attendant to keep it dry.
- If the client is in shock, follow instructions provided below for shock.
- If there is no relief from pain, refer client for medical attention.
- If injury is extensive, refer client to a higher-level surgical intervention.

Shock

Shock can occur as a result of severe bleeding and/or pain. The management of shock associated with FGM/C is the same as the management of shock under any other circumstances. Health care providers should observe the following procedures:

- Assess the severity of shock by checking vital signs and record every quarter of an hour (15 minutes).
- 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 if available.
- Have a resuscitation tray nearby.
- Give IV fluids to replace lost fluid. If facilities for IV are not available, fluids may be given rectally.
- If client's condition does not improve, refer her for medical attention to a tertiary level facility immediately.

Infection and Septicaemia

Infection may occur as a result of unhygienic surroundings and dirty instruments used to carry out FGM/C. The patient will present with an elevated temperature and a dirty, inflamed wound. Manage the condition 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.
- Any obstruction found should to be removed, and the client treated with antibiotics and analgesics.
- If the wound is infected, it should be cleaned and left dry.

- If the equipment is available, take a vaginal or pus swab and a urine sample to test for the presence of infection and to identify the organisms involved. If you suspect septicaemia, take a blood culture before commencing antibiotic therapy. If you are in a primary health facility, refer the patient to higher level after initial antibiotic and first aid measures.
- Follow up the client after seven days to assess the progress, and if the infection persists refer the client for medical attention.

Urine Retention

Urine retention may be the result of injury, pain and fear of passing urine, or occlusion of the urethra during infibulation. Acute retention of urine occurs due to swelling and inflammation around the wound. The management of this condition is as follows:

- Carry out an assessment to determine the cause of retention.
- 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 and personal encouragement and support.
- If inability to pass urine is due to infibulation, open up the infibulation after counselling the client, or her attendant if the client is a child.
- If retention is due to injury of the opening of the urethra, refer to a tertiary facility for surgical intervention under anaesthetic.

Anaemia

Anaemia can be due to bleeding or infection as a result of FGM/C. The management of this condition is as follows:

- Assess the severity of anaemia and send blood for haemoglobin (Hb) and grouping.
- Investigate for other causes of anaemia and manage appropriately.
- If anaemia is mild, give folic acid and iron tablets and advise on nutritious diet.
- If anaemia is severe, refer for blood transfusion.

SECTION 4: MANAGING LONG-TERM PHYSICAL COMPLICATIONS

Keloid formation

A keloid may form in the scar tissue and may cause obstruction to the vaginal opening. The management of this condition is as follows:

- Inspect client's genitalia to assess the size of the keloid.
- If the keloid is insubstantial, advise the woman to leave it undisturbed, and reassure her that it will not cause harm.
- If the keloid scar 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 and her partner, in which case you should consider referring her for surgery for psychological reasons.



Vulval keloids

Source: CNLPE, Burkina Faso

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 with all types of FGM/C. A woman may present with these early, when they are the size of a pea, or later when they have grown to a larger size. The 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 the client to accept the condition. Alternatively the client may be referred to have them removed under local or regional anaesthesia.
- Before interfering with a small cyst it is important to find out if the procedure could result in further damage and scarring of the existing sensitive tissue. If such a risk exists, the woman should be fully informed and 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 marsupialisation through surgery. The procedure is usually done under general anaesthetic. 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.



Vulval cyst

Source: CNLPE, Burkina Faso

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 anteriorly over the fibrous swelling. With such a condition, sexual intercourse, or even the friction from underwear, will cause pain. The 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 underwear 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 of pain around the clitoris may be psychosomatic rather than a neuroma, as a result of the traumatic experience of FGM/C, or the fear of sexual intercourse.

Vulval abscess

A vulval abscess may develop as a result of deep infection due to incomplete healing of the wound following FGM/C, or an embedded stitch if the labia have been sewn together. The management of the condition 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 anaesthetic.
- Administer antibiotics as indicated by swab culture.

Reproductive tract infections

Many health care facilities in developing countries lack the equipment and trained personnel required for etiological diagnosis of reproductive tract infections (RTIs). RTIs may be more commonly found in women who have undergone FGM/C, due to obstruction of urine in infibulated women, or the presence of urinary stones or previous injury to the urethra. The syndrome-based approach to the management of RTIs has been developed and promoted in Kenya, based on the identification of syndromes (i.e. consistent groups of symptoms and easily recognized signs) and their treatment through medication of the most serious organisms responsible for the syndrome.

The Ministry of Health has developed a simplified tool (a flowchart or algorithm) to guide health workers in the implementation of syndromic management of RTIs³⁹. To manage suspected RTIs in a woman with FGM/C, proceed as follows:

- Inspect the vulva carefully and ask the woman questions about indicative signs to establish the nature of the syndrome.
- Follow the syndromic management guidelines established by the MOH.
- If infibulation is the primary cause of the infection, counsel the woman or her attendant on the need to open up the infibulation.

Acute / chronic pelvic infection

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

- Identify the type of FGM/C and the likely cause of the problem.
- If the client has type III FGM/C, counsel her and/or her attendants on the need to open up the infibulation after providing an initial broad-spectrum antibiotic cover, seek their informed consent for de-infibulation and then deinfibulate. If necessary, refer the woman to a higher level facility so that de-infibulation can be undertaken safely.
- Take a vaginal swab for culture and sensitivity testing.
- Give antibiotics that are appropriate and locally available, for example, tetracycline 500mg 6 hourly for 10 days, or doxycycline 100mg twice daily for 10 days and Flagyl 400mg 8 hourly for 10 days (refer to the Kenyan Ministry of Health Syndromic Management Chart).
- If the client has a husband or partner, treat him also for the same infection.
- If symptoms persist, refer the client for further medical intervention.
- If the cause of the infection is obstruction due to stones or injury, refer the client for surgical intervention.

³⁹ National Guidelines for Reproductive Tract Infection Services, Ministry of Health, Kenya. 2006

Infertility

Infertility is usually a complication of pelvic infection, and can be classified as either primary or secondary infertility. In rare cases, it can arise from failure of penetration because of a very tight vaginal opening. Manage the client 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 the client to a fertility specialist for further management following standard procedures for infertility.

Fistulae and incontinence

Vesico-vaginal fistula (VVF) or recto-vaginal fistula (RVF) fistulae, resulting in incontinence, occur as a result of injury to the external urethral opening, or obstructed labour, conditions that may be exacerbated by FGM/C. The management of these conditions is as follows:

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

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 of amenorrhoea and swelling of the abdomen caused by this condition. Management is as follows:

- Assess the client to identify the problem and type of FGM/C.
- If the client has been infibulated, counsel on the need for opening up. The counselling might include family members. Then open up or refer.
- If the client has haematocolpos or stones or stenosis, refer her for surgical intervention under general anaesthetic.

Menstrual disorders

Many women with FGM/C report severe dysmenorrhoea with or without menstrual regularity. Possible causes of this problem are a tight infibulation or severe scarring leading to narrowing of the vaginal opening, an increase in pelvic congestion due to infection, anxiety over the state of the genitals, sexuality or fertility, or other unknown causes. Manage client 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 blood 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. The 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.
- Refer for, or 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.

SECTION 5: MANAGEMENT OF PSYCHOSOCIAL AND SEXUAL COMPLICATIONS OF FGM/C

Managing psychosocial problems

Girls and women who have undergone FGM/C may visit a health facility complaining of a wide variety of physical problems, of which no sign can be found on examination. Such symptoms are "psychosomatic" – psychological problems that the client experiences, or disguises, as physical discomfort. Anxiety about their genitals or about sexual relationships may manifest itself in psychosomatic symptoms. Often the girl or woman is unaware that her symptoms are based on psychological anxieties. But in some cases they are aware 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.

Common psychosocial problems can include any of the following: chronic anxiety, 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 psychosocial problems is as follows:

- Assess client to identify the exact problem (take a detailed history).
- If the client has type III FGM/C, counsel her and her partner (if any) on the need for opening up the infibulation.
- If she has other types of FGM/C, continue the counselling sessions until she is relieved of her symptoms.
- If symptoms are severe, refer client for further management.

Managing Painful intercourse (dyspareunia)

- Interview the client to identify the nature of the problem.
- Examine the client to identify the type of FGM/C.
- If opening up an infibulation 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.
- Advise the couple of the changes to expect as a result of the opening up operation – for example, changes in the urine flow and with sexual intercourse.
- Give antibiotics and analgesics.
- Where opening up is not indicated, encourage foreplay to stimulate maximum arousal, and the use of a lubricating jelly.
- Counsel the client and her husband about the importance of discussing sexual matters.
- Invite them to come back whenever they have problems.
- Follow-up client to monitor progress.
- If the sexual problem is severe and recurring, refer to a specialist.

Sexual problems in the male partner

The male partner may experience failure or difficulty in penetration as a result of FGM/C. The procedure for managing such problems is as follows:

- Interview the client to find out what the problem is.
- Assess the type of FGM/C in the female partner.
- Counsel the woman and her husband/partner together.
- Obtain informed consent for opening up of opening.
- Follow the opening up procedure.

Counselling young girls and unmarried adolescents who have had infibulation

Each girl or woman should be treated as a unique individual with distinct 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. Counselling requires special skills that not all health workers possess, and so if a health worker does not feel comfortable in the role of a counsellor, s/he should refer the girl or woman to a qualified and experienced counsellor.

In counselling a girl or young woman with FGM/C, the health worker or counsellor must create an environment that enables the client to speak openly by reassuring her about confidentiality, showing respect and answering her questions patiently and fully. The client must be given clear, accurate and specific information, which will enable her to think about her situation and understand her own needs.

The information provided must be tailored to the individual client's needs, and throughout the session she must be treated as an individual. The role of the counsellor is to help the client think through her situation and not to give her instructions or to pressurise her in any way to make certain choices.

The aim of the counselling session is to build a trusting relationship with the client, so that she feels safe in discussing her concerns with the counsellor.

The following factors are important for the counsellor to consider:

- **Privacy and confidentiality** – Ensure that counselling is carried out in a room where nobody can come in without permission, and where other people cannot overhear the discussion.
- **Patience** – As the counsellor, you need to be relaxed and not pressed for time.
- **A carefully considered seating plan** – The counsellor and the client should be seated at the same level, 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 the counsellor becomes aware of her mannerisms and body

language, as these may tell a different story from her words. (Remember that actions speak louder than words). Observe the whole person and her actions.

- **Attentive listening** – Listen to the client's tone of voice as well as what she is saying, as this may indicate more than her words. Allow the client to do most of the talking, but try to paraphrase what the client has said from time to time to check that you as the counsellor have understood her correctly.
- **Showing concern** (empathizing) – As the counsellor, try to put yourself in the client's position, and to show that you care.
- **Appropriate facial expressions** – the counsellor should be aware of her/his own facial expressions and ensure that these are appropriate to what the client is saying. She should smile when she greets the client, and show sympathy and concern if the client cries during the session.
- **Respect** – the counsellor should always show respect to the clients, as dignified human beings with their own religious and cultural beliefs.
- **A non-judgmental attitude** – it is very important that the counsellor is not judgmental. Counsellors therefore need to be aware of their own biases and prejudices, and ensure that these do not interfere with the counselling process.

Preparing for a 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 both of you 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 a culturally appropriate manner.
- Ask the client what her name is, 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.
- Let the woman 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 discuss with the client the need for opening up her infibulation, give her detailed information about the procedure, and advise her on how her genitalia will be changed by the operation.
 - 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 not in every case that FGM/C leads to inability of a woman to achieve orgasm or enjoy sex, because it depends on the extent of the damage to the organs particularly the clitoris.
 - 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 possibility of opening up the tight opening should be addressed during counselling.
- Assist the woman, 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.

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. Nurses/midwives should be prepared to spend as much time as is necessary for this process.

SECTION 6: MANAGEMENT OF PREGNANCY, CHILDBIRTH AND THE POSTPARTUM PERIOD

Managing pregnancy for women with type I, II and IV

Type I, II and IV FGM/C can produce severe vulval and vaginal scarring, which may cause obstruction during assessment and delivery. Infection and inflammation at the time FGM/C 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.

Infection at the time that types I and II are performed, as well as scraping around the vaginal opening or the use of herbs and corrosives (e.g. type IV), can produce a tight fibrotic barrier in the lower vagina which may prevent delivery unless extensive episiotomy (occasionally bilateral) is carried out. All women who have undergone type I and type II must be examined at their first antenatal attendance to assess the degree of damage. Without this examination, serious problems may become apparent only during labour, when it may be too late to obtain the skilled assistance needed for safe delivery.

If women with type I, II, and IV have not experienced 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 the condition of her genitals or any other issues relating to her pregnancy. Find time to counsel her about sexual relationships and to give her support. Provide more information about FGM/C. During follow-up visits, ask the woman if she needs any special help, but show that you have knowledge and experience on the issue and that you are willing to discuss issues related to FGM/C if the woman is willing.

Pregnancy provides a good opportunity to give women education and information on:

- Basic health
- Normal and cut genitals
- Childbirth and postnatal care.

Many women may approach pregnancy and delivery with great fear of the possible outcomes, including death, and so support and counselling is required as well as normal medical management procedures.

Managing pregnancy for women with Type III

Women who have undergone type III require sensitive antenatal care. They may be apprehensive about a pelvic examination, particularly if the opening is very tight and digital vaginal examination is likely to be uncomfortable. It is important for health workers to be knowledgeable about FGM/C and its different types so that they do not ask women embarrassing questions, blame them for FGM/C, or convey any signs of misapprehension to their clients. Health workers should relate to the women in a sensitive, empathic manner. Good rapport should be developed with clients and information provided about the appropriate care during pregnancy and after childbirth.

Careful explanations should be given about any intimate examination considered necessary and consent obtained. In some cultures, it is usual for a husband to give consent before his wife undergoes any form of treatment or investigation. In such situations, it may be necessary to involve husbands or other relevant family members in pre-examination discussions.

In women having their first baby, examination will establish the extent of the damage and the degree of physical barrier presented. Women with a tight opening following FGM/C (opening 1 cm or less) are at greater risk of major perineal damage during labour than those who have not been closed too tightly or whose mutilation has been partly reversed (“opened up”) to allow marriage to be consummated. As a general guideline, if the urinary opening can be observed or if two fingers can be passed into the vagina without discomfort, the mutilation is unlikely to cause major physical problems at delivery, whether in a clinic or at home. Digital assessment is not always needed, as the visual appearance may provide all the information required.

Recording the appearance of the vulva on the client’s ANC card can help to avoid unnecessary examinations in the future, or to highlight when specific procedures may be difficult to carry out. In communities where type III is common, the vulval area must always be inspected at the first antenatal visit as a matter of routine.

Give the client factual information about the potential effects of type III on her 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-infibulating her after delivery. Give the client and her husband detailed information about the changes that will occur in such functions as urination and sexual intercourse.

If the woman has had previous pregnancies, the history of the deliveries will help to indicate whether she is likely to have recurrent problems. It is important to find out whether re-suturing has taken place following previous deliveries. In this respect, there are major variations among communities, even in the same country. Repeated de-infibulation and re-infibulation leave extensive scarring, which is often unstable. If there are any doubts, the perineal area should be inspected to assess the extent of existing damage.

Opening up the infibulation during pregnancy also allows for clean samples of urine to be obtained, and vaginal infections, premature rupture of membranes and antepartum bleeding can be easily investigated if they occur.

Once the woman has been opened up, it may be possible for the woman to deliver with the perineum intact; episiotomy should only be carried out if necessary and not as routine. Ideally, opening up of the infibulation 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 during the first trimester when there is always a higher risk of spontaneous abortion; if the woman does happen to have a spontaneous abortion after de-infibulation, she may wrongly blame the surgery for her miscarriage, triggering fears in her community that the opening up procedure is dangerous.

Some women prefer to have the de-infibulation during the episiotomy in late second stage of labour. This option should be discussed with the woman and she must feel involved and in control and her wishes should be respected at all times. Aim to get parental consent in the case of an adolescent, in the interest of minimising family conflict and trauma.

Women who refuse to be opened up during pregnancy should be informed about the dangers associated with infibulation during delivery and advised strongly to deliver in hospital. All health providers should assist women delivering without de-infibulation to make plans and obtain family support to go to the nearest 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/C. The objective should be to discourage women from subjecting their own daughters or granddaughters to FGM/C, as well as to discourage them from demanding re-infibulation after delivery. Counselling 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. It also provides an opportunity to explain the dangers of repeated surgery to open up the vulva before and re-stitching after every delivery.

Follow-up support during the postpartum period is important to prevent re-infibulation at a later time, especially in communities where community midwives and TBAs play a major role. If possible, recruit women against infibulation to act as role models within the family who can assist with counselling and providing support to women to prevent re-stitching.

The physiological changes affecting menstruation and urination after de-infibulation must be discussed at length, so that women are well prepared. For example, it is essential to prepare women about the change in voiding patterns that will follow opening up the closed vulva, as bladder emptying will be much quicker and noisier than before. Some women have mistakenly thought themselves incontinent or that too much air was entering the vagina and the body owing to the dramatic changes noted while urinating following the opening up procedure. In younger women, if the hymen is intact, this still provides some barrier to intercourse and some women may feel that the operation has failed.

Problems anticipated during pregnancy in women who have undergone FGM/C

Reproductive tract infections

Reproductive tract infections are common in pregnancy. While it is often assumed that some infections, such as vaginitis, are more common in women with type III FGM/C, there is no evidence and the extent of the added risk is poorly documented. A tight opening (1 cm or less) will hinder pelvic examination, as well as hamper efforts to obtain appropriate urine samples for testing. A catheter sample cannot be obtained and vaginal secretions contaminate other urine samples. Where the diagnosis cannot be established with certainty, where urinary infections are recurrent, or where there has been an attack of severe pyelonephritis, the vaginal entrance should be opened up.

A tight opening may also prevent some therapy, for example, with pessaries. Treatment initially may be empirical – for example, if there is itching, assume a candidial infection and treat with clotrimoxazole (e.g., Canesten) cream and pessaries. Oral metronidazole (e.g., Flagyl) could be used for other symptomatic discharges; however, this drug should not be given in the first three months of pregnancy. If the infection discharge continues despite empirical treatment, de-infibulation should be undertaken to facilitate a full assessment, including speculum examination. Vaginitis and bacterial vaginosis should be identified and managed as far as possible because of their association with premature labour.

Spontaneous abortion and antenatal haemorrhage

If the woman has a spontaneous abortion, any retention of products in the vagina due to a tight opening may lead to serious infection. An incomplete abortion cannot be managed if the opening is too narrow to allow a speculum to pass. Consequently where there is pain and bleeding in early pregnancy, opening up of an infibulation is important to help establish the diagnosis and facilitate management of the abortion. The same principles apply for antenatal haemorrhage – if the infibulation interferes with appropriate assessment and management, it will be necessary to open up the closed vulva.

De-infibulation procedure

Deinfibulation which is a term used for reversal of infibulation (type III FGM), or opening of the vaginal introitus. The surgical procedure required is usually simple and the women are usually young and fit for anaesthesia and are therefore appropriate for either day case surgery or inclusion on a list reserved for simple urgent cases like Bartholin abscess or miscarriages so long as the client do not have vulval/vaginal infections or that the client is not in her menses.

Anaesthesia. The majority of deinfibulation can be done under local but this could not be appropriate for elective reversal when the patient is apprehensive. Deinfibulation may bring back memories of the original infibulation and be psychologically traumatic. For this reason a short general anaesthesia or spinal anaesthesia may be more appropriate.

Who can perform deinfibulation

Any skilled health care provider who can perform and repair episiotomy in normal maternity settings.

Minimum clinical equipment

The following are the equipment required for deinfibulation- Two 10" sponge holding forceps, Two long curved artery forceps, Two small curved artery forceps, needle holder, one stitch scissors, surgical blade and blade holder, Curved operating blunt pointed scissors, dissecting forceps tooth and non tooth, kidney dish, gallipot and gloves.

Step One:

Observe an aseptic technique through washing hands thoroughly, wearing gloves, etc. In lithotomy the vulva is washed with antiseptic solution. Often it is not possible to clean inside the vagina due to the narrowness of the vaginal opening.

Step Two:

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. Take care that you do not cause injury to the structures underneath the scar (urethra, labia minora and clitoris). With type III FGM/C, these structures are commonly found intact below the scar. Once the local anaesthesia has taken effect, locate the remaining opening, using a finger feel inside the opening, behind the closed scar tissue for any dense adhesions. Usually the finger slides easily under a free flap of skin. If the opening is too small to allow passage of one finger the closed points of an artery forcep can be inserted and opened to allow initial division from the posterior part of the closed flap for a centimetre or so which will then allow entry of a finger. Palpate the clitoral region to ascertain if a buried clitoris is present below the scar.

Step Three:

Raise the scar tissue from the underlying tissues using a finger or dilator. Make an anterior midline incision with a curved tissue scissors to expose the urethral opening.

Do not incise beyond the urethra. Extending the incision forward may cause haemorrhage, which is difficult to control. Take great care not to incise a buried clitoris.

Urethral opening after de-infibulation



Source: WHO/RHR/01.16

Step Four:

Suturing of the vulval edges after de-infibulation



Source: WHO/RHR/01.16

After dividing the fused labia majora, an intact clitoris and labia minora have sometimes been found concealed by scar tissue. However this operation is more complex and requires careful dissection in good light and with good anaesthesia; it should only be carried out in a health facility/hospital setting. A more extensive opening up of the fused labia majora may not be culturally acceptable to all women, but could be considered in specialized centres. Appropriate counselling and the consent of the women are essential before proceeding with

more extensive de-infibulation. Suture the raw edges using absorbable interrupted sutures to secure haemostasis and prevent adhesion formation. Healing should take place within one week.

Opening beyond the urethra

- Using a dilator to elevate the scar tissue, the scar is frequently perforated due to inadequate healing.
- Careful dissection anterior to the urethra will reveal an intact, normal clitoris.
- Suture the raw edges with fine 3/0 plain catgut to prevent any adhesion formation. Plain catgut dissolves rapidly and the whole area is healed within a week.

Post operative care

De-infibulation can be carried out on a day care basis. The choice of anaesthetic is important. For women who are not pregnant, fear of pain and memories of the FGM/C procedure make it advisable to select a general anaesthesia. Postoperative analgesia is also important and can be provided by infiltrating under the wound with 1% lignocaine, followed up with analgesia for the first 48 hours. It is very important to follow up clients after a de-infibulation procedure.

Many women report increased sensitivity in the vulval area that was previously covered by the scar skin for 2 to 4 weeks following the procedure. They may also report discomfort about having wet genitals and a feeling that air is entering the vulva. 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. 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 to four times a day followed by gentle drying of the area. As this will not be possible for many women who do not have access to water or baths, discuss alternatives that would also assist in the healing and recuperation process. Application of a soothing cream 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 to allow adequate time for the wound to heal. Counselling regarding sexual matters requires great sensitivity, and should be carefully

tailored according to the needs of the client and her family and to what is culturally appropriate. It may also require over several sessions.

Advise the client 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. In the months following surgery, vulval hypertrophy often occurs, presumably due to some erectile tissue remaining in the base of the residual vulva. In favourable cases, by six months, the vulva is indistinguishable from normal.

It is important to be aware of women's expectations surrounding sexuality after surgery, and to provide appropriate counselling. Some women have very high expectations and have consequently been disappointed. Traditionally, in some communities, intercourse occurs immediately after the woman has been de-infibulated to prevent the wound edges adhering. It is therefore important to counsel the couple to wait at least ten to fourteen days for the wound to heal and a lubricant should be offered to assist with intercourse. Women should be advised to bathe or wash daily, and a follow up appointment should be given.

Management of delivery

Where the opening is tight, it is difficult to assess the degree of cervical dilatation. If there is a problem of assessment, the scar can be opened in the mid-line as described above.⁴⁰ Ideally, this should be performed under a local anaesthetic, but in settings without access to anaesthesia the cut should be made at the height of a contraction. Topical analgesic ointments have so far proven ineffective in providing any significant pain relief, although recent research by the pharmaceutical industry suggests that effective anaesthetic creams may soon be available, providing a useful alternative to local anaesthesia.

Usually there is little bleeding from the scar tissue as it has few blood vessels. In these circumstances, suturing should be delayed until after delivery. With a wider opening, normal assessment is possible, and a decision about anterior division of the scar, often combined with episiotomy, can be delayed until the second stage of labour.

The second stage of labour may be complicated if the foetal head is held up on the scar tissue. This is dangerous to both the mother and baby and this is the time when uncontrolled tears can occur, as well as foetal asphyxia. There should be no delay in performing a mid-line cut in the anterior scar to minimize trauma. To avoid unnecessary bleeding, the incision should not be extended beyond the urethra – doing so creates no extra space. On average, this will leave 4-5 cm of the old scar unopened as the mutilation always extends to the clitoral area.

⁴⁰ WHO. *Female Genital Mutilation: Integrating the Prevention and the Management of the Health Complications in to the Curricula of Nursing and Midwifery. A Teacher's guide*, WHO, Geneva, Switzerland. 2001

Once delivery is complete and the placenta delivered, the incision and any tears should be sutured. The edges of the anterior incision should be oversewn. The incision should not be closed to recreate a barrier at the opening. Since several centimetres of scar tissue remain anterior to the urethra, the repair as described may be acceptable in most communities who view this as widening the opening but not totally reversing the infibulation. Demands for re-suturing to recreate a smaller opening (i.e. re-infibulation) must be resisted and the potential future health problems of such a procedure should be explained. In areas where type III is virtually universal, even if re-suturing is refused after delivery, it is likely that the woman will find someone willing to do the re-suturing at some later date, often as a result of direct or indirect pressure from her husband or from immediate family. Every effort should be made to discourage the practice through engaging with the husband and family.

Postpartum care of women with FGM/C

In the period immediately following delivery, major problems may occur – extensive lacerations and haemorrhage from tears may be added to the usual puerperal difficulties.⁴¹ Extensive uncontrolled lacerations result if the woman has delivered through an intact scar, or if an anterior incision has been incorrectly performed. Tears may involve the urethra and bladder anteriorly and the rectum posteriorly. In ideal circumstances, e.g. in a hospital setting with skilled attendants and experienced surgeons, the damage can be limited. At the village level, good results can still be obtained by applying a pressure dressing to reduce blood loss and then transferring the patient to hospital. However, in resource-poor areas, communication and transfer may be difficult or impossible, and the absence of available expertise almost certainly contributes to a high level of fistula formation, although the extent to which type III adds to the fistula risk is very poorly documented. In resource poor areas and the absence of accessible midwives, training of TBAs in safe practice, such as safe techniques for incision of vulval scars performed at a sufficiently early stage in labour, may be desirable to reduce the severe risks associated with delivery of infibulated women outside of clinics.

Later, sutured lacerations in the puerperium may become infected and break down. Simple, inexpensive remedies should be taught and utilized by TBAs and midwives where transfer to hospital is not feasible. Sugar and sugar paste dressings have proven efficacy and do not require sterile preparation.

⁴¹ WHO. *Management of pregnancy, childbirth and the postpartum period in the presence of female genital mutilation*. WHO, Geneva, Switzerland. 1997

SECTION 7: THE ROLE OF HEALTH CARE PROVIDERS IN PREVENTING FGM/C

Introduction

Though much has been achieved over the past two decades in lifting the veil of secrecy surrounding FGM/C, there is still an enormous amount to be done to provide quality services to those affected, and to prevent other girls and women from adding to their numbers. It is hoped that bringing FGM/C into mainstream education for health professionals will increase the pressure for abandonment of the practice, while at the same time helping those who have felt isolated with their problems for so long.

There have been fears in the past that some health workers do not see FGM/C as a serious health issue – this indicates clearly the importance of professional education. If health workers are not convinced that FGM/C is a major public health issue, then there is little hope of convincing communities to abandon the practice. Health workers have an important role to play, not only in the care of women affected by FGM/C, but also in the provision of education about FGM/C, and advocacy and community sensitization against sustaining the practice. They are in a unique position to do this owing to their medical training, the respect they command in the community, the relevance of health issues to FGM/C and the frequency with which they are likely to interact with affected community members. Education provided by health workers can give strong support to other arguments made against FGM/C through media campaigns, criminalization, etc. Information in a health context provides a non-threatening and objective criticism of FGM/C, particularly when backed up by tangible evidence of the health consequences. The way forward must include improved training for all health workers.

“Medicalization” of FGM/C in Kenya

There is substantial evidence that health professionals are increasingly performing FGM/C, both in hospitals and health clinics as well as in community settings, sometimes, but not always, using medical supplies. The justification given for having health professionals perform FGM/C is that it reduces the pain and the risks to the girl’s health, because the operation is performed hygienically. Health professionals who perform FGM/C claim that medicalization is the first step towards abandonment of the practice, and that if they refuse to perform FGM/C the families will go back to a traditional practitioner in unhygienic conditions and without pain relief.

Whether FGM/C is performed in the village or a clinical setting, it is wilful damage to healthy organs for non-therapeutic reasons. It violates the expectation of medical staff to “do no harm”, and is totally unethical and unacceptable by any standards. It clearly contravenes the policies of the Ministry of Health in Kenya which, in 2001, circulated a policy directive banning FGM/C by all health workers and in all facilities.

However, the active involvement of health personnel in undertaking and supporting the practice continues. To curb this sustained involvement in the practice, several recommendations have been made that would strengthen the role of the Ministry of Health in managing the complications among those already cut:

- Strengthen supervision in those districts where it is known that health workers are involved in genital cutting and re-infibulation through developing and enforcing guidelines for district supervisors on appropriate actions to deter their staff from engaging in the practice.
- Disseminate the MOH's policy against health workers practising FGM/C, and ensure that all health staff understand that FGM/C contravenes the law.
- Include a component on FGM/C in pre-service training to educate nurses and other medical staff in identifying the different types of cutting, recognising associated complications and their management, and understanding the socio-cultural factors that drive the practice.
- Provide training to clinical staff in the medical management of gynaecological complications associated with FGM/C, especially the more severe forms. Train and equip providers working among populations that practice infibulation to safely provide de-infibulation, and assist them to offer this service at the time of marriage, during antenatal visits, or during the second stage of labour.
- Train nurses providing antenatal care to infibulated women in counselling about the likelihood and types of problems that may occur during delivery, and the need to deliver at a health facility to minimise these risks. Such counselling should include information on de-infibulation and must discourage requests for re-infibulation.
- Build the capacity of health staff and the equipment and supplies at facilities that handle deliveries among infibulated women to provide an optimum quality of care needed to handle the associated complications. This could include de-infibulation, correct management of obstructed labour, perineal tears, and postpartum haemorrhage, including episiotomy and caesarean section. It should also include handling birth asphyxia, and being aware of the increased likelihood of perinatal death.
- Provide facilities for surgical reconstruction to repair anatomical damages arising from the more severe forms of FGM/C.
- Build the capacity of health workers to advocate against the practice during routine health talks and consultations (on any issue) and during community outreach activities.

In addition, the MOH could work closely with the medical professional associations and regulatory bodies, including the National Nursing Council, to enforce measures to curb the involvement of health facility staff in FGM/C. The MOH can also support other key efforts for the abandonment of FGM/C by:

- Supporting punitive measures against those caught practicing FGM/C. Local administration personnel (such as police, chiefs, Children's Officers, and social workers) should actively pursue those known to be involved and to close health facilities that carry out the practice.
- Implementing community-wide approaches that present FGM/C not just as a health issue but also as a practice that subjugates women and violates their rights to bodily integrity. Such an approach should include all stakeholders, political, religious, cultural leadership, and involve women and girls as well as men and

boys. The involvement of men is particularly important, as it is their overall dominance in society that has led to women supporting FGM/C as a means of gaining social identity and access to resources.

Members of the major health and legal professional bodies in Kenya should support their ethical stand against FGM/C with appropriate sanctions, which including removal of membership from those found responsible for promoting and practising FGM/C. In particular, members of the health professions have a moral obligation to protect women and children from harmful traditional practices.

Performing FGM/C violates the ethical principles of medicine: “do no harm” and “do not kill.”

Community Education: Public education in the broadest sense is one of the most important factors in producing behaviour change. Health professionals and their associations should, as a group, assert a leadership role in public education on FGM/C. They are in key positions to brief policy-makers and liaise with community, religious, traditional and women’s organizations in mobilizing the public for education. Medical staff should increase their knowledge about FGM/C and raise awareness among colleagues, other professionals and their communities about the harmful effects of FGM/C and discourage the community from practicing it. Building partnerships with relevant community groups, agencies and professional groups will help in gaining insights into the issues involved, as well as in bringing health promotion to a wider public.

All avenues to raise public awareness should be explored. Information, education and communication (IEC) programmes on FGM/C should be designed and tested at community level. Community education should incorporate information on the immediate and direct health complications of FGM/C for girls and on the subsequent health complications that may occur during pregnancy, childbirth and the postpartum period. Education on FGM/C for women and couples should also be integrated into management during pregnancy, childbirth and the postpartum period. Education about FGM/C prevention should be encouraged in schools, through its integration into science, biology and hygiene lessons, personal social education, gender and religious education. Nurses, midwives and doctors can facilitate and assist teachers with such education. Young people should receive sound, reliable sex education to prepare them for a healthy future life as men and women, and this should include information about the adverse effects FGM/C, and especially infibulations, can have on fertility and sexual pleasure.

SECTION 8: POLICY STATEMENTS REGARDING THE PREVENTION OF FGM/C

WHO and international medical bodies strongly oppose FGM/C

Policy No. 1: Opening up of Type III FGM/C (infibulation)

Female genital mutilation, especially type III, can result in a very small opening, which may cause difficulties in urination, menstruation and sexual intercourse, as well as serious problems in childbirth. During delivery the constricted vulva in type III FGM/C needs to be opened up to allow the passage of the baby to prevent the formation of vesico-vaginal fistula (VVF) and rectovaginal fistula (RVF). Such action is necessary to prevent undue suffering of mother and baby, including the increased risk of stillbirth and/or maternal death.

Rationale

Nurses and midwives are often the primary caregivers, and in many circumstances the only trained health care providers available. Women and girls may seek professional help because of urine retention, haematocolpos, infection, or psychological trauma due to sexual harassment or dyspareunia. Having the knowledge and skills necessary to open up a type III FGM/C will allow nurses and midwives to address these immediate problems in their clients and to prevent further complications from arising. As this brief discussion suggests, there are many circumstances in which opening up of infibulation is indicated.

Policy statements

1. Nurses and midwives need to be trained to open up type III FGM/C, and their competency to perform the procedure maintained to ensure that care is safe and effective.
2. Nurses and midwives need to be given the administrative and legal authority to carry out the opening up procedure.

Policy No. 2:

Refusal of requests to re-stitch an opened up vulva (Re Infibulation)

After opening up a closed vulva to resolve a specific problem (for example during childbirth), the nurse/midwife may be requested by the woman herself, or her partner or family members, to re-stitch the opened vulva to create a small opening. Such a request may pose professional and ethical dilemmas for the health worker.

Rationale:

Re-infibulation of an opened up vulva is equivalent to performing the initial act of female genital mutilation. It poses the same threat to health as the initial act, putting the girl or woman at risk of a wide range of physical, psychological and sexual complications.

Policy statements:

1. Health workers must not, under any circumstances, close up (re-infibulate) an opened vulva in a girl or woman with type III FGM/C in a manner that makes intercourse and childbirth difficult.
2. Nurses and midwives need to be given the administrative and legal authority to refuse a demand for re-infibulation, regardless of the client's cultural and social background.
3. Nurses and midwives need to be given appropriate training and support to enable them to counsel families who expect them to perform a reinfibulation.

Policy No. 3:**Performance of functions that are outside the nurse's/midwife's legal scope of practice**

Some situations may demand that the nurse or midwife take action that is outside his/her current legal scope of practice. In relation to FGM/C this may involve prescribing antibiotics and analgesics, and/or performing an episiotomy, or opening an infibulation.

Rationale:

Nurses and midwives are often the primary caregivers and the only trained health care providers available. It is important, therefore, that restrictions on their practice be removed, so that they are able to provide comprehensive primary care that is safe and effective to girls and women with FGM/C complications.

Policy statements:

1. Nurses and midwives need to be given the appropriate training, and the competency to perform all necessary functions maintained, to ensure that care is comprehensive, effective and safe.
2. Nurses and midwives need to be given the administrative and legal authority to perform, without undue restriction, the functions that may be necessary to treat the conditions they encounter as primary caregivers.

Policy No. 4:**Documentation of FGM/C**

Information regarding FGM/C is inadequate because the condition is rarely noted in clinical records or recorded in health information systems (HIS). Lack of information conceals the extent of FGM/C and hinders the effort to plan for the health needs of affected communities and to eliminate the practice.

Rationale:

At the clinical level, good documentation is necessary for the efficient management of cases, and for providing quality health care and follow up to clients with FGM/C.

At the national level, a health information system that records FGM/C is necessary to raise awareness on the extent of the practice. The data on FGM/C are useful for planning health services, prevention of the practice and monitoring health outcomes related to FGM/C.

Policy statements:

1. The presence of FGM/C and related complications should be noted as a matter of routine in the clinical records of health service clients.
2. Health information systems should include appropriate data on FGM/C.

Policy No. 5:**Prevention Of Female Genital Mutilation By Nurses, Midwives, And Other Health Care Professionals**

With increased awareness of the harmful effects of FGM/C and greater access to health care services, there are moves towards “medicalization” of FGM/C, i.e. having the operation performed by health professionals in clinical settings in the belief that it is safer. Health care workers may find themselves under pressure from individuals and families to carry out FGM/C.

Rationale: “Medicalization” of FGM/C legitimises a procedure that is harmful to the health and well being of girls and women. Furthermore, it is a violation of the ethical code governing the professional conduct of nurses, midwives and other health care workers.

Policy statements:

1. Nurses, midwives and other health care workers must be expressly forbidden to perform female genital mutilation.
2. Any nurse, midwife or other health care worker found performing, or reported to have performed, FGM/C should be brought to the attention of the appropriate authorities for professional discipline and/or legal action.

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), International Council of Nurses (ICN), and the Federation of Gynaecologists and Obstetricians (FIGO), have all declared their opposition to medicalization of FGM/C, and have advised that it should never, under any circumstances, be performed in health establishments or by health professionals.

Suggestions that type III FGM/C should be replaced by types I and II should also be resisted on both medical and ethical grounds.

The agreed definition of the term “infibulation” (type III FGM/C) is that it is a “stitching together of the labia. ” In this context, the terms “de-infibulation” and “reinfibulation” for the opening up procedures of cutting for childbirth and subsequent re-stitching are thought to be inappropriate, hence the occasional use of “opening up” and “repair” or “reconstruction” as suitable replacements when addressing the general public. When an obstetrician or midwife is faced with the repair of the vulva of a woman who has delivered a baby vaginally following previous type III FGM/C, it is unethical to carry out the procedure intentionally in such a way that intercourse and vaginal delivery are made difficult or impossible. National and international laws should guide nurses, midwives and doctors on FGM/C, ethics and the codes of practice of their professional associations in this regard. Clearly, in this situation, counselling is needed for women/couples and appropriate family members on the long-term health complications of repeated opening up and reconstruction, in particular the implications for psychosexual and gynaecological health.

The Kenya Ministry of Health strongly opposes FGM/C

In 1999, the Ministry of Health (MOH) launched the National Plan of Action for the Elimination of Female Genital Mutilation in Kenya. The plan was aimed at accelerating the elimination of FGM/C, in order to improve the health, quality of life and well being of women, girls, families and communities in Kenya.

The objectives of the National Plan of Action (NPA) include:

- Reducing the proportion of women and girls who undergo FGM/C in Kenya;
- Increasing the proportion of communities that support the eradication of FGM/C;
- Increasing the proportion of healthcare facilities that provide care, counselling and support to girls and woman affected by FGM/C;
- Increasing the technical and advocacy capacity of institutions and communities to develop and manage FGM/C eradication programs.

To achieve this, the NPA proposed five broad strategies:

- Establishment of national and district FGM/C program co-ordination committees;
- Establishment of a multisectoral collaboration to ensure integration of anti-FGM/C interventions in key development programs;
- Mapping of new and on-going interventions on FGM/C;
- Co-ordination of new and on-going FGM/C interventions;
- Establishment of proactive mechanisms for resource mobilization and allocation to the FGM/C elimination program.

The NPA has been widely disseminated in the country, and some districts have already set up FGM/C co-ordination committees. The NPA's specific targets and indicators are stated as follows:

- Reduce by 40% the proportion of girls and women undergoing FGM/C by the year 2019.
- Increase by 40% the number of communities and districts openly discussing issues of FGM/C and reporting positive changes including KAP on FGM/C by the year 2019.
- Increase by 40% the availability and use of support services for victims/ resistant of FGM/C at community, District and National levels. Services (psychological, medical, social counselling, referral and mentoring for girls choosing not to undergo FGM/C.
- Reduce by 30% by the year 2019 the incidence/prevalence of other harmful traditional practices among girls and women.
- Increase by 59% the proportion of girls enrolled in and completing primary and secondary education in FGM/C practicing communities.
- Existence and effective implementation of consistent and supportive FGM/C and related policies and programs. FGM/C monitoring indicators integrated into key health and social development program plans including socio-economic, demographic health and gender relation's surveys.

FGM/C is illegal in Kenya

Kenya has a long history of vigorous efforts to encourage the abandonment of FGM/C, dating back to the 1930s' efforts by the colonial administration and Christian missionaries. Anti-FGM/C campaigns have employed various strategies, including alternative rites of passage for adolescent girls, empowerment of the girl child, public education campaigns, promotion of the girl child education, and advocacy programs for women and girls.

The Government has passed legislation outlawing the practice (the Children's Act 2001), and key figures have made public pronouncements against the practice, while the mass media has increased its coverage of the practice. The Kenya Gazette Supplement Bill 2001, which outlawed FGM/C, stated the following:

Section 13. "No person shall subject a child to cultural rites, customs or traditional practices that are likely to negatively affect the child's life, health, social welfare, dignity or physical or psychological development."

Section 18. "Notwithstanding penalties contained in any other law, where any person wilfully or as a consequence of culpable negligence infringes any of the rights of a child as specified in sections 4 to 17 such person shall be liable upon summary conviction on a term of imprisonment not exceeding twelve months, or to a fine not exceeding fifty thousand shillings or to both such imprisonment and fine."

The procedure is illegal in the United Kingdom under the prohibition of Female circumcision Act of 2003, which replaced the 1985⁴² act and any one found guilty of performing this operation is liable to a fine or imprisonment. The Royal College of Obstetricians and Gynaecologists condemns all forms of FGM/C. The 1985 Act, which is more explicit than our Kenyan Act, states that it is an offence for any person:

- a. *'To excise, infibulate or otherwise mutilate the whole or any part of the labia majora or clitoris of another person'*
- b. *'To aid, abet, counsel or procure the performance by another person of any of these acts on that other person's own body'*

The above act makes it an offence for UK nationals or permanent UK residents to carry out FGM abroad, or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where the practice is legal. The agreed definition of the word infibulation is that of it is 'a stitching together of the labia'. By definition, therefore, when an obstetrician is faced with the repair of the vulva of a woman who has been delivered of a baby vaginally following a previous infibulation, surgery can be performed for purposes connected with that labour or birth but it is illegal to repair the labia intentionally in such a way that intercourse is difficult or impossible. Further, although the law states that a surgical operation can be performed on the vulva if it is necessary for the mental health of the person, it cannot be performed if required as a matter of custom or ritual.

⁴² RCOG Statement No. 3. Setting standards to improve women's health. May 2003

SECTION 9: FGM/C VIOLATES HUMAN RIGHTS

The Convention on the Rights of the Child protects the child's right to equality irrespective of sex (article 2), to the highest attainable standard of health (article 24.1); to freedom from all forms of mental and physical violence (article 19.1); and freedom from torture, or cruel, inhuman or degrading treatment (article 37.a). FGM/C has recognized implications for the human rights of women and children. It is also considered to be a form of violence against girls and women. The Vienna Declaration and Programme of Action strongly support the rights of women and girls. It is applicable to FGM/C because of its specific mention and condemnation of harmful traditional practices. The specific rights that should protect girls and women from female genital mutilation include:

The right to health

Because FGM/C threatens the health and lives of women and children, the failure of the state to protect them from the practice may be seen as a violation of several United Nations (UN) agreements. The Universal Declaration of Human Rights (1948) proclaims the right for all human beings to live in conditions that enable them to enjoy good health and health care. Article 3 of this declaration guarantees the right to life, liberty and security of person. This principle has been articulated as providing the basis for mental and physical integrity. The Convention on the Rights of the Child (1989) can be interpreted as offering children protection from female genital mutilation. Article 24(1)(f) of the Convention on the Rights of the Child requires States Parties to "develop preventive health care, guidance for parents, and family planning education and services".

Article 12(1) of the Convention on the Elimination of All Forms of Discrimination Against Women requires that States Parties "eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning".

In addition to the above, the African Charter on the Rights and Welfare of the Child, (1990), protects many of the rights enshrined in the Convention on the 15 World Health Assembly Resolution:

Rights of the Child. The Charter can be interpreted as offering protection from FGM/C. Article 16 of the African Charter states that "every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health". Article 18(3) declares that: "the state shall ensure the elimination of every discrimination against women and also ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions."

The right to be free of cruel and degrading practices

FGM/C constitutes cruel and degrading treatment of girls and women. Many United Nations documents require states to protect the rights of women and girls to ensure freedom from such treatment.

Article 5 of the Universal Declaration of Human Rights, states that “no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment”. In addition, Article 22 states that “everyone, as a member of society, has the right to . . . social and cultural rights indispensable for his dignity and the free development of his personality.”

Article 1 of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1989) can be interpreted as offering protection to women from genital mutilation. It states: “*For the purposes of this Convention, torture means any act which causes severe pain or suffering, whether physical or mental, is intentionally inflicted on a person... for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity...*”

Article 37 (a) of the Convention on the Rights of the Child (1989) requires State Parties to ensure that no child is subjected to torture or other cruel, inhuman or degrading treatment or punishment. The rights of women and girls to protection from female genital mutilation are also implicit in the African Charter. Article 5 declares that “every individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status. All forms of exploitation and degradation of man, particularly . . . torture, cruel, inhuman or degrading punishment and treatment shall be prohibited. The African Charter urges States Parties to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child (article 21.1b).

The right to sexual and corporal integrity

Female genital mutilation violates the rights of women and girls to sexual and corporal integrity. Article 3 of the Universal Declaration of Human Rights states that “everyone has the right to life, liberty and security of person.” The Convention on the Elimination of All Forms of Discrimination against Women (1979) also protects the right of women and girls to sexual and corporal integrity. For the purpose of the Convention the term “discrimination against women” shall mean any distinction, exclusion, or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field (Article 1). The African Charter may also be interpreted as obliging states to protect the rights of women and girls to sexual and corporal integrity.

The Right to reproduction

FGM/C, and particularly infibulation, interferes with the right of women to reproduce. The practice frequently leads to sexual and psychosocial complications, and may result in infertility. In 1994 CEDAW adopted a General Recommendation on equality in marriage and family relations, which also entitles women to decide on the number and spacing of their children.

There is documented evidence that FGM/C damages the health of girls and women. Thus the practice infringes their right to the highest attainable standard of physical, sexual and mental health. FGM/C is also:

- Associated with gender inequalities
- A form of discrimination against girls and women
- Torture, cruel, inhuman, or degrading treatment of children and women
- An abuse of the physical, psychological and sexual health of children and women.

SECTION 10: ANNEXES

Annex 1: International policy statements related to female genital mutilation

World Health Organization

The World Health Organization (WHO) issued the following statement on the medicalization of female genital mutilation in 1992 and 1997.

WHO has consistently and unequivocally advised that female genital mutilation in any form should not be practised by health professionals in any setting – including hospitals or other health establishments. WHO's position rests on the basic ethics of health care whereby unnecessary bodily mutilation cannot be condoned by health providers. Genital mutilation is harmful to girls and women and medicalization of the procedure does not eliminate this harm. Medicalization is also inappropriate as it reinforces the continuation of the practice by seeming to legitimise it. In communities where infibulation is the norm, it has been noted that many families revert to clitoridectomy when health education programmes commence. However, the formal policy messages must consistently convey that all forms of female genital mutilation must be stopped.

International Federation of Gynaecology and Obstetrics

The International Federation of Gynaecology and Obstetrics (FIGO) adopted the following resolution on FGM/C at its General Assembly on 27 September 1994 in Montreal, Canada.

The FIGO General Assembly, CONSIDERING that female genital mutilation (female circumcision) is a harmful traditional practice which is still prevalent in over 30 countries of the world, including areas of Africa, Asia and the Middle East; CONCERNED about the serious adverse effects of the practice on the physical and psychological reproductive health of children, adolescents and women; RECOGNIZING that female genital mutilation is a violation of human rights, as a harmful procedure performed on a child who cannot give informed consent; RECALLING the 1994 World Health Assembly resolution WHA47.10 welcoming the policy declarations to the United Nations Special Rapporteur on traditional practices by governments in countries where female genital mutilation is practised;

1. INVITES Member Societies to:

- (a) URGE their governments to ratify the Convention on the Elimination of All Forms of Discrimination against Women, if they have not already done so, and to ensure the implementation of the articles of the Convention, if the Convention has already been ratified.
- (b) URGE their governments to take legal and/or other measures to render this practice socially unacceptable by all sectors and groups in society.
- (c) COLLABORATE with national authorities, non-governmental and intergovernmental organizations to advocate, promote and support measures aiming at the elimination of female genital mutilation.

2. RECOMMENDS that obstetricians and gynaecologists:

- (a) EXPLAIN the immediate dangers and long-term consequences of female genital mutilation to religious leaders, legislators and decision makers.
- (b) EDUCATE health professionals, community workers and teachers about this harmful traditional practice.
- (c) SUPPORT those men and women who want to end the practice in their families or communities.
- (d) ASSIST in research for the documentation of the prevalence of the practice and its harmful consequences.
- (e) OPPOSE any attempt to medicalise the procedure or allow its performance, under any circumstances, in health establishments or by health professionals.

International Confederation of Midwives

The International Confederation of Midwives Council adopted the following statement on childbirth practices at its meeting in Kobe in October 1990.

The International Confederation of Midwives recognizes that there are many practices relating to childbearing based on religious or cultural beliefs. We believe those practices that are harmful to the health of the mother or infant should be modified or eliminated. In keeping with this belief:

- (i) Midwives should evaluate the effect of all birth practices in their country;
- (ii) Midwives should promote only those practices that do not compromise the well-being of the mother or infant;
- (iii) The International Confederation of Midwives supports the Inter Africa Committee's Plan of action to eliminate harmful practices, such as female circumcision.

International Council of Nurses

The International Council of Nurses adopted the following position statement in 1995.

Elimination of FGM/C and other harmful traditional practices are a reflection of gender discrimination and violence practised against women and children in both public and private life and constitutes a violation of basic human rights. FGM/C is an issue for all nurses, as girls and women who have undergone FGM/C are likely to suffer a wide range of physical, mental and psychological problems. The World Health Organization estimates that between 85 to 115 million women and girls have suffered FGM/C throughout the world and each year a further 2 million girls are at risk of the practice.

While it is recognised that some traditional practices may be beneficial or harmless, others, such as FGM/C, early marriage and certain nutritional limitations, have a profound negative effect on the health and well being of children and women. The International Council of Nurses actively opposes any moves to 'medicalise' FGM/C and pledges to work to eliminate the practice of FGM/C by health professionals in any setting. It believes that nurses can contribute positively and effectively to national efforts to eliminate FGM/C.

Nurses, through their national nurses associations, can undertake programmes of information and education on the nature, impact and issues involved in FGM/C directed towards not only all nurses and other care professionals but the public, women, decision makers, religious leaders and other appropriate community groups. In addition the International Council of Nurses and national nurses' associations can act to discourage and eventually eliminate FGM/C by joining with other interested parties such as international, intergovernmental; and nongovernmental organizations; other professionals; local religious leaders, and women's, nongovernmental and pressure groups for the adoption of appropriate policies, strategies and, where appropriate, the enactment of legislation.

Approaches to the eradication of FGM/C also include collaborating with national groups specifically working in this field; promoting the inclusion of FGM/C awareness, counselling and treatment into health services for women and children and primary health care programmes; and working with nurse educators to ensure that educational programmes include adequate knowledge of FGM/C and prepare nurses to provide culturally sensitive care and counselling to parents, women and children suffering the effects of FGM/C.

Medical Women's International Association

This statement on FGM/C and other harmful traditional practices was made by the Medical Women's International Association (MWIA) at the Nordic Forum, held in August 1994, and the International Conference on Population and Development, held in Cairo in September 1994.

Between 85 and 114 million girls and women throughout the world are the victims of the traditional practice of FGM/C. Each year a further 2 million girls are at risk. Many girls and women suffer severe physical, psychological, and emotional problems and even death as a result of the procedure. Severe pain, haemorrhage, urinary retention, tetanus and other infections including HIV may occur initially. In addition other serious complications, which may not appear to be connected with this practice, arise in the ensuing years. These include pelvic infections, infertility, sexual difficulties, urinary tract infections, obstructed labour, anxiety and depression and the risk of HIV infection through lesions of the scarified vaginal tissue during intercourse.

This harmful traditional practice is no longer confined to the 26 Sub-Saharan African countries where it has been prevalent for centuries. Migrants from these countries seek to continue with this procedure within African Communities in Western countries, where legislation in more and more countries prohibits this practice.

The human right to dignity, health and protection from physical abuse is denied by harmful traditional practices such as Female Genital Mutilation, child marriages and dietary taboos and limitations associated with pregnancy. Therefore:

MWIA condemns all harmful traditional practices regardless of where they occur and actively supports organisations in Africa and the Western World who work for the elimination of these harmful practices.

MWIA recommends health education for the communities concerning the health hazards of Female Genital Mutilation and urges support of the men and women in Africa who work for the eradication of all harmful traditional practices.

MWIA urges support for the dissemination of educational programmes and information to both men and women on the health hazards of these harmful traditional practices in all countries where they are practised including host countries to migrants in the Western World.

MWIA welcomes the resolution against traditional practices harmful to health of women and children passed during the World Health Assembly, May 1994.

Annex 2: International agreements relevant to the elimination of female genital mutilation

International human rights covenants underscore the obligations of Member States of the United Nations to respect and to 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. In this regard, most governments in countries where female genital mutilation is practiced have ratified several United Nations Conventions and Declarations that make provision for the promotion and protection of the health of girls and women, including the elimination of female genital mutilation as indicated below.

1948: The **Universal Declaration of Human Rights** proclaims the right of all human beings to live in conditions that enable them to enjoy good health and health care and the entitlement in motherhood and childhood to special care and attention.

1966: The **International Covenant on Civil and Political Rights** and the **International Covenant on Economic, Social and Cultural Rights** condemns discrimination on the grounds of sex and recognized the universal right to the highest attainable standard of physical and mental health.

1979: The **Convention on the Elimination of All Forms of Discrimination against Women** can be interpreted to require State Parties to take action against female genital mutilation, namely:

“To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against women” (Article 2f)

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 stereotyped roles for men and women” (Article 5a).

1990: The **Convention on the Rights of the Child** protects the right to equality irrespective of sex (Article 2), to freedom from all forms of mental and physical violence and maltreatment (Article 19.1), to the highest attainable standard of health (Article 24.1), and to freedom from torture or cruel, inhuman or degrading treatment (Article 37a). Article 14.3 of the Convention explicitly requires States to take all effective and appropriate measures to abolish traditional practices prejudicial to the health of children.

1993: The **Vienna Declaration and the Programme of Action of the World Conference on Human Rights** expanded the international human rights agenda to include gender-based violations that include female genital mutilation.

1993: The Declaration on Violence against Women expressly states:

“Violence against women shall be understood to encompass, but not be limited to, the following: Physical and sexual and psychological violence occurring in the family, including dowry-related violence. Female genital mutilation and other traditional practices harmful to women” (Article 2).

1994: The **Programme of Action of the International Conference on Population and Development** included recommendations on female genital mutilation that 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”.

1995: The **Platform for Action of the Fourth World Conference on Women** included a section on the girl child and urged governments, international organizations and nongovernmental groups to develop policies and programmes to eliminate all forms of discrimination against the girl child, including female genital mutilation.

In order to make these agreements meaningful, mechanisms must be developed to implement them at grassroots level and concerted efforts must be made to protect the rights of girls and women.

