



NATIONAL TRAINING MANUAL
FOR THE MANAGEMENT
AND PREVENTION OF
**FEMALE GENITAL
MUTILATION (FGM)**
FOR HEALTH PROFESSIONALS

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Reproductive, Maternal, Neonatal,
Child and Adolescent Health Unit
Ministry of Health & Social Welfare



NATIONAL TRAINING
MANUAL FOR THE
MANAGEMENT AND
PREVENTION OF FEMALE
GENITAL MUTILATION (FGM)
FOR HEALTH PROFESSIONALS

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FOR REMOVAL

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Female Genital Mutilation (FGM) is a global health issue. It affects around 200 million girls and women in 30 countries in Africa, Asia, and the Middle East. FGM is deeply rooted in beliefs and perceptions in practising communities and every year, more than 3 million girls are at risk of undergoing the practise.

FGM refers to all procedures involving partial or total removal of the external female genitalia or other injuries to the female genital organs for non-medical reasons. FGM has no known health benefit. It is considered a harmful traditional practise because it is associated with unnecessary pain, health complications, permanent bodily damage, and even deaths. It is internationally recognised as a breach of human rights because it violates women's and children's fundamental rights to life, liberty, security, dignity, and integrity, both physical and mental.

In The Gambia, the practice is widespread; around **73%** of women aged 15-49 are circumcised. FGM is practised across all regions, age groups, and most ethnicities. Although its prevalence has slightly decreased, thanks to the activism of several NGOs and the adoption in December 2015 of the Women's (Amendment) Act prohibiting all types of FGM, more effort is needed to sustain the achievements made. This is essential, first, for providing quality health services to those affected, and second, for preventing new girls from being cut.

The physical, psychological, and sexual complications resulting from FGM require skilled management by healthcare professionals, who need to be capacitated to diagnose those complications and manage them. This is essential to ensure that those involved in caring for women during pregnancy, labour, delivery and the postpartum period, are equipped with relevant skills. Additionally, health education of communities, civil society organizations, families and individuals on FGM-related complications in a participatory manner, is equally important. Once healthcare professionals have gained appropriate insight into the socio-cultural dimensions of the practice, they would be able to effectively engage with communities for prevention in a more productively and fruitfully way.

Over the years, the Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) Unit of the Ministry of Health, together with Wassu Gambia Kafo, have conducted a series of training for health workers on FGM complications management with reliance on training materials from partners. This necessitated the elaboration of a national training manual to be used by all institutions and care providers in the country.

This Manual provides healthcare professionals with the skills needed to identify the complications of FGM and manage girls and women who suffer the consequences. It also equips them with relevant knowledge to advocate for the abandonment of the FGM and encourage community members to observe good practices that enhance the health of women and girls. This document is a new milestone, a step forward on the long road that the Ministry of Health, together with international organizations and NGOs such as Wassu Gambia Kafo, have undertaken to achieve the goal of eliminating the practice of FGM in The Gambia.



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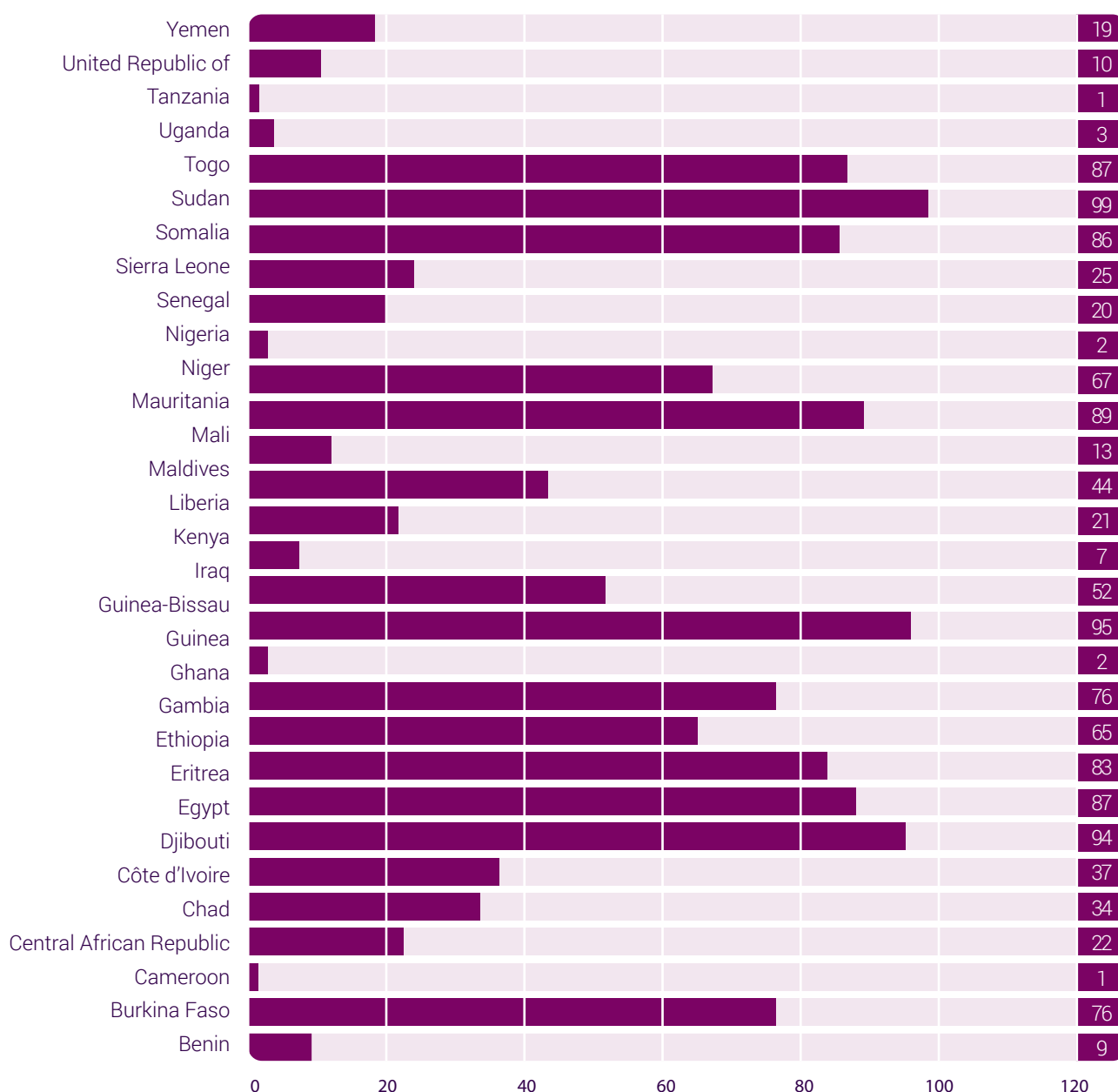
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01 | GENERAL INTRODUCTION TO FGM

Female genital mutilation (FGM) is a global health issue. Around 200 million girls and women in 30 countries in Africa, Asia, and the Middle East have undergone FGM [1], and more than 3 million girls are annually at risk of being cut [2]. Over the last three decades, there has been an overall decline in the prevalence of FGM, but the progress and pace of decline are uneven between countries [1]



TABLE 1 FGM PREVALENCE AMONG GIRLS AND WOMEN (%)

Source: UNICEF global databases, 2021, based on DHS, MICS, and other national surveys

FGM is deeply rooted in beliefs and perceptions in practising communities. It is carried out as a heritage of the past and is often associated with ethnic identity, enforced by the community or peer pressure and the threat of stigma [3, 4]. FGM has no known health benefit. It is considered

a harmful traditional practise because it is associated with unnecessary pain, health complications, permanent bodily damage, and even deaths. The continuation of FGM in a practising community is motivated by a complex mix of interlinked sociocultural factors [5]. FGM violates women's

and children's fundamental rights to life, liberty, security, dignity, and integrity both physical and mental [6]. Internationally, it is recognised as a breach of human rights. FGM perpetuates gender inequality and discrimination within practising communities.

In The Gambia, 73% of women aged 15-49 are circumcised [7]. The highest prevalence of FGM is observed in Basse (97%) and the lowest in Kerewan (42%) [7]. Across ethnic groups, FGM is commonly practised by Madinka/Jahanke (96.2%), Sarahule (91.4%), and the Jola/Karoninka (85.5) [7]. Among circumcised mothers, 54% of their daughters underwent the practice, and 22% of these were circumcised before their first birthday. The prevalence of FGM among daughters generally decreases with increasing mothers' level of education, 49% among those whose mothers have no education and 39% among those whose mothers have secondary education or higher [7]. Although the prevalence of FGM has slightly decreased across the country over the recent years, more effort is needed to sustain achievements made. This is essential, first, for providing quality health services to those affected, and second, for preventing new girls from undergoing the practice.

The physical, psychological, and

sexual complications resulting from FGM require skilled management by healthcare professionals. This means that healthcare professionals need to be capacitated to diagnose those complications and to manage them. Furthermore, the acquired knowledge of the consequences of FGM will also enable them to sensitise families about the potential negative effects of the practice and contribute to its abandonment. Their legitimated roles as healthcare providers, make them key actors to rely on within communities.

Training practitioners in interpersonal communication skills, including counselling, is crucial to their role in the prevention of FGM and the pressure for its elimination. Health education of communities, civil society organizations, families, and individuals on FGM related complications in a participatory manner is equally important. Once health workers have gained appropriate insight into the socio-cultural dimensions of the practice, they would be able to

effectively engage with communities more productively and fruitfully. The outcome is to empower them to be the ones who transfer this knowledge to their communities, promoting preventive actions for the abandonment of the practice.

The present Manual and its 10 modules aim to be part of the Academic Curriculum for the faculties and schools where health students are trained. It is also designed to set the stage for the active participation of medical doctors, nurses, and public health officers in the prevention of FGM, management of its related complications and advocacy for its abandonment. It is important that such gaps in professionals' training and education are adequately addressed in societies where FGM is performed. This is essential to ensure that health professionals, especially those involved in caring for women during pregnancy, labour, delivery, and the postpartum period are equipped with relevant skills.

1.1 ORIGIN

The cultural and geographical origins of FGM remain uncertain. However, it is believed that female circumcision has been practised for nearly 2500 years, prior to either Islam or Christianity [8]. Infibulation, the most extreme form of FGM, has been traced back to ancient Egypt, hence, the name Pharaonic circumcision [8]. It is also noted that the female circumcision (the same as male circumcision), was initially part of the traditional puberty rites, in which young women were introduced into the adult world, a "rite of passage". [8]. Nevertheless, the prevalence, typology, and circumstances

surrounding the practice show wide variations between countries and regions [9].

The ancient history of the Dogon culture in Mali relates an incident of significance to the origin of FGM [10]. According to the myth, Amma, God of the Sky, was alone and wanted to have intercourse with the Earth, whose form was like the female body. The Earth's sexual organs were like ants' nest and the clitoris was raised like a termite mound. Amma drew close but the termite mound rose up, blocking penetration.

It happened that the Earth had the same sex as Amma, causing discord in the Universe. Amma, angry at being thwarted, cut down the termite mound and successfully coupled with the Earth. Amma consorted many times with his wife and harmony was restored to the universe once the termite mound had been removed. Nowadays, it is believed in some cultures that if the clitoris is not removed it will grow to the same size as the penis and, once erect, will prevent a man to penetrate a woman's vagina.

1.2 DEFINITION

The term “Female Genital Mutilation” (also called “Female Genital Cutting” and “Female Genital Mutilation/Cutting”) refers to all procedures involving partial or total removal of the external female genitalia or other injuries to the female genital organs for non-medical reasons [11]. When it was first discussed outside practising groups, the practice was generally referred to as “female circumcision”, a way to draw a parallel with male circumcision [11]. In The Gambia, the Women’s (Amendment) Act (adopted December 2015) that prohibits all

types of FGM refers to it as “female circumcision” [12].

The expression “Female Genital Mutilation” gained growing support from the late 1970s. The word mutilation establishes a clear linguistic distinction from male circumcision and emphasizes the gravity and harm of the act [11]. The use of the word “mutilation” reinforces the fact that the practice is a violation of girls’ and women’s rights, and thereby helps to promote national and international advocacy for its

abandonment. Nevertheless, some United Nations agencies use the term “Female Genital Mutilation/Cutting” wherein the additional term “cutting” is intended to reflect the importance of using non-judgemental terminology with practising communities [11].

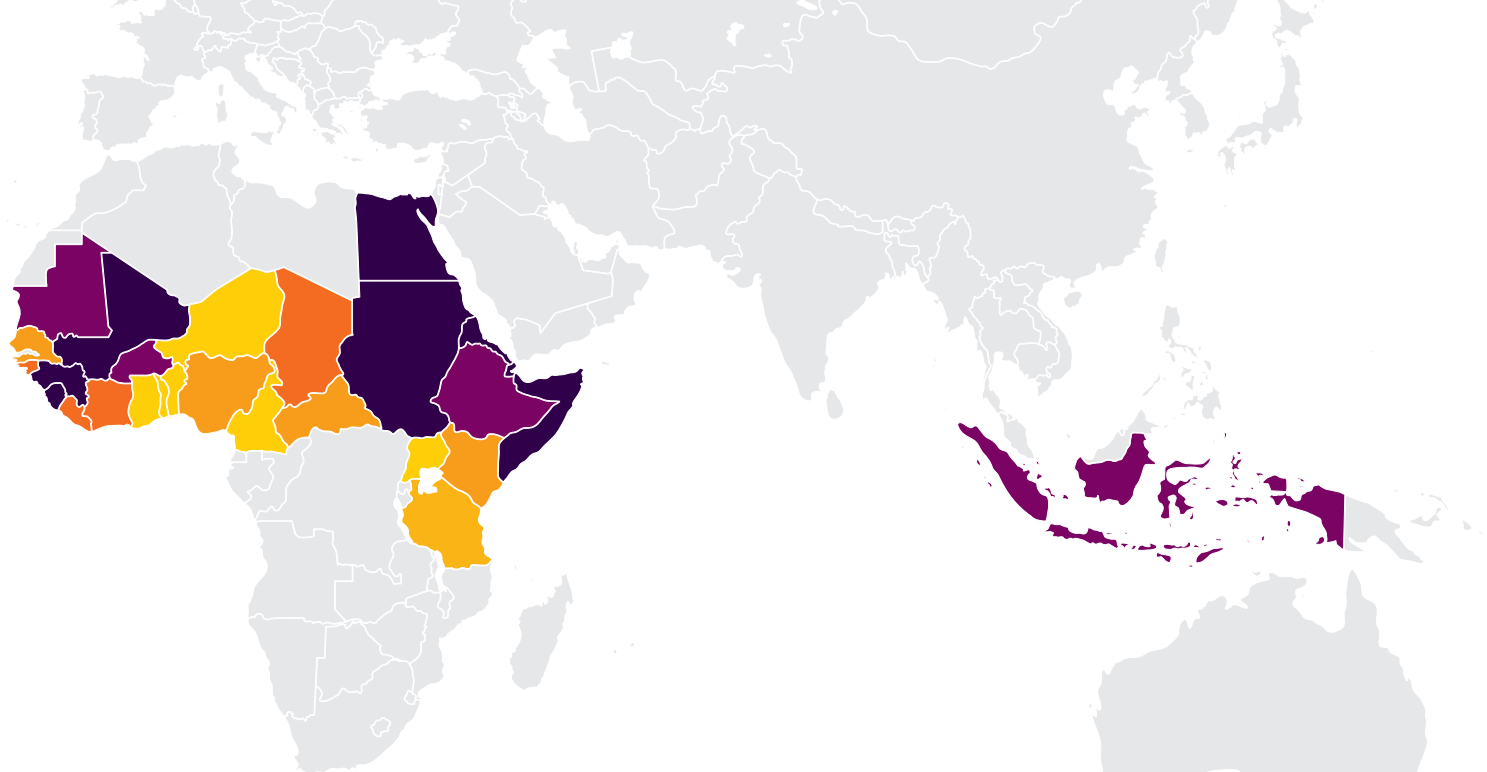
In this manual, the expression “Female Genital Mutilation” is therefore used. This is in line with the reinforcement of the international advocacy for its abandonment and in support of the Women’s Amendment Act in The Gambian context.

1.3 MAPPING AND PREVALENCE OF FGM

FGM is practised across the world, at least in 92 countries in Africa, Asia, the Middle East, Latin America, Europe, and North America, amongst indigenous and/or diaspora communities [13]. Of those, 32 countries have nationally

representative data available on FGM and the practice is documented in the 60 others, either through indirect estimates (usually used in countries where FGM/C is mainly practised by diaspora communities), small-scale studies, or anecdotal

evidence and media reports [13]. The 32 countries that have nationally representative prevalence data on FGM are concentrated in Africa, but also include Iraq, Yemen, Indonesia, Malaysia and the Maldives. [13]



MAP 1 PERCENTAGE OF GIRLS AND WOMEN AGED 15 TO 49 WHO HAVE UNDERGONE FEMALE GENITAL MUTILATION



Source: UNICEF global databases, 2021, based on DHS, MICS, and other national surveys.

The prevalence considerably varies both between and within regions and countries. Ethnicity is a key predictor. In eight countries the national prevalence ranges from 83% to 99% (Djibouti, Egypt, Eritrea, Guinea Conakry, Mali, Sierra Leone, Somalia, Sudan).

In five others, the national prevalence ranges from 52% to 76% (Burkina Faso, Ethiopia, Gambia, Guinea Bissau, and Mauritania). The rest of the countries have a national prevalence from 44 to 1%.



1.4 CLASSIFICATION AND TYPES

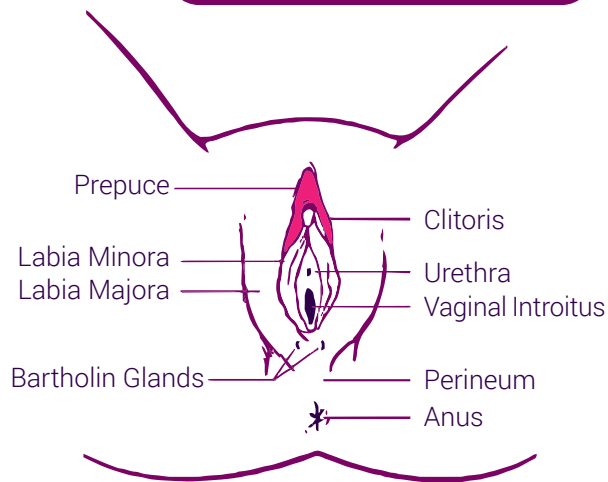
Different types of FGM are practised across regions of the globe, as classified by WHO [11].

Type I: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy) – following subdivisions are proposed to distinguish between the

major variations of **Type I** mutilation. These include **Type Ia**, removal of the clitoral hood or prepuce only; **Type Ib**, removal of the clitoris with the prepuce.

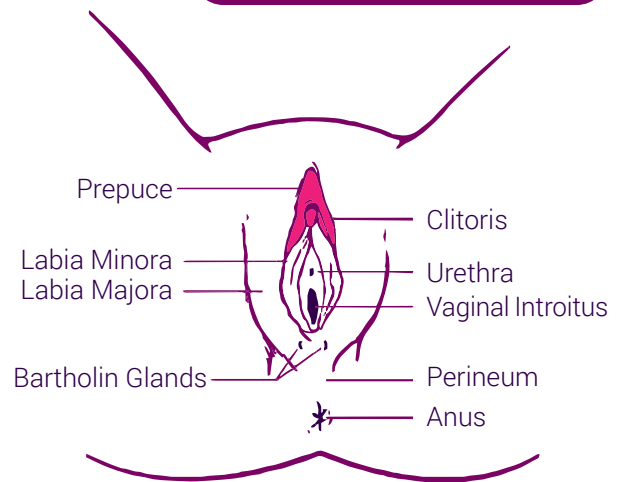
FGM TYPE I

Ia: REMOVAL OF THE PREPUCE/ CLITORAL HOOD (CIRCUMSION)



FGM TYPE II

Ia: REMOVAL OF THE CLITORIS WITH THE PREPUCE (CLITORIDECTOMY)



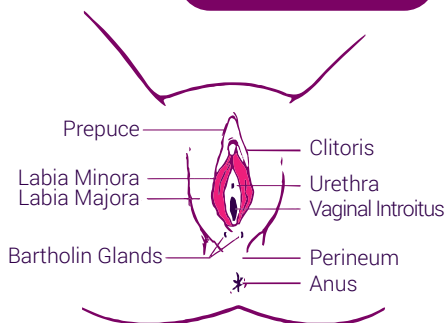
Type II: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision) - the following subdivisions

are proposed to distinguish between the major variations. These are **Type IIa**, removal of the labia minora only; **Type IIb**, partial or total removal

of the clitoris and the labia minora; **Type IIc**, partial or total removal of the clitoris, the labia minora and the labia majora.

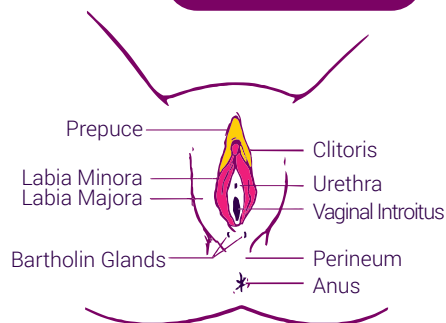
FGM TYPE II

IIa: REMOVAL THE LABIA MINORA ONLY



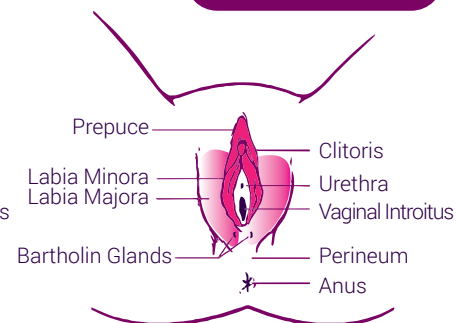
FGM TYPE II

IIb: PARTIAL OR TOTAL REMOVAL OF THE CLITORIS AND THE LABIA MINORA



FGM TYPE II

IIc: PARTIAL OR TOTAL REMOVAL OF THE CLITORIS, THE LABIA MINORA & MAJORA



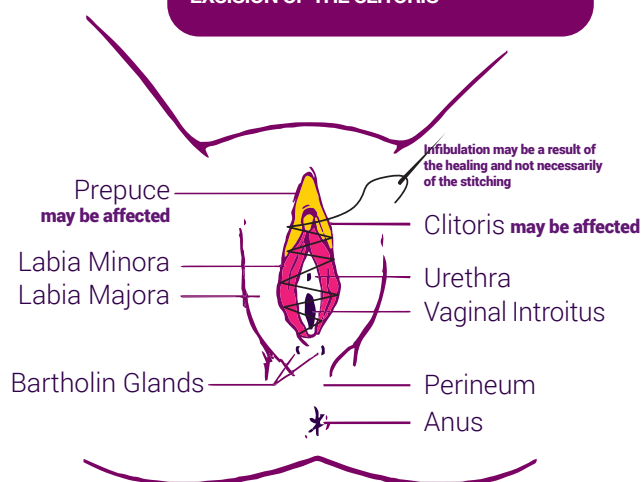
Type III: Narrowing of the vaginal orifice with the creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora,

with or without excision of the clitoris (infibulation) – following subdivisions are proposed to distinguish between variations in infibulations. These

include **Type IIIa:** removal and apposition of the labia minora; **Type IIIb:** removal and apposition of the labia majora.

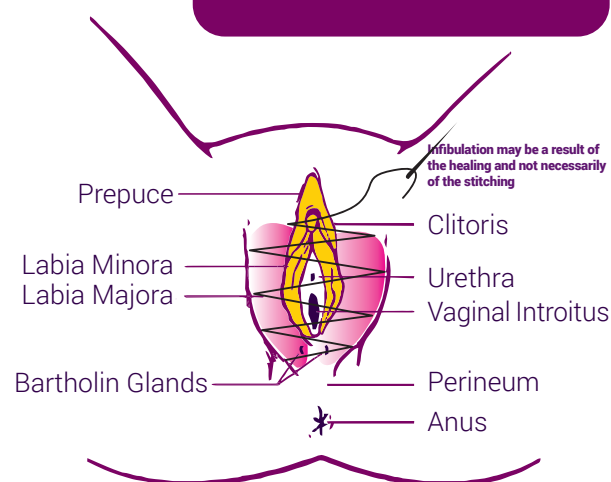
FGM TYPE III

IIIa: REMOVAL AND APPPOSITIONING THE LABIA MINORA WITH OR WITHOUT EXCISION OF THE CLITORIS

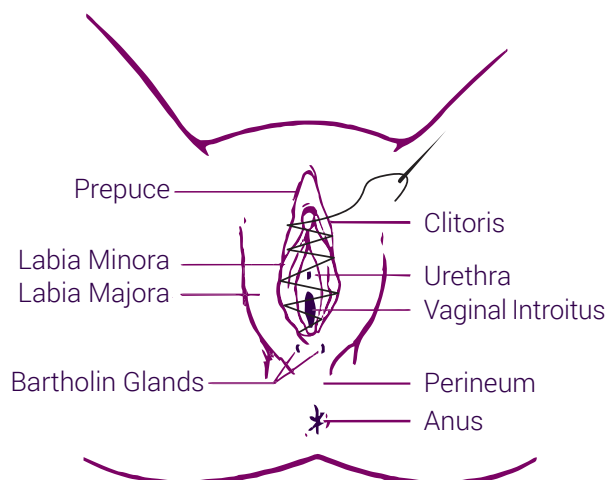


FGM TYPE III

IIIb: REMOVAL AND APPPOSITIONING THE LABIA MAJORA WITH OR WITHOUT EXCISION OF THE CLITORIS



Type IV: Unclassified: All other harmful procedures to the female genitalia for non-medical purposes, for example, pricking, piercing, incising, scraping and cauterization.



FGM TYPE IV

UNCLASSIFIED

Types I and II are the most common ones with variations between countries. **Type III** – infibulation – is experienced by about 10 per cent of all affected women and is most likely to occur in Somalia, northern Sudan, and Djibouti [14].



1.5 PROCEDURES AND CIRCUMCISERS

FGM/C is usually carried out using blades or razors. Other instruments used include special knives, scissors, or pieces of glass. On rare occasions, sharp stones have been reported to be used, for instance in Eastern Sudan. Cauterisation, or burning, is practised in some parts of Ethiopia. Fingernails have been used to pluck out the tip of

the clitoris of babies in some areas in The Gambia. Instruments used for cutting may be re-used without being cleaned. Anaesthesia is rarely used, and the girl is held down by some women, often including her relatives. The procedure may take 15 to 20 minutes, depending on the skills of the circumciser, the extent of flesh to

be cut, and the amount of resistance put up by the girl. The wound is dabbed with different products, including alcohol, lemon juice, ash, herb mixtures, porridge, or cow dung. The girl's legs may be bound together until healing is completed. In certain countries, scalpels are used for cutting in local health clinics.

1.6 DECISION-MAKING AND AGE

Decisions to perform FGM on girls involve a group of persons with varying degrees of influence within a community. Consultations usually take place between close family members. Perceived as a women's affair, the decision-making process is led by female elders. These are key figures in the ceremony arrangements as being custodians of the tradition [16]. Men are rarely involved in the process. The decision to perform FGM may also give rise to intense discussions within family circles or localities. Some family members may decide unilaterally to organise the procedure against the will of others, including the mother of the daughter to be cut. The multiple decision-makers and broad social pressure to conform renders individuals less able to act upon intentions to abandon the practice [17].

The age at which girls undergo FGM varies widely, depending on the ethnic group or geographical location. Timing is often flexible even within communities. The procedure may be carried out on infant girls, during childhood or adolescence, at the time of marriage, or during the first pregnancy. In most societies, parents and close family members have the greater say in the timing of the practice. In some African communities, the age has been deliberately brought down in response to heightened efforts to abolish the practice.

In most countries, the majority of girls were cut before age 5. In Yemen, 85 per cent of girls experienced the practice within their first week of life. [1].

1.7 CUSTOMS AND TRADITIONS UNDERPINNING FGM

In communities where FGM is practised, it is entrenched in the traditional beliefs, values, and attitudes of the people. Traditions are the customs, beliefs, and values of a community, which govern and influence people's behaviour. Traditions constitute learned habits that are passed on from generation to generation. In some communities, FGM is valued as a rite of passage into womanhood (e.g., Kenya, The Gambia and Sierra Leone). Others value it as a means of preserving a girl's virginity

until marriage (e.g., Sudan, Egypt, and Somalia). In each community where FGM/C is practised it is an important trait of gender identity. Elderly women consider it as a fundamental trait of their womanhood and believe that it is essential for their daughters' acceptance into their society. In some societies, FGM is a prerequisite to marriage, which is vital to a woman's social security.

FGM is mainly performed by traditional practitioners (traditional circumcisers or traditional birth attendants). However, in recent years, there has been a dramatic increase in the proportion of FGM carried out by healthcare providers in many settings [15]. Families are increasingly requesting that healthcare providers perform FGM, based on the belief that it would prevent health consequences for girls.

1.8 REASONS FOR FGM EXISTENCE AND PERSISTENCE

Communities continue to practice FGM based on some reasons. These include

- a. Socio-cultural;
- b. Spiritual and religious;
- c. Hygienic and aesthetic;
- d. Psycho-sexual.

a. SOCIO-CULTURAL REASONS

In some communities, FGM/C marks the rite of passage into womanhood and is accompanied by ceremonies to mark the occasion when a girl becomes a mature woman. In communities that practice it, girls and their mothers are generally subjected to powerful social pressure from their peers and family members to undergo the procedure. They are threatened with rejection by the group or family if they do not follow the tradition.

There is a belief that a girl's clitoris must be removed for her to become a mature woman or even a full member of society. Otherwise, she will face some rejection to associate with her agetates or her elders.

Some communities believe that a woman's external genitalia have the power to blind anyone attending her during delivery. Others believe that the external genitalia has the power to cause the death of an infant or bring about physical deformity or madness. In some societies, it is believed that being uncircumcised can cause the death of one's husband or harm his penis. FGM is believed to ensure a girl's virginity. In many traditional societies, virginity is a prerequisite for marriage, which is necessary to maintain a family's honour.

b. SPIRITUAL AND RELIGIOUS REASONS

Some communities believe that removing the external genitalia is necessary to make a girl spiritually clean and is therefore required by religion. In some Muslim societies where FGM is practised, people believe that it is required by the Qur'an or Sunnah (Muslim tradition), even though the practice is not mentioned in the Holy Book. The response of religious leaders to FGM varies. Those who support it tend either to consider it a religious act or to see efforts aimed at eliminating it as a threat to culture and religion. Other religious leaders support and participate in efforts to eradicate it. When such leaders are unclear or avoid the issue, they may be perceived as being in favour of FGM.

c. HYGIENIC AND AESTHETIC REASONS

It is believed in FGM practising communities that a woman's external genitalia are ugly and dirty. Removing these structures makes a girl clean and smart. In many societies, it is believed that eating food prepared by an unexcised girl is taboo. This is of relevance for some communities in The Gambia.

d. PSYCHO-SEXUAL REASONS

The uncut girl is believed to have an overactive and uncontrollable sex drive and is thus likely to lose her virginity prematurely; girls who have lost their virginity before marriage are a disgrace to their families. The belief in FGM as means of controlling sexual urge still persists in The Gambia and elsewhere in Africa.

In some communities, uncut girls have slim chances of marriage. The belief is that the uncut clitoris will grow big, and the slightest touch of the organ will arouse intense sexual desire. It is also believed that the tight vaginal orifice of an infibulated woman or a woman who has had chemicals placed in the vagina to narrow it will enhance male sexual pleasure, thus preventing divorce or unfaithfulness. In some communities, it is believed that excising a woman who fails to conceive will solve the problem of infertility.

1.9 RELIGION AND FGM

In many practising communities, FGM is significantly driven by religious misperceptions. Even though the practice can be found among Christians, Jews and Muslims, none of the holy texts of any of these religions prescribes female genital mutilation and the practice pre-dates both Christianity and Islam [18, 19].

The ordinary people in African countries, where the practice is common, have little knowledge of the fundamental teachings of Islam/Christianity. Women, in particular, have fewer chances of learning the fundamental teachings of their religion because they have less access to education in general. Moreover, misconceptions like the uncertainty regarding the origins of the practice lead to link the practice with religion. Many Islamic academics and authorities in countries, however, demonstrate a positive position on the issue and condemn the practice when they are given the opportunity to articulate their views. Despite these attitudes among Islamic religious scholars, the practice still persists on a large scale.

In July 1998, a symposium for religious leaders and medical personnel was held in Banjul, The Gambia. Participants came from 15 countries in Africa. Also, attendants were delegates from the Inter-African Committee (IAC) on Practices Affecting the Health of Women and Children, international NGOs, and representatives from several

UN agencies. The participants made strong declarations at the meeting. They declared “We, the participants at the symposium for Religious Leaders and Medical Personnel on FGM as a Form of Violence, organised by the IAC in collaboration with The Gambia Committee on Traditional Practices (GAMCOTRAP) declare as follows:

- Having examined and appreciated the health and human rights implications of violence against women and girls, particularly FGM;
 - Having recognized that in Africa over 100 million women and girls are victims of FGM;
 - Having confirmed that FGM has neither Islamic nor Christian origin or justification;
 - Seriously concerned about the incorrect interpretations and misuse of Islamic teaching to perpetuate violence against women, particularly as regards FGM;
 - Upholding the principle of equality and justice for all, without discrimination between men and women;
 - Reaffirming the universality of human rights principles and their indivisibility;
- (I)** Hereby strongly condemn the continuation of FGM;

(II) Prohibit the misuse of religious arguments to perpetuate FGM and other forms of violence;

(III) Commit ourselves to clarify the misinterpretation of religion and to teach the true principles of Islam and Christianity about violence against women, including FGM/C”.

In October 2007, the Fourth Symposium for African Religious Leaders on Human Rights, Gender and Violence against Women was held in Abidjan, Ivory Coast. Thirty-six (36) participants from 25 African countries attended. A strong declaration and a string of recommendations were made at this symposium too. The spirit and letter of the declaration and recommendations are very similar to those made at the Banjul symposium in July 1998.

In September 2011, the Colloquium on “Islam and FGM/C” was held in Nouakchott (Mauritania). The debate generated during this colloquium leads to the promulgation of a Fatwa (resolution) for the prevention of FGM – a significant step in a country with a prevalence of 72% where religion is the main justification for the practice. With these results, the Office of the Vice-President of The Gambia, organizes every year since 2011 a meeting with the religious leaders from the Supreme Islamic Council of The Gambia, opening a dialogue to drive effective legislation to prevent the practice.

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02 | FGM IN THE GAMBIA

2.1 COUNTRY PROFILE

The Republic of Gambia is located on the West African Coast. It is surrounded by the Republic of Senegal on the Northern, Southern and Eastern borders, and the Atlantic Ocean on the Western borders. It extends about 480 km inland forming a narrow enclave in the Republic of Senegal, except for a short seaboard on the Atlantic Coastline (see the map below). The country is less than 48.2 km (30.0 miles) wide at its widest point, with a total area of 11,295 km² (4,361 sq. mi). Approximately 1,300 km² (500 sq. mi) (11.5%) of The Gambia's area is covered by water.

The country has a population of 1,882,450 people and with a population density of 174 persons per km² [1]. The overall median age is 18.2 years (with 17.8 for males and 18.5 years for females) [1]. The crude birth rate is 34.4 per 1,000 population [2]. The country record an increasing child (under 5) mortality from 54 (2013) to 56 (2019-2020) deaths per 1,000 live births [2]. The Average life expectancy at birth is 62 years [3].

Several ethnic groups peacefully cohabite in The Gambia. The Mandinka constitute the largest proportion (34.4%) [1]. These are followed by the Fula/Tukulor/Lorobo (24.1%), the Wollof (14.8%), Jola (10.5%), Sarehuleh (8.2%), Serere (3.1%); the Manjago, Bambara, and Creole/Aku Marabous accounted for the least ethnic groups (respectively 1.9%, 1.3%, and 0.5%) [1].

The Gambians are predominantly Muslim (96%). Other religions practised by the population include Christianity (3.8%) and traditional religions (0.1%) [1].

The country is divided into eight local government areas (LGA), including the national capital, Banjul. However, there are two municipalities (Banjul and Kanifing) and five Administrative regions (West Coast, Lower River, Central River, North Bank, and Upper River). The Gambia is led by a President who is appointed through election. The five administrative regions are administered by Governors (appointed by the President of the Republic) and the municipalities are headed by

Mayors (elected through democratic process). Regions are further divided into districts (43 in total), each of which is headed by a District Chief. Districts and Municipalities consist of wards, which are further divided into villages.

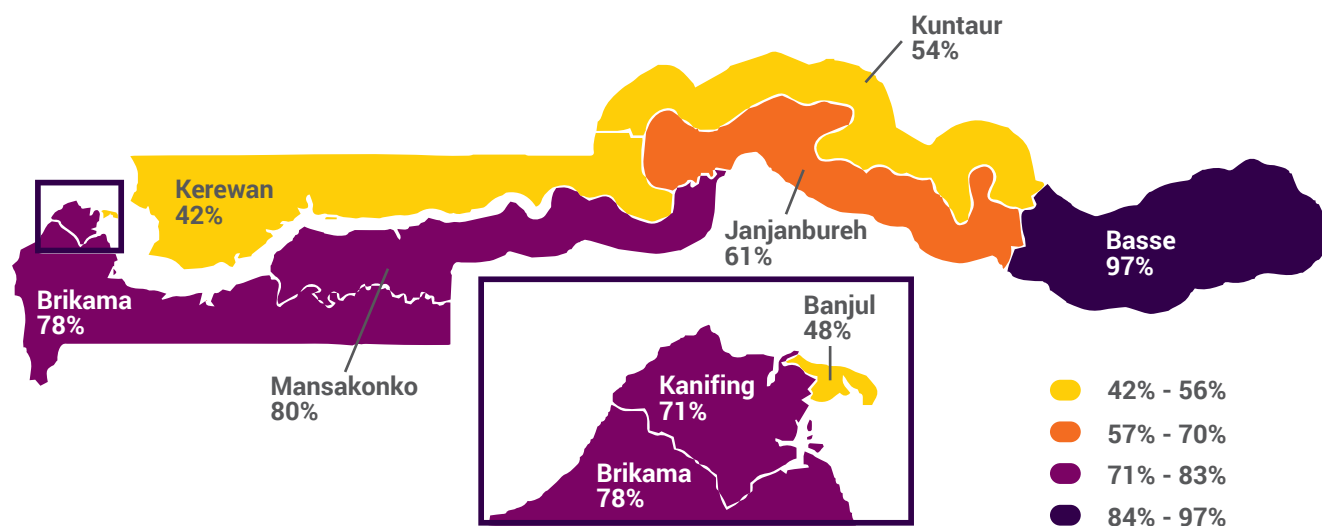
The biggest contributor to The Gambian GDP is the remittances from the diaspora, followed by the tourism sector, and agriculture. While 70% of the population is engaged in agriculture, it contributes to only about 22% of the GDP [1]. The Gambia is classified as a low-income country with a GDP per capita, estimated at US\$693.07 [4]. Around 9.2% of the population lives below the international extreme poverty line (on less than US\$1.9 a day) [5]. In 2019, The Gambia's Human Development Index value was 0.496, which puts the country in the low human development category and ranks it at 172 out of 189 countries and territories [6].

2.2 FGM SITUATION: PREVALENCE AND TYPES

Over the past decade, the prevalence of FGM has slightly decreased across the country. However, more effort is still

needed as The Gambia is ranked among the ten African countries that practiced FGM the most. 73% of women aged

15-49 in The Gambia are circumcised [2]. Such prevalence sharply varies between areas of the country (map below).



Source: The Gambia Demographic and Health Survey 2019-2020

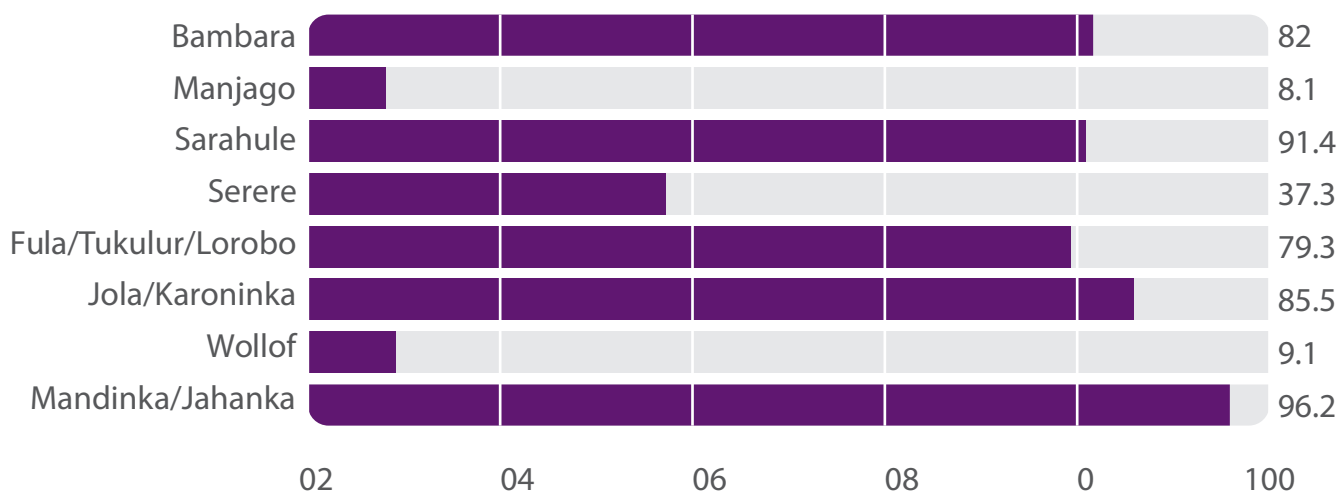
Basse has the highest prevalence of FGM (97%) whereas Kerewan recorded the lowest (42%). The place of residence is also of significance; women in urban areas are likely to have experienced FGM more than the ones in rural areas (75% and 67%, respectively) [2].

TREND AMONG AGE 15-49 YEARS & CURRENT SITUATION AMONG UNDER 5 YEARS PREVALENCE

Area	DHS 2013 (15-49yrs)	DHS 2019/2020 (15-49yrs)	Children under 5 cut (DHS 2019/2020)
Banjul	47.40%	48.30%	10.80%
Kanifing	69.70%	70.60%	19.50%
Brikama	77.60%	78%	22.20%
Mansakonko	94%	80.10%	18.50%
Kerewan	58.60%	42%	12.30%
Kuntaur	57.10%	53.50%	17.50%
Janjanbureh	74.70%	60.70%	21%
Basse	96.70%	97%	63.20%

Source: The Gambia Demographic and Health Survey 2013 and 2019-2020

THE ETHNIC GROUP IS A KEY PREDICTOR OF THE PRACTICE OF FGM IN THE GAMBIA.



Source: The Gambia Demographic and Health Survey 2019-2020

The Mandinka/Jahanka that also represent the largest population practise FGM the most (96.2%). The other most FGM practising

communities include the Sarahule (91.4%), Jola/Karoninka (85.5), Bambara, and Fula/Tululur/Lorobo (79.3) [2]. However, the Wolof, the third

largest Gambian population are among communities that practise FGM the least. The proportion of Senegalese women having undergone FGM

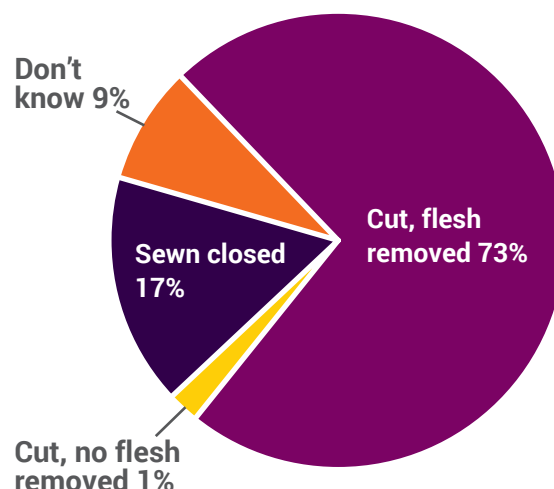
provides some insights into the link between ethnicity and practise of FGM. In Senegal, the FGM prevalence is 24%

and less than 1% of Wolof that are the largest Senegalese population (43%) practise FGM [7]. Similarly, likewise in

The Gambia, the Mandinka in Senegal are also among the highest FMG practising Senegalese communities [7].

CLASSIFICATIONS OF FGM: PERCENTAGE AMONG WOMEN AGED 15-49

Source: The Gambia Demographic and Health Survey 2019-2020



The Gambia DHS (2019-2020) classifies three types of FGM that are commonly practised across the country. These include i.) cut, no flesh removed; ii.) cut, flesh removed; iii.) sewn closed. These correspond

roughly to the abovementioned first three types classified by the WHO. The type two, meaning cut, flesh removed, is the most prevalent in The Gambia. Among the circumcised women, 73% have undergone the type two. The

type three, the most extreme form, meaning sewn closed, also known as infibulation, was performed on 17% of women. Only 1% circumcised women have had the less severe form, meaning clitoris nicked, no flesh removed.

2.3 AGE AT WHICH FGM IS PERFORMED

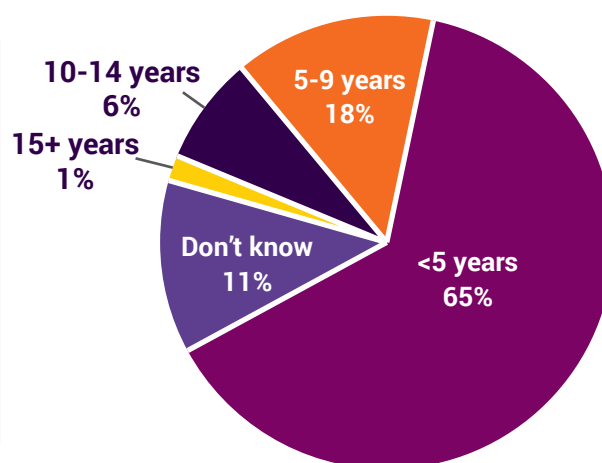
Over the past decade, the prevalence of FGM has slightly decreased across the country. However, more effort is still

needed as The Gambia is ranked among the ten African counties that practiced FGM the most. 73% of women aged

15-49 in The Gambia are circumcised [2]. Such prevalence sharply varies between areas of the country (map below).

PERCENTAGE DISTRIBUTION OF WOMEN

Source: The Gambia Demographic and Health Survey 2019-2020



Across the country, FGM is commonly practised throughout childhood. Nearly two-thirds of circumcised women

underwent the practise younger than age 5. Others (18%) were circumcised at age 5-9 and 10-14 (6%). Only 1% were

circumcised when they were 15 years old or older [2].

2.4 DECISION-MAKING

The decision to perform FGM on a girl usually results from a complex process involving multiple actors. Women are in general responsible for the practical arrangements of the event. In a practising community, a woman may intend to not circumcise her daughter. However, the (implicit or explicit) pressure from peers and feeling of helplessness for not being actively supported by her husband and other influential male leaders may make her

surrender [8]. Despite being decision-makers regarding family matters in Gambian communities, men do not actively participate in FGM decision making process [8]. Though, such a non-active involvement of husbands in the decision making does not imply that they are powerless to influence. It also indicates their positive perception towards the practice. It was noted that a substantial proportion (60.7%) of men intended to have FGM performed

on their daughters [8]. Furthermore, a few (14.2%) men made the final decision to circumcise their daughters [8]. Nevertheless, those aware of the health consequences of the practise were willing to play important role in its prevention [8]. Furthermore, a decreasing discriminatory attitudes and social pressure towards individuals unwilling to perform FGM on their daughters was also noted [9].

2.5 PROCEDURES

The operation is performed by elderly women, mainly from the blacksmith caste. These traditional practitioners are commonly called circumcisers (Ngangsimbas, meaning the mother of circumcised girls/women, in Mandinka) [10]. Circumcisers are believed to be persons who possess supernatural powers. The operation is mainly

carried out at home, in the backyard or occasionally indoors [8]. It is usually performed using knives or razor blades without anaesthesia [11]. The girl is physically held down on the floor or a mat by close family members, mainly elderly women. After the operation, the girl is treated with a variety of remedies; these include herbal concoctions or

other substances such as tomato paste, engine oil, cooking oil or cow dung. Some circumcisers tried to modernise their practises while adopting some clinical techniques, such as dressing the wound by using iodine, gentian violet, antibiotic ointments, vaseline or balms.

2.6 RITUAL AND SECLUSION PERIOD

Preparations are made by the girl's parents and/or grandmother. Usually, the family raise money to meet the cost of the ritual, which depends on several factors. The circumciser and her assistant are given hard cash or paid in-kind donations; food is provided in abundance; medicines (remedies) needed to heal the wound are procured.

Furthermore, the girls during the seclusion period are provided with gifts. Seclusion period lasts until the wound is healed and during which girls are initiated into women's secret societies. The teachings consist of passing on practical skills and communication using signs. The girls also learn songs, stories, fables, and proverbs. The initiates

are threatened to not reveal the secrets acquired during the seclusion to those girls/women who are not circumcised. It is believed that those who infringe such rules may suffer the consequences or even die.

When the seclusion ends, the girls come out; the end of seclusion ceremony

takes place (Nansing janjango, meaning convocation of circumcised in Mandinka). The girls are presented as

initiates in their new stage within their communities. This is celebrated with a big party, bringing ethnic and gender

identity, as well as belonging to the secret society of women.

2.7

CUTTING WITHOUT RITUAL - AN EMERGING PHENOMENON

The rituals (above mentioned) that surrounded the practise of FGM in The Gambia are vanishing. Initially practised as a rite of passage to womanhood by communities, most girls are now circumcised alone or together with very

few others and traditional seclusion or coming out ceremonies are no longer organised [12]. Several factors may be put forth. First, the lowering of the age at which FGM is performed; second, the schooling; third, the adoption of law that

prohibits the practise in The Gambia. In addition, some communities that adhere to a more rigoristic interpretation of Islam consider the traditional “circumcision” rituals as non-Islamic; they find cutting without ritual more appropriate.

2.8

PERCEPTIONS OF THE NEED FOR FGM

The practise of FGM is widespread across the country. Reasons for communities to perpetuate it are diverse. The most common ones include:

- FGM is a means of controlling the sexual desire of girls/women” thereby ensuring premarital virginity, marital fidelity, and preventing sexual behaviour that is considered deviant and immoral.

- FGM makes a girl “clean” (spiritually) and beautiful; the removal of genital parts is thought as eliminating “masculine” parts such as the clitoris.

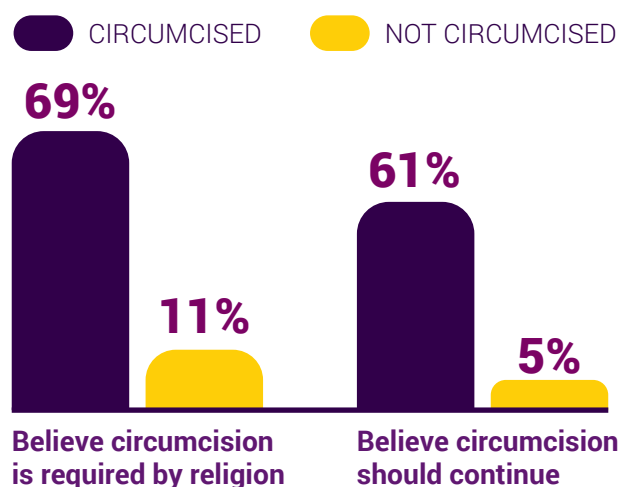
- FGM is practised in the belief that if the clitoris is not cut, it will grow to be the size of the penis and may produce a discharge that may be harmful to the husband.

- FGM gives girls a sense of belonging to the community; uncircumcised girls/women may be perceived as uncivilised, sexually loose, and incapable of showing proper respect.

Another most widely held justification for the continued practice of FGM is the importance of tradition; no other reason is given except that it is a “tradition” and conventional norms of behaviour.

ATTITUDE ABOUT FGM BY CIRCUMCISION STATUS

Source: The Gambia Demographic and Health Survey 2019-2020



2.6

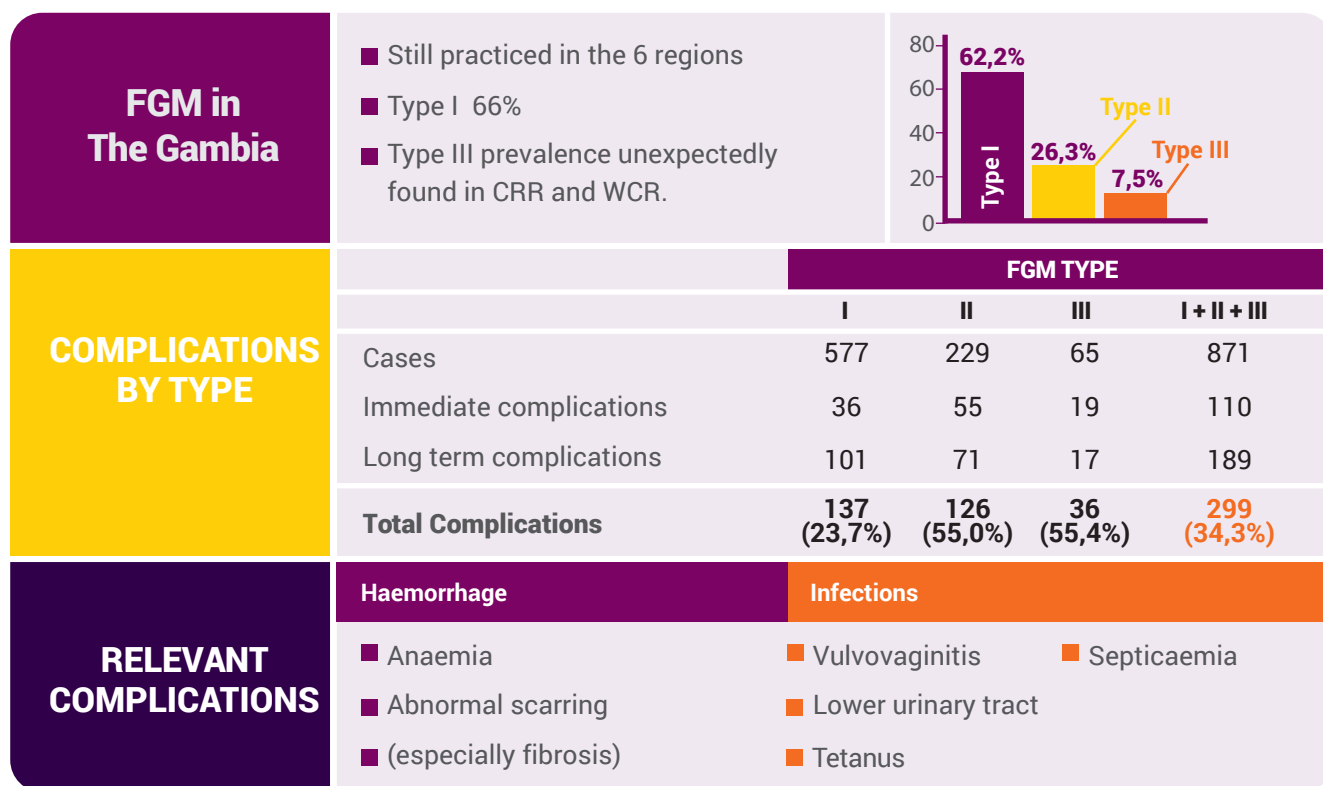
STATE OF SCIENTIFIC KNOWLEDGE
ON FGM IN THE GAMBIA

FGM has been ongoing in the country since ancient times. However, evidence on the practice and its related health complications is recent and remain a bit scanty.

Major research conducted on the issue has been carried out by Wassu Gambia Kafo, one of the research and knowledge transfer centre of the Transnational Observatory of Applied Research and New Strategies for the Prevention of Female Genital Mutilation since 1989. The observatory with its two field stations based in The Gambia and Spain has been providing two clinical studies and qualitative data on the practice of FGM across the country. Other studies were conducted to explore the knowledge, attitudes and practices (KAP) of health professionals and other key actors. Resulting data

were used to design context based educational materials and programs for care, management, and prevention of FGM in The Gambia. Additionally, other institutions and individual researchers had explored similar FGM related issues in the country. In “The long-term reproductive health consequences of female genital cutting in rural Gambia: a community-based survey” [13], the association between practices of FGM and women’s reproductive morbidity in rural Gambia was examined. The study found a higher prevalence of Bacterial vaginosis (BV), Herpes Simplex Virus 2 (HSV2) and anaemia in circumcised women. However, a lower prevalence of Chlamydia was found. Drawing on the higher prevalence of HSV2, the study suggested that circumcised women may be at increased risk of HIV infection.

In “Health consequences of female genital mutilation/cutting in The Gambia, evidence into action” [14], types and complications related to FGM were assessed through direct clinical exam of the genitalia. It was found that the majority of patient (66.2%) had FGM type I. Other patients had FGM types 2 and 3, respectively 26.3% and 7.5%. Complications due to FGM, whether immediate or late, were found in 23.7% of the patients with type I FGM, in 55.0% of patients with type II, and in 55.4% of patients with type III. The most common immediate complication, for all types, was infection, associated with haemorrhage and anaemia in some cases. In total, 34.3% (299 out of 871 registered patients with FGM) of patients who sought a gynaecological consultation developed immediate or late complications due to FGM.



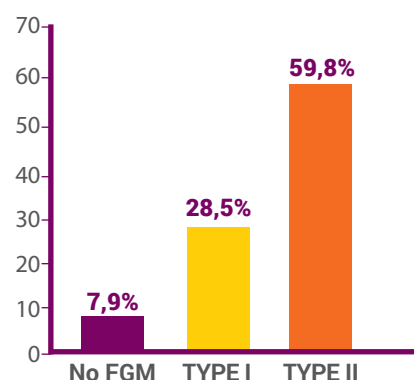
Source: Kaplan, A. et al. 2011

In “Female Genital Mutilation/Cutting in The Gambia: long-term health consequences and complications during delivery and for the new-born” [15], types of FGM, its long-term health consequences, and complications during delivery and for the new-born were assessed. It was found that fibrosis,

keloids, synechia, and clitoral neuroma were consequences of FGM and that their prevalence rose progressively from type I to type II. Furthermore, rates of perineal tear, need for episiotomy, and prolonged labour significantly increased in women who had undergone type I or II FGM. The number of stillbirths followed

similar trend. Although the need for caesarean section was low in all groups, it was significantly higher for those with FGM type III. These consequences can lead to complications also for the baby such as foetal distress, kaput of the foetal head, and even death.

Complications during delivery



% delivery complications	NO FGM	TYPE I	TYPE II
Perineal Tear	64,3	71,8	76,8
Episiotomy practised	23,1	54,8	56,0
Fresh Stillbirth	0	7,0	16,3

Source: Kaplan, A. et al. 2013

In “Knowledge, attitudes and practices of female genital mutilation/cutting among health care professionals in The Gambia: a multi-ethnic study” [16], the knowledge, attitude and practice of 468 health care professionals were examined. The study found that 42.5% of Gambian health care professionals working in rural areas supported the continuation of FGM, 47.2% intended to perform the practice on their daughters, and 7.6% of them reported having already performed it during their medical practice. The study showed some differences depending on sex and ethnic background. Women showed less approval for the continuation of FGM than men. However, health professional from traditionally practising communities (practicing Mandinka, Jola, and Fula) were more favourable to the perpetuation and medicalisation of FGM. They also expressed doubt about its eventual elimination and were less supportive of FGM prevention strategies than the others.

In “Female Genital Mutilation/Cutting: changes and trends in knowledge,

attitudes, and practices among health care professionals in The Gambia” [9], the knowledge, attitudes, and practice of 1,288 health care professionals including students were analysed. The findings showed that 76.4% of health care professionals were eager to abandon FGM. Also, 71.6% of respondents perceive it as a harmful practice with negative consequences on the life and health of girls/women. The study, in comparison with the previous one, showed some improvement in the knowledge, attitudes, and practises of health care professionals about FGM. However, 25.4% of health professionals still supported the continuation of the practice. Furthermore, 24.4% of them were willing to perform FGM on their daughters, and 10.5% had declared having already conducted the procedure as part of their routine medical practises. This study showed an increase in the medicalisation of FGM across the country.

In “Female Genital Mutilation (FGM) in 37 Health Facilities, 2013-2016: An assessment of data quality, obstetric

and delivery complications and their management” [17], obstetric and delivery complications associated with FGM and management of those complications were assessed in 37 public and private health facilities across the country. The study found that FGM type II was the most common one (51.5%), followed by type I (Clitoridectomy, 35.9%), and type III (infibulation, 5.2%) - FGM status was not recorded for 7.4% of the women. It was also found that the FGM type III was now on the increase in The Gambia and was practised across ethnic groups. Tears (10.4%), excessive scarring (1.3%), prolonged labour (1.2%) and haemorrhage (0.6%) were major FGM related complications experienced by circumcised mothers. Types of care provided to patients in labour were suturing/repair (50.9%), episiotomy (7.8%), augmentation, i.e., introducing drugs to stimulate contractions in labour (1.1%), packing/pack, i.e., introduction of gauze into the birth canal to control bleeding after delivery (0.6 %), and referral (1.8%).

2.10

LEGISLATION IN THE GAMBIA (LEGAL IMPLICATION OF FGM, LAWS AND DECREES AGAINST THE PRACTICE OF FGM)

LEGISLATION

In November 2015, the President of The Gambia has made a public statement on the abolition of FGM in the country. On December 27th, 2015, The Gambian Parliament passed a bill banning and sanctioning the performance of the practise [18]. The Women's Act 2010/December 2015 was then amended through insertion of Sections 32A and 32B.

SECTION 32A – PROHIBITION OF FEMALE CIRCUMCISION

- 1) "A person shall not engage in female circumcision
- 2) A person who engages in female circumcision commits an offence and liable on conviction
 - a) to imprisonment for a term of three years or a

fine of fifty thousand Dalasis or both, and;
b) where female circumcision causes death, to life imprisonment."

SECTION 32B – ACCOMPLICES TO FEMALE CIRCUMCISION

- 1) "A person who requests, incites or promotes female circumcision by providing tools or by any other means commits an offence and is liable on conviction to imprisonment for a term of three years or a fine of fifty thousand Dalasis or to both.
- 2) A person who knows that female circumcision is about to take place or has taken place, and fails, without good cause, to warn or inform, as the case may be, the proper authorities promptly, commits an offence and is liable on conviction to a fine of ten thousand Dalasis."



2.11

KNOWLEDGE OF LAW BANNING
FGM IN THE GAMBIA

FGM has been illegal in The Gambia since 2015. Overall, 89% of women and 65% of men who have heard of FGM are aware that it has been banned.

PATTERNS BY BACKGROUND CHARACTERISTIC

KNOWLEDGE OF LAW AGAINST FGM	
GENDER	
Men	Women
65%	89%
GENDER AND RELIGION	
Muslim	Christian
MEN 66% and Women 89%	MEN 54% and WOMEN 80%
GENDER/URBAN/RURAL	
Urban Men and Women	Rural Men and Women
Men 67% and Women 91% Men 60% and Women 84%	

Source: The Gambia Demographic and Health Survey 2019-2020

Among both women and men, more Muslims (89% and 66%, respectively) than Christians (80% and 54%, respectively) are aware that FGM is

illegal. Also, urban women and men (91% and 67%, respectively) are more likely to be aware that FGM is illegal than their rural counterparts (84% and 60%,

respectively). And the awareness that FGM is illegal generally increases with increasing education and household wealth. [10]

BEFORE THE NEW BILL, THE GAMBIA HAD ALREADY SIGNED INTERNATIONAL
HUMAN RIGHTS CONVENTIONS OPPOSING FGM.

Women's Human Rights

Convention on the Elimination of All Forms of Discrimination against Women, 1980 (ratified 1993);

Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children, supplementing the United Nations Convention against Transnational

Organized Crime Preamble, supplementing the United Nations Convention against Transnational Organized Crime, 2000 (ratified 2003).

Protection from Torture, Ill – Treatment and Disappearance

- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1985.

Rights of the Child

- Convention on the Rights of the Child, 1990 (ratified 1990).
- Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflicts, 2000.

Moreover, even if FGM is not explicitly named, the Children's Act 2005 includes an article on harmful practices:

“19. No child shall be subjected to any social and cultural practices that affect the welfare, dignity, normal growth, and development of the child and, in particular, those customs and practices that are:

- prejudicial to the health and life of the child; and
- discriminatory to the child on the grounds of sex or other status.”

In addition, the section 21 of the Women's Act 2010 guarantees the women's right to protection of health, including the right to safeguard their reproductive health. The section 31 of the Act also includes the right of women “to be educated on the health aspects of harmful traditional practices”.

INTERNATIONAL FORUM ON HARMFUL TRADITIONAL PRACTICES. EXPLORING STRATEGIES AND GOOD PRACTICES: FROM LOCAL TO GLOBAL

The first International Forum on Harmful Traditional Practices was held in The Gambia between 5th – 7th May 2009 organized by Wassu Gambia Kafo and the Interdisciplinary Research Group for the Prevention and Study of Harmful Traditional Practices (HTPs) of the Department of Anthropology of the Autonomous University of Barcelona in collaboration with UN

agencies (WHO, UNICEF and UNFPA). Her Excellency the Vice President inaugurated the Forum and endorsed the first public declaration of the overriding need to prevent the practice. She fully welcomed the documentary film “Initiation without Cutting” [19], screened at the Forum; considering FGM as a culturally sensitive issue, she requested the translation of the

film into five local languages to reach more communities in the country.

The Brufut Declaration 2009 (see appendix), signed by the participants, captures the success of this initiative, as it expresses the commitment to join efforts towards FGM prevention and highlights the need to conduct further research.

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03 | HUMAN RIGHTS AND FGM

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

3.1

ETHICS AND LEGAL IMPLICATIONS AND RIGHTS IN FGM

Professional ethics are moral statements or principles which guide professional behaviours. Ethics are not bound by law. For example, nursing ethics include maintaining the confidentiality and showing respect to patients regardless of their cultural background, socioeconomic status, or religion.

In some countries, physicians, nurses, midwives, and other health personnel are reported to be performing FGM in both public and private health facilities. The WHO and most governments have expressed

their unequivocal opposition to the “medicalisation” of the practice [1]. The WHO state that “under no circumstance should FGM be performed by health professionals or in health institutions”. [2] The practice of FGM by medical professionals is a serious betrayal of the professional ethics of the medical practise since it involves causing harm without therapeutic reasons. Performing FGM is a violation of the ethical principles “do not harm” and “do not kill”.

The enactment of a law to protect girls and women from FGM makes

it clear what is wrong and what is right. Having a law in place offers legitimacy to the police, women’s organizations, advocacy groups, health professionals, social workers, and others to intervene.

Passing laws is not enough to fully protect girls and women from FGM. The fear of prosecution may deter individuals from seeking help in the advent of complications. Therefore, laws must go hand in hand with community education to raise awareness of the harmful effects of FGM and to change attitudes.

3.2

HOW FGM VIOLATES HUMAN RIGHTS

The evidence that FGM damages the health of girls and women is well documented. It interferes with healthy genital tissue and can lead to severe consequences for a woman’s physical and mental health. Therefore, it violates a person’s right to the highest attainable standard of physical, sexual, and mental health of women and girls. Female Genital Mutilation violates a series of well-established human rights principles, norms, and standards. Key principles among these are:

- ✿ The right to life when the procedure results in death;
- ✿ Equality and non-discrimination based on sex;
- ✿ The right to freedom from torture or cruel/inhuman treatment;
- ✿ Freedom from degrading treatment or punishment.
- ✿ Individuals and organizations working against the practise of FGM bear witness to the fact that the practise is:
- ✿ Associated with gender inequalities;
- ✿ A form of discrimination against girls and women;
- ✿ A form of torture, cruel, inhuman, and degrading treatment of girls and women;
- ✿ An abuse of the physical, psychological, and sexual health of girls and women.

3.3 RIGHTS OF THE CHILD

Human rights law grants special protection to children because of their vulnerability and need for care and support. “The best interests of the child” is the primary consideration of one of the guiding principles of the Convention on the Rights of the Child. Parents who decide to subject their daughters to FGM perceive that the benefits to be gained from the procedure outweigh the risks involved. However, such a perception cannot justify a violation of the fundamental human rights of girls and women.

The Convention on the Rights of the Child refers to the capacity of

children to make decisions regarding matters that affect them. Even if girls apparently desire to undergo the procedure, this is because of social pressure, expectations, and aspirations to be accepted as full members of the community. Accordingly, a girl’s decision to undergo FGM cannot be called ‘free’.

FGM is most often performed on minors, which is a violation of the rights of the child. The practice also violates the rights to health, security and physical integrity of the person, the right to be free from torture and cruel, inhuman, or degrading

treatment, and the right to life, as the procedure, may result in death. Legal instruments for the protection of children’s rights call for the abolition of traditional practices that put their health and lives at risk. The Convention on the Rights of the Child makes explicit reference to harmful traditional practices. The Committee on the Rights of the Child, as well as other United Nations Human Rights Treaty Monitoring Bodies, have frequently raised FGM as a violation of human rights. They have called on State Parties to the Convention to take all effective and appropriate measures to abolish the practice.

3.4 VIOLENCE AGAINST WOMEN

Definition

Article 1 of the UN Declaration on the Elimination of Violence against Women, proclaimed by the UN General Assembly in its resolution 48/104 of 20 December 1993, defines the term “violence against women” as: “Any act of gender-based violence that results in, or is likely to result in physical, sexual or psychological harm or suffering to women”. The Article further states that violence includes “threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life”.

Three contexts of violence are differentiated in Article 2 of the Declaration – family, community, and state. The forms of violence are classified as follows:

(I) Physical, sexual, psychological, and emotional violence occurring in the family:

- Wife beating;
- Sexual abuse of female children in the household;
- Dowry-related violence;
- Marital rape;
- Female Genital Mutilation/Cutting and other traditional practices harmful to women;
- Spousal and non-spousal violence;
- Violence related to exploitation;
- Violence related to exercise of authority and power.

(II) Physical, sexual, and psychological violence occurring within the general community:

- Rape, sexual abuse, sexual harassment and intimidation in the workplace, at leisure or educational institutions and other settings outside the household;
- Trafficking in women and forced prostitution;

(III) Physical, sexual, and psychological violence perpetrated or condoned by the State in any form.

The various forms of violence listed in Article 2 may not be exhaustive, but they show that much violence against women stems from unequal power relations and society’s insistence on controlling women’s sexuality.

3.5

INTERNATIONAL CONVENTIONS AND DECLARATIONS RELEVANT TO FGM

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

Treaties and consensus

The Committee on the Elimination of All Forms of Discrimination against Women, the Committee on the Rights of the Child and the Human Rights Committee are all active in condemning FGM and recommending measures to combat it. They are pushing for the criminalisation of the practice.

The Committee on the Elimination of All Forms of Discrimination against Women issued its General Recommendation on Female Circumcision. It calls upon states to take appropriate and effective measures to eradicate the practice. It also requests them to provide information about measures being taken to eliminate FGM in their reports to the Committee.

International Treaties of direct relevance to FGM include:

- Universal Declaration on Human Rights, 1948;
- Convention for the Suppression of the Traffic in Persons and of the Exploitation of Others, 1949;
- The Geneva Conventions and their Additional Protocols, 1949 and 1977;
- Convention on Consent to Marriage, Minimum Age for Marriage and Registration of Marriages, 1964;

- International Covenant on Civil and Political Rights, 1966;

- International Covenant on Economic, Social and Cultural Rights, 1966;

- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and its Optional Protocol, 1981;

- Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, 1987;

- Recommendation 19 of the Committee on the CEDAW, 1992;

- Vienna Declaration and Plan of Action (VDPA Vienna), 1993;

- United Nations Declaration on Violence Against Women, 1993;

- Declaration and Programme of Action of ICPD (International Conference on Population and Development), 1994;

- The Beijing Declaration and Platform for Action, 1995;

- Convention on the Rights of the Child 1989 and its two Optional Protocols 2000;

- Convention against Transnational Organized Crime and its Optional Protocols, 2000;

- UNESCO Universal Declaration on Cultural Diversity, 2001;

- African Charter on Women's Right, Maputo Protocol, 2005;

- United Nations Economic and Social Council (ECOSOC), Commission on the Status of Women. Resolution on the Ending of Female Genital Mutilation, 2007;

- United Nations General assembly first resolution calling on States to intensify efforts to eliminate FGM/C, 2012.

Regional treaties

- European Convention for the Protection of Human Rights and Fundamental Freedoms, 1956.

- African Charter on the Rights and Welfare of the Child, 1999;

- African Charter on Human and Peoples' Rights (the Banjul Charter) and its Protocol on the Rights of Women in Africa, 2005;

Convention on the Rights of the Child (1989)

- Protection of all fundamental rights irrespective of sex;

- The right to the highest attainable levels of health;

- Freedom from all forms of mental and physical violence and maltreatment.

African Charter on the Rights and Welfare of the Child (ACRWC):

The ACRWC was adopted in July 1990 by Heads of State and Governments of the African Union and entered into force in November 1999. The Charter has 48 Articles covering a wide range of issues affecting children. Article

21 is specifically committed to "Protection against Harmful Social and Cultural Practices". It states that "State Parties to the Charter shall take all appropriate measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child and in particular (a) those customs and practices prejudicial to the health or life of the child and (b) those customs and practices discriminatory

to the child on the ground of sex or other status".[3]

Article 16 provides "Protection against Child Abuse and Torture. State Parties to the Charter shall take specific legislative, administrative, social, economic and educational measures to protect the child from all forms of torture, inhumane or degrading treatment and especially physical and mental injury or abuse, neglect or

maltreatment including sexual abuse, while in the care of the child".[3] The spirit and intent of these two articles clearly run against the practice of FGM/C. Seen from a human rights perspective, the practice reflects deep-rooted inequality between the sexes and constitutes an extreme form of discrimination against women.



3.6 THE LAW IN AFRICA

Laws against FGM are most common across the continent. 27 African countries have enacted specific laws or specific legal provisions against FGM.

	No	COUNTRY	YEAR	LEGISLATION
TABLE 1 LAWS OR SPECIFIC LEGAL PROVISIONS AGAINST FGM ACROSS THE CONTINENT	1.	Benin	2003	Specific national anti-FGM law which prohibits FGM
	2.	Burkina Faso	1996	Specific criminal law provision
	3.	Cameroon	2016	Specific criminal provision
	4.	Central African Republic	1966, 1996, 2016	Specific criminal law provision
	5.	Cote D'Ivoire	1998	Specific criminal provision
	6.	Djibouti	1994, 2009	Specific criminal law provision
	7.	Democratic Republic of Congo	2006	Specific criminal law provision
	8.	Egypt	1996, 2008	Specific criminal law provision
	9.	Eritrea	2007	Specific national anti-FGM law which prohibits FGM
	10.	Ethiopia	2004	Specific criminal law provision
	11.	Gambia	2015	Specific criminal law provision
	12.	Ghana	1994, 2007	Specific criminal law provision
	13.	Guinea	1965, 2000	Specific criminal law provision
	14.	Guinea Bissau	2011	Specific national anti-FGM law that prohibits FGM. Cross-border FGM also criminalised
	15.	Kenya	2001, 2011	Specific national anti-FGM law that prohibits FGM. Cross-border FGM also criminalised
	16.	Mauritania	2005	Specific criminal law provision
	17.	Niger	2003	Specific criminal law provision
	18.	Nigeria	2015	Specific criminal law provision that does not apply in all states of Nigeria
	19.	Senegal	1999	Specific criminal law provision
	20.	South Africa	2003	Specific criminal law provision
	21.	South Sudan	2016	Specific criminal law provision
	22.	Sudan	2008, 2009, 2020	Criminalised in April 2020 by amending the Criminal Code. Already restricted or banned in 6/18 states between 2008 and 2020.
	23.	Tanzania	1998	Specific criminal law provision
	24.	Togo	1998	Specific criminal law provision
	25.	Uganda	2010	Specific national anti-FGM law that prohibits FGM. Cross-border FGM also is being criminalised
	26.	Zambia	2005, 2011	Specific criminal law provision
	27.	Zimbabwe	2007	Specific criminal law provision

Source: Equality Now, End FGM European Network, and the US End FGM/C Network (2020) [4] and 28 Too Many (2018) [5]

Of these 27 countries, only five (Benin, Eritrea, Guinea-Bissau, Kenya, Uganda) have enacted a specific national anti-FGM law. FGM is specifically mentioned/covered

within other laws in the twenty-two others [4]. On the other hand, in countries (Chad, Liberia, Mali, Sierra Leone, Somalia, and Somaliland) that currently do not prohibit FGM within

their domestic legal frameworks, most have either draft laws waiting to be passed or have expressed an intention to draft a law [5].

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04 | COMPLICATIONS OF FGM

FGM has no known health benefits. Girls and women who have undergone the practise are at great risk of suffering from its complications throughout their lives. The procedure is painful and traumatic. It is often performed under unsterile conditions by a circumciser who has limited knowledge of the female anatomy and how to manage possible adverse events [1]. Moreover, the removal of or damage to healthy genital tissue interferes with the natural functioning of the body. The complications caused by FGM can be classified into immediate physical complications, long term physical complications, psychosocial complications, sexual complications, and dangers of FGM/C to childbirth [2].

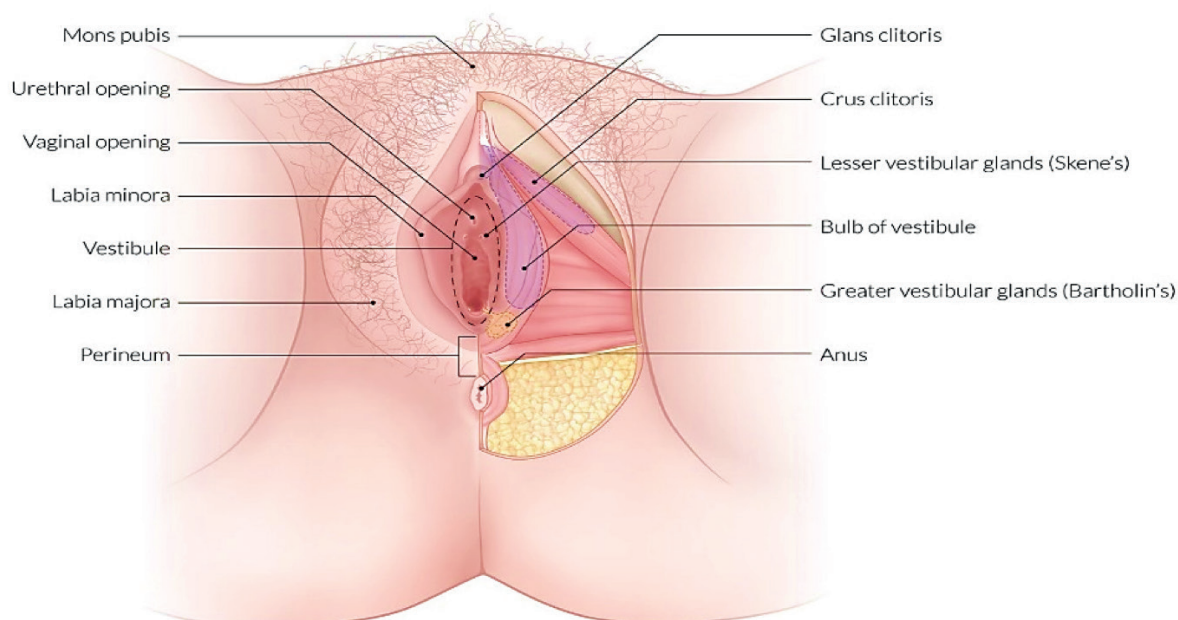
4.1 OVERVIEW OF THE FEMALE GENITALIA

The normal external female genitalia comprises the following parts:[3]

- Urethral meatus: allows emptying of the bladder within a few minutes;
- Labia Minora: protects internal structures and orifices;
- Skene's and Bartholin glands: lubrication of the vagina;
- Clitoris: assists the woman to achieve sexual satisfaction;
- Labia Majora: protects the inner structures and orifices.
- Vaginal orifice: allows menstrual flow, sexual intercourse and delivery of baby;
- Perineum: supports the pelvic organs and separates vagina from anus;

FIGURE 1

FEMALE GENITALIA



SOURCE: [HTTPS://WWW.AMBOSS.COM/US/KNOWLEDGE/FEMALE_REPRODUCTIVE_ORGANS/](https://www.amboss.com/us/knowledge/female_reproductive_organs/)

4.2 IMMEDIATE COMPLICATIONS

The range of complications associated with FGM is wide. The most immediate

ones include pain, haemorrhage, shock, tissue injury, acute urine retention,

fracture or dislocation, infection, and failure to heal.

4.2.1 PAIN

The pain resulting from FGM is produced by two fundamental aspects: first, by the extensive innervations of

female genitalia; second, by the use of inappropriate instruments and without anaesthetics. Sometimes

the pain can be so intense to the extent to cause shock.

4.2.2 HAEMORRHAGE

Excision of the clitoris involves cutting the clitoral artery which has a strong blood flow at high pressure. Packing, tying, or stitching to stop bleeding may not be effective and

leading to haemorrhage, which is the most common and life-threatening outcome of FGM. Secondary haemorrhaging may also occur after the first week of the operation as a

result of sloughing of the clot over the artery due to infection. Cutting of the labia causes further damage to blood vessels and Bartholin glands.

4.2.3 SHOCK

Immediately after the procedure, the girl may go into shock because of the sudden loss of blood (haemorrhagic shock). Haemorrhagic shock occurs when there is a reduced volume of blood circulating in the body due to severe bleeding. In the case of

FGM, severe damage caused to the genital tissues can lead to excessive blood loss. Death can occur within a relatively short time if the patient fails to receive adequate treatment. It is important to know that a large part of the female population in

these regions has chronic anaemia, including girls. 45% of children aged 6-59 months and 44% of women aged 15-49 are anaemic [4]. With anaemia, the onset of haemorrhagic shock is faster.

4.2.4 INJURY TO TISSUE

Injury to the adjacent tissue of the urethra, vagina, perineum, and rectum can result from the use of rudimentary instruments, or because of the poor knowledge of the circumciser of the

anatomy and physiology of the female external genitalia. Poor eyesight of circumcisers, the use of inappropriate techniques, or poor lighting condition increase the risk of injury, which is

especially likely if the girl struggles because of pain and fear. Damage to the urethra can result in incontinence.

4.2.5 ACUTE URINE RETENTION

Urine retention can result from swelling and inflammation around the wound, the girl's fear of the pain when passing

urine on the raw wound, or injury to the urethra. Retention is very common, which may last for hours or days. This

condition can lead to urinary tract infections.

4.2.6 FRACTURE OR DISLOCATION

Fractures of the clavicle, femur or humerus, or dislocation of the hip joint

can occur if heavy pressure is applied to restrain the struggling girl during the

cutting. It is common that several adults hold a girl down during the procedure.

4.2.7 INFECTION

Infection is very common because of the following:

- Unhygienic conditions;
- Use of unsterilized instruments;
- Application of substances such as herbs or ashes to the wound, which may act as a growth medium for bacteria;

- Binding of the legs following FGM type III (infibulation), which prevents wound drainage;

- Contamination of the wound with urine and/or faeces.

Infections may cause delayed healing, which may result in an abscess, fever, ascending urinary tract infection, pelvic infection, tetanus, gangrene,

or septicaemia. Severe infections can be fatal. Group circumcisions, in which the same unclean instruments are used on several girls may pose a risk of transmission of blood-borne diseases such as HIV and hepatitis B. Nevertheless, there have been no confirmed cases of such transmission to date.

4.2.8 FAILURE TO HEAL

The wounds may fail to heal quickly because of infection, irritation from

urine or rubbing when walking. This can lead to a purulent, weeping wound

or to a chronic infected ulcer.

4.3 LONG-TERM COMPLICATIONS

Long-term physical complications may include the following:

• Difficulties in passing urine

This can occur as a result of damage to the urethral opening

or scarring of the meatus.

• Recurrent urinary tract infection

Infection near the urethra can result in ascending urinary tract infections. This is particularly

common following FGM type III, when the normal flow of urine is affected and the perineum remains constantly wet and susceptible to bacterial growth. Stasis of urine resulting from difficulty in micturition can also

lead to bladder infections. These infections can spread to the urethra and kidneys.

Pelvic infections

Pelvic infections are painful and may be accompanied by a discharge. Infections may spread to the uterus, fallopian tubes, and ovaries, and may cause infertility.

Infertility

Infertility may happen if pelvic infection causes irreparable damage to the reproductive organs.

Keloid scar

Slow and incomplete healing of the wound and post-operative

infection can lead to the production of excess connective tissue in the scar (keloids). This may obstruct the vaginal orifice, leading to dysmenorrhoea (painful menstrual period). Following infibulation, scarring can be extensive to the extent of preventing penile penetration and result in sexual and psychological problems.



FIGURE 2 ABSCESS ON THE VULVA

Abscess

Deep infection resulting from defective healing or an embedded stitch which may require surgical intervention (See Figure 2).

Source: Abdulcadir J. et al. (2016).[5]



FIGURE 3 CYSTS ON THE VULVA

Cysts on the vulva

Implantation dermoid cysts are the most common complication of infibulation (see figure 3). They vary in size, sometimes growing as big as a ball, and occasionally becoming infected. They are extremely painful and inhibit sexual intercourse.

Source: Abdulcadir J. et al. (2016).[5]



FIGURE 4 CLITORAL NEUROMA

Clitoral neuroma

A painful neuroma can develop as the clitoral nerve is being trapped in a stitch or in the scar tissue of the healed wound. This leads to hypersensitivity and dyspareunia.

Source: Abdulcadir J. et al. (2016).[5]

Difficulties in menstruation

Difficult menstruation can occur because of partial or total occlusion of the vaginal opening.

Occlusion of the vagina

This can cause difficulties such as dysmenorrhoea and accumulation of menstrual blood in the vagina (haematocolpos); Haematocolpos may appear as a bluish bulging membrane in the vaginal orifice and can prevent penetrative sexual intercourse. It can also cause distension of the abdomen which, together with the lack of menstrual flow, may give rise to suspicions of pregnancy, with potentially serious social implications to the women affected.

Calculus formation in the vagina

This can occur as a result of the accumulation of menstrual debris and urinary deposits in the vagina or in the space behind the scar tissue formed after infibulation.

Fistulae

These are holes or false passages between the bladder and the vagina (vesico-vaginal) or between the rectum and vagina (recto-vaginal); they can develop, as a result of injury to the soft tissues during cutting, opening up infibulation or re-suturing an infibulation, sexual intercourse or obstructed labour. Urinary or faecal incontinence can be life-long and have serious social consequences, such as the isolation of women who develop such condition.

Dyspareunia (painful sexual intercourse)

Dyspareunia is a consequence of FGM. It is caused by the scarring related to the practice resulting in reducing the vaginal orifice. Vaginal penetration may be difficult, or even impossible, therefore necessitating a re-cutting. Vaginismus may result from injury to the vulval area, the vaginal opening spasms, causing considerable pain and soreness.

Sexual dysfunction

Sexual dysfunction may affect both partners because of pain and difficulties in vaginal penetration and reduced sexual sensitivity following a clitoridectomy.

Problems in childbirth

These are more common following severe forms of FGM; the tough scar tissue that forms causes partial or total occlusion of the vaginal opening. Difficulties in performing an examination during labour can lead to incorrect monitoring of the stages of labour and foetal presentation. Prolonged and obstructed labour can lead to tearing of the perineum, haemorrhage, fistula formation, as well as uterine inertia, rupture or prolapse. These complications can cause harm (including stillbirth) to the neonate and maternal death. In the event of miscarriage, the foetus may be retained in the uterus or birth canal.

4.4 PSYCHOSOCIAL COMPLICATIONS

Various circumstances related to FGM can lead to psychosocial problems. The practise is commonly performed on young girls. Usually, intimidation, coercion, and violence exerted by people surrounding the child precede the performance of the practise. Girls are generally conscious when the painful cutting occurs. They are often physically restrained because they struggle. In some instances, they are also forced to watch the circumcision of other girls.

For some girls, circumcision is an occasion marked by fear, ambivalence, and suppression of feelings. The

experience leaves a scarring memory that can affect their mental development. They suffer in silence.

Girls may suffer feelings of betrayal, bitterness, and anger for being subjected to such an ordeal even if they receive support from their families immediately following the procedure.

Long-term memories of the pain resulting from FGM may affect the relationship between the girl and her parents. It may also affect her ability to develop trusting relationships in the future with parents.

The experience of FGM has been associated with a range of mental and psychosomatic disorders. For instance, girls have reported disturbances in their eating patterns, sleeping habits and mood. Symptoms include sleeplessness, nightmares, loss of appetite, weight loss or excessive weight gain. Some victims experience panic attacks, difficulty in concentration and learning, and other symptoms of post-traumatic stress.

As they grow older, women may experience some of the following disorders:

- Stress;
- Feelings of incompleteness;
- Feelings of fear of humiliation and betrayal;
- Loss of self-esteem;
- Depression;
- Chronic anxiety;
- Phobias ;
- Panic attacks.

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

4.5 SEXUAL COMPLICATIONS

Sexual problems because of FGM can affect both partners in a marriage, from fear of the first sexual intercourse onwards. As mentioned above, circumcised women may suffer painful sexual intercourse because of the following conditions:

- Scarring;
- Vaginal dryness;
- Narrow vaginal opening;
- Obstruction of the vagina due to elongation of labia minora;
- Complications such as infection.

The removal of women's genital parts may lead to damaged nerve endings

and the development of inelastic scar tissue and adhesions surrounding the excised areas, which contribute to causing impaired sexual functioning [6].

Studies that explored the Female Sexual Function Index (FSFI) in circumcised women reported that women without FGM experienced more sexual desire than women with FGM [7, 8]. Among circumcised ones, that sexual desire was felt more in types I and II than type III [9]. Similar trends were found regarding sexual arousal; women with FGM experience less sexual arousal than women with FGM and sexual arousal was felt more in types I and II than type III. [8-10]. Regarding lubrication, orgasm, and satisfaction, these were felt more

by uncircumcised women than circumcised ones and the lubrication, orgasm, and sexual satisfaction were present more in types I and II than type III [8, 9]. Pain during sexual intercourse, women with FGM experienced it more than women without FGM and pain during intercourse was less felt in women with FGM types I and II than those of type III [8, 9]. The fact that FGM decreases sexual satisfaction, reduces sexual desire and arousal, decreases lubrication during sexual intercourse and reduces the frequency of orgasm or anorgasmia is justified the fact that in women with FGM, parts of the erogenous genital zones and sexually responsive vascular tissue are cut. [6]

4.6 DANGERS FOR CHILDBIRTH

Evidence shows that FGM significantly increases risks adverse pregnancy outcomes. Women with FGM type I, II and III were reported having higher incidences of caesarean section and post-partum haemorrhage compared to those who had not undergone FGM; also, the risk increased with the severity of the procedure [2]. In addition to mothers, new-born babies also suffer the consequences of FGM. A study conducted in The Gambia reveals higher death rates among

babies born of mothers with FGM during birth or immediately compared to those born of uncircumcised mothers. Whereas complications rate in new-borns was only 5% for mothers without FGM, rates were 16% and 38% respectively for mothers with FGM types I and II. [11]

Foetal distress was observed in 3% of cases for mothers without FGM; however, rates were 9% and 27% for mothers with FGM types I and II.

Caput of the foetal head was also found in 14% and 34% for mothers with FGM types I and II whereas only 1% was observed for mothers without FGM.[11]

With a proportion of 15% of homebirth [4], the consequences of FGM during labour or following the delivery can be more for mothers and babies across the country. The high incidence of postpartum haemorrhage, a life-threatening condition, is of particular

concern where health facilities face limited capacity to deliver emergency obstetric and new-born care services.

In health facilities, good documentation is necessary for the efficient

management of cases, and for providing quality health care and follow up of women with FGM. In some countries, nurses and midwives have been provided with protocols to record the presence of FGM, the types involved,

and the resulting complications as a matter of routine. Some health institutions have incorporated record keeping in their internal policies.

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05 | MANAGEMENT OF GIRLS AND WOMEN WITH PHYSICAL COMPLICATIONS

All girls and women who undergo FGM will suffer some forms of negative health consequences associated with the practice. Some will experience immediate, short-term, and long-term health conditions that require rapid medical treatment.

These conditions include

- Severe pain and injury to tissues;
- Haemorrhage (severe haemorrhage can lead to anaemia);
- Haemorrhagic shock;
- Infection and septicaemia;
- Genital tissue swelling;
- Acute urine retention.

Students of medicine, nursing, midwifery, and public health should be aware of these and how to manage them. During assessment of the patient, the nurse/midwife should identify what kind of care is appropriate for her.

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

- Interviewing the girl/woman by asking relevant questions (history taking)
- Examination of the genitalia (clinical examination).

5.1 CREATING A TRUSTY RELATIONSHIP

For history taking and clinical examination, it is crucial that the nurse/midwife establish a trusting relationship with the woman. This means:

- Showing empathy – i.e., using interpersonal skills to create a rapport with the patient;
- Showing respect;
- Having patience.
- Maintaining confidentiality;

5.2 TAKING A HISTORY

Success in history taking will depend largely on good use of interpersonal communication skills to create a trusting relationship. Women who have undergone FGM will most likely come to a health facility for other health reasons than FGM. The health care personnel will have to address the health problems presented. However, there will be need, to be

alert to the fact that the woman may have undergone FGM. The healthcare provider will have to find out by asking direct or indirect questions.

The procedure is as follows:

- Greet the patient in the culturally accepted manner. Ask her to sit comfortably near and facing you.

- Introduce yourself and address the patient by her name.
- Begin by asking general questions, such as: “How are you? How is the family? Do you have any information you would like to share with me?”

When the patient is relaxed and seems ready to talk about personal matters, ask her tactfully about any operations she has had, including FGM. Use terminology which is familiar to the patient. Ask her if she would like to share any information about the operation and any problems, she may have due to FGM, and reassure her that you are comfortable dealing with her condition and that it is not a barrier to her getting services.

Let the patient express her feelings and give you the information she wants to share. If she starts crying, be patient and give support. Listen carefully and empathize with her. Show concern to the patient and let her know you can help her. Encourage the patient to talk by using facilitation skills, such as nodding, saying “ah, ah”, and making eye contact when you look at her. Patients may be very slow in sharing information about excision; be patient and do not force her to speak. If the patient

is not ready to share information yet, make an appointment with her for another visit.

- Once it has been established that the woman has undergone excised, this information and the subsequent clinical examination should be handled with professionalism and discretion.
- The information (the type and the complications) should be recorded as required by the policy.

5.3 CLINICAL EXAMINATION

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

In some places, consent from the partner or husband may be necessary before examining the genitalia of a woman.

The woman should be made to feel confident that she is in safe hands, she will not be judged and will not be made an object of curiosity or put on display.

The preparation for a clinical examination includes:

- Preparation of patient – i.e., explain the procedure carefully and fully, and get her consent, and/or that of her partner if applicable.

- Preparation of equipment – it is essential to use sterile equipment and materials. i.e., gloves, kidney dish with gallipot, sterile swabs and cleansing lotion, and receptacle for used swabs.

The procedure is as follows:

- Explain procedure to the patient in detail and check that she has understood.
- Ask patient's consent to examine her. If there is another member of the health staff present, explain the reason for his/her presence to the patient and ask her permission for the person to be present. The patient has the right to refuse, and this must be respected.

The nurse/midwife should emphasize that care is not conditional on the patient's consent to allow others to attend the examination.

- Ensure privacy and confidentiality.
- Instruct the patient to take off her underwear and help her to lie down

on the examination couch with her legs apart and flexed.

- Expose the necessary area for inspection and examination. Cover the patient until you are ready for the examination.
- Wash your hands thoroughly and put on gloves.
- Expose the genitalia. Inspect the external genitalia to identify type of FGM, and to check for ulcers, infection, abscesses, or any abnormal swelling.
- Tactfully ask the patient about her experiences of urination, menstruation, and sexual intercourse, if relevant.
- Check for the clitoris, labia majora, labia minora, urethra meatus and vaginal opening (introitus)
- Do not introduce anything into the vagina opening (introitus) including your fingers.
- In cases of type III FGM (infibulation), the introitus may

be very tight and may not allow the introduction of even the tip of a finger. In such cases, you should not attempt to introduce any fingers.

- After completing the procedure, thank the patient for her cooperation.

- Take off gloves and wash your hands.

- Help the patient to a sitting position; assist her with dressing, if appropriate, and seat her comfortably for next step of the procedure.

- Record your findings and share these with the patient.

- All equipment used should be put to soak in disinfectant for half an hour before sterilization.

5.4

MANAGEMENT OF IMMEDIATE AND SHORT-TERM PHYSICAL COMPLICATIONS

Managing physical complications varies from giving simple support, to giving counselling, or to surgical interventions. Don't forget to document all findings.

5.4.1

BLEEDING

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. Haemorrhage is the most common and life-threatening complication of FGM. 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 due to infection. The management of bleeding associated with excision is the same as the management of bleeding in any other circumstances.

The management of this condition is as follows:

- Inspect the site of the bleeding.
- Clean the area.

- Apply pressure at the site to stop the bleeding by packing with sterile gauze or pad.

- Assess the seriousness of the bleeding and the condition of the girl or woman.

- If patient is in shock, see instructions under shock.

- If necessary, replace fluid lost. If you are managing the patient at a primary level facility, give I.V. fluids, monitor vital signs and transfer her immediately to a secondary level facility for blood transfusion, if necessary.

- If you are seeing her at a secondary level facility where blood transfusion is not available but is required because of severe bleeding, transfer her to a tertiary level facility immediately.

- It may be the policy of the health institution to prescribe Vitamin K, especially in the case of babies. If so, act 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, you should give tetanus vaccine and antibiotics in accordance with national guidelines.

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

5.4.2 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.

The management of this condition is as follows:

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

5.4.3 SHOCK

Shock can occur because 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.

The management of this condition is as follows:

- Assess the severity of shock by checking vital signs;
- Treat the shock by raising the patient's extremities above the level of the head to allow blood to drain to the vital centres in the brain;
- Cover the patient to keep her warmth;
- If she is having difficulty breathing, administer oxygen;
- Have a resuscitation tray nearby;
- Give I.V. fluids to replace lost fluid (if facilities for I.V. are not available, fluids may be given rectally);
- Check vital signs and record every 15 minutes;
- If patient's condition does not improve, refer her to the hospital.

5.4.4 INFECTION AND SEPTICAEMIA

Infection may occur as a result of unhygienic surroundings and dirty instruments used to carry out FGM. The patient will present an elevated temperature and a dirty, inflamed wound.

The management of this condition is as follows:

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

5.4.5 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 cause.
- Use appropriate nursing skills and techniques to encourage the patient 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 patient, or her attendant if the patient is a child.
- Catheterization can be done and use the smallest size 14F
- If retention is due to injury of the opening of the urethra, refer for surgical intervention under anaesthetic.

5.4.6 ANAEMIA

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

The management of this condition is as follows:

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

5.5 MANAGEMENT OF LONG-TERM PHYSICAL COMPLICATIONS

The long-term physical complications of FGM include the formation of keloids, cysts, clitoral neuroma, vulval

abscesses, urinary tract infection (UTI), chronic pelvic infection, infertility, fistulae and incontinence,

vaginal obstruction, menstrual disorders, and ulcers.

5.5.1 KELOID FORMATION

A keloid may form in the scar tissue and may cause obstruction to the introitus.

The management of this condition is as follows:

- Inspect patient genitalia to assess size of keloid.
- If the keloid is small, advise the woman to leave it undisturbed, and reassure her that it will not cause harm.
- If the keloid scar is large, causing difficulty during intercourse or possible obstruction during delivery, the woman should be referred to a specialist experienced in removing keloid scars.
- The presence or appearance of a keloid may cause excessive distress to a woman, in which case you should consider referring her for surgery for psychological reasons.

5.5.2 CYSTS

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

The management of this condition 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 patient to accept the condition. Alternatively, the patient may be referred to have them removed under local or regional anaesthesia.

- However, before interfering with a small cyst it is important to find out if the procedure could result in further damage and scarring of existing sensitive tissue. If such a risk exists, the woman should be fully informed and 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 patient must be referred for excision or marsupialization. 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.

5.5.3 CLITORAL NEUROMA

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

The management of this 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 patient if she feels any pain. Under general anaesthetic the neuroma can be felt as a small pebble under the mucosa.

- Advise the woman to wear loose pants and give her something to apply to the area, for example, lidocaine cream.

- If the symptoms are severe, refer the patient for surgical excision of the neuroma. This is not commonly required, and the woman should be carefully counselled before such a step is taken since the symptoms may be psychosomatic – the result of the traumatic experience of excision, or the fear of sexual intercourse.

5.5.4 VULVAL ABSCESSES

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

The management of this 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.

5.5.5 URINARY TRACT INFECTION (UTI)

Urinary tract infections are a common symptom of women who have undergone type III FGM. This type III can be due to obstruction of the urine in infibulated women or the presence of urinary stones or previous injury to the urethra.

The management of this condition is as follows:

- Inspect the vulva carefully to establish the cause of infection.
- If infibulation is the cause, counsel the woman or her attendant on the need to open up the infibulation.
- Carry out urine analysis to identify specific infection for appropriate antibiotics.
- Give antibiotics and/or urinary antiseptics (A mixture of potassium may also be prescribed).
- Advise the patient to drink a lot of water.
- If UTI is recurrent, refer the patient for medical attention.

5.5.6 CHRONIC PELVIC INFECTION

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

The management of this condition is as follows:

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

5.5.7 INFERTILITY

Infertility can be primary or secondary. It is usually a complication of pelvic infection. In some cases, it may be due to failure of penetration because of a very tight vaginal opening.

The management of this condition is as follows:

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

5.5.8 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 meatus, or obstructed labour.

The management of this condition is as follows:

- Assess the child or woman to identify cause of incontinence and type of FGM.
- Ascertain the severity and level of fistula by dye test.
- In cases of stress incontinence, counsel the patient and start a programme of exercises to

strengthen the pelvic floor muscles or refer patient to a urologist for treatment.

- Patients with vesico-vaginal fistula (VVF) or recto-vaginal fistula (RVF) must be referred for specialist repair.
- If the patient has infection give antibiotics as appropriate.

5.5.9 VAGINAL OBSTRUCTION

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

amenorrhoea and swelling of the abdomen.

- The management of this condition is as follows:
- Assess the patient to identify the problem and type of FGM.

- If the patient has been infibulated, counsel on the need for opening up. This might include family members or significant other.

- If the patient has haematocolpos or stones or stenosis, refer her for surgical intervention under general anaesthetic.

5.5.10 MENSTRUAL DISORDERS

Many excised women report severe dysmenorrhoea with or without menstrual regularity. Possible causes of this problem are tight infibulation or severe scarring leading to narrowing of the vaginal orifice; an increase in pelvic congestion due to infection; or other unknown causes, or anxiety over the state of the genitals, sexuality, or fertility.

The management of this condition is as follows:

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

- Give antispasmodic drugs to relieve pain.

- If dysmenorrhoea is due to the accumulation of menstrual flow as a result of infibulation, counsel the patient on the need for opening up.

- If the condition is severe refer to a gynaecologist for further management.

5.5.11 ULCERS

Vulval ulcers may develop because of the formation of urea crystals in urine trapped under the scar tissue.

The management of this condition is as follows:

- Counsel the patient on the need for opening up the infibulation and advise her that the vulva should

be kept open thereafter.

- Perform the procedure after getting her informed consent.

- Apply antibiotics locally with or without 1% hydrocortisone cream.

- If the ulcer is chronic and fails to heal, refer the patient for surgical excision of the tough fibrous walls.

In managing women with FGM, it is crucial that the type of FGM and its associated Complications, are always documented by practitioners.

5.6 REFERRAL OF CASES

Referral is necessary when a client presents with a problem that is beyond the competence of the care provider. However, referral is not a simple matter, it is a skill. If patients

are not well informed about where to go and why referral is necessary, the process may fail, and the patient would remain untreated. The nurse/midwife and other health workers

must know what services available and which ones are appropriate for the different conditions.

5.6.1 FGM COMPLICATIONS THAT MAY REQUIRE REFERRAL

- Severe bleeding;

- Calculus;

- Dermoid cyst;

- VVF (Vesico-vaginal fistula) or RVF (Recto-Vaginal Fistula);

- Clitoral neuroma;

- Depression;

- Infertility;

- Obstructed labour.

5.6.2 PROCEDURE FOR REFERRAL OF PATIENTS

- Perform a proper assessment of the woman;

- Provide necessary information and offer counselling on the importance of referral;

- Carefully document the findings of the assessment, the clinical findings and any measures taken before the referral;

- Check that she has understood what you have said;

- Involve others, such as her husband/partner, who will accompany her to the referral facility;

- Give them detailed information about what to expect and what to do at the referral point;

- Write and give the referral letter to the patient, or escort when appropriate, and give detailed instructions about who to give the letter to at the referral point;

- Ask the woman to return for follow-up and monitoring of progress after she has received specialist treatment;

- Ask the patient to repeat the important information she has been giving to check that she has understood.

- Wish her good luck and tell her you will see her when she comes back from the referral point.

A referral note must include the following information:

- Woman's demographic data including age, marital status and any other relevant information;
- Summary of health history;
- Clinical findings;

- Management, including both medical and surgical care given to patient prior to referral;
- Reason for referral;
- Contact for feedback.

The surgery to correct complications is performed in a hospital where

appropriate conditions exist with qualified medical personnel. This procedure is used, primarily, for the process of opening women with FGM type III, having sometimes difficulties and pain during penetration.

5.7 OPENING UP OF FGM TYPE III

The surgical procedure required is usually simple. The majority of de-infibulation can be done under local anaesthesia, but this could not be appropriate for elective reversal when the patient is apprehensive.

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

5.7.1 INDICATION FOR THE OPENING UP PROCEDURE

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

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

5.7.2 PREPARATION OF THE PATIENT

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

- Teach her about the genitalia using visual aids – make her aware of the difference between normal and infibulated genitalia.
- Provide information about complications associated with infibulated genitalia.
- Inform her of the legal status of FGM in the country.
- Give full and clear information about the procedure and make sure she has understood.
- Inform her that the sides will be sutured separately, and not re-sutured together to create a small opening.

- Inform her about the physical changes that will result from the procedure. This information must be given to her partner also, if she is married; because the procedure will result in changes in urination, menstrual flow, sexual intercourse.
 - If the family refuses to give consent for an adolescent or the woman to be opened up (because of fear of rejection by family and community members), the provision of a medical certificate may help to alleviate these concerns.
 - Counsel the patient the procedure. Several sessions may be needed to prepare her psychologically for the procedure. Her partner and/or guardians should also be counselled where appropriate.
 - Make it clear to the woman (and others as appropriate) why it is advisable that she has the procedure. Sometimes a woman may be in two minds about being opened up - i.e., she may want it on one level, but be fearful of the consequences on another level.
- Counselling should aim to help her reach an informed decision about which she is confident. Reassure her about privacy and confidentiality.
- Discuss pain relief options.
 - Make sure you complete the required records and documentation accurately.

5.7.3 PREPARATION OF EQUIPMENT AND MATERIALS

The following equipment and materials are required for de-infibulation:

- 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.

5.7.4 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 (Figures 1 and 2).

FIGURE 1



FIGURE 2

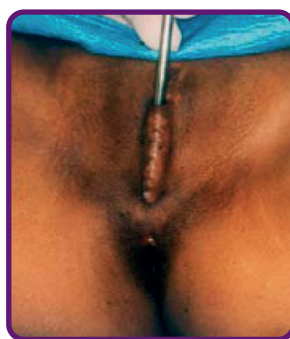


FIGURE 1

INTRODUCING FINGER(S) UNDER THE SCAR

FIGURE 2

INTRODUCING A DILATOR UNDER THE SCAR

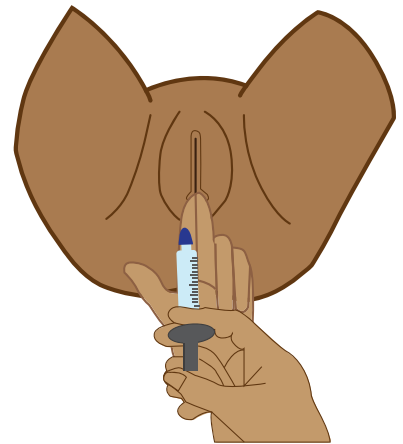
5.7.5 STEP TWO

Infiltrate 2-3 ml of local anaesthetic into the area where the cut will be made, along the scar and in both sides of the scar (figure 3). Take care that you do not cause injury to the structures underneath the scar (urethra, labia minora and clitoris). With type III FGM, these structures are commonly found intact below the scar. Once the local anaesthesia has taken effect, locate the remaining opening, using a finger to feel inside the opening, behind the closed scar

INFILTRATING THE SCAR AREA WITH LOCAL ANAESTHETIC

FIGURE 3

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 artery forceps can be inserted and open. This allows 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.



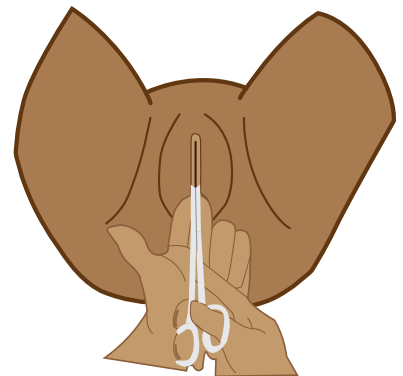
5.7.6 STEP THREE

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 (figure

CUTTING OPEN THE SCAR

FIGURE 4

4). 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.



5.7.7 STEP FOUR

After dividing the fused labia majora, an intact clitoris and labia minora are sometimes found being 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 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.

FIGURE 5

AN OPENED INFIBULATION



FIGURE 6

SUTURED SIDES OF THE OPENED



5.7.8 OPENING BEYOND THE URETHRA

- Use a dilator to elevate the scar tissue; the scar is frequently perforated due to inadequate healing.
- Careful dissection anterior of 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.

5.7.9 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 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 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 sensibility. Reassure her that the sensibility will disappear after a while and that she will get used to the feeling of wet genitals.

Suggest that she takes sitz bath (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 bath, 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 woman and her family and to what is culturally appropriate. It may also require over several sessions.

Advise the woman 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 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.

06 | MANAGEMENT OF GIRLS AND WOMEN WITH PSYCHOSOCIAL & SEXUAL COMPLICATIONS

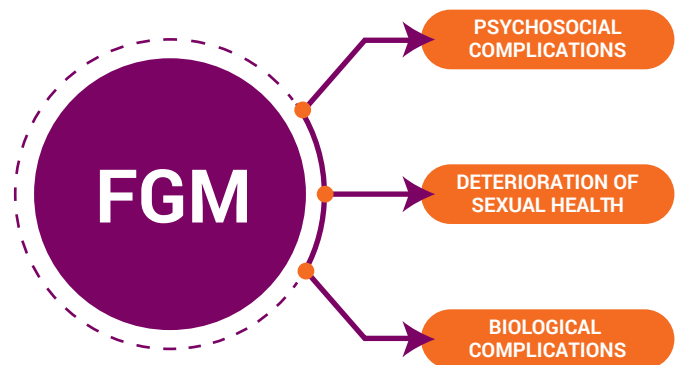
For girls and women who undergo FGM, the practise can be a traumatic experience that may leave a lasting psychosocial mark and adversely affect their sexual and mental health.

Psychosocial and sexual problems are identified by interviewing clients using interpersonal communication, observation and listening skills. It is not easy for a client to talk about a sexual problem as it is a sensitive issue. Therefore, a woman will rarely speak directly about it.

Practitioners should remember that counselling is the principal tool used in managing psychosocial and sexual

problems. Counselling of a girl or woman should be strictly confidential. If the patient has a partner, he should be counselled separately, if necessary, until the right moment arrives for them to be counselled as a couple (see Module 9: Counselling). The woman who has undergone FGM frequently presents psychosocial

and sexual complications that will easily develop in biological complications having negative consequences in her sexual health.



6.1

IDENTIFYING PSYCHOSOCIAL AND SEXUAL PROBLEMS

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

- ❖ Take the patient to a room where privacy and confidentiality are assured and ask her if she has time to talk to you.
- ❖ If she has time, ensure that she is comfortable and seated near to you. Counselling should never be hurried: if either of you is pressed for time it may be better to make an appointment for another mutually convenient time.
- ❖ Make it clear with body language and the way you are sitting that you are ready to listen to her concerns and that she should feel
- ❖ free to share with you anything she wishes. Encourage her to talk using facilitation skills such as eye contact, nodding your head, and listening attentively while also observing non-verbal cues.
- ❖ When the patient has opened up to you, ask her about her eating and sleeping patterns. Ask about menstrual patterns and sexual relationships in a very tactful manner, as these questions may embarrass the patient and result in communication breakdown.
- ❖ Use "open-ended" questions - i.e., questions that require more than a simple 'yes' or 'no' answer and thus offer the patient the chance to explain things in some detail.
- ❖ Use observation skills continuously to pick up non-verbal cues and tell the patient what you have observed to give her the chance to tell you more about the situation. Listen carefully and empathetically (showing concern).
- ❖ Use all your senses to try to understand the patient's world. It may not be easy the first time you meet her but arrange for subsequent visits to explore more.
- ❖ Support the patient throughout the interview to give her psychological strength.
- ❖ Assess the patient's intellectual status - that is her ability to understand information and comprehend a situation.

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

Remember that, throughout the counselling session, the emphasis should be on:

- Privacy and confidentiality;
- Patience;
- Creating a trusting relationship;
- Remaining non-judgemental;
- Understanding of non-verbal cues;
- Using facilitation skills;
- Record your findings and share these with patients wherever appropriate.

6.2

KEY ELEMENTS IN MANAGING PSYCHOSOCIAL AND SEXUAL COMPLICATIONS

In some instances, girls and women from FGM practising communities may visit a clinic complaining of a wide variety of physical problems for which no sign can be found when they are examined. Their complaints are, in fact, "psychosomatic". These are psychological problems that the patient experience, or disguise, as physical discomfort. Anxiety about their genitals or about sexual relationships may manifest themselves in psychosomatic symptoms. Often the girl or woman is unaware that her

symptoms are based on psychological anxieties. But in some cases, the woman knows the symptoms she is presenting are not the real cause of her problem, but she is too shy to discuss them directly. She attends the clinic hoping the health care provider will be able to read between the lines.

The key elements in managing psychosocial and sexual complications are:

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

6.3

MANAGING PSYCHOSOCIAL COMPLICATIONS

Psychosocial problems include:

- Chronic anxiety;
- Feelings of fear of humiliation and betrayal;
- Stress;
- Loss of self-esteem;
- Depression and phobias;
- Panic attacks.

These may manifest as psychosomatic symptoms such as nightmares, sleeping and eating disorders, disturbances of mood and cognition, loss of appetite and excessive weight loss or gain.

Psychological problems are managed as follows:

- Assess woman to identify the exact problem (take a detailed history);
- Counsel woman, and partner where appropriate;

- If she has type III FGM/C, counsel her on the need for opening up;
- If she has other types of FGM/C, counsel her until she is relieved of her symptoms;
- If symptoms are severe, refer patient for further management.

6.4

MANAGING SEXUAL PROBLEMS AND PAINFUL INTERCOURSE (DYSPAREUNIA)

The manifestation of these complications is influenced by several factors. These range from the type of FGM that was practised on the woman, to the preparation for the sexual life that she (and her sexual partner) has had. Each girl or woman should be treated as a unique individual with distinct needs. It is very important to consider that sexual complications are a delicate matter that needs to be attended to with high care and sensitivity (see also Module 9 - Counselling).

Another frequent problem is dyspareunia or pain during sexual intercourse, mediated by biological rather than physiological conditions. This means anatomical changes at that level secondary to FGM, in addition to psychological traumas generated by the practice. Dyspareunia may induce the loss of sexual desire and even anorgasmia, but it cannot be assumed that all women subjected to FGM/C suffer from it because of the existence of other areas of sexual arousal, among other factors. It is necessary to conduct qualitative research from a scientific point of view to know more about the sexuality of these women and how to handle it.

Health practitioners should manage sexual problems as follows:

- Interview the woman to identify the real problem;
- Assess her to identify the type of FGM;
- If opening up the introitus is indicated, counsel her and her husband/partner about the need for this, obtaining their informed consent. Follow the procedure for opening up and repair by giving antibiotics and analgesics, or refer to the appropriate facility for the procedure;
- Where opening up is not necessary, encourage foreplay to stimulate maximum arousal, and the use of appropriate lubricating jelly;
- Follow-up the patient to monitor the progress;
- Counsel the patient and her husband/partner about the importance of discussing sexual matters;
- Invite them to come back whenever they have problems;

- Advise the couple of the changes to expect as a result of the opening up operation – for example, changes in urine flow and during sexual intercourse.

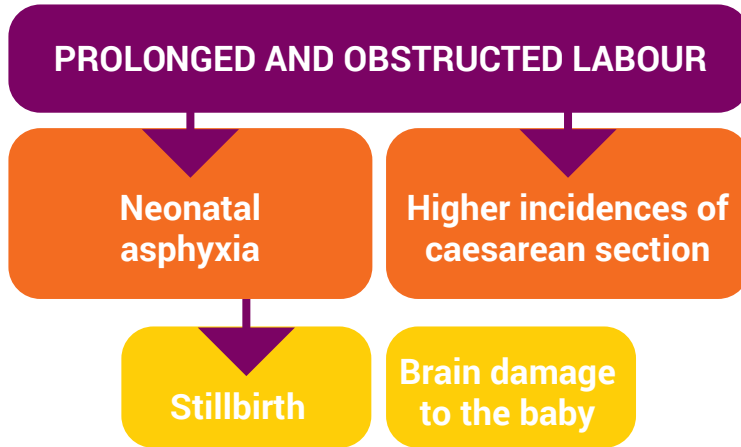
- If the sexual problem is severe and recurring, refer patient to a gynaecologist;

Offer psychological support and ongoing counselling.

Other sexual problems

- Failure or difficulty in penetration by husband/partner is a common form of sexual problem. This is managed as follows:
- Assess the type of FGM;
- Interview the woman to find out what the problem is;
- Counsel the woman and her husband/partner together;
- Obtain informed consent for opening up of the introitus;
- Follow the opening-up procedure (see section 5.7 above in the module 5).

07 | MANAGEMENT OF WOMEN WITH FGM DURING PREGNANCY, LABOUR, AND DELIVERY



Source: Wassu Gambia Kafo

Many women who have undergone FGM experience a healthy pregnancy and childbirth. However, evidence shows that FGM is associated with several obstetric complications. Types I, II and III can produce severe vulval and vaginal scarring which may cause obstruction during labour and delivery. Infection and inflammation when FGM was performed may result in vulva adhesions which narrow or completely occlude the vaginal orifice. Insertion of herbs or other substances may also cause severe scarring and stenosis.

Where FGM did not result in any particular complications (did not limit the space or skin turgor of the introitus, and did not lead to any chronic complications), the woman will require no special

management or treatment during pregnancy. Some women do not require any special management during pregnancy other than emotional/social support and anticipatory guidance for the delivery. Reassure the woman that you do not expect any FGM-related complications and invite her to ask any questions related to FGM or other issues.

Remember that many women approach pregnancy and delivery with great fear of its outcome, including fear of death. Therefore, special support and counselling is required during this period.

7.1 PROBLEMS ASSOCIATED WITH FGM DURING PREGNANCY

Complications which may occur during pregnancy include,

- A tight introitus may make vaginal examinations difficult, e.g., during assessment for antepartum haemorrhage, management of incomplete abortion, etc.
- Urinary infections, which are common in women with FGM, may interfere with the normal progress of the pregnancy.

- Chronic pelvic infections which are common in women with FGM, may interfere with normal progress of the pregnancy and may cause abortion.

- Vulval abscesses may cause pain and discomfort to the woman.

- Dermoid cysts, and keloids may cause discomfort and perhaps obstruction during delivery.

- Psychosocial and sexual problems may arise as a result of FGM.

7.2

ASSESSING PROBLEMS ASSOCIATED WITH FGM

Women coming to clinic may present with many types of FGM. FGM-associated complications during pregnancy can be identified through history taking and during pelvic examinations.

During assessment, it is very important to create a trusting relationship with the woman by:

- Using interpersonal communication skills;
- Ensuring privacy and confidentiality;
- Showing respect and patience.

During assessment, check for the presence of conditions that are likely to interfere with vaginal examinations or treatment, or cause problems during labour and delivery. These may include:

- Tight introitus;
- Infections;
- Abscess;
- Cysts and keloids.

All complications identified in the woman with FGM should be recorded including the type of FGM in the ANC register

7.3

MANAGEMENT OF WOMEN WITH FGM DURING PREGNANCY

The woman who has undergone FGM is at risk of complications during this period. The consequences of FGM in the female genital tract hinder the required accurate examinations for proper antenatal care. Sometimes, insertion of the vaginal speculum and bimanual vaginal exam is difficult because of stenosis or narrowing of the vaginal introitus. This makes it difficult for a

proper examination and specimen collection for diagnosis of diseases such as vaginal infections, urinary tract infections and sexually transmitted infections. Moreover, the lack of proper diagnosis causes inadequate treatment of the above-mentioned infections, therefore, increasing the risk of premature rupture of membranes,

chorioamnionitis, preterm birth and dystocic delivery (caesarean).

In case of type III, de-infibulation will have to occur prior to delivery. It is recommended that de-infibulation is done in the second trimester of pregnancy, but can also be done just prior to delivery (See Module 5 of this Manual on how to perform de-infibulation).

7.4

MANAGEMENT OF WOMEN WITH FGM DURING LABOUR AND DELIVERY

Women with type I and II FGM without complications, and women who undergo de-infibulation during pregnancy, are all likely to have a childbirth that will require routine management.

However, women with an intact infibulation (type III FGM) and those who have extensive scarring of the external genitalia have a higher risk of encountering complications during childbirth, both for themselves and for their babies.

The management procedure is as follows

In addition to the standard management of all women in labour the following points should be given special consideration about women who have undergone FGM.

- If there is a problem with assessment such as a tight introitus making vaginal examination impossible, the scar can be opened along the midline.

The incision should be made at the height of a contraction, and usually after the administration of a local anaesthetic. Use of episiotomy may be preferred. There may be little bleeding from the relatively avascular scar tissue and suturing of the incision can be delayed until after delivery. If the situation allows, labour can be assessed using other parameters such as contractions, descent of the presenting parts, and foetal heart rates.

- Observe the woman closely and monitor vital signs as condition requires;
- Give clear and simple information to the patient about what she should expect during delivery, and allay anxiety/fear;
- Record all observations in the partograph.

7.4.1 ASSESSMENT OF THE INTROITUS DURING LABOUR

It is important to inspect the introitus carefully during the second stage of labour to assess whether it is going to be able to stretch sufficiently during delivery of the baby.

The procedure is as follows:

- Prepare the woman psychologically for this procedure by telling her what you are going to do and why such an assessment is needed;
- Ask her permission to examine her genitalia;
- Prepare equipment – a tray with antiseptic, sterile swabs and gloves;
- Prepare the woman by putting her into a lithotomy position; expose only the necessary parts of the body;
- Wash hands with soap and water and put on gloves;
- Clean the external genitalia with antiseptic swab;
- Kindly request the patient to relax by taking a deep breath while you are introducing a finger into the introitus;
- Try slowly and carefully to introduce first one finger into the vagina to measure the tightness of the introitus. If it allows one finger, try to move the finger upward and downward and left to right. If there is space for a second finger, try to widen the two fingers and check the resistance;
- If it is impossible to introduce a finger, or even the tip of a finger, the introitus is extremely tight – equivalent to FGM type III;
- If it is possible to introduce a finger but impossible to stretch the opening at all because of resistance due to scar tissue, it will be necessary to open up the introitus by performing an episiotomy;
- If there is need for an episiotomy, inform the patient, and perform the procedure following the guidelines described in this manual.

It is important to note that when the progress is slow, nurses/midwives should anticipate a difficult delivery and make appropriate arrangements in good time:

- If it is clear that an episiotomy would facilitate delivery and it should be skilfully performed.
 - If there is a need for opening up the infibulation, the woman should be prepared, and the procedure should be undertaken.
 - If a caesarean section is required, the woman should be referred in plenty of time to a health centre with appropriate facilities.
- In many cases, the doctor decides to perform caesarean section on patients in labour for various reasons. In cases where the problem is due to stenosis caused by FGM, it may be hard to introduce the Foley catheter. In such cases, the patient is subjected to caesarean section without a bladder catheter, which presents as a challenge to the surgeon and a great risk of injury to the bladder during surgery.

7.4.2 ASSESSMENT AND MANAGEMENT OF WOMEN WITH TYPES I AND II FGM DURING LABOUR AND DELIVERY

Management of women with FGM during labour is the same as for any other women, except for where FGM has caused vaginal stenosis and inelasticity of the perineal muscle. In such cases, there may be a need for an episiotomy (in women with type III, the infibulation must be opened during the second stage of labour).

In general, women with type I FGM tend to be able to deliver vaginally without episiotomy unless there is extensive scarring causing inelasticity of the perineum.

If FGM has caused a tight introitus there is a need to increase the vaginal opening by performing an episiotomy. This is usually performed during the second stage of labour, when the presenting part is pressing on the vulva.

Usually, a tight introitus will have been identified during the first stage of labour, and the woman should have been prepared for the performance of episiotomy at that time.

If, however, the woman has already arrived at the ward in the second stage of labour, explain to her the need

to increase the opening by performing an episiotomy, and inform her of when and how this will be done.

The procedure to perform an episiotomy is as follows

- Prepare (consent) the patient;
- Prepare a tray with antiseptic swabs, episiotomy scissors, sterile gloves, a 5 ml syringe and local anaesthetic;
- Inform the patient that you are going to cut open the perineal area to increase space for the baby to pass easily;
- Wash hands, put on gloves, clean the perineal area;
- Introduce one or two fingers (they should go in easily), positioning them where you are going to administer the anaesthetic. This protects the baby's head;
- Infiltrate 2-3 ml of local anaesthetic along the fingers to avoid injuring the baby and into the area where the cut will be made;
- With your finger or fingers inside the vagina – they should be between the scissors and the baby's head – introduce the scissors and cut along the fingers to avoid injury to the baby. Start at the centre of the perineum and angle (slant) your scissors out at a 45-degree angle. If you are right-handed, cut towards the mother's right buttock. If left-handed, cut towards the mother's left buttock.
- Following cutting, the baby is usually delivered slowly;
- Press a gauze firmly over the cut area while the woman continues to push;
- Immediately after delivery, the cutting and any tears must be sutured;
- Take care of the mother and the baby;
- Educate patient on vulva hygiene and keeping the perineum clean;
- Wash hands and clear equipment.

7.4.3 MANAGEMENT OF WOMEN WITH TYPE III FGM DURING LABOUR AND DELIVERY

If the woman attended antenatal clinic, the infibulation may have been opened during the antenatal period. In cases where the infibulation has not been opened during pregnancy, the woman should be informed during

the first stage of labour of the need for this procedure.

- The patient should be told that her vulva will be opened up during delivery to allow the passage of

the baby. She should also be informed that the sides of the infibulated vulva will be sutured separately and not re-sutured to a small opening, and told why.

- She should be informed that the procedure will result in changes in the pattern of urination and menstrual flow, and also in sexual intercourse.
- The vulva should be opened up during the second stage of labour, at the height of a contraction to minimize pains.
- The cut should be made along the midline scar towards the pubis, taking care not to cause injury to the baby or structures along the scar. As stated earlier, it is common with type III FGM to find the structures below the scar intact, e.g., clitoris and labia minor.
- Follow the opening up procedure described on page 104. In some cases, where the scar has caused extensive inelasticity of the skin around the vagina, a posterior lateral episiotomy may be needed in addition to the opening up of the infibulation.
- Usually after cutting, the baby is delivered slowly.
- After delivery of the baby and the placenta, and after the immediate needs of the baby have been taken care of, the entire cutting and any tears must be sutured.
- If there is not sufficient time to discuss the procedure in detail with the woman – if, for example, she arrives at the labour ward already in the second stage – everything should be discussed with her after delivery. At this point the woman should be counselled about the procedure, and the importance of not re-suturing to create a small opening (re-infibulation) impressed upon her. This counselling will require great patience as the woman will be used to having a closed vulva as this is all she has experienced in life. The changes brought about by opening her up will need to be explained carefully and with sensitivity. She should be reassured that she will get used to changes in time.
- Reassure the woman that you are ready to discuss the situation with her husband/partner and/or anyone else she wishes. They may need to be counselled also. They should be informed of the procedure of opening up, the importance of keeping the genitalia open, and the health consequences of closing them again.
- Post-operative care for an infibulated woman opened up during labour is the same as for any other women whose infibulation has been opened up. Inform the woman of the need for good personal hygiene, and suggest she takes sitz baths to prevent infection. Dressings of sugar and paste have proved to be effective in treating the wound.

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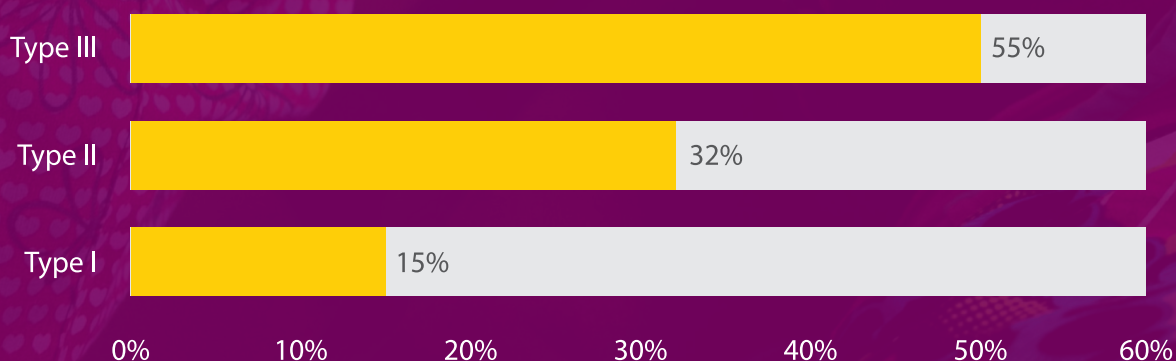
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08 | MANAGEMENT OF WOMEN WITH FGM DURING THE POSTPARTUM PERIOD AND CONDITION OF THE BABY

The postpartum period (the days and weeks following childbirth) is a critical phase in the lives of women and new-born babies. Health-care providers must be aware that certain health complications related to FGM may also occur after childbirth. These include extensive lacerations and haemorrhage from tears. If an incision has been incorrectly performed, tears may involve urethra and bladder anteriorly and rectum posteriorly.

Later in the puerperium, sutured lacerations may become infected, and they may break down. In cases of type III FGM and if the infibulation has not been opened, both mother and baby may suffer severe injuries, e.g., VVF (Vesico-vaginal fistula) and RVF (recto-vaginal fistula) in the case of the mother, and asphyxiation, stillbirth, or severe brain injuries in the case of the baby. Therefore, it is vital that a woman with FGM and her baby are properly assessed after delivery.

INCREASE OF DEATH RATE AMONG BABIES ACCORDING TO TYPE FGM



Source: WHO 2006



8.1

IMMEDIATE ASSESSMENT OF MOTHER AND BABY

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

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

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

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

Subsequent assessment of mother and baby to be conducted as follows

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

8.2

COMPLICATIONS AFTER DELIVERY

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

Management of women with FGM during the postpartum period is the same as for any other women. However, these women will need more psychological care in cases where the vulva has been opened up and not closed to restore the genitalia to the condition they were in before pregnancy and delivery. Such women will have to learn to accept dramatic changes to the vulva from what they have known all their lives. The opened vulva will be different in both appearance and function from the infibulated vulva.

8.3

IMMEDIATE CARE IN CASES OF HAEMORRHAGE

Health care providers should perform the following

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

8.4

IMMEDIATE CARE IN CASES OF NEONATAL ASPHYXIA

In cases of neonatal asphyxia, health care providers should resuscitate the new-born and send for medical attention if severe.

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09 | COUNSELLING

Counselling is helping someone to explore a problem so that the person can cope more effectively and make an informed choice or decision. It is an important element in the prevention of FGM and in the management of complications.

Counselling of a girl or woman with FGM complications should be strictly confidential. If the patient has a partner, he should be counselled separately until the right moment for them to be counselled as a couple arrives. The aim of counselling is to help a woman, couple, or family to come to terms or solve problems. During a counselling session it is important to build a trusting relationship with the patient so that he/she feels safe in discussing her/his concerns with you as the counsellor.

The strategy is to provide confidential counselling support to help people in need. It is a tool to prevent damage and promote positive changes regarding FGM in girls and women. Counselling as a tool of communication takes place in the environment where people who need it live. It establishes a dialogue that allows participants to engage, starting out from their own needs and emotions. Counselling provides orientation, information, emotional support and help in decision-making.

The counselling should be addressed to women and girls who have been subjected to FGM, and to couples, families, and the whole community. It is a way to offer knowledge about the issue, explained by a person properly trained from the community itself.

There are different types of counselling. Select those that are more feasible given the situation where it takes place. The most widely used and effective is face-to-face counselling, which establishes a direct dialogue between

counsellor and counsellee. This is usually the most suitable, considering the ethical and human aspects of the FGM issue. Other alternatives may be using email or phone call to provide information. However, the final choice depends, among other factors, on the actual conditions and the subject matter being addressed.

Who provides the counselling service? People who are previously trained in the subject matter and have experienced it in their professional life. These persons should be characterised as being sensitive, tolerant, unbiased, sincere, trustworthy, discreet, understanding, and willing to self-train.

There are several factors to be considered in making the counselling more effective. These are related to the place where the counselling is developed, the attitude of the counsellor and the relationship between him/her and the other party. There must always be an atmosphere of confidentiality, respect, trust, and safety for the patient.

Important factors to consider succeeding in counselling include:

- **Reception:** Receive the patient warmly and greet her.
- **Privacy and confidentiality:** make sure that counselling is carried out in a room where nobody can come in without permission, and where the discussion cannot be overheard by other people.
- **Patience:** you should be relaxed and not pressed for time.
- **A carefully considered seating plan:** counsellor and patient should be on the same level and seated opposite to each other, with no barriers between them

so that the counsellor can lean towards the patient to demonstrate attentiveness and support during the discussion.

- **Eye contact:** it is important to look at the patient directly and to observe her carefully so that you become aware of her facial expressions (body cues), as these may tell a different story from her words. You should not look her straight in the eye all the time, but observe the whole person and her actions.
- **Attentive listening:** observe the patient's tone of voice as well as what she is saying as this may tell you more than her words. You should allow the patient to do most of the talking, but try to summarise what has been said from time to time to confirm that the information shared is well understood by both.
- **Show concern (empathising):** try to put yourself in the patient's position and show that you care.
- **Appropriate facial expressions:** you should be aware of your facial expression and ensure it is appropriate to what is being said. Smile when you greet the patient, but if she cries during the session your facial expression should show sympathy and concern.
- **Respect:** you should always show respect for your patients as dignified human beings with their own values and religious and cultural beliefs.
- **A non-judgmental attitude:** it is very important not to be judgmental. As a counsellor you need to be aware of your prejudices so that they do not interfere with the counselling process.

9.1 PREPARATION FOR COUNSELLING SESSION

In preparing for a counselling, it is important to:

- 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 the person, and make sure that you both have allowed adequate time for the discussion

9.2 COUNSELLING SESSION

The procedure for a counselling session is as follows:

- Welcome the patient (and her partner/husband if appropriate) and invite her to sit down.

- Greet her and introduce yourself in the culturally appropriate manner.

- Ask the patient her name and ask if you can help her with anything.

- Let the patient talk and encourage her by nodding or saying "yes" from time to time.

- Give the patient information about the services available (e.g., management of FGM complications) in your clinic or centre and the staff who will care for her.

- Let the patient explain her concerns.

- Be patient, as she may find it hard to express her experiences and feelings.

- Listen carefully and observe non-verbal clues (e.g., body language, tone of voice) to enhance your understanding of the patient's situation.

- Summarise the patient'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.

- Empathise with the patient when she is describing a disturbing experience, which may make her weep.

- Explain to the patient how you can help if the purpose of counselling

is to discuss the need to manage an FGM/C related complication.

- Give her detailed information about the problem and the procedure you will use to address it.

- Give her information about any operations that may be necessary and the post-operative care.

- If counselling is for psychosocial or sexual problems, ask such questions as may be appropriate to draw out as much information from the patient as possible about her problems.

It must be considered that the patient's problem may not be resolved in a single counselling session. Several sessions may be required to resolve a relationship problem and reach optimal psychological well-being. The counsellor should be prepared to spend as much time as necessary for this process.

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10 INVOLVING INDIVIDUALS, COMMUNITIES, POLITICAL, AND GOVERNMENT LEADERS IN THE PREVENTION OF FGM

Prevention of FGM and helping affected individuals to cope with its effects require concerted and collective action. To achieve that, communities need to be involved in appraising and addressing FGM-related issues through organised health education sessions. This module aims to equip health professionals with knowledge and skills relevant to FGM prevention, as well as with strategies for involving different community groups, e.g., women, men, youth, children, and political and government leaders.

A community is a social and cultural unit of any size that shares common values. The community may share beliefs, resources, preferences, needs and risks, and may have cultural, ethnic, religious, or other characteristics in common. In the context of FGM, the community is a group of people (including individuals and families) living in an urban or rural area, and who tend to share beliefs, values, and attitudes regarding this practice. Community involvement means working with the people to

address their needs and find solutions to their problems. It is a process where community members take the lead.

Health professionals, because of their legitimated roles as healthcare providers, have an important role to play in influencing community members' perceptions, attitudes, and behaviours towards FGM. Therefore, health professionals must understand the art of effecting positive behaviour change in communities regarding FGM to contribute to its abandonment.

10.1 EXAMINING BELIEFS, VALUES, AND ATTITUDES

The practise of FGM is supported by communities' beliefs, values, and attitudes. In each community where

FGM is practised, it is an important part of the culturally defined gender identity, which explains why many

mothers and grandmothers defend the practice.

10.1.1 MEANING OF BELIEFS

Belief is defined as a conviction, a principle or an idea accepted as true or real, even without positive proof. There are many belief systems, such as religious beliefs, cultural beliefs, group, and individual beliefs.

Some examples of beliefs include:

- the existence of God;
- the uvula causes coughing and retards the growth of children;

• if the clitoris touches the baby at birth the baby will die;

• if a pregnant woman eats eggs, she will deliver a baby with no hair;

• an unexcised woman will have an overactive sex drive.

10.1.2 MEANING OF VALUES

Value is defined as the moral principles and beliefs or accepted standards of a person or social group. Our values

are the criteria against which we make decisions. We inherit many of our values from our families, but they

are also influenced by religion, culture, friends, education, and personal experiences as we go through life.

10.1.3 MEANING OF ATTITUDES

Attitude is defined as a mental view or disposition. Attitudes are largely based on our personal values and perceptions.

Beliefs, values, and attitudes are formed and developed under a multitude of influences, i.e., our parents, families, society, culture, traditions, religion, peer groups, the

media (TV, music, videos, magazines, advertisements), school, climate, environment, technology, politics, the economy, personal experiences, friends, and personal needs.

10.2 SOME CONSTRUCTIVE APPROACHES TO CHANGING A HARMFUL TRADITION

Individuals, families, and communities have their own reasons for valuing FGM. In discussing the issue of prevention with them, one needs to help them to analyse their feelings and to clarify their values regarding FGM, before explaining to them the consequences of upholding these values.

Health professionals must appreciate that values and attitudes develop over a lifetime and changing them is never an easy or quick process. However, helping the community to examine their feelings about FGM will allow them to make conscious decisions about which of the values and attitudes underpin the practice they wish to keep and which they think may no longer be valid. Health professionals should also help people to identify good practices and dangerous practices and to understand the implications of FGM on the health of girls and women.

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

to adulthood without circumcising her.

To assist in this process, the health professional should:

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

To change any behaviour, behavioural scientists have demonstrated that an individual goes through a series of steps. These are as follows:

- 1.** Awareness.
- 2.** Seeking information.
- 3.** Processing the information and “personalizing” it, i.e., accepting its value for oneself.

- 4.** Examining options.

- 5.** Reaching a decision.

- 6.** Trying out the behaviour.

- 7.** Receiving positive feedback or “reinforcement”.

- 8.** Sharing the experience with others.

According to this model, someone deciding to reject FGM will go through a process that starts with realising that rejection of FGM is an option. This will be followed by finding a choice desirable; reaching the decision to reject FGM; figuring out how to put this decision into practise; doing so and seeing what happens; then receiving positive feedback from others that encourages the person to continue with his/her stand against FGM. The final stage is when the person feels confident enough in his/her decision to “go public” with it, i.e., share his/her reasoning and experience with others, thus encouraging them to follow the example. This is called the “multiplier effect”. At every step, and whoever the person is, there is the risk of failure; individuals must struggle with the personal and wider repercussions of the choice they have made.

10.3 STRATEGIES FOR INVOLVING TARGET GROUPS

Because of the personal and cultural sensitivity of the subject, discussions must be carefully planned and conducted appropriately. As a rule, discussions should be held with

individuals alone unless and until people are ready to discuss the issue more openly, for example in family or peer groups, or even with their spouses. Separate discussions

should be held with the different target audiences, e.g., youth, men, community elders, women, religious leaders.

10.3.1 MEN

To involve men in the prevention of FGM, health professionals should:

- Identify all appropriate forums for meeting the target group, for example, men's organizations, social groups, and contact relevant people.

- Use community leaders and other influential people as an entry point.

- Give clear information about the health effects and human rights implications of the practice of FGM for children and women, and identify and discuss misconceptions.

- Use film shows or posters, as appropriate, and encourage everyone to participate in the discussions.

- Assist the men with developing their own strategies for prevention.

10.3.2 WOMEN

To involve women in the prevention of FGM, health professionals should:

- Identify appropriate forums for meetings with the target group, and make contact with relevant people.

- Give clear information about the anatomy and physiology of the female genitalia, the health effects, and human rights implications of FGM, and identify and discuss misconceptions.

- Use a participatory approach in discussions.

- Address women's lack of power and self-esteem by teaching self-awareness, assertiveness, and problem-solving skills.

10.3.3 YOUTH

To involve the youth in the prevention of FGM, the health professional should:

- Identify appropriate forums for meeting with young people, such as in youth clubs, schools, colleges, and make contact with relevant people.

to address sensitive issues of direct relevance to them, including teaching basic life skills aimed at empowering girls.

- Give clear information about the health effects and human rights implications of the practice, and identify misconceptions.

- Use a participatory approach. Advocate for the issue of FGM to be addressed in school health programmes, and included in the curricula of schools.

- Provide special support to girls how have already undergone FGM.

- Establish peer education (i.e., youth to youth) programmes.

10.3.4

STRATEGIES FOR COMMUNICATING WITH TARGET GROUPS

In communicating with the various audiences, health professionals should observe the following rules:

- Assess and decide on appropriate ways of communicating on FGM. For example:

One-to-one discussions;

- Group discussions, such as with a family, organised group or focus groups;
- Health talks at clinics;
- Use of drama;
- Songs by traditional communicators;
- Storytelling;
- Use of peer educators;
- Workplace sessions;
- School-based activities including Koranic Schools.

- Know the target audience:

- Identify the participant group (individuals, families or groups);
- Decide who to reach (women, youth, men or mixed);
- Know the background of the intended participant group (educational level, language,

age, socio-economic status, level of exposure).

- Find out about the practice of FGM locally. Explore the following:

- What type of FGM is performed locally?
- What are the reasons for practising FGM?
- Which instruments are used to perform FGM?
- What perceived problems or complications do people experience during or after the procedure and how they are handled?
- Who performs FGM?
- Perceptions about girls who are not cut.

- Identify who the chief decision-makers are in the community regarding FGM;

- Ensure that people who will be involved in implementing the Community Education programme are well trained.

- Prepare yourself very well:

- Have all the information and

materials you need;

- Organise your materials and equipment;
- Make sure the intended programme participants are well informed and prepared before any session;
- Ensure that any communication materials and messages used are based on research.

- Create and maintain trusting relationships:

- Establish a rapport with the target audience;
- Show respect for people's beliefs and values regarding FGM;
- Greet people in a culturally respectful manner;
- Always introduce yourself and the rest of the team;
- Make sure people are comfortable with you and with the setting before opening a dialogue;
- Show regard for the community's values and norms;
- Anticipate possible questions and get your facts together.

10.4 INVOLVING POLITICAL LEADERS IN THE PREVENTION OF FGM

Identify influential people in local and national politics and civic structures. These might include parliamentarians, who can be encouraged to advocate for laws and policies on FGM, women's and youth leaders, and heads of professional associations (e.g., lawyers, physicians, nurses, midwives, etc.) who can be encouraged to

create pressure groups to lobby the government.

- Contact relevant people and organise seminars or workshops to inform people of the issues surrounding FGM, e.g., its health consequences, human rights implications.

- Lobby influential people in all relevant forums (e.g., political gatherings, professional conferences) to encourage them to pass laws, develop policies, and become actively involved in efforts to eliminate FGM.

10.5 INVOLVING SCHOOLS IN THE PREVENTION OF FGM

Involving schools offer opportunities to not only raise awareness of the practice but also to safeguard and support girls and young women. Schools' engagement on FGM needs to be grounded in a gendered and human rights approach that promotes the rights of girls and women to safety, bodily integrity, non-discrimination, and equal participation in decision-making and society[1].

Prior to engagement with pupils/students, comprehensive training of staff on FGM is necessary. Teachers should be trained on how to safeguard girls including what to look out for and how to respond. Staff should be clear on their responsibilities, confident in acting on their concerns, proactively engaging with pupils/students, as well as dealing with disclosures sensitively and effectively.

- Strategies to consider include when involving schools in the prevention[1]:

- Include FGM in the curriculum (e.g., citizenship curriculum) to ensure that pupils/students have a context in which to place FGM so that they will not consider it as abstract or isolated or single sessions.

- Ensure that pupils/students understand that talking about FGM can be emotional and difficult; but at the same reassure them that the subject will be approached sensitively and appropriately.

- Model appropriate and sensitive behaviour and reinforce the importance of pupils/students maintaining this behaviour. This behaviour should be one that is empathetic towards girls, women who have undergone FGM.

- Remind students about the school's ground rules prior to any sessions on FGM. In particular, the limits to confidentiality should be

- explained to pupils/students at the beginning of every session.

- Engage pupils/students on FGM through interactive activities where students can engage in discussion and question and in smaller group settings.

- Allocate sufficient time to ensure that the issues are covered adequately, and pupils/students could ask questions and understand the issues.

- Both mixed and single-sex sessions should be made available to enable pupil/students' full participation. Both teachers and external facilitators should have a clear understanding of safeguarding policies and procedures.

10.6 ADVOCACY

The change will only occur when people who practise FGM are convinced of the case for eliminating it. Therefore, working with communities to raise awareness of the issues, and educating and informing them is a vital part of any advocacy programme.

10.6.1 CONCEPT AND DEFINITION

Advocacy means speaking up or making a case in favour of a specific cause in order to win support for it. The involvement of political and community leaders and key policy-makers at all levels in the effort to eliminate FGM is very important. These people are major opinion-leaders and decision-makers in society.

Advocacy includes tools to facilitate the active participation of people involved in the processes of social and political management and resource

mobilisation in the different fields, at regional, national, and international levels. It is a strategy to influence policy that includes several sectors of the population. In the case of FGM, it contributes to bringing together women and girls and building a new vision in defending their rights.

Over the last decade, numerous organizations and individuals have become involved in community-based activities aimed at the elimination of FGM. These efforts have raised awareness of FGM worldwide and






brought the issue to the attention of influential people at all levels of those societies where FGM is practised. Elimination of the practice depends on the concerted effort of everyone with an interest in protecting the health of women and girls.

There are different steps to be considered in advocacy, such as information gathering and analysis, identification of target audiences and key individuals for advocacy, the setting of advocacy objectives and monitoring and evaluation.





10.6.2 STEPS IN THE ADVOCACY PROCESS

Information gathering and analysis

Before launching an advocacy programme, it is necessary to collect reliable information on FGM, including the following:

-  Prevalence of the practice locally and nationally;
-  Who the circumcisers are;
-  Rationale and reasons are given for the practice;
-  Age at which excision is performed;
-  Factors that motivate the

community and individuals to maintain the practice;

-  Those who make the decisions;
-  Perceptions of girls who are not cut;
-  Current knowledge of the health and social consequences of the practice;
-  Responses of the community to past efforts directed at preventing the practice.

Detailed background information is essential for planning advocacy strategies and formulating

appropriate messages.

Identification of target audiences and key individuals for advocacy

Politicians, government officials, community leaders and parents are key in promoting, supporting, or blocking the initiative in their positions, as decision-makers or legislators. All these categories should be targeted with appropriate messages.





The setting of objectives for an advocacy programme

The change sought on the part of each target audience for advocacy should be clearly spelt out. For

instance, advocacy could be aimed at legislation against the practice of FGM or at establishing penalties for health professionals who engage in the practice.

The development of an action plan

The following should be identified:









-  Target audiences,
-  Activities to be carried out,
-  Objectives, and
-  Who will be responsible for what.

Monitoring and evaluation

The advocacy programme must be monitored using clearly developed indicators and objectives. Through routine monitoring, managers of an advocacy programme will be able to keep track of successes, changes, and problems.

10.6.3 ESSENCE OF ADVOCACY IN FGM

Advocacy should be aimed at achieving the following:

-  Development of professional regulations and programmes;
-  Visible political commitment to eradicating the practice;
-  Signing of international declarations that condemn the practice;
-  Making local conditions conducive to the application of international conventions (domestication of conventions and protocols);
-  Developing policies and plans of action for eliminating the practice, including setting targets for elimination and developing national and district-level indicators for monitoring and evaluating programmes;
-  Integrating efforts to include FGM into mainstream health and education programmes;
-  Legislating against the practice;
-  Building partnerships with NGOs, CSOs and communities to bring about change.

10.6.4 ADVOCACY STRATEGIES

Organised communication is the backbone of advocacy. The selection of an advocacy strategy from the many possibilities that may be considered is influenced by objectives, the issue at hand and the intended target audience.

The most important strategies in advocacy include:

-  Building coalitions with, for example, NGOs, CSOs or institutions with similar interests;
-  Effective use of mass media;
-  Working with communities;
-  Conferences and seminars;
-  Lobbying through direct personal contact.

10.6.5 ADVOCACY KITS

An advocacy kit is a collection of facts neatly packaged and disseminated to an audience. It contains strong and compelling arguments to support a cause.

10.7 BUILDING COALITIONS

Building partnerships with other active organisations or individuals in the same field has several advantages. It allows for the sharing of experience and expertise, and the pooling of resources. Besides, there is strength

in numbers. Well-briefed pressure groups can be a key ally in a coalition that intends to push for changes in policies, laws and programmes or services and to influence major decisions.

Examples of pressure groups include trade unions, student unions, communities, consumer groups and professional bodies.

10.8 WORKING WITH THE MASS MEDIA

Both the electronic and print mass media can be used to reinforce advocacy activities. The media is a powerful tool and can provide a significant impact if used properly. The media may be employed to

articulate the views of advocates and those affected by an issue. Articles published in newspapers or stories broadcast on the radio and television spread the message far and wide. Building partnerships with

media organisations is, therefore, a valuable exercise and the first task in establishing such a relationship is to educate relevant people in the media about FGM.

10.9 CONFERENCES

Conferences are the most suitable type of strategy for some categories of the intended target audience. They usually need a great deal of planning.

10.10 PUBLIC EVENTS

Public events can also be used as a channel to articulate FGM as an undesirable and harmful traditional practice. They can range from rallies, exhibitions, and celebrations to parades and seminars.

10.11 LOBBYING

This means canvassing support “behind closed doors” and applying pressure to try to influence people’s opinions and actions. It is usually a slow process, requiring great patience and persistence on the part of the lobbyist, and can take the form of one-to-one direct personal contact. For successful lobbying health professionals should:

- Identify decision-makers and other influential people, and make contact with them. People can be reached through their wives or husbands, relatives, friends, secretaries, or colleagues, where necessary.
- Make sure you are clear about what needs to be done and what role they could play.
- Organize a meeting with them, and use the tactics and skills described

above to convince them of your case.

- Suitable forums for lobbying include, for example:
 - parliamentary and other political meetings
 - religious gatherings
 - relevant international conferences.

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

- Strong and capable anti-FGM programmes at the national, regional, and local levels.
- A committed government that supports FGM elimination with policies, laws, and resources.
- Making FGM a mainstream issue – integrating FGM prevention into all relevant government and non-government programmes, e.g., health, family planning, education, social services, human rights, religious programmes etc.
- Health care providers at all levels are trained to recognize and manage the complications of FGM and to prevent the practice.
- Good coordination among governmental and non-governmental agencies.
- Advocacy that encourages a supportive policy and legal environment for the elimination of FGM, increased support for programmes, and public education
- Empowerment of women.

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APPENDIX

CASE STUDIES

Case 1

Fatima is a 27-year-old woman from the Upper River Region. She sells groundnut in a weekly market. She has been married for four years but has had no child. She is a member of a Kafoo and has made friend with Isatou who is a midwife working in health centre. One day, Fatima asked her friend Isatou if she would fast and pray for her because life was becoming miserable with her failure to become pregnant. Isatou agreed, but also took the time and opportunity to talk to her about the problem. Fatima told her friend that she was a virgin when she got married, and she thinks that is why her husband loves her even though she is still childless. However, Fatima wants to have children because her mother-in-law has been asking her husband about it. She also thinks that although her husband does not seem bothered at present, that may change since no man could be happy for long with a wife who does not produce children. When asked about her childhood, Fatima revealed that she was excised when she was eight years old. Following the procedure, she was very sick for over a month. She had fever and the wound was sore and smelly. She remembers the room where she was being nursed smelling so bad that she was embarrassed when people came to see her. She said that her mother had given her traditional medicine to drink and to apply to her genitalia, but she did not improve. She was taken to hospital when her condition was very serious, and everybody thought she was going to die. Isatou advised her friend to visit a doctor for investigations, and

made an appointment for Fatima to see one of the gynaecologists in the clinic where she was working. The investigations at the clinic revealed that Fatima's fallopian tubes were completely blocked, and the doctor told her it was due to infection. Her problem was therefore primary infertility. The doctor said they could try to clear the obstruction in fallopian tubes with surgery. But Fatima and her husband have so far not been able to raise the money necessary for the operation.

Case 2

Abdoulie is a 38-year-old-male midwifery tutor in a medical school in The Gambia. His wife works as a clerk in the hospital where he teaches. They have one daughter who is 3 years old. They both come from an area where traditionally every baby girl has her clitoris excised during her first month of life. Before he got married, Abdoulie had the chance to attend a workshop on female genital mutilation, which sensitised him and made him realise that the tradition is harmful. He decided not to allow his daughter to be excised. He had sensitised his wife and she supported the idea of not excising their daughter. But Abdoulie's mother who stays in the family wants her grand-daughter to be excised. She complains constantly that the girl is becoming more and more naughty because she is not excised. "It is time you decide to excise this girl, look at how she behaves. Who is going to marry her?" Or she says to Abdoulie's wife "I cannot sit here and look at you violate our tradition. This girl belongs to our clan; she must be

excised; it is our culture." Abdoulie keeps on talking to his mother about the harmful effects of female genital mutilation, and he has made it clear to her that under no circumstances he will excise the little girl. He says it is hard to keep challenging his mother, but he will persist.

Case 3

Bintou is a 30-year-old-housewife. At the age of 6 she was infibulated. She still remembers the pain and brutality of the procedure. She was married at the age of 18, and says the pain she experienced when her husband penetrated her made her terrified of him for a long time because she thought he was so brutal. Intercourse continued to be painful for the first 6 months of her marriage, and she has never enjoyed sex but accepts it as an obligation in marriage. Bintou has four children, one of whom is a 2-month-old-girl. At each delivery she is opened to allow the passage of the baby, and then re-stitched after the birth. Her husband insists that she should have a tight vagina. Bintou is currently debating with herself whether or not to have her daughter infibulated. She feels that if it is done, then it should be less extensive than her own type of FGM, because she does not like to think of her daughter experiencing the agony she has been through.

Case 4

Mariama is a 35-year-old university lecturer who decided that her two daughters would not be excised as she and her sisters had been. Mariama's daughters were born while she and her husband were studying abroad. When the family returned

home Mariama's mother and mother-in-law asked her if the girls had been excised. Mariama said they had not, and explained to the older women that she and her husband had agreed the girls would not be circumcised. Mariama went back to work, but she was unable to find a maid to look after the children while she was out of the house. Since her mother-in-law lives in the same town, she decided to leave the girls with her during the week and to fetch them on Friday evenings to take them home for the weekends. One Friday evening when she went to fetch the girls, she was surprised not to find them playing outside as usual. Her mother-in-law explained that they could not come out because they were not well. Mariama thought perhaps they just had a fever. But as

she entered the room, the girls cried out: "Mum it hurts!" It did not occur to her immediately that the girls had been genitally circumcised, but then her mother-in-law announced proudly: "I have excised my grand-daughters; I have done what is right for them".

Case 5

Haddy is a village woman who was excised when she was a child. She does not remember how old she was at the time, only that she grew up with this scar. She was married at age 17 and realized four months after her marriage that she was pregnant. Haddy decided to deliver at home, and her husband called a well-known and experienced traditional birth attendant when labour started. She was in labour for two days, and finally

gave birth to a stillborn baby. Haddy was badly torn during the delivery and had to be taken to hospital to have the tears stitched. She also bled profusely and was transfused with one unit of blood. However, the tear was so extensive that Haddy developed a vesico-vaginal fistula (VVF), which she had repaired eight months after delivery. However, the operation was unsuccessful, and she is to have another operation to try to repair the fistula, which she hopes very much will be successful. While she is undergoing treatment, she is living with her parents again. But she says her husband, who is a farmer, is very supportive and visits her regularly.

THE BIJILO DECLARATION

The International Forum on Gender Based Violence and Harmful Traditional Practices: The Bijilo declaration

We, participants at the V International Forum on Gender Based Violence and Harmful Traditional Practices in The Gambia and West Africa, held in Bijilo, The Gambia on 7-8th February 2022, have come together to explore strategies, share experiences, success stories and good practices in efforts to promote the abandonment of Harmful Traditional Practices, such as FGM/C and Child Marriage.

Expressing our sincere and deep gratitude to Wassu Gambia Kafo, the Wassu Foundation and the Universitat Autònoma of Barcelona for organizing this Forum sponsored by the Catalan Agency for Development Cooperation, the Catalan Fund for Development Cooperation and UNICEF, and to The Gambia-OIC Secretariat and Government of The Gambia, for supporting this initiative.




Recognizing that:

a) Since the Brufut Declaration of 2009 approved at the I International Forum on FGM, great progress has been made in The Gambia, in West African countries and globally in terms of eliminating the various Traditional Practices that are harmful to the health of girls and women.

b) These advances have occurred in a changing and increasingly complex international context, in which the international community has had to face great challenges such as the global economic crisis, the increasingly frequent health pandemics, the challenge of climate change, the growing migratory flows, as well as the new sustainable development goals.

c) The new challenges increasingly need global responses and strategies that require enhanced international cooperation, in which regional and global intergovernmental organizations acquire a more fundamental role than they did a decade ago.

d) The Sustainable Development Goals to be achieved by 2030 establish a new Development Agenda that includes, among others, the following goals in terms of gender equality and empower all women and girls:

-  End all forms of discrimination against all women and girls everywhere,
-  Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation,
-  Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation,
-  Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of

shared responsibility within the household and the family as nationally appropriate,

- Ensure women's full and effective participation and equal opportunities for leadership at all levels of decision-making in political, economic, and public life,
- Ensure universal access to sexual and reproductive health and reproductive rights.

Agreeing that:

a) FGM/C and Child Marriage, as well as other Harmful Traditional Practices, are one more manifestation of the different Gender Based Violence that feed each other, which erode the human rights and dignity of women and girls, and as such must be addressed from a global approach of eradication of all types of Violence against Women and Girls, with multisectoral strategies.

b) Harmful Traditional Practices are a global issue. Most of the 57 member countries of the OIC present some type of harmful traditional practices, especially among the 27 African member countries, and specifically in the 13 West African member countries.

c) Religion continues to be often misinterpreted to sustain FGM/C and other Harmful Traditional Practices, despite the Fatwa on the Position of Islam regarding Harmful Practices to Women, issued at the International Conference of Ulemas held in Nouakchott on September 14th, 2011.

d) Organizations and stakeholders working to end Harmful Traditional Practices still face many challenges and constraints, even though the movement of several decades has become increasingly active both in Africa and in the African diaspora.

e) Quality and adequate scientific knowledge is essential to policy formulation and its application.

f) The member countries of the OIC, whose next Summit will be held in The Gambia in 2022, have the responsibility to promote policies that contribute, both at the national level and in the multilateral framework, to the achievement of the goals of the 2030 Agenda, and the eradication of all types of Violence against Women and Girls, including Harmful Traditional Practices.

Urge that:

a) Governments multiply efforts to guarantee human rights of women and girls and gender equality through new policies and strategies as well as to channel human, technical and economic resources to develop public policies devoted to the elimination of Harmful Traditional Practices.

b) Informed religious scholars be engaged in the movement to end FGM/C, Child Marriage, and other Harmful Traditional Practices, as well as all kinds of Gender Based Violence, in order to definitely separate religion from these practices, and positively link Islam with the Human Rights of Women.

c) Universities provide intellectual leadership to promote research on the abandonment of Harmful Traditional Practices and cooperate with civil society organizations to enrich its work through knowledge transfer.

d) All those involved foster closer cooperation between the diaspora and home countries, by building networks and coalitions based on a non-confrontational approach and focusing on prevention strategies to enable real personal and collective commitment to change, rather than interventions that create dependence.

e) All educational stakeholders involved to appeal to the role of men, to promote education in respect and values, especially in male co-responsibility and non-discriminatory gender roles,

as well as in sexual and affective education.

f) Legislators and judiciary system to strengthen law enforcement and to promote laws in favour of women's rights and against Harmful Traditional Practices.

g) To support and strengthen civil society organizations that work to eliminate all discrimination against women.

h) To establish and strengthen mechanisms for monitoring progress in the field of eliminating Gender Based Violence.

Finally, **The Bijilo Declaration** emphasizes that:

1. Information is power, and people should be empowered by providing them information.

2. Health, education, social services professionals as well as community mediators and facilitators play a crucial role in the movement for abandonment of Harmful Traditional Practices and should be so engaged.

3. Governments, development partners and other funding institutions must increase budgetary allocations and funding for efforts to end those practices following the Sustainable Development Goals and the Agenda 2030.

4. To jointly build a safe world free from violence against women and girls

Bijilo, The Gambia, February 8th, 2022

THE BRUFUT DECLARATION

INTERNATIONAL FORUM ON HARMFUL TRADITIONAL PRACTICES: BRUFUT DECLARATION

We, participants at the International Forum on Harmful Traditional Practices (HTPs) held in Brufut, The Gambia, from 5 to 7 May, 2009, have come together to explore strategies and good practices in efforts to promote the abandonment of harmful traditional practices, and in particular, female genital mutilation/cutting (FGM/C),

Expressing our sincere and deep gratitude to Wassu Gambia Kafo and the Universitat Autònoma of Barcelona (UAB) in Spain for organizing this conference sponsored by Foundation “la Caixa”, and to the Government of The Gambia, for supporting this initiative.

Agreeing that:

a) FGM/C is a global issue, and that, as a result, the movement of several decades to end HTPs has become increasingly active both in Africa and in the African diaspora.

b) HTPs, and FGM/C in particular, significantly erode the human rights and dignity of women and girls and adversely affect prospects for achieving the Millennium Development Goals (MDGs), that require multisectoral strategies.

c) Religion is often misinterpreted to sustain HTPs and FGM/C.

d) Organizations and stakeholders working to end FGM/C still face many challenges and constraints.

e) Quality scientific knowledge is essential to policy formulation and its application.

Urge that:

a) Informed religious scholars be engaged in the movement to end FGM/C and other HTPs.

b) Universities provide intellectual leadership to promote research on the abandonment of FGM/C and related issues.

c) Policy makers and funding institutions base their decisions on the conclusions of sound scientific knowledge and support ending FGM/C by fostering policies and projects for the wellbeing of women and girls, with a specific mention and attention to HTPs and FGM/C.

d) Civil society and governments initiate and/or strengthen community initiatives with an educational and human rights foundation, in an effort to explore alternatives to FGM/C (e.g., initiation without mutilation, where appropriate) and with a commitment to avoid stigmatizing the uncircumcised within communities,

as well as migrant groups in general.

e) All those involved foster closer cooperation between the diaspora and home countries, by building networks and coalitions based on a non-confrontational approach and focusing on prevention strategies to enable real personal and
f) collective commitment to change, rather than interventions that create dependence.

Finally, the Brufut Declaration emphasizes that:

Information is power, and people should be empowered by providing them with information.

Health, education, social services professionals as well as community mediators and facilitators play a crucial role in the movement for abandonment of FGM/C and should be so engaged.

Governments, development partners and other funding institutions must increase budgetary allocations and funding for efforts to end FGM/C and other HTPs.

Brufut, The Gambia, May 7th, 2009



INTERNATIONAL CONFERENCE OF ISLAMIC SCHOLARS (ULEMAS) OF THE WEST AFRICAN REGION ON THE POSITION OF ISLAM REGARDING PRACTICES HARMFUL TO WOMEN

IN THE NAME OF ALLAH, THE COMPASSIONATE, THE MERCIFUL
PEACE AND SALVATION ON THE HOLY PROPHET MOHAMMED
FATWA PRAISE BE TO ALLAH

An International Conference of Islamic Scholars (Ulemas) of West Africa, Egypt and Sudan on the position of Islam regarding practices harmful to women was held in Nouakchott, capital of the Islamic Republic of Mauritania during the period of 14 to 16 Shawwl 1432 AH corresponding to September 12-14, 2011.

The symposium brought together Islamic Scholars from Egypt, Sudan, Senegal, Gambia, Guinea Conakry, Guinea Bissau, Mali, Niger, Burkina Faso, in addition to an elite of scholars and imams from Mauritania. The symposium was devoted to discussion of the phenomenon of Female Genital Mutilation/cutting (FGM/C), common in the above cited countries, and brought to light the texts and purposes of The Sharia, in addition to the experiences of experts and views of doctors on the topic.

After much discussion on the fatwas issued by Al-Azhar Cherif and other Islamic scientific institutions, After learning about the foundations of the fatwa issued by some of the scholars of Mauritania in January 2010.

Considering all this, and based on the following general information and specific Islamic teachings:

1. The legal discourse on FGM/C states that it is not on the level of a mandatory requirement of Islam, but it has constituted an honor among the Maaliks, and he who leaves it behind incurs no penalty and is not condemned by the Sharia and therefore its abandonment has become widespread among many Muslim nations including some areas of Mauritania.
2. The form practiced in parts of Mauritania and West Africa is similar.
3. International health institutions have demonstrated through research the damage of this practice for girls and women in the short term and the long term of their lives.
4. Among the accepted rules of Sharia is that warding off all harm to oneself trumps all other interests.

Considering the above and based on the verse: "... Do not expose yourself unnecessarily to deadly dangers," Qur'an, II, 195 and: "Truthfully Allah is compassionate towards you," Qur'an, IV, 29.

In light of the hadith of the Prophet, peace and salvation to him, "You will do no harm and will not suffer prejudice."

And on the basis of the decision of the scholars of the foundations of the Sharia changing the fatwa is not a change in the rules but an application of the rules to specific deeds and cases. Considering all this, the form of FGM/C known and practiced in Mauritania and Islamic countries being the same is not justified and it is prohibited by Sharia.

It is Allah who knows all!

Nouakchott, September 14, 2011

On behalf of the participants, the drafting committee:

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-  Dr. Youssouf Al Kewda: Sudan
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WOMEN'S ISLAMIC INITIATIVE IN SPIRITUALITY AND EQUALITY

MUSLIM WOMEN'S SHURA COUNCIL

FEMALE GENITAL CUTTING: HARMFUL AND UN-ISLAMIC

The Shura Council is a global and inclusive council of Muslim women scholars, activists, and specialists. The Council endeavours to connect Islamic principles to society's most pressing issues and develop holistic strategies for creating positive social change. In this statement, the Shura Council condemns Female Genital Cutting as a harmful and un-Islamic practice and makes suggestions for its elimination.

In this, the Council is in accordance with the rising religious consensus on the issue, the views of the international human rights community, and published medical research.

INTRODUCTION

Female Genital Cutting (FGC) is the partial or total removal of the external female genitalia for non-medical reasons. The term describes a varied range of practices, including the following: slight pricking or nicking of the clitoral hood; hoodectomy (excision of the clitoral hood); clitoridectomy (excision of the clitoris); the excision of the clitoris and labia minora and majora; and infibulation (suturing) with excision of the external genitalia.

Commonly cited reasons for the practice include the faulty beliefs that FGC is "a good tradition" or a religious requirement or that it ensures "cleanliness" and prevents excessive clitoral growth. FGC is also deeply connected to marriage rituals and ideas about protecting virginity and preventing promiscuity.

FGC is practiced openly in 28 different African countries, as well as secretly

in parts of the Middle East, Europe, Australia, and the United States. Over 130 million women worldwide have been affected by some form of FGC, and three million girls are at risk every year. Most children are subjected to FGC between the ages of four and ten years; however, there has been a recent downward shift in the age of victims.

FGC IS HARMFUL

Medical consequences of FGC include, but are not limited to, the following: death through shock and/or excessive bleeding; infection; sepsis; urine retention; ulceration of the genital region; injury to adjacent genital tissue; scarring; infertility; cysts; painful sexual intercourse; increased risk of transmission of sexually transmitted diseases, including HIV/AIDS; and a range of resulting psychological and psychiatric problems.

The procedures are often performed in unsterile environments and with little or no anaesthesia. Children who develop uncontrolled bleeding or infection under such conditions die within hours of the first incision. Risks associated with FGC are reduced but not eliminated when FGC is performed in modern medical facilities.

The practice has been widely condemned by medical, political, and religious authorities and is banned by a wide network of local, national, and international laws.

FGC IS UN-ISLAMIC

FGC is not a Muslim Practice: FGC precedes the birth of both Islam and

Christianity. Virtually unknown in many Muslim-majority countries, it is performed by Muslims, Christians, Jews, and members of non-Abrahamic religions in areas where it is common.

FGC contradicts every principle of Islam and every source of Islamic law. Based on every single source guiding Islamic ethics, FGC is unjustifiable on Islamic grounds. These sources include the Qur'an, the example, and sayings of the Prophet Muhammad (sunnah and hadith), the objectives and principles of Muslim religious law (maqasid al-shari'a), religious consensus (ijma), legal opinions (fatwah), and analogical deduction (qiyas).

I. FGC Contradicts The Holy Qur'an:

- The Qur'an does not mention female genital cutting, and the Qur'anic messages of health, justice, and compassion clearly contradict the practice.
- The Qur'an promotes mutual pleasure during marital sexual intercourse (2:187 and 30:21), which is severely limited by FGC.
- The Qur'an repeatedly condemns acts that negatively affect the human body (30:30 and 2:195).

II. FGC Contradicts the Prophet's Example (Sunnah) and Words (Hadith):

- There is no evidence that any female members of the Prophet's household were cut, whereas there is evidence that his grandsons were circumcised.

The Prophet was exemplary in his kindness and gentleness towards all members of his family and is known to have said, "Whoever becomes the father of a girl, he should neither hurt her nor treat her with contempt."

Scholar's past and present have deemed all hadith that mention FGC weak, therefore not suitable for legal argumentation; even these weak hadith depict a curbing of the practice.

III. FGC is Not Supported by Legal Consensus (Ijma) or Legal Opinions (Fatawa)

In accordance with the principle of protecting life and in confirmation of the important hadith, "there should be neither harming nor reciprocating harm," Islamic law forbids any attack on the human body, including any form of corporal harm or sexual assault. There is no consensus within classical legal (fiqh) schools on FGC; however, it is likely that classical scholars who called FGC permissible were not aware of its harm, because only a cultural practice that does not hurt an individual or the society can be called permissible under Islamic law.

With the increase in scientific and medical knowledge on the effects of FGC on children, women, and families, extensive scholarly consensus has begun to form among contemporary scholars. Numerous learned fatwas have been issued against the practice worldwide, and an increasing tide of Islamic scholarship has been wearing down the cultural walls of FGC. In a global 2006 conference, an impressive array of high-level Islamic religious scholars from around the world declared FGC to be both contrary to Islam and an attack on women. In 2009, Egypt's Dār al-Iftā', the international flagship for Islamic legal research, released a fatwa, which denounced "female circumcision" as a harmful cultural rite: "Anyone who is acquainted

with the reality of the matter cannot speak except in favour of its prohibition."

IV. FGC Cannot Be Supported by Analogy (Qiyas)

FGC is not analogous to male circumcision because a) it has no basis in Islamic texts b) functional organs as opposed to skin tissue are cut c) there is no unity of practice: it is performed only in some Muslim communities who differ to the extent of the incision d) there are proven medical benefits to male circumcision, including protection against HIV/AIDS, yet only medically proven harm from FGC, including increased transmission of HIV/AIDS.

V. FGC Contradicts the Principles of Islamic Jurisprudence (maqasid al-shari'a)

According to scholarly consensus, the six objectives and principles of Muslim religious law (Shari'a) include the protection and promotion of religion (al-din), life (al-nafs), mind (al-aql), family (al-nasl), wealth (al-mal), and dignity (al-ird). FGC violates at least five of these principles:

The Protection of Life: FGC harms infants, girls, and women, endangering their lives and the lives of their future children. In fact, FGC practicing regions have the world's highest maternal and infant mortality rates.

The Protection of Mind: FGC harms girl's minds by undermining their mental and psychosexual health, causing psychosis and trauma.

The Protection of Family: FGC prevents the proper fulfilment of conjugal relations and forecloses mutually pleasurable sexual relationships for husband and wives. It has been linked to infertility and divorce.

The Protection of Dignity: FGC harms a woman's dignity, condemning her to a life of serial infections and intimate

scars. Disfiguring genitalia, on the unproven assumption that the practice prevents promiscuity, denies humans their divine right to free will and dignity.

The Protection of Religion: In many cases, suturing and scars make it impossible for the cut female to attain ritual cleanliness (tahara), denying her the right to worship. The unnecessary health problems caused by FGC prevent a woman from enjoying the two blessings the Prophet has praised: "health and free time for doing good."

CONCLUSION AND RECOMMENDATIONS

The Shura Council condemns FGC as a harmful and un-Islamic practice that contradicts the spirit and the letter of Islam, violates international laws on children's and women's rights, and endangers populations in need. Research suggests that FGC can be eliminated very rapidly if communities themselves decide to do so. The Shura Council believes that the dissemination of religious information of FGC will help eradicate FGC, especially when combined with context-specific, culturally sensitive, grassroots measures. The Council suggests that activists seek the collaboration of local, national, and international religious authorities in the struggle to eliminate FGC.

CAMPAIGNS AND ACTIVISM

To read the longer Shura Council statement against FGC, find information about current campaigns, and to connect with organizations and activists working to eradicate FGC, please visit:

<http://www.wisemuslimwomen.org/currentissues/femalegenitalcutting>.

