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MANUAL ON FEMALE GENITAL MUTILATION/CUTTING

FOR HEALTH PROFESSIONALS

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MANUAL
FOR HEALTH PROFESSIONALS
AND STUDENTS
ON
FEMALE GENITAL MUTILATION/CUTTING

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Presentation

Female Genital Mutilation/Cutting (FGM/C) is an ancient practice that remains a deeply rooted tradition in more than 28 countries in sub-Saharan Africa and has widespread in other continents along with African diaspora. Reports and surveys have shown that about 78% of girls and women (UNICEF MICS 2007) in The Gambia undergo the practice. According to a community-based survey on the long-term reproductive consequences of FGM/C (MRC 2001) conducted in rural Gambia, 98% of Mandinkas, 32% of Fullas, and 4% of Wollofs shows signs of FGM/C. Other surveys conducted by other NGO´s like GAMCOTRAP and BAFROW respectively, estimate the practice among Mandinkas and Sarahules at 100%, 96% among Jolas and 84% among Fullas. Prevalence of the practice is driven by deep-seated traditional beliefs, rewards and the belief that it is a religious injunction in a predominantly Muslim country.

Prior to the 1980s FGM/C was seldom openly discussed. From late 1980s concerted efforts have been directed at educating communities on the negative health consequences of the practice. The Women's Bureau in collaboration with a number of NGOs involved in addressing reproductive health, gender and girls/women's rights issues have been in the forefront in the fight against the practice. In the decade of 1980s to 1990s those who perceive a need to eradicate the practice and those who seek to preserve it engaged an intense debate. Despite acceleration of the campaign against FGM/C, the practice continues in Gambian communities.

Numerous players are involved in the effort to eliminate FGM/C, health professionals are yet to play a proactive role. This Manual, along with an Academic Curriculum for the University of The Gambia, is designed to set the stage for the active participation of medical doctors, graduate nurses and graduate Public Health Officers in The Gambia in response to FGM/C.

The physical, psychological and sexual complications of FGM/C require skilled management carried out by health care workers. In many societies where FGM/C is performed, the practice is not covered in the training curricula of medical students, nurses, midwives and other health professionals. It is important that these gaps in professional training and education are addressed adequately. The training gives health workers the skills needed to identify the complications of FGM/C and to manage girls and women who present such complications. Advanced training prepares midwives and those involved in caring for women during pregnancy, labor, delivery and the postpartum period. Training also enables medical professionals to open up type III FGM/C.

Moreover, integrating FGM/C into mainstream training of health professionals in the Gambia will increase the pressure for the elimination of the practice. Training of practitioners in interpersonal communication skills, including counseling, is crucial to their role in the prevention of FGM/C. Health education of communities, civil society organizations, organized community groups, families and individuals on FGM/C issues in a participatory manner is equally important. Empowering through information and education.

Female genital mutilation/cutting is underpinned by deep- rooted cultural forces which need to be understood in their proper context by health personnel. Once health workers have gained sufficient insight into the socio-cultural dimension of the practice, they would be able to relate to the issues in a more sensitive manner. Their legitimated roles in the territory reinforce their capacity to enable changes towards this issue.

The Manual for Health Professionals and Students has been developed to facilitate understanding, care and prevention of FGM/C, a major challenges in Sexual and Reproductive Health and Rights of African girls and women. There are basically ten modules, structured into units which follow a consistent pattern of flow.

Through this new educational resource, Wassu Gambia Kafo (WGK) continues its historical contribution on the training of health students and professionals so they can take an active role in promoting the abandonment of the practice. Since the creation of this NGO, Wassu Gambia Kafo has been collaborating through assessment and equipment donations with the School of Medicine and Allied Health Sciences (SMAHS), creating sustainable institutional links as such as the cooperation agreement between Autonomous University of Barcelona (UAB) and the University of The Gambia (UTG). At the same time, WGK has been cooperating with the Team of Cuban Doctors that provides the Gambian public health system with 80% of the professionals, who had also taken part in the elaboration of this Manual.

The Manual is published within the context of the «Transnational Applied Research Observatory. New strategies for the prevention of FGM. A circular approach Gambia Spain. Initiation without mutilation» , which is inline with the Gambian government development policies and thus has the backing of the Gambian government for its implementation throughout the Country. The project is developed by WGK and GIPE PTP (UAB), with the financial support of Social Projects “la Caixa” Foundation» and the Provincial Council of Alava (Spain).

In progress since 2008, this program aims to implement a new strategy for addressing FGM. A strategy based on research, awareness, prevention and empowerment in order to be women and their communities the ones who take alternative proposals to avoid mutilation. It seeks to safeguard the fundamental right of women to physical and mental integrity, reconciling this perspective with respect to tradition, the right to privacy and free movement of persons.

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I

Introduction

Harmful traditional attitudes and practices that affect the well-being of women and girls are prevalent worldwide as part of the patriarchal architect. Bride burning, female infanticide, rape, female genital mutilation, honour killing, early and forced marriage are some among a huge range that happen at a normative scale. Traditional beliefs and values are advanced as justification to perpetuate Harmful Traditional Practice (HTPs).

The socializing process which molds the attitudes of girls and women prepares them to accept pain and suffering as an inevitable part of a woman's life and as an obligation to be observed for acceptance by their respective societies.

Female Genital Mutilation (FGM) is a practice that violates the basic human rights of women to life and general well-being. Despite its cruel nature, the practice is prevalent to the detriment of millions of women and girls.

Mothers and grand mothers insist on excising their daughters and grand-daughters to prepare them for the eligibility of marriage, the only social security within the community. It is out of love and care for the future of their daughters that mothers persist on the practice.

In the last 20 years there is a mounting global awareness on the harmful effects of FGM and campaigns continue to intensify for its elimination. In the African front where the practice is prevalent non-governmental organizations, UN agencies and some governments are engaged in the fight to free women from FGM.

Since 1984, the Inter-African Committee has been implementing programmes of education, information, training, lobbying and advocacy regionally in the 28 African countries where it has affiliates, as well as at the international level in collaboration with other organization. It campaigns to advance a holistic and an integrated approach backed by legislation with a human face.

IAC fully supported the Barcelona Declaration on FGM adopted on July 31st 2004 where treating FGM in isolation and genital checking of African girls every six months, holding passports and prohibition of parents to travel with girls are rejected as discriminator practices which could insight racism.

Education of social and health workers, orientation of parents and law enforcing agents can be more effective tools especially if these are based on research findings on FGM.

It is also indispensable to build bridges between organizations in Africa and those working among African immigrants in order to foster collaboration and synergy of action. Experiences can be shared as well as materials and research findings. Girls could be protected by organizations dealing with the issue in their home countries upon their return. Parents could be briefed on changes taking place among their communities. With a well defined common strategy and action, zero tolerance to FGM can be reached in Africa as well as in countries where practicing immigrants live.

In this common endeavour the role of health workers is crucial. This target group can play a decisive part among the communities as TBAs, nurses, midwives and doctors. Their knowledge about the relationship between HTPs and health coupled with the respect and confidence they win from the population give them the potential to become effective change agents.

As part of the strategy, the positive parts of the initiation ceremony involving the relevant education on proper social interaction, sex education, home making are encouraged while mutilation is totally discouraged.

For all these reasons, we fully support the work carried out by the Interdisciplinary Group for the Study and Prevention of Harmful Traditional Practices (GIPE PTP) by providing knowledge, training and methodological proposals for the prevention of FGM. Also, we welcome this Manual for Primary Care Professionals.

Mrs. Berhane Ras Work,
Executive Director
Interafrican Committee on Traditional Practices
affecting the Health of Women and Children (IAC).

1

Origin and definition

The origins of FGM/C

It is not known when or where the tradition of Female Genital Mutilation/Cutting (FGM/C) originated. Some people believe the practice started in ancient Egypt while some believe it began during the slave trade when black slave women entered ancient Arab societies. It is believed in some quarters that FGM/C initiated with the arrival of Islam in some parts of sub-Saharan Africa. Yet still others believe it started independently in sub-Saharan Africa, prior to the arrival of Islam, notably among warrior-tribes. Some believe the practice developed somehow among certain ethnic groups in sub-Saharan Africa as part of puberty rites.

FGM/C is performed by followers of different religions, including Muslims, Christians and Animists, as well as by non-believers in the countries concerned.

Ancient history of the Dogon culture in Mali relates an incident of significance to the origin of FGM/C[1]. According to the myth, Amma, God of the Sky, was alone and wanted to have intercourse with the Earth, whose form was like that of the female body. The Earth's sexual organs were like an ants' nest and her clitoris was raised like a termite mound. Amma drew close but the termite mound rose up, blocking penetration of his penis. It so happened that the Earth had the same sex as Amma, causing discord in the Uni-

[1]GRIAULE, Marcel: *Dieu d'eau*, Fayard Editions, 1948.

verse. 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, there are still cultures that believe that if the clitoris is not removed it will grow to the same size as the penis and, once erect, will prevent a man penetrating a woman's vagina.

Definition of FGM/C

Female Genital Mutilation/Cutting (FGM/C) is defined as all procedures involving partial or total removal of the external female genitalia, or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons. Prior to the adoption of "female genital mutilation", the practice was referred to as female circumcision. This term is still used in societies where FGM/C is practiced. In those communities it is perceived as an equivalent of male circumcision. **"***Only this terminology [FGM/C] reflects the full seriousness and the extent of the damage caused by these practices and captures the element of violence and physical assault which mutilations entail"*[2].

Classification

Different types of Female Genital Mutilation/Cutting are known to be practiced today. They are the following:

Type I: Excision of the prepuce, with or without excision of part or all of the clitoris. It is also called clitoridotomy (-τομια, in Greek, means "incision"). In Islamic culture, this type is known as "Sunna" ("tradition") and is compared to male circumcision.

Type II: Excision, also known as clitoridectomy (εκτομη is a Greek word meaning "cut") of the clitoris with partial or total excision of the labia minora.

[2]See *Ninth report and final report on the situation regarding the elimination of traditional practices affecting the health of women and the girl child* prepared by Ms. Halima Embarek Warzazi, E/CN.4/Sub.2/2005/36, 11 July 2005 at 35.

Type III: Infibulation of part or all of the external genitalia and stitching/narrowing of the vaginal opening, with or without the removal of the clitoris. Two small holes are left for urine and menstrual blood. This type is sometimes referred to as' 'Pharaonic', and its name comes from the Latin word "infibulare" ("fasten with a clasp").

Type IV: Unclassified types of FGM/C: All other harmful procedures to the female genitalia for non-medical purposes, for example:

- Pricking, piercing or incision of the clitoris and/or labia;
- Stretching of the clitoris and/or labia;
- Cauterisation (burning) of the clitoris and surrounding tissue;
- Scraping (angurya cuts) of the vaginal orifice or cutting (gishiri cuts) of the vagina;
- Introduction of corrosive substances into the vagina to cause bleeding, or of herbs into the vagina with the aim of tightening or narrowing it;
- Any other procedures which fall under the definition of FGM/C given above.

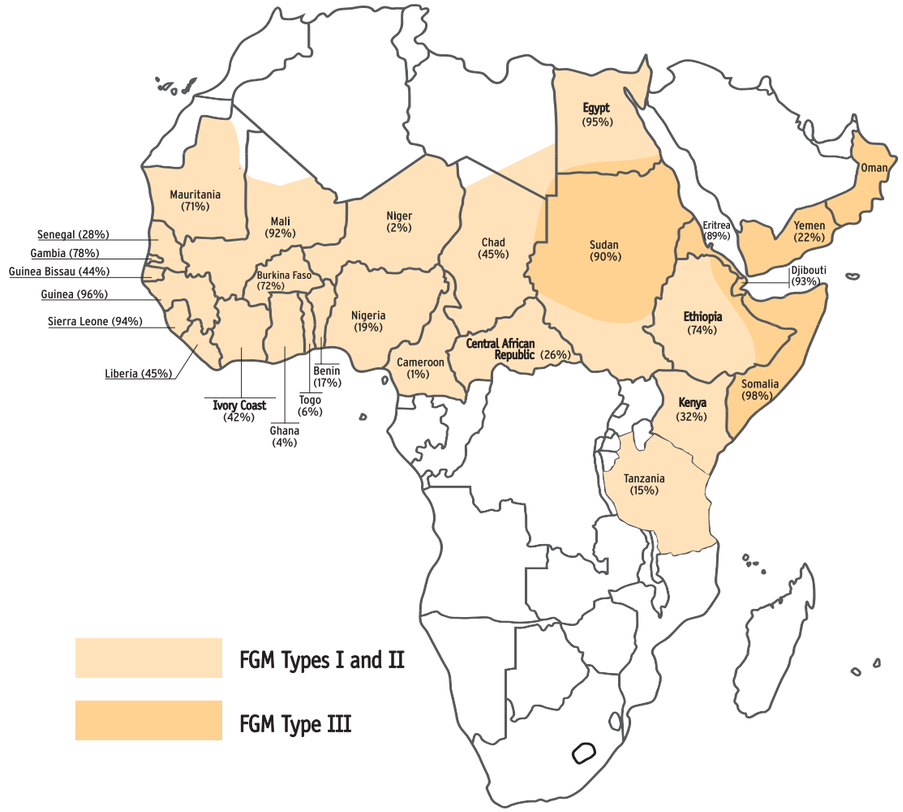
The most common type of Female Genital Mutilation/Cutting is excision of the clitoris and the labia minora, accounting for up to 85% of all cases. The most extreme form is infibulation, which constitutes around 15% of all procedures and takes place mainly in Eastern Africa. FGM/C is mostly performed on girls between the ages of zero and 15 years, prior to the onset of menstruation. However, adult and married women are also occasionally subjected to the procedure. Types I and II are the most common forms of FGM/C practiced in The Gambia, according to clinical research conducted by Cuban doctors and the NGO Wassu Gambia Kafo in 2009.

Prevalence of FGM/C

Distribution of FGM/C

The prevalence of FGM/C has been estimated through surveys that invariably involved asking women aged 15–49 years of age whether they had been cut. It is predominantly practiced in 28 African countries. Due to the migration of people who follow this tradition, FGM/C is today seen in Europe, Australia, Canada, and the United States of America, mainly among migrants from Sub-Sahara Africa.

This prevalence varies considerably, both between and within regions and countries. Ethnicity is the most decisive factor. In seven countries the national prevalence is almost universal, (over 85%); four countries have high prevalence (60–85%); medium prevalence (30–40%) is found in seven countries, and

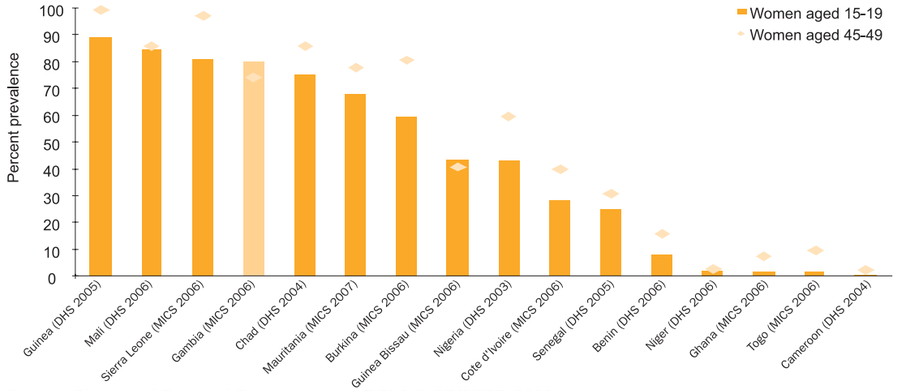


low prevalence ranging from 0.6% to 28.2% is found in the remaining nine countries. However, national averages hide marked variations in prevalence in different parts of most countries.

In 1997, the World Health Organization (WHO), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), United Nations Economic Commission for Africa (UNECA), United Nations Programme on HIV/AIDS (UNAIDS), United Nations Development Programme (UNDP) and United Nations Educational, Scientific and Cultural Organization (UNESCO) issued an interagency statement on FGM/C. It describes the implications of the practice for public health and human rights and declared support for its abandonment. According to the statement, between **100 and 140 million** girls and women in the world are estimated to have undergone the procedures and three million girls are calculated to be at risk of undergoing the ordeal every year.

Prevalence in Africa

The figures in the following table are an estimation of the number of women aged 15-49 years with FGM/C in 20 African countries, as stated in the most recent document on the issue: "Numbers of Women Circumcised in Africa: The Production of a Total" (Yoder & Khan). They are based on International Demographic Health Surveys in the countries where these are conducted. The information is complemented by UNICEF MICS (Multiple Indicator Cluster Surveys) data, since they have the most recent information on many of these countries.



Source: Global and Regional Perspectives on FGM/C (UNICEF, 2009).

2

DISCUSSION AND EXPLANATION OF FGM/C

Procedures, decision-making and age

FGM/C procedures

FGM/C is carried out using special knives, scissors, razors, or pieces of glass. On rare occasions sharp stones have been reported to be used, for instance in Eastern Sudan. Cauterisation, or burning, is practiced in some parts of Ethiopia. Finger nails 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 a number of women, often including her own relatives. The procedure may take 15 to 20 minutes, depending on the skills of the exciser, the extent of excision and the amount of resistance put up by the girl. The wound is dabbed with anything from alcohol or lemon juice to ash, herb mixtures, porridge or cow dung, and the girl's legs may be bound together until healing is completed. In certain countries scalpels are used for cutting in local health clinics.

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

Decision to Perform FGM/C

Decisions to perform FGM/C on girls involve a wide group of people who may have varying degrees of influence in society. Consultations usually take place behind closed doors between close family members. In some instances, FGM/C can give rise to intense arguments within family circles or localities. There are cases in which some family members have organised the procedure against, or not taking on account, the will of others, including the mother of the girl to be cut. Women are usually responsible for the practical arrangements for the ceremony.
In The Gambia, elderly women are key figures in making decisions about FGM/C.

Age at which FGM/C is performed

The age at which girls undergo FGM/C 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, circumcision age has been deliberately brought down in response to heightened efforts to abolish the practice.

Mutilation is often performed when girls are young and uninformed. They are generally conscious when the painful operation is undertaken as no anaesthetic is used and have to be physically restrained because they struggle. Sometimes, they are forced to watch the mutilation of other girls, increasing the probabilities of psychosocial problems as a consequence.

Excisers and medicalisation of FGM/C

Description of the excisers

In cultures where FGM/C is a custom the operation is performed by traditional excisers, usually elderly women in the community specially designated this task. In most societies the art is handed down through family lineage. In Gambia, it is practiced by women who originate from the blacksmith caste. Traditional Birth Attendants (TBAs) are known to be involved in the practice in many societies. Traditional excisers are powerful and well-respected members of the community and FGM/C is an extra source of income, thus giving them a personal interest in keeping the tradition alive.

“Medicalisation” of FGM/C

FGM/C is increasingly being performed in hospitals and health clinics by health professionals, using anaesthetics and antiseptics. The justification is that it reduces pain and the risks to the victim’s health because the operation is performed under hygienic conditions. Health professionals who perform FGM/C claim that medicalisation is the first step towards prevention of the practice. They also argue that if they refuse to carry out an operation, the girl/woman will simply have it performed by a traditional exciser in unhygienic conditions and without pain relief.

The medical profession ought to appreciate the fact that FGM/C, whether carried out in a hospital or any other modern setting, is wilful damage to healthy organs for non-therapeutic reasons. It violates the professional injunction to “do no harm”, and is unethical by any standards.

According to the World Medical Association Declaration of Helsinki (1964) the physician’s mission is to safeguard people’s health. Trained health professionals who perform Female Genital Mutilation/Cutting are violating girls’ and women’s right to life, to physical integrity and health. Yet in some countries and societies medical professionals have performed and continue performing FGM/C (UNICEF, 2005), and evidence shows the trend to be increasing in many of them. In addition, FGM/C in the form of reinfibulation has been documented as being performed as a routine procedure after childbirth in some countries. Reports also indicate that among groups that have immigrated to Europe and North America reinfibulation is occasionally performed even where it is prohibited by law.

A range of factors can motivate medical professionals to perform FGM/C, including financial gain and pressure from society. In countries to which groups that practice FGM/C have emigrated, some medical personnel abuse the principles of Human Rights. They perform reinfibulation in the name of upholding what they perceive is the patient’s culture and her right to choose medical procedures, even in cases where the patient did not request it.

There are serious risks associated with the medicalisation of Female Genital Mutilation/Cutting. Its performance by medical personnel may wrongly legitimise the practice as medically sound or beneficial for

girls' and women's health. It can also further institutionalise the procedure, as medical personnel often hold power, authority, and respect in society. In Egypt, the issue of medicalisation was intensely debated but the custom has now become almost legitimised.

Regulatory Bodies

Medical licensing authorities and professional associations have joined the United Nations organisations in condemning actions to medicalise FGM/C.

All countries have regulatory bodies for doctors, nurses and midwives. These bodies have the legal mandate to take appropriate action against a health professional who acts against the standards set for professional conduct. The International Confederation of Midwives (ICM) and the International Council of Nurses (ICN) are the regulatory bodies in all matters concerning professional midwifery and nursing respectively. Both have policies against the practice of FGM/C.

The International Federation of Gynaecology and Obstetrics (IFGO) passed a resolution in 1994 at its General Assembly opposing the performance of Female Genital Mutilation/Cutting by obstetricians and gynaecologists. The Federation "recommends strong opposition to any attempt to medicalise the procedure or to allow its performance under any circumstances in health establishments or by health professionals» (International Federation of Gynaecology and Obstetrics, 1994).

Customs and traditions underpinning FGM/C

Introduction

All human behaviour has an explanation and FGM/C is no exception. In societies where FGM/C is practiced, 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 which are passed on from generation to generation.
In some communities, FGM/C 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 practiced it is an important part of gender identity, which explains why many mothers and grandmothers defend the practice. They consider it a fundamental part of their own womanhood and believe it is essential to their daughters' acceptance into their society. In most of these communities, FGM/C is a pre-requisite to marriage, and marriage is vital to a woman's security.

Discussion on Tradition

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

Beliefs:
A 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, including religious and cultural beliefs.

Values:
Values are defined as moral principles and beliefs or accepted standards of a person or social group. Values are the criteria against which people make decisions. Many values are inherited from the family, but they are also influenced by religion, culture, friends, education, and personal experiences as people go through life.

Attitudes:
Attitude is a mental view or disposition. They are largely based on personal values and perceptions. Examples of Beliefs, Values and Attitudes with regard to FGM/C:

- FGM/C improves fertility;
- FGM/C prevents maternal and infant mortality;
- FGM/C prevents promiscuity;
- FGM/C helps keep the genitalia clean;
- FGM/C prevents the clitoris from growing;
- FGM/C is an essential part of culture;
- FGM/C is performed to please husbands;
- Type 1 FGM/C does not lead to any complications; it is therefore acceptable;
- Performing FGM/C in a hospital environment is more hygienic and less painful for the girl/woman;
- Type IV FGM/C is harmless, thus its practice should be allowed to continue;
- FGM/C is not a health issue;
- FGM/C is an equivalent of male circumcision.

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

Male complications of FGM/C

The immediate and long-term complications of FGM/C are well documented but the male complications and attitudes towards the practice are seldom described. A study conducted in a rural area of Sudan along the Blue Nile in March-May 1997 was focused on this issue. A total of 59 young men and grandfathers were interviewed on a set of issues. Male complications resulting from FGM/C, such as difficulty in penetration, wounds/infections on the penis and psychological problems were cited by the majority of respondents. The first and second responses came up most frequently in chronological order. They also mentioned decreased sexual desire and enjoyment of the woman. Many of them also felt that the man 'hurts' the woman during sexual intercourse. Most of the subjects were also aware of the female complications of FGM/C. Interestingly, a majority of men said they would have preferred to marry a woman without FGM/C.

There was a high level of awareness that FGM/C has negative health consequences for women. The study revealed that even the majority of grandfathers answered that the practice negatively affects the health of girls and women.

Reasons for FGM/C existence and persistence

Reasons

There is a wide variety of reasons why Female Genital Mutilation/Cutting continues to be practiced. The reasons given by practicing communities are grouped as follows:

- Socio-cultural;
- Hygienic and aesthetic;
- Spiritual and religious;
- Psycho-sexual.

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 the 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 tradition.

There is a belief that unless a girl's clitoris is removed she will not become a mature woman, or even a full member of the human race. She will have no right to associate with others of her age, or her elders.

Some communities believe that a woman's external genitalia have the power to blind anyone attending to her in childbirth. Others believe that the external genitalia have 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/C is believed to ensure a girl's virginity. In many traditional societies, virginity is a pre-

requisite for marriage, which is necessary to maintain a family's honour. The societies practicing FGM/C are largely matrilineal. Women's access to land and security is through marriage, and only excised women are considered suitable for marriage.

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/C is practiced, people believe that it is required by the Qur'an or Sunnah, even though the practice is not mentioned in the Holy Book. It is noteworthy that neither the Bible nor the Qur'an subscribe to the practice of FGM/C, although it is carried out in many societies with Muslim, Coptic-Christian and Jewish Falasha communities (e.g. Egypt and Ethiopia).

The practice pre-dates both Christianity and Islam (WHO, 1996a; WHO and UNFPA, 2006). The response of religious leaders to FGM/C 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 eliminate it. When such leaders are unclear or avoid the issue, they may be perceived as being in favour of Female Genital Mutilation/Cutting (IAS 1997).

Hygiene and aesthetic reasons:

In FGM/C practicing communities it is believed 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 considered true in many communities in The Gambia.

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, and girls who have lost their virginity before marriage are a disgrace to their families. This belief that FGM/C is a means of controlling sexual urge still persists in The Gambia. 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.

Why FGM/C continues to be practiced

In every society in which FGM/C is practiced it is simply a manifestation of gender inequality that is deeply entrenched in the life of the community. Harmful traditional practices like FGM/C tend to perpetuate gender roles that are unequal and harm girls and women. In societies where it is widely practiced it is supported by both men and women, usually without question, and anyone departing from the norm may face humiliation and harassment. In extreme cases, girls and women who have not undergone FGM/C are ostracised. Female Genital Mutilation/Cutting is a social convention influenced by rewards and punishments which are a powerful force for continuing the practice. In view of this complex nature of FGM/C, it is difficult for families to abandon the practice without support from the wider community. In fact, it is often carried out even when it is known to inflict harm upon girls, because the perceived social benefits of the practice are deemed higher than its disadvantages (UNICEF 2000).

There is a strong perception in many societies that FGM/C is a rite of passage. It forms part of raising a girl properly and preparing her for adulthood and marriage. In some societies, the practice is an entry point into women's secret societies, which are considered necessary for girls to become adult, responsible members of the society. Girls themselves may desire to undergo the procedure as a result of social pressure from peers and because of fear of stigmatisation and rejection by their communities if they do not follow the tradition.

Girls who undergo the procedure are given rewards such as celebrations, public recognition and gifts. This form of reward is an important factor in The Gambia. Thus, in cultures where it is widely practiced FGM/C has become an important part of the cultural identity of girls and women. It may also impart a sense of pride, a coming-of-age (the feeling that one is now mature) and a feeling of community membership.

The desire for a proper marriage may play an important part in the persistence of the practice. In many societies where FGM/C is performed it is considered necessary in order for a woman to become a «proper» wife. As mentioned before, it is often believed that the practice ensures and preserves a girl's or woman's virginity.

Female Genital Mutilation/Cutting is also considered to make girls «clean» and beautiful. Removal of genital parts is thought of as eliminating such «masculine» elements as the clitoris. It is also felt that infibulation is performed in order to make the genitalia 'smooth' thereby making a woman/girl beautiful. A belief sometimes expressed by women is that female genital mutilation enhances men's sexual pleasure.

The practice of FGM/C is often upheld by such influential people and local structures of power as traditional leaders, religious leaders, circumcisers, elders, and even some medical personnel.

In some countries there is evidence of an increase in the performance of FGM/C by medical personnel. In many societies, older women who have themselves been mutilated often become advocates of the practice, seeing it as essential to the identity of women and girls. This is probably one reason why women are more likely to support the practice and tend to see efforts to combat the practice as an attack to their culture.

Preservation of ethnic identity to mark a distinction from non-practicing groups is also an important factor. For example, it is carried out by immigrant communities living in countries that have no tradition of the practice. Female Genital Mutilation/Cutting is also occasionally performed on women and their children from non-practicing groups when they marry into groups/societies in which it is widely practiced. In certain areas of The Gambia, Wollofs living in predominantly Mandinka and Sarahule communities are compelled to undergo FGM/C because of this pressure.

Religion and FGM/C

Is the voice of religious leaders heard?

In Africa, the practice of FGM/C is driven significantly by religious misperceptions. Unfortunately, the vast majority of the ordinary people in African countries where the practice is common have little or no knowledge of the fundamental teachings of Islam. Most of them are carried away by the personal feelings and opinions of individuals who are not necessarily religious scholars. Many Islamic academics and authorities in these 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. Perhaps the explanation for this phenomenon needs investigating.

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 in attendance 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/C 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/C;
- Having recognized that in Africa over 100 million women and girls are victims of FGM/C;
- Having confirmed that FGM/C 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/C;
- 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/C;
(ii) Prohibit the misuse of religious arguments to perpetuate FGM/C and other forms of violence;
(iii) Commit ourselves to clarify the misinterpretation of religion and to teach the true principles of Islam and Christianity with regard to 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 October 2007.

Ethics, legal implications and rights in FGM/C

Ethical Implications

Professional ethics are moral statements or principles which guide professional behaviours. Ethics are not bound by law. For example, nursing ethics include maintaining confidentiality and showing respect for patients as individuals 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/C in both health institutions and private facilities. The WHO and most governments have expressed their unequivocal opposition to the "medicalisation" of the practice. The WHO position is that under no circumstance should FGM/C be performed by health professionals or in health institutions. The practice of FGM/C by medical professionals is a serious betrayal of professional ethics, since it involves causing harm without therapeutic reasons.

Legal implications of FGM/C

The enactment of a law to protect girls and women from FGM/C makes it clear what is wrong and what is right. Having a law in place offers legitimacy to the police, women's organisations, anti-FGM/C advocacy groups and health professionals to intervene in cases of FGM/C.

Passing laws is not enough on its own to protect girls and women from FGM/C. There is a danger that fear of prosecution will inhibit people from seeking help in the case of complications. Therefore, laws must go hand in hand with community education to raise awareness of the harmful effects of FGM/C and to change attitudes. In some countries, excisers are now facing litigation for excising little girls and in most cases advocacy groups and women's organisations give good backing to complainants. In Senegal excisers are now taken to court for the practice.

Countries with laws against FGM/C

COUNTRY	LEGISLATION
BENIN	3RD MARCH 2003
BURKINA FASO	13TH NOVEMBER 1996
CAMEROON	
CENTRAL AFRICAN REPUBLIC	1996
CHAD	2002
COTE D'IVOIRE	1998
DEMOCRATIC REPUBLIC OF CONGO	
DJIBOUTI	1995
EGYPT	1996
ERITREA	
ETHIOPIA	
GAMBIA	
GHANA	1994
GUINEA	FEBRUARY 2006
GUINEA BISSAU	
KENYA	2001
LIBERIA	
MALI	24TH JUNE 2002
MAURITANIA	2005
NIGER	2003
NIGERIA	
SENEGAL	1999
SIERRE LEONE	
SOMALIA	
SUDAN	
TANZANIA	1998
TOGO	1998

Source: "A Fifteen year Review of the Implementation of the Beijing Platform for Action in Africa – Main Report 1995-2009", United Nations Economic Commission or Africa (UNECA, The Gambia, 2009).

In other countries, national laws make provisions for protection against injury, even if FGM/C is not specified. Laws and decrees have a variety of stipulations that can be used to regulate or ban the practice of FGM/C. So far (as at 2009) there is no law against FGM/C in The Gambia although the Children's Act of 2005 has a clause on harmful traditional practices, which is precisely what FGM/C is.

Human Rights and FGM/C

Introduction

Female Genital Mutilation/Cutting violates a series of well-established human rights principles, norms and standards. Key among these are:

- Equality and non-discrimination on the basis of sex;
- The right to life when the procedure results in death;
- The right to freedom from torture or cruel/inhuman treatment;
- Freedom from degrading treatment or punishment.

As FGM/C interferes with healthy genital tissue and can lead to severe consequences for a woman's physical and mental health, it is clearly a violation of a person's right to the highest attainable standard of health, being characterised by the following:

- Gender inequalities;
- Discrimination against girls and women;
- Torture, cruel, inhuman and degrading treatment of girls and women;
- Abuse of the physical, psychological and sexual health of girls and women.

The rights of the child

Because of children's vulnerability and their need for care and support, human rights law grants them special protection. One of the guiding principles of the Convention on the Rights of the Child is the primary consideration of «the best interests of the child». Parents who take the decision to subject their daughters to Female Genital Mutilation/Cutting perceive that the benefits to be gained from this procedure outweigh the risks involved. However, this 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 in cases where there is an apparent desire by girls to undergo the procedure, in reality it is the result of social pressure, community expectations and girls' aspiration to be accepted as full members of the community. That is why a girl's decision to undergo female genital mutilation cannot be called 'free'.

FGM/C is nearly always carried out on minors and is therefore 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 prejudicial to their health and lives. 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/C 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.

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/C and recommending measures to combat it. They are pushing for 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 with a view to eradicating the practice. It also requests them to provide information about measures being taken to eliminate FGM/C in their reports to the Committee (Committee on the Elimination of All Forms of Discrimination against Women, 1990).

International Treaties of direct relevance to FGM/C include:

- Universal Declaration on Human Rights, 1948;
- Convention for the Suppression of the Traffic in Persons and of the Exploitation of Others, 1949;
- 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;
- The Geneva Conventions and their Additional Protocols, 1949 and 1977;
- Convention on the Rights of the Child (1989) and its two Optional Protocols (2000);
- Convention against Transnational Organized Crime and its Optional Protocols, 2000;
- African Charter on Women's Right (Maputo Protocol, 2005);
- UNESCO Universal Declaration on Cultural Diversity, 2001;
- United Nations Economic and Social Council (ECOSOC), Commission on the Status of Women. Resolution on the Ending of Female Genital Mutilation, 2007.

The Convention on the Rights of the Child (1990)

This Convention provides for:

- 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.

The Vienna Declaration and the Programme of Action of the World Conference on Human Rights (1993)**:** These two instruments expand the international human rights agenda to include gender-based violence which includes FGM/C.

The Declaration on Violence against Women (1993): This Declaration states that violence against women must be understood to include physical and psychological violence occurring within the family, including FGM/C and other traditional practices harmful to women.

The Programme of Action of the International Conference on Population and Development (ICPD, 1994) includes a recommendation on FGM/C which commits governments and communities to: "urgently take steps to stop the practice of female genital mutilation and to protect women and girls from all such similar unnecessary and dangerous practices".

The Platform of Action of the Fourth World Conference on Women (1995) includes a section on the girl-child and urges governments, international organisations and non-governmental groups to develop policies and programmes to eliminate all forms of discrimination against the girl child, including FGM/C.

Regional treaties

- African Charter on Human and Peoples' Rights (the Banjul Charter) and its Protocol on the Rights of Women in Africa;
- African Charter on the Rights and Welfare of the Child;
- European Convention for the Protection of Human Rights and Fundamental Freedoms.

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".

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”. The spirit and intent of these two articles clearly run against the practice of FGM/C, which is not only a harmful traditional practice but is also inhumane and degrading. Seen from a human rights perspective, the practice reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women.

Violence against women

Definition of violence against women

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 in 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 work place, 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.

Response of the International NGO Fraternity to Violence against Women

Women’s organisations and other non-governmental organisations have done a lot to bring violence against women to the attention of the international community. The Geneva-based NGO Working Group on Female Circumcision, precursor of the present NGO Working Group on Violence against Women, was formed in 1977.

NGOs continue to call for resolutions against FGM/C and other harmful traditional practices. The initiative of NGOs in providing evidence and alerting the world community spurred United Nations special agencies and bodies to use their resources to give wider support to the effort to combat customs and traditional practices which are harmful to women and children.

The World Health Organisation’s World Report on Violence (2002) clearly demonstrates that violence is a major and very costly health problem, affecting a sizable percentage of women. The United Nations Population Fund, the United Nations Children’s Fund and the United Nations Development Fund for Women have cooperated with NGOs in the field, paving the way for universal acceptance of this problem. The International Labour Organisation and the United Nations Educational, Scientific and Cultural Organization (UNESCO) have both addressed this issue. All of these organisations have collaborated with NGOs and other civil society groups to establish definitions and recommend guidelines for action.

3

Country profile

The Gambia is situated on the Atlantic coastline of West Africa. It has a total land area of 10,689 square kilometres and stretches 400 km from the Atlantic coastline inland. There are two distinct seasons, the rainy season (early June to late October) and the dry season. Climatic conditions are typically tropical savannah.

The country attained independence from Britain on February 16, 1965 but it was in April 1970 that it gained the status of Republic. It has a multiparty parliamentary system of government. There are five provincial administrative regions and two municipalities, headed by governors and mayors. The regions are further divided into districts, which are headed by Chiefs (Seyfos). There are 1,860 settlements in the country.

The **Population** of the country at the 2003 Census was **1.37 million,** with an annual growth rate of 2.74%. The population is projected at 1.6 million for 2008. The current crude birth rate is 46/1,000 population and the crude death rate is 11/1,000 population. The country has an infant mortality rate of 75/1,000 live births. Average life expectancy at bi rth is 64 years overall. The main ethnic groups are Mandinka (42% of population), Fulla (18%), Wollof (16%), Jola (10%) and Sarahule (9%).

The Gambia is one of the world's least developed countries, ranking 155 out of 177 on the UNDP Human Development Index for 2007. Groundnut export is the leading foreign exchange earner. Fishing, tourism and export trade are also important sources of national income.

FGM/C situation

Prevalence

A survey conducted in rural Gambia in 1999 indicated that 98% of Mandinka women, 4% of Wollof women and 32% of Fulla women had signs of FGM/C. Other studies reveal that the national prevalence is as high as 80 percent, according to UNICEF (MICS, 2008).

Type of FGM/C

Types I and II FGM/C are the most prevalent in The Gambia. According to a situation analysis conducted in June-August 1999 and other sources, type III is not practiced at all. However, in 1999 a survey of 1,348 women aged 15-54 was conducted in rural Gambia to estimate the prevalence of reproductive morbidity on the basis of women's reports, gynaecological examination and laboratory analysis of specimens. A total of 1,157 women consented to gynaecological examination and 58% of them had signs of genital cutting. The survey involved Mandinka, Fulla and Wollof women. Of the women who reported being mutilated/cut, three were 'sealed' (WHO type III FGM/C) while the majority had type II FGM/C.[3]

The ethnic factor as a driving force; the Sene-Gambia lesson

The Gambia and Senegal vary in colonial history, size, official language and economic circumstances. Nevertheless, they share much in common in terms of culture, landscape, climate, ethnicity, dominant religion (Islam) and subsistence activities. Along the border between the two countries it is not uncommon to find communities sharing very similar characteristics and even extended families divided on different sides of the boundary.

[3]MORISON, L. et. Al. (2001) "The long-term reproductive health consequences of female genital cutting in rural Gambia: a community-based survey" in *Tropical Medicine and International Health* vol. 6 Nº 8, London. U.K. 643-53.

There is ample evidence that the practice of FGM/C is closely tied to ethnic affiliation. Because of this factor, prevalence rates for the two countries vary: in The Gambia it is around 80% while the figure in Senegal is about 28%. For instance, the Wollof, who do not practice FGM/C on a large scale, make up 16% of the Gambian population but form the majority (43%) in Senegal, while the Mandinka, who almost universally practice FGM/C, constitute 42% of the population in The Gambia but constitute less than 9% in Senegal.

Age at which FGM/C is performed

There is no fixed age at which the practice is carried out on girls/women. It ranges from young, even week-old babies to girls in adolescence. There are significant ethnic variations when it comes to age. In Sarahule communities, babies are cut in their first week of life while in many Fulla communities the practice is performed on girls from three to seven years old. In Jola communities, girls are spared until they attain the age of puberty. One survey conducted in 1999 revealed that the maximum age for cutting is 16. In most communities, FGM/C is scheduled by elderly women in consultation with the excisers. If a girl/woman happens to miss a scheduled ceremony she has to wait for the next, which could take many years. Communal FGM/C schedules are now more flexible because people are highly socially mobile and migration is common.

Decision-making

FGM/C is widely perceived as a women's affair and, as such, decisions regarding the practice are taken predominantly by elderly women. In one particular study, 32% of respondents said it was mothers who made the decisions and fathers are only casually informed. Grandmothers and paternal aunts are typically in the forefront of decision-making.

Procedures

The operation is performed by elderly women, mainly of the blacksmith caste. Excisers are believed to be people who possess supernatural powers. It is carried out in a variety of settings: the bush, backyard and, occasionally, indoors. It is done without any anaesthesia. The girl is physically held tight by close family members or the exciser's aids. After the operation the girl is treated with a variety of herbal con-

coctions or other substances, which may include leaves, tomato paste, engine oil, cooking oil and cow dung, intended to aid healing. Some excisers have tried to modernise dressing by using iodine, gentian violet, antibiotic ointments, Vaseline or balms.

The ritual and seclusion period

Girls who are to be cut are seldom informed in advance. Preparations are made by the girl's parents and/or grandmother. Usually, the family concerned has to raise money to meet the cost of the rituals, which depends on several factors. The exciser and her assistant are paid; food is provided in abundance for the girls for the period of seclusion; medicines and healing devices are procured and celebrations are paid for. Presents and gifts are given to girls during the seclusion period.

As stated earlier, the practice is characterised by a period of seclusion. The girls are led, one by one, to the place of cutting by an aunt or grandmother. They may or may not meet other girls before the operation. During the period, which may last for two weeks, the girls are initiated into women's secret societies. The teachings consist of practical skills and communication by use of signs. The girls also learn songs, stories, fables and proverbs. The initiates are threatened that if they reveal the secrets of the seclusion to those girls/women who are not cut they will suffer, even die. The day they come out of the seclusion is celebrated with a big party and fanfare.

Perceptions of the need for FGM/C

Reasons given for the practice of FGM/C in Gambian communities are wide and varied, the most commonly cited in many studies being:

"FGM/C is a rite of passage in life"
"It shows that one is coming of age"
"It is a means of controlling the sexual urge of girls/women"
"Uncircumcised women are not clean spiritually"
"If the clitoris is not cut it will grow to unimaginable proportions"
"It gives girls a sense of belonging to the community"

The rituals and ceremonies surrounding the practice are a form of social incentive. Another reason for practicing FGM/C strongly defended in Gambian communities is respect for tradition and conventional norms of behaviour.

Cutting without ritual – an emerging phenomenon

The rituals that go with FGM/C in The Gambia are taking a downward turn. Many girls are now excised alone, or together with very few others. This trend is explained by several factors, key among them the lowering of the age at which FGM/C is performed, the lavish celebrations, and schooling. In addition, some clans that adhere to a more orthodox interpretation of Islam argue that cutting without ritual is better, because they consider traditional 'circumcision' rituals as un-Islamic.

Scientific knowledge on FGM/C

Compared to several other countries in Africa, there is a paucity of research data on FGM/C in The Gambia. This situation continues to affect the planning and programming of strategies aimed at eradicating the practice. It also casts a shadow of doubt over international available data on FGM/C regarding The Gambia.
Since 2008, the Observatory of Applied Research and New Strategies for the Prevention of Female Genital Mutilation (Wassu Gambia Kafo-Autonomus University of Barcelona) is starting to provide new scientific knowledge on the issue. Based in The Gambia and Spain, it provides inside information obtained from clinical and qualitative research within health students and professionals working in primary care services.
The clinical case record conducted in cooperation with the Mission of Cuban Doctors helps to identify the types of FGM/C practiced in the country, ethnic groups that practice it and the consequences it has on health.[4]
The KAP questionnaires explore the knowledge, attitudes and practices of health students, what enables the design of suitable educational materials and programs aimed at their training in attention and prevention of FGM/C.

[4]Scientific findings available at www.mgf.uab.es

Legislation

At this moment in The Gambia there is no specific legislation banning FGM/C.

Addressing FGM/C cases through the Penal Code. Articles 212 and 214 could both be applicable to address FGM/C, dealing with grievous harm, according to the Inter African Committee (IAC).

Article 214 refers only to causing grievous harm to another, and article 212 establishes that "Any person who, with intent to maim, disfigure, or disable any person, or to do some grievous harm to any person... unlawfully wounds or does any grievous harm to any person by any means whatever; or unlawfully attempts in any manner to strike any person with any kind of projectile or with a spear, sword, knife or other dangerous or offensive weapon; is guilty of a felony, and is liable to imprisonment for life".

Another article (210) could lead to the punishment of parents who subject their daughters to FGM/C, since it states that any person over the age of 16 years who has custody, care or charge over a child under 14 years and who mistreats this child in any way or exposes the child to suffering or injury to its health, is guilty of a misdemeanour.

Efforts aimed at eradication

Over the past two decades, the Gambia Committee on Traditional Practices (GAMCOTRAP, the national representative of the Inter African Committee, IAC), the Foundation for Research on Women's Reproductive Health, Development and Environment (BAFROW), the Association for the Promotion of Girls' and Women's Advancement in The Gambia (APGWA) and the Gambia Family Planning Association (GFPA) have been involved in anti-FGM/C advocacy work in the country. Being the first voices to bring up the issue in the adverse context of the early 80s, they paved the way for the public fight against FGM/C in The Gambia.

Until the mid 1980s it was almost inconceivable to discus FGM/C openly in Gambian communities. The anti FGM/C campaign started gathering momentum from 1984 to 1986, but the actions of the advocates and their partners generated mixed feelings in all circles. The Women's Bureau was in the forefront of that campaign, which started when the Bureau was represented at a meeting in Dakar in 1984, organised by the Senegalese government and the Working Group on Traditional Practices. The Inter African Committee (IAC) was formed at this meeting, and its Gambian chapter was born swiftly after the Dakar meeting (in 1992 its name was changed to GAMCOTRAP). The IAC is the largest[5] and most experienced[6] international network of non-governmental organisations working on FGM/C and other harmful traditional practices such as early/forced marriage, nutritional taboos, and other skin cutting practices.

Campaigns were mounted by the Bureau, mainly through its field officers to create awareness of the adverse effects of the practice. This was done in collaboration with the Ministry of Health and a coalition of NGOs and voluntary organizations. The response of Islamic scholars was fast and harsh. However, more players joined the advocacy constituency and the issue became a subject of intense debate.

Today the taboo and the mystery surrounding the practice have been dampened, it is discussed in all circles and people of all walks of life are engaged in the dialogue in one way or the other. The mere fact that the issue is now openly discussed and has become a subject of public debate is a significant gain, facilitated by the emergence of alternative approaches to FGM/C prevention, respectful to the culture and to the rights of the people involved.

At the beginning of the XXI century, following more than ten years of governmental veto of the topic due to aggressive campaigns against FGM/C, the international NGOs TOSTAN and Wassu Gambia Kafo (WGK) joined the cause, as part of a drive that has already set important milestones. One is the project of transnational research and training of health students and professionals, proposed by WGK, taking place in Spain with Gambian migrants and in The Gambia, where the International Forum on Harmful Traditional Practices[7] was held recently (2009) with governmental support. Another is the public declaration against FGM/C of 80 villages as a result of the Tostan-UNICEF campaign (June 2009).

Also in this century, the IAC has maintained its leadership in the issue by promoting ratification in 2005 of the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol, 2003).

Eventually, in cooperation with UN agencies and other sponsors, NGOs in the country targeted different groups and communities to raise awareness and encourage mobilisation and advocacy. These included religious leaders, community leaders, media workers, excisers, CSOs, youth groups and organizations, women's groups, media practitioners, traditional rulers, medical workers and politicians. Many strategies have been attempted, but real impact on prevalence rates is still a challenge in The Gambia. They remain at 80% in spite of the wide presence of local and international initiatives against FGM/C implemented throughout the small territory of the country, where fewer than 1.5 million people live.

[5] 16 Group Sections in Europe, Canada, New Zealand, Japan and the USA.

[6] In more than 20 years of networking, the IAC had been pioneer in cooperating with UN International agencies, and religious and community leaders, promoting international conferences and public multisectorial declarations against FGM, and lobbying for suitable regulations and positioning of African governments, etc.

[7] See the Brufut Declaration and further information on this forum at www.mgf.uab.es

4

COMPLICATIONS OF FGM/C

Introduction

FGM/C violates the integrity of the female reproductive tract and is almost always practiced with rudimentary instruments such as glass, knives and rusty old razor blades. It causes multiple complications and many girls die because of bleeding or due to infections after the cutting. Circumcised women have more problems during birth than those not circumcised and many babies die because of this. The practice of FGM/C currently affects around 140 million women and girls around the world. According to them, this practice is a cultural issue, while the rates of morbidity it causes increase continuously.

The complications caused by FGM/C can be classified into: immediate physical complications, long term physical complications, psychosocial complications, sexual complications and dangers of FGM/C to childbirth.

Overview of the female genitalia

The normal external female genitalia comprise the following parts:

- Skene's and Bartholin glands: lubrication of the vagina;
- Vaginal orifice: allows menstrual flow, sexual intercourse and delivery of baby;
- Urethral meatus: allows emptying of the bladder within a few minutes;
- Clitoris: assists the woman to achieve sexual satisfaction;

- Perineum: supports the pelvic organs and separates vagina from anus;
- Labia Minora: protects structures and orifices;
- Labia Majora: protects the inner structures and orifices.

Immediate complications

The range of complications associated with FGM/C is wide. The most immediate include: pain, haemorrhage, shock, tissue injury, acute urine retention, fracture or dislocation, infection, and failure to heal.

Pain:

Severe pain is one of the immediate physical complications and is produced by two fundamental aspects. Firstly, by the extensive innervations of female genitalia (Fig. 1), and secondly because this bloody operation is practiced with inappropriate instruments and without anaesthetics. Sometimes the pain is so intense that it can cause shock.

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 this can lead to haemorrhage. Secondary haemorrhaging may occur after the first week as a result of sloughing of the clot over the artery due to infection. Cutting of the labia causes further damage to blood vessels and Bartholin glands. Haemorrhaging is the most common and life-threatening outcome of FGM/C.

Shock:

Immediately after the procedure, the girl may go into shock as a result of the sudden loss of blood (haemorrhagic shock), severe pain and trauma, which can be fatal.

It is important to know that a large part of the female population in these regions has chronic anaemia that does not exclude girls. With anaemia, the onset of haemorrhagic shock is faster.

In Figure 2 we show the irrigation of the female reproductive system. One can observe the variety of small, medium and large blood vessels available at that level, illustrating how damage to their integrity may be life threatening.

Actual case:

In 2008, at a hospital in the North Bank Region, a gynaecologist visited a 12 year old girl who had undergone FGM/C and was rushed to the hospital as an emergency. She presented severe acute bleeding and was in hypovolaemic shock. All necessary measures to resuscitate her failed and she finally died as a result of lack of adequate knowledge and technique to control and arrest the bleeding by those who performed the excision.

Injury to tissue:

Injury to the adjacent tissue of the urethra, vagina, perineum and rectum can result from the use of crude instruments, or because the operator is ignorant of the anatomy and physiology of the female external genitalia. Poor eyesight of circumcisers, the use of careless techniques or poor lighting increase risk of injury, which is especially likely if the girl struggles because of pain and fear. Damage to the urethra can result in incontinence.

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 and it may last for hours or days. This condition can lead to urinary tract infections.

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 to hold a girl down during the mutilation/cutting.

Infection:

Infection is very common as a result of the following:

- Unhygienic conditions;
- Use of unsterilized instruments;
- The 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/C Type III (infibulation), which prevents wound drainage;
- Contamination of the wound with urine and/or faeces.

Infections may prevent the wound healing, and may result in an abscess, fever, ascending urinary tract infection, pelvic infection, tetanus, gangrene or septicaemia. Severe infections can be fatal. Group mutilations, in which the same unclean instruments are used on 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.

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.

Long-term complications

Long-term physical complications may include the following:

- **Difficulty 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/C 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:**

They are painful and may be accompanied by a discharge. Infections may spread to the uterus, fallopian tubes and ovaries, and may cause infertility. (Fig. 3).

- **Infertility:**

Infertility can result if pelvic infection causes irreparable damage to the reproductive organs.

- **Keloid scar:**

Slow and incomplete healing of the wound and post-operative infection can lead to the production of excess connective tissue in the scar (keloids). This may obstruct the vaginal orifice, leading to dysmenorrhoea (painful menstrual period). Following infibulation, scarring can be so extensive that it prevents penile penetration and may cause sexual and psychological problems.

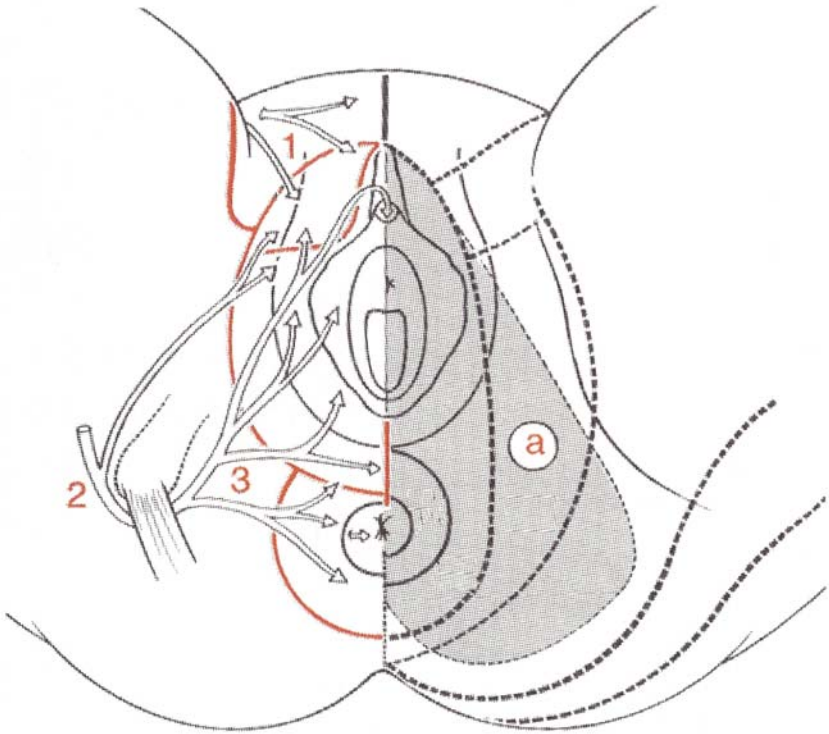


Figure 1
Innervation of the vulva: a. pudendal nerve area; 1. iliohypogastric, ilioinguinal and genitofemoral nerves; 2. posterior thigh cutaneous nerve; 3. pudendal nerve

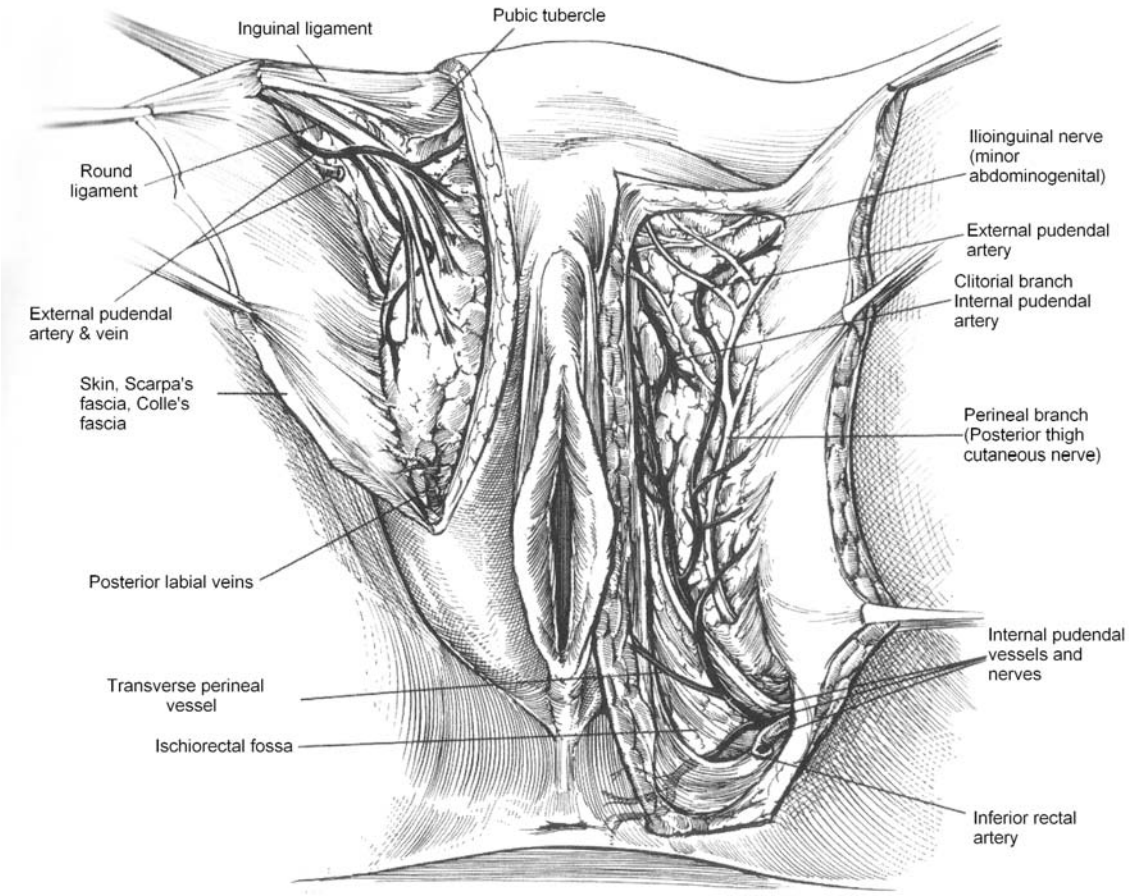


Figure 2
Irrigation and Innervation of the Femenine Reproductive Tract

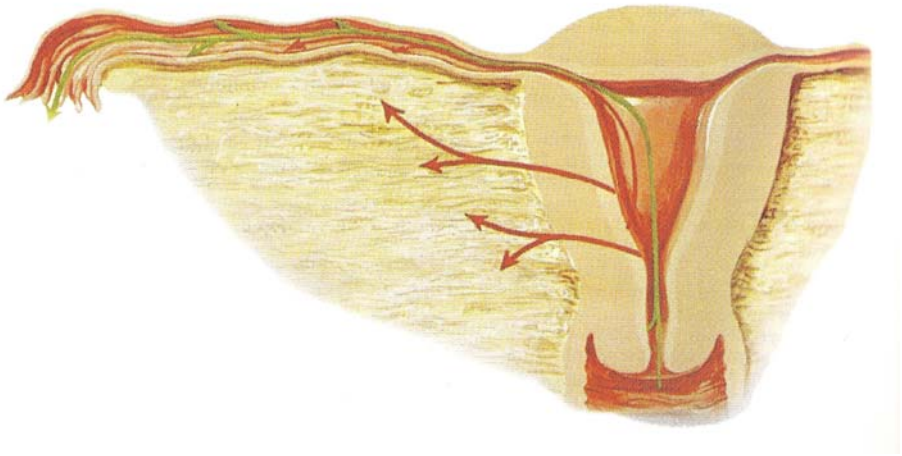


Figure 3
Spread of the Infection

Introducing a dilator
under the scar

An opened infibulations

Sutured sides
of an opened scar

Figure 4
Surgical intervention in the process of opening up a woman with Type III FGC

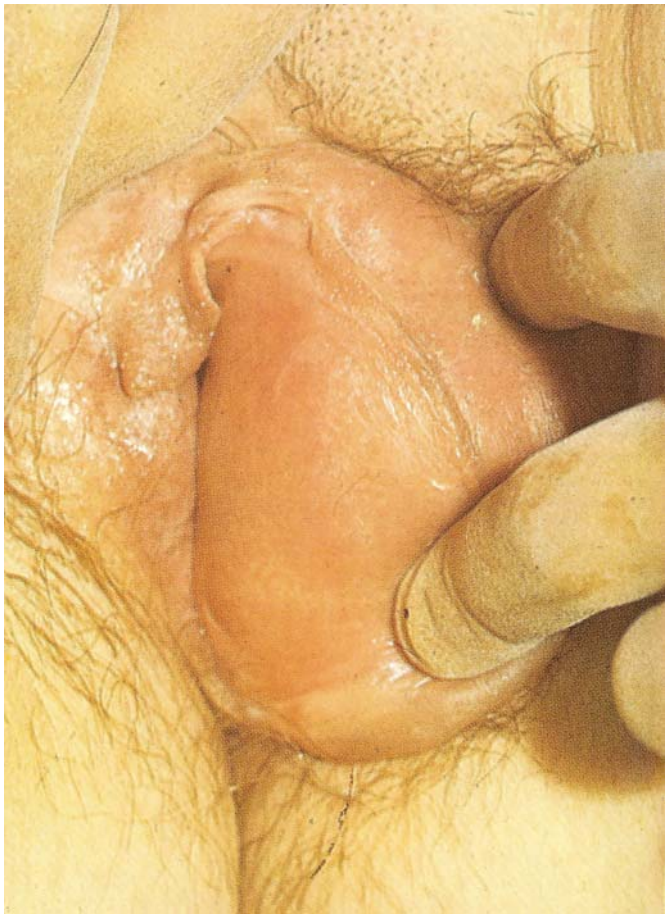


Figure 5
Abscess on the vulva

· Abscess:

Deep infection resulting from defective healing or an embedded stitch can cause an abscess, which may require surgical intervention (Fig. 4).

· Cysts and abscesses on the vulva:

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

· Clitoral neuroma:

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

· Difficulty in menstruation:

Difficult menstruation can occur as a result 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 mutilation/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 these women.

· Dyspareunia (painful sexual intercourse):

This is a consequence of many forms of FGM/C because of scarring, the reduced vaginal orifice and such complications as infection. Vaginal penetration may be difficult or even impossible and re-cutting may be necessary. Vaginismus may result from injury to the vulval area; the vaginal opening spasms, causing considerable pain and soreness.

· Sexual dysfunction:

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

· Problems in childbirth:

These are more common following severe forms of FGM/C, because the tough scar tissue that forms causes partial or total occlusion of the vaginal opening. Difficulty in performing an examination during labour can lead to incorrect monitoring of the stage 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 to the neonate (including stillbirth) and maternal death. In the event of miscarriage, the foetus may be retained in the uterus or birth canal.

Psychosocial complications of FGM/C

Various circumstances related to his practice can lead to psychosocial problems. Genital Mutilation/Cutting is commonly performed when girls are young. It is often preceded by acts of deception, intimidation, coercion and violence by people surrounding the child. 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 mutilation of other girls.

For some girls, mutilation 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 at being subjected to such an ordeal even if they receive support from their families immediately following the procedure.

Long-term memories of the pain of FGM/C may affect the relationship between the girl and her parents, and may also affect her ability to develop trusting relationships in the future.

The experience of FGM/C has been associated with a range of mental and psychosomatic disorders. For instance, girls have reported disturbances in their eating pattern, 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.

Sexual complications of FGM/C

Sexual problems as a result of FGM/C can affect both partners in a marriage, from fear of the first sexual intercourse onwards. As explained before, excised women may suffer painful sexual intercourse because of one or some of the following:

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

Vaginal penetration for women with a tight introitus may be difficult or even impossible without tearing or re-cutting the scar. This may lead to loss of self-esteem and sexual dysfunction. Vaginismus may result from injury to the vulval area. Inhibition of coitus due to fear of pain may damage marital relationships and even lead to divorce.

Findings from a study conducted in the Ismailia Governorate in the Suez Canal area of Egypt reveal that over 80% of women who were circumcised complained of some form of psychosexual impact of the practice. Their complaints include: dysmenorrhoea (80.5%); vaginal dryness during intercourse (48.5%); lack of sexual desire (45%); less frequency of sexual desire per week (28%); less initiative during sex (11%); being less pleased by sex (49%); being less orgasmic (39%); less frequency of orgasm (25%); having difficulty reaching orgasm (60.5%).

Dangers for childbirth

Findings from a WHO multi-country study, in which more than 28,000 women participated, confirm that women who had undergone FGM/C had significantly increased risks for adverse effects during childbirth. Higher incidences of caesarean section and post-partum haemorrhage were found in the women with Type I, II and III compared to those who had not undergone genital mutilation, and the risk increased with the severity of the procedure *(WHO Study Group on Female Genital Mutilation and Obstetric Outcome, 2006).*

A striking new finding from the study is that genital mutilation of mothers has negative effects on their newborn babies. Most seriously, death rates among babies during birth and immediately after were higher for those born to mothers who had undergone genital mutilation compared to those who had not. The risk of death among babies is as follows:

15% higher for those whose mothers had Type I;
32% higher for those with Type II;
55% higher for those with Type III.

The consequences of FGM/C for most women who deliver outside the hospital setting are expected to be even more severe. The high incidence of postpartum haemorrhage, a life-threatening condition, is of particular concern where health services are weak or women cannot easily access them.

Documented evidence on the frequency of FGM/C-related health complications is rather scant. Lack of information conceals the extent of FGM/C and hinders efforts to plan considering the health needs of affected communities. The information gap also undermines efforts to eliminate the practice.

At the clinical level, good documentation is necessary for the efficient management of cases, and for providing quality health care and follow up for women with FGM/C. In some countries, protocols have been provided for nurses and midwives to record the presence of FGM/C, the type involved and the relevant complication as a matter of routine. Some health institutions have incorporated record keeping in their internal policies.

5

MANAGEMENT OF WOMEN WITH PHYSICAL COMPLICATIONS OF FGM/C

During and after the completion of the FGM/C, complications may arise in the short, medium and long term that students of medicine, nursing and public health should be aware of. They include bleeding at different levels, anaemia, severe pain and tissue damage, infection and septic shock, and the retention of urine[8].

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.

Instruct students that they should observe the following procedure:

- Inspect the site of the bleeding.
- Clean the area.
- Apply pressure at the site to stop the bleeding by packing with sterile gauze or pad.
- Assess the seriousness of the bleeding and the condition of the girl or woman.
- If client is in shock (see instructions under **shock**).

[8]Management of Bleeding, Pain, Shock, Infection, Anemia and Urine retention is extracted from the document *FGM, Integrating the Prevention and the Management of the Health Complications into the curricula of nursing and midwifery*, WHO, Geneva, 2001.

- If necessary replace fluid lost. If you are managing the client at a primary level facility, give I.V. fluids, monitor and transfer her immediately to a secondary level facility for blood transfusion if necessary.
- If you are seeing her at a secondary level facility where blood transfusion is not available but is required because of severe bleeding, transfer her to a tertiary level facility immediately.
- It may be the policy of the health institution to prescribe Vitamin K, especially in the case of babies. If so, take action as required by the policy.
- A traditional compound (e.g. containing ash, herbs, soil, cowdung) may have been applied to the wound, and this can lead to tetanus or other infection. Therefore, you should give tetanus vaccine and antibiotics in accordance with national guidelines.
- If the problem is not serious, clean the site with antiseptic and advise client or attendants to keep it dry. Follow up client to monitor progress by making an appointment for her to return so that you can check her progress.

Severe pain and injury to tissues

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

Instruct students that they should observe the following procedure:

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

Shock

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

Instruct students that they should observe the following procedure:

- Assess the severity of shock by checking vital signs.
- Treat for shock by raising the client's extremities above the level of her head to allow blood to drain to the vital centres in the brain.
- Cover the client to keep her 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 IV are not available, fluids may be given rectally).
- Check vital signs and record every quarter of an hour (15 minutes).
- If client's condition does not improve, refer her for medical attention.

Infection and septicaemia

Infection may occur as a result of unhygienic surroundings and dirty instruments used to carry out FGM/C. The patient will present with an elevated temperature and a dirty, inflamed wound.
Instruct students that they should manage the condition as follows:

- Take a vaginal swab and a urine sample to test for the presence of infection and to 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 obstruction of urine.
- Any obstruction found should to be removed, and the client treated with antibiotics and analgesics.
- If the wound is infected, it should be cleaned and left dry.
- Follow up client after 7 days to assess the progress.
- If infection persists refer the client for medical attention.

Urine retention

Urine retention may be the result of injury, pains and fear of passing urine, or occlusion of the urethra during infibulation. Acute retention of urine occurs due to swelling and inflammation around the wound.

Instruct students that management of this condition is as follows:

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

Anaemia

Anaemia can be due to bleeding or infection or it can be due to malaria, especially in children.
Instruct students that management of this condition is as follows:

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

Management of long- term physical complications

The long-term physical complications of FGM/C include the formation of keloids, as well as cysts, clitoral neuroma, vulval abscesses, urinary tract infection (UTI), chronic pelvic infection, infertility, fistulae and incontinence, vaginal obstruction, menstrual disorders and ulcers.

Their management should be carried out as follows.

Keloid formation

- Inspect patient genitalia to assess size of keloid;
- If the keloid is insubstantial, advise the woman to leave it undisturbed, and reassure her that it will not cause harm;
- If the keloid scar is large, causing 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.

Cysts

- Inspect the site to assess the size and type of cyst;
- Small and non-infected cysts may be left alone after counselling the woman about her condition. Alternatively the woman 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 danger 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 marsupialisation; the procedure is usually performed under general anaesthetic. During the operation, great care should be taken to avoid further damage to sensitive tissue or injury to the blood or nerve supply of the area.

Clitoral neuroma

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

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

Vulval abscesses

- Inspect the site to assess the extent of the problem;
- Dress the abscess with a local application to relieve pain and to localise the swelling;
- Refer for surgical intervention, which may involve incision and drainage of the abscess under local anaesthesia;
- Send drainage fluid for microscopy, culture and sensitivity;
- Administer antibiotics as appropriate/prophylactically.

Chronic urinary tract infection (UTI)

Urinary tract infections are a common complication of women who have undergone all types of FGM/C. Practitioners should manage **UTI** as follows:

- Examine the vulva carefully for any anatomical abnormalities that may or may not establish a link with FGM/C;
- If infibulation is the cause, counsel the woman on the need to open up the infibulations (see section on defibulation);
- Carry out urine analysis and vaginal swab for discharges to identify causative organisms and for appropriate antibiotics;
- Give antibiotics and/or urinary antiseptics as required (a mixture of potassium may also be prescribed);
- Advise the patient on adequate fluid intake and on vulva hygiene;
- If UTI is recurring, refer patient for further medical attention.

Chronic pelvic infection

- Examine the woman. Identify type of FGM/C. based on history and exam; likely cause of the problem you may be able to establish the connection between FGM/C and the infections
- If the woman has type III FGM/C, counsel her and/or her attendants on the POSSIBLE 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;
- If the cause of the infection is obstruction due to stones or injury, refer the woman for surgical intervention.

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. Medical practitioners should manage **infertility** as follows:

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

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. Practitioners should manage the condition as follows:

- Assess the child or woman to identify cause of incontinence and type of FGM/C;
- 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 the woman to a urologist for treatment;
- Patients with vesico-vaginal fistula (VVF) or recto-vaginal fistula (RVF) must be referred for specialist repair;
- If patient has infection, give antibiotics as appropriate.

Vaginal obstruction

- Assess the patient to identify the problem and type of FGM/C;
- If the patient has been infibulated, counsel on the probable need for deinfibulation. This might include family members or other people who are close to the patient;
- If the patient has haematocolpos, stones or stenosis, refer her for surgical intervention under general anaesthetic.

Menstrual disorders

Many excised women report severe dysmenorrhoea with or without menstrual regularity. There are many possible causes. Management is as follows:

- 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 (haematocolpos) as a result of infibulation, counsel the patient on the possible need for opening up;
- If the condition is severe refer patient to a gynaecologist for further management.

Ulcers

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

In managing women with FGM/C, practitioners should always document the type of FGM/C and its associated complications.

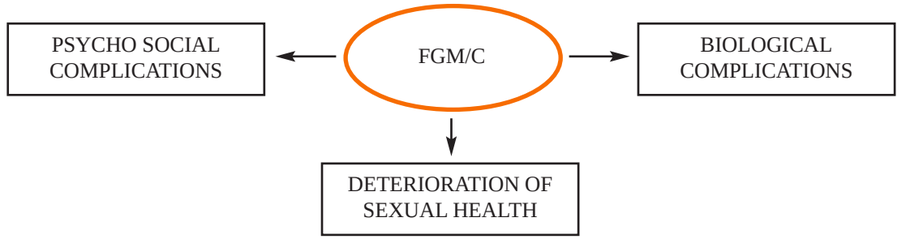
6

MANAGEMENT OF GIRLS OR WOMEN WITH PSYCHOSOCIAL AND SEXUAL COMPLICATIONS OF FGM/C

Introduction

All medical 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 FGC frequently presents psychosocial and sexual complications that gain huge importance in her life. Sexual health may be compromised due to the close relationship between biological and psychological factors that reinforce and aggravate each other when not being served on time. What can be viewed as a cultural practice and «necessary» for women from a social and even a certain individual perspective may easily become a factor of fear and pain, constraining pleasures and causing a handicapped sexual performance.



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.

Managing sexual problems

The manifestation of these complications is influenced by several factors ranging from the type of FGM/C that was practiced on the woman to preparation for the sexual life that she and her sexual partner have led. To illustrate this, the following paragraph describes a case treated by a Cuban physician, an OB-GYN specialist with a master's degree in sexology.

Mr. MJ, 27 years young, is a businessman married to two wives. He has been married to his second wife for two months but has not yet been able to have sexual penetration with her, so he goes to ask the doctor to check her out and operate on her, because «she was closed when she was a child». When examining Mrs. MJ, the doctor finds a Type I FGM/C. This should readily allow the passage of the penis, but the hymen is intact. It is decided to call Mr. MJ to be examined, but a macropenis or very large penis that might have difficulty in penetrating any virgin woman is ruled out. Upon further questioning it is discovered that attempts to penetrate were frustrated because of pain in the woman, even though Mr. MJ said they had engaged in prior sexual games. The physician suggests focusing on the couple's sexual games and using a gel lubricant for penetration, as well as Mr. MJ being patient and gentle when penetrating. A week later, Mr MJ called to thank him because the problem had been resolved. In this case the influence of the FGM/C practiced is clear, producing long-lasting fears and psychological problems in the woman, an additional factor being the couple's lack of preparation to approach sex.

Management of painful intercourse (dyspareunia)

Another frequent problem is dyspareunia or pain during sexual contact, mediated by biological rather than physiological conditions. This means anatomical changes at that level secondary to FGM/C, 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 point G and the vaginal orgasm, among other factors. It seems 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/C;
- If opening up the introitus is needed, 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 patient to monitor 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 with 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/C;
- Interview the patient 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 as explained elsewhere in this material.

Referral procedures

- 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 where 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;
- Evaluate counselling and assess patient's understanding.

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 Type III FGM/C.

See in central page III (figure 4) pictures taken during surgical intervention in the process of opening up a woman with Type III FGM/C. After marrying she had difficulty with penetration and was taken for help to RVTH in Banjul by her husband. Five women in this situation were examined in 2008 by Cuban doctors; one of them told the physicians that before going to the hospital she had visited the same woman who had practiced the FGM/C on her 12 years before, but she had told her she could not do anything and suggested a visit to the hospital.

There are various elements to consider when carrying out the surgical procedure or technique:

- Consent form;
- Explain procedure to the patient and offer appropriate preoperative care. Mention the use of anaesthesia to allay fear and anxiety;
- The procedure must comply with all measures of asepsis;
- Use preferably local anaesthesia;
- Use Kelly haemostatic forceps to separate the skin edges fused in the midline and remnants of the labia minora. While opening, avoid damage to the mucosa of the introitus below, and take into account the protection of the urethral meatus. The Kelly clamp should be inserted in a vertical position avoiding damage to the hymen;
- Suture the edges carrying homeostasis; sometimes only four stitches are required. Chromeic 2.0 catgut absorbable suture is preferred. When performing the suture take care with the urethral meatus;
- Offer health education on vulva hygiene to keep the area clean and dry with the use of soap and water for washing;
- Advise the couple to abstain from sex for the first 10 days after the procedure and to use lubricating gel for the first sexual encounters;
- Prescribe antibiotics as appropriate.

Introducing finger(s) under the scar | Infiltrating the scar area with local anaesthetic | Cutting open the scar

Source: *FGM, Integrating the Prevention and the Management of the Health Complications into the curricula of nursing and midwifery*, WHO, Geneva, 2001.

7

MANAGEMENT OF WOMEN WITH FGM/C DURING PREGNANCY AND LABOUR, DELIVERY AND THE POSTPARTUM PERIOD

Introduction

Women with FGM/C require sensitive antenatal care. Types I, II and III can produce severe vulval and vaginal scarring which may cause obstruction during labour and delivery. Infection and inflammation at the time FGM/C 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/C did not result in any particular complications (did not limit the space or skin turger of the introitus, and did 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/C-related complications and invite her to ask any questions related to FGM/C or other issues.

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

Management of women with FGM/C during pregnancy

The woman who has undergone FGM/C is at risk of complications during this period. The consequences of FGM/C 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. Furthermore, the lack of proper diagnosis causes inadequate treatment of the above-mentioned infections, increasing the risk of premature rupture of membranes, chorioamnionitis, preterm birth and dystocic delivery (caesarean).

In case of type III FGM/C defibulation will have to occur prior to delivery. It is recommended that defibulation be done in the third trimester of pregnancy, but can also be done just prior to delivery. The procedure is as follows: PAGINA 104 WHO

Management during labour and delivery

Procedure

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

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 posterior episiotomy may be preferred. There tends to 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;
- Record all observations in the partograph.

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;
- Instruct 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 type III FGM/C;
- 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 material.

It is important for practitioners to know that when labour is slow, they should **anticipate** a difficult delivery and make appropriate arrangements in good time:

- If it is clear that an episiotomy would facilitate delivery, it should be performed skilfully;
- 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 good time to a health centre with appropriate facilities.

In many cases, the doctor decides to perform caesarean section on patients in labour and delivery for various reasons, not all of them directly related to FGM/C. However, due to stenosis caused by FGM/C, it is hard to introduce the Foley catheter. In these 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.

Assessment and management of women with Types I, II and III FGM/C during labour

Management of women with FGM/C during labour is the same as for any other woman, except where FGM/C 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 FGM/C, the infibulation must be opened up during the second stage of labour).

Women with Type I FGM/C tend to be able to deliver vaginally without episiotomy unless there is extensive scarring causing inelasticity of the perineum.

If FGM/C 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 the woman has arrived at the ward already 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.

If a woman presents with Type III FGM/C and Caesarean section is more appropriate than defibulation and vaginal delivery, explain the need for the operation and ask her consent to perform it.

Demonstration the performance of an episiotomy:

- Prepare 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 come out;
- 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.

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MANAGEMENT OF WOMEN WITH FGM/C DURING THE POSTPARTUM PERIOD AND CONDITION OF BABY

Procedures for assessment

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

- Check for retained products and make sure uterus is well contracted. Check the bladder and empty if necessary, or administer oxytocic drugs;
- If you have delivered the baby, change gloves for 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 good light to assess for tears in the vaginal wall and on the cervix if you are unable to visualise a speculum maybe required;
- 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.

Practitioners must ensure that the **baby is assessed** immediately after delivery as follows:

- Apply the Apgar score test;
- If the baby is asphyxiated, resuscitate and send for appropriate medical attention.

Complications after delivery

Complications after delivery for a woman with FGM/C may include the following:

- Excessive primary bleeding due to injury of the arteries and veins as a result of tears.
- Secondary bleeding as a result of retained products.
- Infection which may lead to septicaemia.
- Urine retention;
- Injury to adjacent tissue due to tears, if the delivery was not managed correctly. This may result in incontinence of urine and/or faeces, vesico-vaginal fistula (VVF), and sexual problems if repair was not carried out properly;
- Neonatal asphyxia due to obstructed labour; this may result in brain damage to the baby.

Management of women with FGM/C following delivery

Introduction

It must be remembered that the management of women with FGM/C during the postpartum period is the same as for any other woman. 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.

Immediate care in cases of haemorrhage:

The medical practitioner should do the following:

- Suture any tears and episiotomies immediately. Also suture any lacerations on an opened infibulation. NEVER REFIBULATE.
- If the uterus does not contract, expel any clots, massage the uterus to aid contraction and administer oxytocic drugs if necessary.
- Keep the patient warm.
- Collect blood sample for full blood count (FBC), grouping and cross matching;
- If postpartum haemorrhage is severe, call or refer for adequate medical intervention.

In cases of neonatal asphyxia **r**esuscitate the new-born and send for medical attention.

9

COUNSELLING

Counselling is defined as helping someone to explore a problem so that they cope more effectively and make an informed choice or decision. It is an important element in the prevention of FGM/C and in the management of complications. Counselling of a girl or woman with FGM/C 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. The aim of counselling is to help a woman, couple, or family to come to terms with 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 their 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 changes related to FGM/C 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/C, as well as to those who have not experienced it, and to couples, families and the whole community. It is a way to offer knowledge about the issue, explained by a person from the community itself, previously trained and preferably a woman because of the subject matter in question.

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 interlocutor. This is usually the most suitable, taking into account the ethical and human aspects of the FGM/C issue. There are alternatives, such as using email or telephone to provide information, but 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 and experienced in this type of professional help. They 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 it is developed, the attitude of the counsellor and the relationship between him or her and the other party. There must at all times be an atmosphere of confidentiality, respect, trust and safety for the patient.

Important elements to consider are:

- **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 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.

In counselling there are certain rules that facilitate communication and can serve as a guide to establish dialogue:

- 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/C 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 cues (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;
- Assist the patient, and her partner where appropriate, to make an informed decision on the steps to be taken to solve the problem;
- Assist them to act on their decision by giving advice on how to proceed;
- Give the patient an appointment for another counselling or follow-up session to prepare for the next step, if necessary;
- If the problem persists, refer to a specialist.

It must be taken into account 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.

10

COMMUNITY HEALTH EDUCATION AND ADVOCACY

Prevention of FGM/C and enabling people cope with its effects require concerted collective action. Health workers have an important role to play in influencing people's perceptions, attitudes and behaviours as regards FGM/C. Communities need to be involved in appraising and addressing the issues related to FGM/C through organised health education.

Health professionals are influential members of society and as such they are key actors in community education against FGM/C. It is important that they understand the art of effecting positive behaviour change with regard to FGM/C. They need to involve communities in this process.

A **community i**s a collection of people who live in the same neighbourhood and who have many cultural, ethnic, religious or other characteristics in common. In the context of FGM/C, the community is a group of people (including individuals and families) who live in either an urban or rural area and who tend to share common 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.

Community Health Education

Health education is recognised as a essential strategy to achieve good health indicators, addressing the impact of the disease and prolonging capable and autonomous life. It includes the processes that enable people to understand and accept responsibility for their own health, as well as to develop the skills necessary to maintain it. It fosters positive habits that promote individual and collective welfare.

Health education is the process of bringing about positive change of attitudes and behaviours among individuals, groups and the community. It enables individuals and groups to make informed decisions and choices. The objective of community health education in the context of FGM/C is to encourage and promote positive change of attitudes and behaviours with regard to FGM/C. It is important that community members take full control and responsibility for any decisions reached by them as individuals, families and groups. As health professionals are respected by individuals, families and communities they have a major role to play in promoting positive responses to FGM/C. Some are already members of non-governmental organisations working to bring about change in their communities with regard to the practice.

For actions of health education in relation to FGM/C to be effective they must take into account the current concepts of health education in the world. The doctor or health worker is no longer considered the only source of expert information or engine of change in the population. Nowadays there is talk of participatory and liberating education in a positive environment for creativity, helping to train individuals in self-esteem, motivation, social awareness and commitment. Thus one objective of health education in relation to FGM/C is to encourage self-care in girls and women, or to foster the personal decision to protect their own health. This is a very complex process and to achieve change it is not enough simply to give information; it becomes necessary to change behaviour with the active participation of the community.

It is also necessary to promote the participation of community leaders in health education with regard to FGM/C. These include religious leaders, politicians, and midwives and so on. Recognising the high level of influence that these individuals exert within the community is one of the elements to use to modify people's knowledge, attitudes and practices in relation to FGM/C.

Another element to consider is the training of women health promoters. It is known that gender inequality and discrimination directly and indirectly harm the health of girls and women throughout their life cycle. It is therefore important that they take an active attitude to FGM/C. One of the strategies that facilitate educational activities on FGM/C in the community is to train girls and women in this type of activity. This can be achieved when the specific conditions of each place allow physicians or other trained health personnel to develop the process, which consists in selecting girls and women who will voluntarily receive preparation that allows them to inform, advise and support women in their own community with regard to FGM/C.

Strategies and means

One aspect that influences the impact of health education of communities against FGM/C is that it must be organised and systematic.

The first requirement is to learn about the practice and to be clear about the reasons given by people for practicing it. Health professionals should know that FGM/C is not just a health issue but a gender, human rights and ethical issue. The solution to the problem lies not only in giving information on the health consequences of FGM/C but also in advising on the various dimensions of the problem. The health workers' role is to contribute to the process of change. Health professionals can assist individuals, families and communities in the process of changing their behaviour and practice as regards FGM/C through various strategies and means.

Key among these are the following:

- Building a good, strong relationship with the community through influential people;
- Demonstrating a caring attitude in the community and participating in community life;
- Integrating education and counselling against FGM/C into day-to-day practice as doctors, nurses, midwifes and public health officers;
- Identifying and collaborating with influential leaders and other key individuals and groups within the community;
- Interacting with individual people or groups in the community, as appropriate;
- Forging partnership with CSOs and organised community groups that may have a stake in FGM/C or other harmful traditional practices;
- Conducting small focus group discussions;
- Enrolling, training and using volunteers and peer health educators in the community;
- Assisting people to think through the practice of FGM/C and its effects on health and on human rights;
- Identifying resources within the community that could be used in FGM/C prevention programmes/activities;
- Suggesting strategies for changing practice, e.g. a culturally acceptable alternative ceremony to mark the rite of passage, and training women, men and youths in problem-solving skills;
- Supporting individuals and families to cope with the problems of FGM/C and with adjusting to change;
- Using other good communication practices of proven effectiveness in the country/community;

- Working through credible agents and intermediaries in the community.

When discussing sensitive issues like FGM/C in traditional settings, it is advisable to always set the scene with a short story or sharing of personal experiences.

Because of the personal and cultural sensitivity of the subject, it is important that discussions are carefully planned and conducted appropriately. As a general rule, discussions should be held with individuals, families and groups alone, unless and until people are ready to discuss the issue more openly in the community.

Setting the stage for Community Health Education

It is always advisable to know the depth of the pool before jumping into it. Likewise, it is important that health professionals or other agents of change involved in FGM/C prevention have adequate working knowledge of the local social environment. Remember to always take the back seat and let local agents/facilitators lead the process.

- **Assess and decide on appropriate ways of communicating on FGM/C**. For example:
  - One-to-one discussions;
  - Group discussions, such as with a family, organised group or focus groups;
  - Health talks at **c**linics;
  - Use of drama;
  - Songs by traditional communicators;
  - Story telling;
  - Use of peer educators;
  - Workplace sessions;
  - School-based activities including the madrassas.

- **Know the target audience:**
  - Identify the participant group (individuals, families or groups);
  - Decide who to reach (women, youths, 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/C locally**. Explore the following:
  - What type of FGM/C is performed locally?
  - What are the reasons for practicing FGM/C?
  - What perceived problems or complications do people experience during or after the procedure and how they are handled?
  - Who performs FGM/C?
  - Perceptions about girls who are not cut.

Identify who the chief decision-makers are in the community regarding FGM/C;
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/C;
  - Greet people in a culturally accepted 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.

- **Strategies for involving specific community groups**

In order to involve a particular group or section of the community in the prevention of FGM/C, the change agent **should do** the following:

- Identify all appropriate forums and opportunities for engaging the target group;

- Establish good relationships with and use community leaders and other influential people as an entry point;
- Share clear information about the health effects, human rights implications and other undesirable effects of FGM/C for children and women;
- Share clear information about the anatomy and physiology of the female genitalia;
- Identify and discuss misconceptions;
- Work hard to enrol local advocates and work with them;
- Use film shows, posters or other types of communication aid, as appropriate, and encourage everyone to participate in the discussions;
- Assist the participant groups with developing their own strategies for prevention;
- Use drama groups where feasible;
- Explore current beliefs, perceptions and attitudes of community members and use the information to plan the FGM/C communication/education strategy;
- Identify and discuss misconceptions;
- Use participatory communication approaches in discussions;
- Borrow any good communication/education practices;
- Involve men and youths right from the beginning to avoid FGM/C being perceived as a women's affair;
- Address women's lack of power and self-esteem by promoting self-awareness, assertiveness, and problem-solving skills;
- Ensure that positive community attitudes and values are identified and reinforced in the Community Health Education programme/activities.

Advocacy

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/C 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/C it contributes to the bringing together of women and girls and their building of 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/C. These efforts have raised awareness of FGM/C worldwide and brought the issue to the attention of influential people at all levels of those societies where FGM/C is practiced. Elimination of the practice depends on the concerted effort of everyone with an interest in protecting the health of women and children.

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 their monitoring and evaluation.

Steps

Information gathering and analysis:

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

- Prevalence of the practice locally and nationally;
- Who the excisers are;
- Rationale and reasons 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 eradicating practice.

Detailed background information is essential for planning advocacy strategies and formulating appropriate messages/arguments.

Identification of target audiences and key individuals for advocacy:

Politicians, government officials, private sector executives and the civil society fraternity are key in the prevention of FGM/C and addressing the issues related to it. Media practitioners, community/religious leaders, organisations for women and youth organisations are also key stakeholders. All of these categories should be targeted for advocacy.

The setting of advocacy objectives:

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 performing of FGM/C or at establishing penalties for health professionals who engage in the practice. A variety of positive responses is needed from political leaders, legislators and key policy and decision-makers in both the public and private sectors, as well as in civil society.

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.

Essence of advocacy in FGM/C:

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 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 Female Genital Mutilation/Cutting into mainstream health and education programmes;
- Legislating against the practice;
- Building partnerships with non-governmental organisations and communities in order to bring about change.

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 or institutions with similar interests;
- Effective use of mass media;
- Working with communities;
- Conferences and seminars;
- Lobbying through direct personal contact.

Building coalitions:

Building partnerships with others active in the same field has several advantages. It allows for the sharing of experience and expertise, and the pooling of resources. Besides, there is strength in numbers. Well-briefed pressure groups can be a key ally in a coalition which 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.

Working with the mass media:

Both the electronic and print mass media can be used to reinforce advocacy activities. The media is a powerful force and can provide 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/C.

Working with communities:

Change will only occur when people who practice FGM/C are convinced of the case for eliminating it. Thus working through community gatekeepers to raise awareness of the issues and educating and informing them is a vital part of any advocacy programme.

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-on-one direct personal contact, possibly in the form of organising a dinner.

Conferences:

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

Advocacy kits:

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

Public events:

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

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SOME ESSENTIAL WEB LINKS; FGM/C, Women, Violence, Human and Children's Right

Conseil de l'Europe
www.assembly.coe.int
European Network for the Prevention and Eradication of Harmful Traditional Practices
www.euronet-fgm.org
GIPE/PTP Interdisciplinary Group for the Prevention and Study of Harmful Traditional Practices
www.mgf.uab.es
Global Fund for Women
www.globalfundforwomen.org
Human Rights Watch
www.hrw.org International Federation of University Women (IFUW)
www.ifuw.org
Inter-African Committee on Traditional Practices Affecting the Health of Women and Children
www.iac-ciaf.com
International Council of Women
www.icw-cif.org
International Women's Tribune Centre
www.iwtc.org
International Alliance of Women
www.womenalliance.com
Lobby Européen des Femmes
www.womenlobbv.org
The International Alliance for Women (TIAW)
www.tiaw.org
United Nations Children Fund
www.unicef.org
United Nations Development Fund for Women
www.undp.org/unifem.org
World Health Organization
www.who.org

Project

This Manual is published within the framework of the project "**Transnational Applied Research Observatory. New strategies for the prevention of FGM. A circular approach Gambia Spain. Initiation without mutilation**", supported by Social Projects of Fundació "La Caixa" and the Provincial Council of Álava.

The applied research program aims to implement a comprehensive strategy for addressing Female Genital Mutilation (FGM), with a circular approach that includes the communities of origin and destination of migrant groups involved, providing inside information on transcontinental social and cultural transformations.

The four pillars of the project are:

1. Applied research
2. Training
3. Design of educational materials and audiovisual
4. Methodological proposal of alternative ritual.

The observatory in Spain has its center in Catalonia, one of the autonomous community with more presence of sub-Saharan population. Studies of knowledge, attitudes and practices related to FGM in primary care professionals -health, education and social work, and within risk groups, are conducted.

Maps of FGM in the whole country (2001, 2005, 2008) have been produced, as well as assessment, training and awareness workshops covering multidisciplinary fields such as social, health, educational, judicial, police, political and community levels. The production of educational reference materials, print and broadcast, is another major activity in Spain.

In Gambia, the project has the backing of the Gambian government, which entrusted the pilot project throughout the national territory as a national program coordinated with the Ministry of Health and Social Welfare.

The Gambia project focuses on training students and health professionals, through the Faculty of Medicine and Allied Health Sciences (University of the Gambia) and the Community Based Medical Program, in alliance with the Cuban Medical Mission.
The purpose is that these actors can be the ones who promote alternative models such as the ritual "initiation without mutilation", leaving out the harmful practice, within the community. The creation of teaching materials and a specific academic curriculum ensures knowledge transfer and long term sustainability of the project within their own country's health structure.

At the same time, the gambian observatory conducts a clinical case record for the types of FGM practiced in the country, ethnic groups that practice it and the consequences it has on health.

Under the observatory is held the “International Forum on Harmful Traditional Practices, exploring strategies and best practices” with a comprehensive and multisectorial approach to FGM. The first took place in Brufut, Gambia, 5-7 May 2009.

RESPONSIBLE ORGANIZATIONS

Wassu Gambia Kafo (WGK) is a non-profit civil society organization created to contribute to the improvement of life quality of the Gambian population through international cooperation projects in health and education. Motivated by research in the field, the intervention of WGK is located in The Gambia and Spain (Catalonia), incorporating the dynamics of migration in their approach to sub-Saharan realities.

The objectives of WGK are:

- Promote and support applied research to improve the health and education of the Gambian population.
- Establish and strengthen personal and institutional bonds of cooperation between Spain and Gambia to meet the reality of the Gambians in origin and migrant destinations.
- Contribute to the training of local professionals for the prevention of Harmful Traditional Practices (HTP), including Female Genital Mutilation (FGM).

More information in www.wassugambia.org

The Interdisciplinary Research Group for Prevention and Study of Harmful Traditional Practices (GIPE/PTP) is an interdisciplinary research group within the Chair of Knowledge and Technology Transfer (Parc de Recerca UAB-Santander), Department of Social and Cultural Anthropology of the Autonomous University of Barcelona.

It consists of various professionals involved in primary health care and social services, assisting migrant population particularly on the issue of FGM. Linked with the 1987 UAB pioneer studies in this field conducted by the Principal Investigator Prof. Adriana Kaplan, in recent years, team members have conducted several study tours to Senegal and Gambia to learn about the situation of this population, the factors that caused their emigration, and those particularly related to the practice of harmful traditional practices. The group also develops educational activity through workshops and multimedia materials, mainly to reinforce Primary Care interventions.

More information in: www.mgf.uab.es