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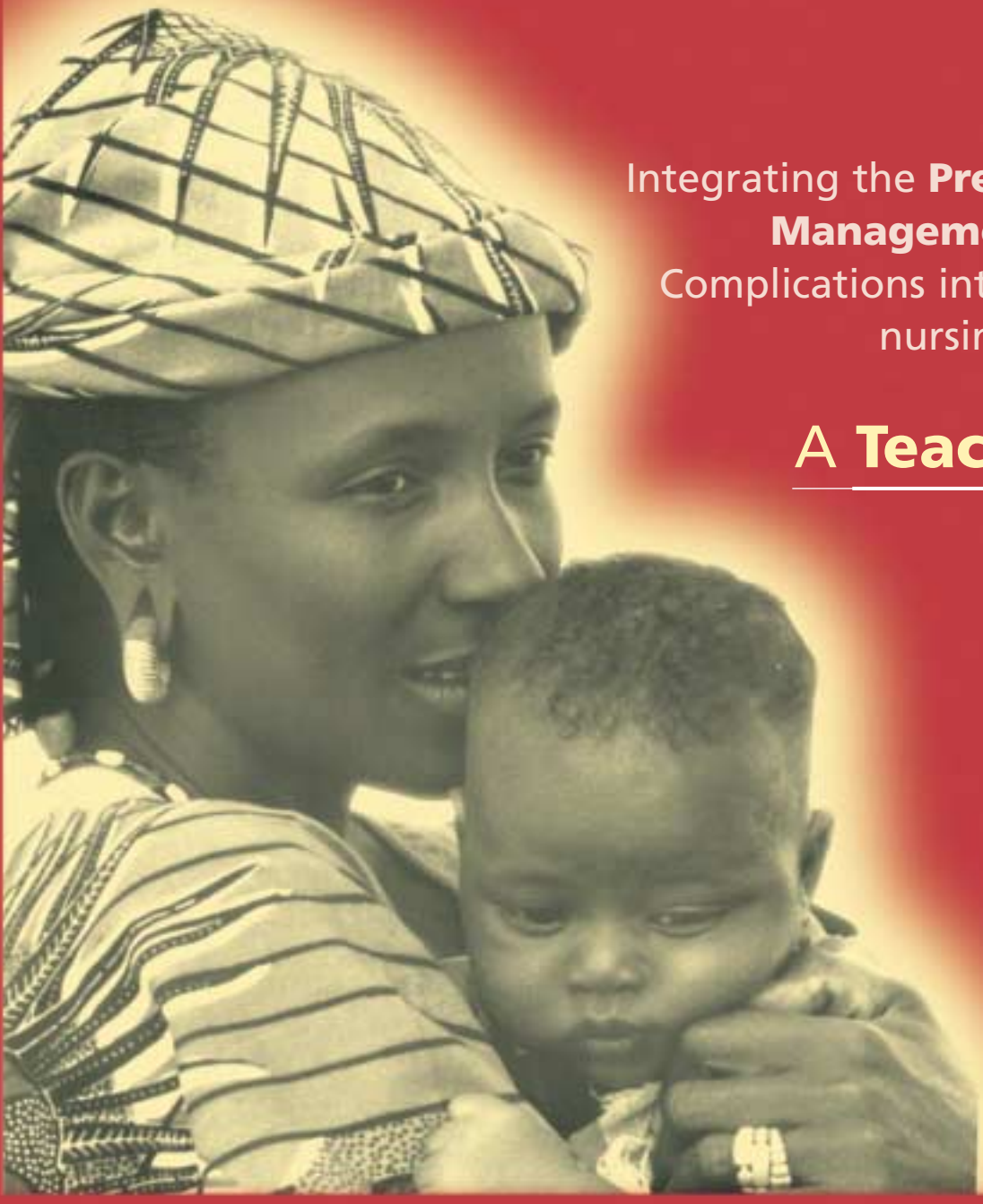
Female Genital **Mutilation**



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

A **Teacher's** Guide

Department of Gender and Women's Health
Department of Reproductive Health and Research
Family and Community Health
World Health Organization
Geneva

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TABLE OF CONTENTS

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Clinical photographs: Dr Harry Gordon

"Tradition! Tradition!" © Efua Dorkenoo, FORWARD (1992)

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Design: Mr Caleb Rutherford – eidetic

Department of Gender and Women's Health
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FOREWORD

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

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

The complications of FGM – physical, psychological, and sexual – require skilled and sensitive management by health care workers, yet FGM is rarely mentioned, let alone covered in detail, in the training curricula of nurses, midwives and other health professionals. WHO is committed to filling these gaps in professional education by producing a range of training materials to build the capacity of health personnel to prevent and to manage the health complications of FGM.

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

Dr Tomris Türmen
Executive Director
Family and Community Health
World Health Organization, Geneva

INTRODUCTION

This document has been prepared by WHO as a teaching guide for those responsible for the training of nurses and midwives. It was developed in response to a proposal on female genital mutilation (FGM) in which nurses and midwives expressed the need for acquiring knowledge and skills that would assist them to prevent the practice and to manage girls and women with FGM complications. The Teacher's Guide is intended for use in conjunction with the student manual and the policy guidelines.

The Teacher's Guide and the student manual provide strategies for the prevention of FGM and the knowledge and skills necessary for nurses and midwives to manage clients with FGM complications. Besides covering theory and principles, they provide step by step guide to assessment, counselling, referral of clients, and to the opening up of Type III FGM. The policy guidelines is intended for use primarily by those responsible for developing policies and directing nursing and midwifery practice.

Who is the Teacher's Guide for?

The Teacher's Guide is intended for use primarily by the teachers of nurses and midwives who are providing basic, post-basic or in-service training. It will also be of use to those responsible for educating and training medical students, clinical officers, public health officers, and other health care providers.

How is the Teacher's Guide organized?

The guide consists of four modules on FGM for teachers to integrate into their different courses. The modules are as follows:

Module 1: Introduction to FGM

This is the foundation module. It can be integrated into medical/surgical nursing and courses in gynaecology, community health and midwifery in places where FGM is practised. The module may also be used with health personnel and other relevant groups during workshops or in-service education to raise awareness on FGM.

Module 2: Community involvement in the prevention of FGM

This module can be integrated into community health nursing and community midwifery courses in places where FGM is practised.

Module 3: Management of girls and women with FGM complications

This module can be integrated into child health, human growth and development, and gynaecology courses for both nurses and midwives. The practical skills can be learned in maternal and child health and family planning clinics. Counselling skills can be practised also in youth centres and in schools, where counselling services are part of health programmes for young people. This module may also be used in sexually transmitted diseases (STDs) and HIV/AIDS programmes in areas where FGM is practised.

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

This module can be integrated into midwifery and obstetric courses. The practical skills can be learned in antenatal clinics, maternity units, labour wards, and postnatal clinics.

Each module is organized as follows:

- brief introduction to the issues covered
- how the module can be used
- the general objectives
- basic qualifications for the module – i.e. the knowledge and skills students will need to have in order to understand the module
- essential competencies – i.e. the knowledge and skills students are expected to acquire from the module
- suggested teaching methods, teaching aids, and reference materials.

Each module is divided into separate sessions, or lessons, which are listed in the introductory section to the module. In addition, tables summarising the sessions in each module are given at the beginning of the Teacher's Guide. They include the following information:

- suggested timings for each session
- lists of topics
- teaching/learning activities
- teaching/learning resources
- evaluation methods.

How should the modules be used?

The contents of the four modules may be integrated into existing training curricula for nurses and midwives and in medical training. The modules may also be used as complete courses during in-service education. They may also be adapted for use with health personnel and other relevant groups during workshops or in in-service education to raise their awareness on FGM.

The contents of the summary of each module may be integrated into the training curricula of nurses and midwives, and the contents in each session may be used during teaching and learning sessions.

Teachers are advised to:

- use this teaching guide in conjunction with the student manual, and the "policy guideline"
- use the suggested time allocations, session contents, teaching and learning activities and resources as guidelines and make adjustments as necessary to suit the situation
- use case studies drawn from real life locally where possible, or else use those provided in the guideline
- make use of appropriate reference materials and teaching resources available locally.

Teaching/learning activities

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

The lecture –

This is a brief talk, used to introduce a session or topic or provide new information. It can also be used to summarise ideas given by students after a group discussion or assignment. However, such talks by teachers should be kept to a minimum to allow students as much time as possible to participate and share their own ideas.

Small group discussions –

These are exercises in which students divide up into groups of six to eight people to discuss an issue between themselves and come up with a common viewpoint. Students should be given a specific assignment to work on, time to complete it, and instructions on presentation. After the groups have presented their work, the teacher/facilitator should summarise. Small group discussions are particularly good for teaching about sensitive issues.

Buzz group discussions –

These are brief discussions between two or three students, designed mainly to encourage participation. Students just turn to their neighbours to discuss a given subject for a short time before sharing their thoughts and ideas with the whole class. This exercise can be used at any time in a session, as appropriate, and is particularly useful for preventing boredom during long sessions.

Plenary, or large group, discussions –

These are sessions in which the teacher engages the whole class in brainstorming about an issue, or in discussing the feedback from small group work. Large group discussion can be used to evaluate the students' understanding of the session. They can also be used as forums for debating controversial issues.

The summary –

This is a very important activity. At the end of every session, the teacher should summarise what has been taught, and relate this to the stated objectives of the session. The teacher may ask the class to do the summary or answer questions on the session they have just completed in order to check that they have understood everything.

Case studies –

For this exercise, students are given the opportunity to share real-life case studies from the community or clinic with others in the classroom. Where this is not feasible, fictional cases can be used for classroom discussion.

Scenarios and situation analysis –

For this activity, students are given case histories, scenarios or situations to analyse. They are asked to decide how such cases or situations should be managed and are asked to justify their decisions. Students may work singly or in groups on these assignments, but a crucial part of the exercise is sharing their analysis with the class.

Role play and drama –

For these activities, students are given a range of roles to play in mini dramas in order to give them insights into different people's situations and points of view regarding FGM. They may, for example, be asked to play the role of a nurse counselling clients in a clinic, or discussing family planning options with an excised woman. A role playing exercise should be well-planned; students should understand the objective and know what it is they are expected to act. After acting they should be given time to share their feelings and perceptions before their fellow students give their comments. Besides allocating roles directly, teachers may wish to work together with students on translating stories or actual case studies into dramas they can act out.

Story telling –

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

Simulation games and exercises –

These are make-believe situations in which the teacher asks a student to perform a procedure. These exercises are particularly effective at teaching skills. It is important that the teacher makes it clear exactly what skill is being taught. In each module there is an indication of where simulation games and exercises may be used.

Demonstration and return demonstration –

This is a very important part of the teaching/learning process. The teacher demonstrates essential skills to the students, advising them to

observe carefully what he/she is doing. The teacher then selects some students to demonstrate, in turn, what they have observed (return demonstration). This is the time for clarifying any uncertainties, and the teacher should encourage students to ask questions. Students should be given opportunity to practise the skills in the clinical setting.

Field trips –

These are visits organized by the teacher to communities, youth centres or schools, where students can observe different situations relevant to their training. The teacher should guide the students as to what they should be looking out for during the field trip, and give them specific projects to write up and present in class afterwards. Projects can be done singly or in groups.

Clinical practice –

In order for students to learn clinical skills, they should be assigned to a clinic where relevant skills are practised. Teachers should organise appropriate clinical practice for students, set the objectives, prepare the students, and help the clinic staff to supervise them.

Assignments –

Assignments offer students the chance to practise their knowledge and skills. It also makes sure that they understand what they have learnt. Students can work individually or in groups. Each module provides suggestions for teachers about the most appropriate assignments to set. Feedback is an essential part of the exercise.

Evaluation

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

SUMMARY OF SESSIONS

Module 1: Introduction to Female Genital Mutilation

Session 1 – Analysing and influencing traditions – 2 hours

Topics	Teaching and Learning activities	Teaching and Learning resources	Evaluation
1. Defining traditions 2. Examination of traditions 3. Thinking about harmful practices	– Lecture – Small group discussion – Buzzing – Brain storming – Simulation games – Individual and group assignments	Dorkenoo, E. (1992) *Tradition! Tradition! A Story of Mother Earth*. FORWARD, London. *Female Genital Mutilation: A Joint WHO/ UNICEF/UNFPA statement. WHO, Geneva (1997)* *Female Genital Mutilation: A handbook for Frontline Workers.* WHO/FCH/GWH/00.5 Rev.1 WHO Geneva (2000)	Pre-test

Session 2 – Description and background of female genital mutilation – 3 hours

Topics	Teaching and Learning activities	Teaching and Learning resources	Evaluation
1. Anatomy of female external genitalia 2. Definition of female genital mutilation 3. The procedures of FGM 4. Age at which FGM is performed 5. Who performs FGM? 6. "Medicalization" of FGM 7. The origins of FGM 8. Reasons for performing FGM 9. Estimated prevalence of FGM among female population and global distribution of FGM practice 10. World Health Organization (WHO) classification of FGM. 11. The prevalence of FGM	– Questions and answer – Lecture – Buzzing – Brain storming – Poster exercise – Small group discussion – Film show – Plenary – Large group discussion – Chart showing prevalence of FGM – Map showing distribution of FGM	*Female Genital Mutilation: A Joint WHO/ UNICEF/UNFPA statement. WHO, Geneva (1997)* *Female Genital Mutilation: An Overview*. WHO, Geneva (1998) *Female Genital Mutilation: A handbook for Frontline Workers.* WHO/FCH/GWH/00.5 Rev.1 WHO Geneva (2000) *The right path to health: Health education through religion. Islamic ruling and female circumcision.* WHO, regional office for Eastern Mediterranean (1996) Film: *Scared for Life*. By ABC Special Program. In A Compilation of videos on female genital mutilation, UNHCR Programme and Technical support Section, P.O. Box 2500, CH-1211Geneva WHO Film : *Female Genital Mutilation*- "The Road to Change" Geneva, (2000.) E mail : Bookorders @who.int	Questions and answer Quiz

Session 3 – Complications of FGM – 1 hour

Topics	Teaching and Learning activities	Teaching and Learning resources	Evaluation
1. Short term physical complications of FGM Long term physical complications of FGM 2. Psychosocial complications of FGM 3. Sexual complications of FGM	– Questions and answers – Small group discussions – Lecture (Illustrated where possible)	References: *A Systematic Review of the Health Complications of Female Genital Mutilation Including Sequelae in Childbirth.* WHO/FCH7WMH/00.2 WHO, Geneva.(2000) *Female Genital Mutilation: A handbook for Frontline Workers.* WHO/FCH/GWH/00.5 Rev.1 WHO Geneva (2000)	Questions and answers Quiz

Session 4 – Professional ethics and legal implications of FGM practice – 2 hours

Topics	Teaching and Learning activities	Teaching and Learning resources	Evaluation
1. The ethical implications of FGM 2. Legal implications of FGM 3. Laws and decrees against FGM	– Buzz groups – Small group discussion – Case studies – Plenary session	Local and International Codes of Conduct for professional nurses and midwives such as International Council of Nurses (ICN) and International Confederation of Midwives (ICM).	Questions and answer

Session 5 – Human rights and FGM practice – 3 hours

Topics	Teaching and Learning activities	Teaching and Learning resources	Evaluation
1. How FGM violates human rights 2. International declarations relevant to the elimination of FGM 3. Rights of women, girls and FGM 4. The regulatory bodies of nurses and midwives and FGM	– Small group discussion – Plenary session – Buzzing – Student exercises	R. J. Cook (1994).*Women health and human rights.* WHO, Geneva. *Female Genital Mutilation: The Prevention and the Management of the Health Complications: Policy Guidelines for nurses and midwives.* WHO/FCH/ GWH/01.5. WHO, Geneva (2001) Dorkenoo, E. (1994). *Cutting the Rose. Female Genital Mutilation: The practice and its prevention.* Minority Rights Publications, London. *Women's Rights in The UN: A Manual on how the UN human rights mechanism can protect women's rights.*International Services for Human Rights (1995). P.O. Box 16 1211 Geneva Film: *A Dangerous Practice*. In a Compilation of Videos on Female Genital Mutilation. UNHCR Programme for Technical Support Section. P.O. Box 2500. CH-1211 Geneva	Questions and answers

Module 2:
Community involvement in the prevention of FGM

Session 1 – Beliefs, values and attitudes – 2 hours

Topics	Teaching and Learning activities	Teaching and Learning resources	Evaluation
1. Defining beliefs, values and attitudes 2. Origins of beliefs, values and attitudes 3. Development of value systems 4. Exploring personal beliefs, values and attitudes 5. The process of valuing	– Small group discussion – Feedback and discussion – Simulation games, – Student exercises – Plenary sessions	Value clarification exercises Locally available reference on value clarification *The right path to health: Health education through religion. Islamic ruling and female circumcision.* WHO, regional office for Eastern Mediterranean (1996) Dorkenoo, E. (1992). *Tradition! Tradition! The story of Mother Earth.* Film: *From Awareness to Action, Eradication of Female Genital Mutilation in Somalia*. UNHCR Regional Liaison Office, P. O. Box 1076 Addis Ababa.	Question and answers Quiz Peer evaluation

Session 2 – Traditional beliefs, values and attitudes towards FGM – 2 hours

Topics	Teaching and Learning activities	Teaching and Learning resources	Evaluation
1. Beliefs, values and attitudes and the practice of FGM 2. Assisting communities to clarify their beliefs, values and attitudes towards FGM 3. Stages of behaviour adoption	– Large group discussion – Lecture – Community visit – Small group discussions	Teachers notes Student manual *Female Genital Mutilation. Programmes To date: What Works and What Doesn't. A Review*. WHO/CHS/WHD/99.5 Geneva (1999) *The right path to health: Health education through religion. Islamic ruling and female circumcision.* WHO, regional office for Eastern Mediterranean (1996) Dorkenoo, E. (1992) *Tradition! Tradition! A Story of Mother Earth*. FORWARD, London. Film: *Welcome to Womanhood* Charlotte Metcalf. TVE Prince, Albert Road, London NM1 4 RZ UK.	Questions and answers

(Session 3 continued overleaf)

Session 3 – Strategies for involving individuals, families and communities in the prevention of FGM – 2 hours

Topics	Teaching and Learning activities	Teaching and Learning resources	Evaluation
1. Defining community and community involvement 2. Strategies for involving individuals, families in the prevention of FGM 3. Strategies for involving men in the prevention of FGM 4. Strategies for involving women in the prevention of FGM 5. Strategies for involving youth in the prevention of FGM 6. Communicating with target groups	– Buzzing – Short story – Small group discussion – Large group discussion – Plenary	Teachers notes and student manual References *Female genital mutilation: A Handbook for frontline workers* WHO/FCH/WMH/00.5 Rev.1 WHO Geneva *Towards the healthy women counselling guide: Ideas form the gender and health research group*. TDR, WHO, Geneva. WHO Film : *Female Genital Mutilation*- "The Road to Change" Geneva, (2000.) E mail : Bookorders @who.int	Pre and post test

Session 4 – Strategies for involving political and government leaders in the prevention of FGM – 4 hours. Field trip – 8 hours

Topics	Teaching and Learning activities	Teaching and Learning resources	Evaluation
1. The role of political and government leaders in the prevention of FGM 2. Tips for effective communication with political and government leaders 3. Advocacy 4. Lobbying	– Brain storming – Buzzing – Small group discussions – Plenary session – Field trip to the community	Any relevant reference material on advocacy and lobbying	Questions and answers

Module 3:
Management of girls and women with FGM complications:

Session 1 – Assessment to identify physical complications of FGM – 2 hours

Topics	Teaching and Learning activities	Teaching and Learning resources	Evaluation
1. The procedure of history taking 2. The procedure of physical examination in the presence of FGM	– Lecture – Role play – Demonstration and return demonstration – Clinical practice – Plenary session – Large group discussion	Use of teacher's notes and student manual Students to practise in clinics on interviewing for history taking and performing physical examination	Checklist for individual students to check their acquisition of required skills

Session 2 – Management of clients with physical complications due to FGM – 4 hours

Topics	Teaching and Learning activities	Teaching and Learning resources	Evaluation
1. Managing immediate and short term physical complications of FGM 2. Managing long term physical complications of FGM	– Large group discussion – Lecture – Questions and answers	References *Female Genital Mutilation: A Systematic Review of the Health Complications of Female Genital Mutilation Including Sequelae in Childbirth.* WHO/FCH7WMH/00.2 WHO, Geneva.(2000) *Female genital mutilation: A Handbook for frontline workers* WHO/FCH/WMH/00.5 Rev.1 WHO Geneva *Female Genital Mutilation: The Prevention and the Management of the Health Complications: Policy Guidelines for nurses and midwives.* WHO/FCH/ GWH/01.5. WHO, Geneva (2001)	Questions and answers Quiz

Session 3 – Using counselling skills – 4 hours

Topics	Teaching and Learning activities	Teaching and Learning resources	Evaluation
1. Qualities of a good counsellor 2. Building a helping relationship 3. The procedure of counselling	– Questions and answers – Lecture – Role plays	References *Counselling skills training in sexuality and reproductive health: A facilitators guide.* WHO/ADH/93.3 WHO, Geneva (1993) Teachers may use other relevant materials on counselling	

Session 4 – Identifying psychosocial and sexual complications of FGM – 2 hours

Topics	Teaching and Learning activities	Teaching and Learning resources	Evaluation
1. Psychosocial and sexual complications of FGM 2. Identification of psychosocial and sexual problems	– Lecture – Small group discussion – Plenary – Simulation exercises – Case study analysis	*A Systematic Review of the Health Complications of female genital mutilation including sequelae in child birth.* WHO/FCH/WHD/00.2 Geneva, (2000) *Female Genital Mutilation: The Prevention and the Management of the Health Complications: Policy Guidelines for nurses and midwives.* WHO/FCH/ GWH/01.5. WHO, Geneva (2001) *Female genital mutilation: A Handbook for frontline workers* WHO/FCH/WMH/00.5 Rev.1 WHO Geneva Toubia. N. *A practical manual of health workers caring for women with circumcision* A RAINBO Publication, New York (1999)	Quiz Peer assessment

Session 5 – Management of girls or women with psychosocial and sexual complications of FGM – 3 hours

Topics	Teaching and Learning activities	Teaching and Learning resources	Evaluation
1. Key elements in managing psychosocial and sexual complications of FGM 2. Managing psychosocial problems of FGM 3. Managing sexual problems	– Lecture – Story telling – Group discussion	*A Systematic Review of the Health Complications of female genital mutilation including sequelae in child birth.* WHO/FCH/WHD/00.2 Geneva, (2000) *Female genital mutilation: A Handbook for frontline workers* WHO/FCH/WMH/00.5 Rev.1 WHO Geneva *Female Genital Mutilation: The Prevention and the Management of the Health Complications: Policy Guidelines for nurses and midwives.* WHO/FCH/ GWH/01.5. WHO, Geneva (2001)	Questions and answers Individual assessment

Session 6 – Demonstrating referral skills – 2 hours

Topics	Teaching and Learning activities	Teaching and Learning resources	Evaluation
1. Complications which a nurse/midwife may need to refer for further management 2. Procedure of referral	– Lecture – Demonstration and return demonstration – clinical practice	Teachers should use locally available referral procedure guidelines	Checklist for the referral procedure Peer assessment

Session 7 – Family planning use in the presence of FGM – 2 hours

Topics	Teaching and Learning activities	Teaching and Learning resources	Evaluation
1. Review of types of FGM 2. Problems which women with type III FGM may encounter if they want to use vaginal methods of family planning. 3. Family planning methods and type of FGM	– Questions and answers – Lecture – Small group discussion – Large group discussion	*A Systematic Review of the Health Complications of female genital mutilation including sequelae in child birth.* WHO/FCH/WHD/00.2 Geneva, (2000) Robert A. et.al (1997). *The essentials of contraceptive technology: A Handbook for clinic staff*. Johns Hopkins Population Information Programme, Centre for Communication Programmes. The John Hopkins School of Public Health 111 Market Place, Baltimore MD 21202, USA.	Questions and answers

Session 8 – The procedure of opening up type III FGM – 3 hours. Clinical practice – 40 hours

Topics	Teaching and Learning activities	Teaching and Learning resources	Evaluation
1. Indication of opening up type III FGM 2. Preparation of the client and equipment 4. The procedure of opening up type III FGM 5. Post care of an opened type III FGM	– Question and answers – Simulation – Clinical observation – Clinical practice	*A Systematic Review of the Health Complications of female genital mutilation including sequelae in child birth.* WHO/FCH/WHD/00.2 Geneva, (2000) *Management of pregnancy, child birth, and postpartum periods in the presence of female genital mutilation. Report of A WHO Technical Consultation.* Geneva, 15 –17 October 1997. WHO/FCH/GWH/01.2. WHO, Geneva (2001) *Female Genital Mutilation: The Prevention and the Management of the Health Complications: Policy Guidelines for nurses and midwives.* WHO/FCH/ GWH/01.5. WHO, Geneva (2001) Students to practise the procedure on a model, then observe the procedure been done in the clinical setting. Students can then be allocated to relevant clinics to practise opening up under supervision	Use of a checklist to assess the skills Peer assessment

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

Session 1 – Assessment and the management of complications due to FGM during pregnancy – 3 hours

Topics	Teaching and Learning activities	Teaching and Learning resources	Evaluation
1. Assessing problems associated with FGM during pregnancy 2. Management of women with type I,II,IV FGM during pregnancy 3. Management of women with type III FGM during pregnancy	– Questions and answers – Small group discussions – Plenary discussion – Lecture	Use of teachers notes and student manual References: A Systematic Review of the Health Complications of *Female Genital Mutilation including Sequelae in Child Birth*. WHO/FCH/WMH/00.2. WHO Geneva, (2000) *Management of pregnancy, childbirth and the postpartum in the presence of FGM. Report of a WHO Technical Consultation. Geneva, 17 –18 October 1997* WHO/FCH/GWH/01.2. WHO, Geneva, (2001). Toubia, N. (1999). *A Practical Manual for Health Care providers: Caring for Women with Circumcision*. A RAINBO Publication. 915 Broadway, Suite 1109, New York	Pre-test Peer assessment

Session 2 – Obstetric complications during labour and delivery – 2 hours

Topics	Teaching and Learning activities	Teaching and Learning resources	Evaluation
1. Complications of FGM during labour and delivery	– Questions and answers – Small group discussion – Large group discussion – Case study	References: A Systematic Review of the Health Complications of *Female Genital Mutilation including Sequelae in Child Birth*. WHO/FCH/WMH/00.2. WHO Geneva, (2000) *Management of pregnancy, childbirth and the postpartum in the presence of FGM. Report of a WHO Technical Consultation. Geneva, 17 –18 October 1997* WHO/FCH/GWH/01.2. WHO, Geneva, (2001).	Quiz Questions and answers

Session 3 – Assessment and the Management of women with FGM during labour and delivery – 4 hours

Topics	Teaching and Learning activities	Teaching and Learning resources	Evaluation
1. Physical examination 2. Monitoring the progress of Labour 3. Assessment of introitus during labour 4. Management of women with type I,II, and IV FGM during labour and delivery 5. Management women with type III FGM during labour and delivery	– Demonstration on assessment of a woman with FGM during labour – Clinical observation and practice	References: *Management of pregnancy, childbirth and the postpartum period in the presence of female genital mutilation: Report of a WHO Technical Consultation Geneva, 15-17 October 1997.* WHO/FCH/GWH/01.2 *Female Genital Mutilation: The Prevention and the Management of the Health Complications: Policy Guidelines for nurses and midwives.* WHO/FCH/ GWH/01.5. WHO, Geneva (2001) Toubia, N. (1999). *A Practical Manual for Health Care providers: Caring for Women with Circumcision*. A RAINBO Publication. 915 Broadway, Suite 1109, New York	Assessment of clinical performance

Session 4 – Management of women with FGM during the postpartum period – 3 hours

Topics	Teaching and Learning activities	Teaching and Learning resources	Evaluation
1. Assessment of the mother's complications after delivery 2. Complications after delivery 3. Management of a woman with FGM after delivery	– Clinical observation and practice	Reference: *Management of pregnancy, childbirth and the postpartum period in the presence of female genital mutilation: Report of a WHO Technical Consultation Geneva, 15-17 October 1997.* WHO/FCH/GWH/01.2 *Female Genital Mutilation: The Prevention and the Management of the Health Complications: Policy Guidelines for nurses and midwives.* WHO/FCH/ GWH/01.5. WHO, Geneva (2001)	Assessment of clinical performance

MODULE 1: INTRODUCTION TO FEMALE GENITAL MUTILATION

Module one is the foundation module. It is intended to equip nurses and midwives with basic information about female genital mutilation, its health consequences and the cultural traditions that underpin it. It also examines the ethical, legal and human rights implications of FGM.

Application of the module

The module can be used as a foundation for the other three modules in this manual. It can also be used as a complete course in itself for raising awareness among nurses, midwives and other health personnel of the issue of FGM.

General objectives

At the end of this module the students are expected to be able to:

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

Background qualifications

Students working on this module should already have basic knowledge of the anatomy and physiology of the human body.

Essential competencies

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

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

Suggested teaching/learning activities

- Lecture.
- Small group discussions.
- Plenary sessions.
- Buzzing.
- Brainstorming.
- Individual and group assignment.

Teaching aids

The teaching aids may include:

- Films.
- Charts, posters, leaflets, writing boards, overhead projector and transparencies, slides and slide projector.
- Anatomical models.

Reference materials

- *A Systematic review of the complications of female genital mutilation including sequelae in childbirth.* WHO/FCH/ WMH/00.2 Geneva (2000).
- *Female Genital Mutilation. A joint WHO/UNICEF/ UNFPA statement.* WHO. Geneva (1997).
- *Female Genital Mutilation. Report of a WHO Technical Working Group*, Geneva, 17-19 July 1995. Geneva, World Health Organization, 1996. (WHO/FRH/WHD/96.10)
- *Female Genital Mutilation. An overview.* WHO, Geneva (1998).
- *Summary of international and regional human rights texts relevant to the prevention of violence against women.* WHO/GCWH/WMH/99.3. Geneva (1999).
- *Regional plan of Action to accelerate the elimination of female genital mutilation.* WHO Regional office for Africa, 1996. AFR/WAH/97.1.
- *Female Genital Mutilation: A Handbook for Frontline Workers.* WHO/FCH/WMH/00.5 Rev.1. WHO, Geneva (2000).
- *The right path to health: Health education through religion. Islamic ruling and female circumcision.* WHO, regional office for Eastern Mediterranean (1996)
- *Visions and discussions on genital mutilation of girls: An international survey*, by Jacqueline Smith. Published by Defense for Children International, Netherlands, 1995.

Regional and national references, for example:

- WHO regional strategy for reproductive health.
- Regional plan of action to accelerate the elimination of FGM in Africa.
- National plans of action on the elimination of FGM.
- Any other locally available reference materials that are relevant.

The Sessions

Time in hours

Session 1:
Analysing and influencing traditions 2

Session 2:
Description and background of FGM 3

Session 3:
Complications of FGM 1

Session 4:
Professional ethics and legal implications of FGM 2

Session 5: Human rights and the practice of FGM 3

Session 1: Analysing and influencing traditions

Session objectives

By the end of the session students are expected to:

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

Key references

- *Tradition! Tradition! A story of Mother Earth*, by Dorkenoo, E. published by FORWARD Ltd. London, 1992.
- *Female Genital Mutilation. A joint WHO/UNICEF/ UNFPA statement.* WHO. Geneva (1997).
- *Female genital mutilation: A Handbook for frontline workers.* WHO/FCH/WMH700.5 Rev.1 WHO Geneva, 2000.
- *The right path to health: Health education through religion. Islamic ruling and female circumcision.* WHO, regional office for Eastern Mediterranean (1996)

Suggested teaching methods

- Lecture.
- Small group discussion.
- Plenary sessions.
- Buzzing.

Teaching aids

The teaching aids may include:

- Films.
- Charts, posters, pictures, leaflets, writing boards, slides and slide projector, overhead projector and transparencies.

Setting the scene

As a warm-up exercise:

- Ask students to identify a few traditions they know of.
- Ask students to give reasons for the existence of these traditions

The Sessions:

Introduce the session and its objectives

Defining tradition

Buzz:

- Ask students: what do you understand by tradition?
- Let students buzz in a group of twos or threes.
- Write down students' responses.

Agree on a definition, for example:

Traditions are the customs, beliefs and values of a community which govern and influence members' behaviour. Traditions constitute learned habits, which are passed on from generation to generation and which form part of the identity of a particular community. People adhere to these patterns of behaviour, believing that they are the right things to do. Traditions are often guarded by taboos and are not easy to change.

Examination of traditions

Small group discussion:

- Divide students into groups and give them group exercise as follows:
  - List the traditions which you know about and decide whether they are beneficial, harmful, or neutral (neither beneficial nor harmful).

Teacher's notes

BENEFICIAL	HARMFUL	NEUTRAL
– Breast feeding – Women relieved of work after delivery – Special care and nutritious diet for a newly delivered mother – Affirming puberty rites (without FGM) which prepare adolescents for womanhood	– Lack of autonomy for women in seeking medical care (decision made only by men) – Food taboos for pregnant women and children – Early marriage and early child bearing for girls – Force feeding for babies – Son preference – Priority of access for men and boys in the family to good food (mothers and daughters eat last) – Tribal marks – Female genital mutilation	– Wearing talisman – Putting a piece of thread on the babies' anterior fontanel to cure hiccups – Wearing charms to keep evil spirits away.

NB: The above table is just an example. Some of the traditions mentioned will not be relevant to all communities. As health professionals we should encourage the beneficial traditions and discourage the harmful ones.

Thinking about harmful tradition

Story telling:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Oh no," said the old woman. "We have so many difficulties carrying out our daily chores with one leg!

"But when it was decreed by Moussa everybody was frightened, and dared not discuss the issue. They all put on a brave face and professed it to be a wonderful tradition!

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

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

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

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

Then Mother Earth asked: "But what about the children?" She could imagine them screaming with fear and pain. Yes, she was told, children would always be children. There were those who screamed and shouted and had to be forced to have the operation for their own good. Most of them, though, wanted to be like their friends and part of the crowd.

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

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

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

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

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

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

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

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

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

After the story telling:

Discuss the following questions with the students:

- Who caused the community to reflect on the phenomenon of one-legged woman?
  - *Response: Mother Earth.*
- Who does Mother Earth represent?
  - *Response: All of us.*
- List the reasons given for the one-legged phenomenon:
  - *Responses: It was the tradition to cut one leg off the women of Myrrh because they believed that:*
  - *otherwise the leg could grow as tall as a tree*
  - *the practice prevented promiscuity, because a one-legged girl would find it hard to run away and become a prostitute*
  - *it made a girl more beautiful*
  - *it was a religious obligation (the Great Creator had decreed that women would behave better with only one leg)*
  - *it was a requirement for marriage, no man would want a woman with two legs*
  - *only one-legged women could bear children*
  - *it made women clean and pure.*

According to the old woman, however, the truth was that being one-legged prevented women from competing and winning during the annual dance festivals. It meant that they were unable to become leaders.

- What was Mother Earth's approach to exploring the tradition?
  - *Responses*
  - *she asked questions*
  - *she was non judgmental in her attitude*
  - *she listened empathetically*
  - *she reflected carefully.*
- What was the outcome of her inquiries?
  - *Response:*
  - *she started reflecting on the practice with some members of the community*
  - *she motivated some people within the community to take action.*
- What happened when the activist group was betrayed?
  - *Response: All action against the practice stopped and people were punished for challenging tradition.*
- What other tradition is comparable to cutting off legs?
  - *Response: The practice of FGM.*

- What is the message at the end of the story?
  - Response: Some traditions are harmful; the new generation needs to be educated and motivated to change harmful traditions.

Summary interpretation of the story

- Cutting off the leg is comparable with FGM.
- Mother Earth represents all of us with our individual and collective responsibility for the actions of society.
- Mother Earth's exploration of the tradition depended on her ability to relate effectively to the community
  - she asked questions
  - she was non-judgmental
  - she listened empathetically
  - she reflected carefully
  - she used a positive approach.

- Mother Earth motivated people in the community to think again about the tradition.
- The ending, where Mother Earth invites children hearing the story to play a game of survival, indicates that the new generation needs to be educated and motivated to change harmful traditions.

Small group discussion:

Ask each group to:

- make up and narrate or write down the next chapter to the story, taking as the topic: "what can the new generation do to change this harmful tradition?"

Checklist for teachers

Constructive approaches to changing a harmful tradition include:

- Raising awareness in communities of the problems associated with the tradition.
- Working with communities to eliminate the practice.
- Education of health care workers to provide knowledge and understanding of the consequences of the practice.
- Mobilisation of youth, women, elders and leaders to work to eliminate the practice.
- Introduction of by-laws against the practice at community level.

All these issues, related to FGM as the harmful tradition, should be discussed with the students.

Closing the session:

- Ask the students questions to check that they have understood the lessons.
- Give them information about the next session.

Session 2: Description and background of FGM

Session objectives

By the end of the session the students are expected to be able to:

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

Key references

See page 11 for teaching and learning resources

Suggested teaching methods

- Lecture.
- Question and answer.
- Buzzing.
- Brain storming.
- Poster exercise.
- Small group discussion.
- Film show.
- Plenary.
- Large group discussion.

Teaching aids

Posters, models, overhead projector and transparencies, slide projector and slides, newsprint, writing board, television set, video cassette player and film.

Setting the scene

Ask students if they have heard about female genital mutilation. If they have heard of it, ask them why communities practise FGM.

THE SESSION

Introduce the session and its objectives

Anatomy of the female external genitalia

- Ask students: "what are the structures of female external genitalia?"

Poster exercise:

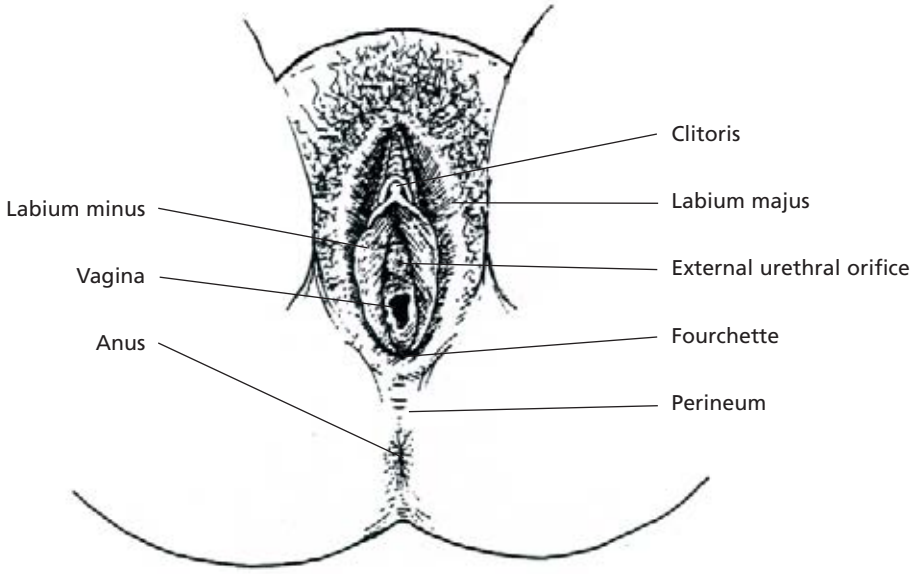
- Have a large poster with an unlabelled diagram of the female external genitalia.
- Give the students pieces of paper with, written on them, the names of the different structures and their functions.
- Ask the students to paste the pieces of papers on the appropriate structures on the poster.

Summarise:

Summarise by using the following chart to explain the structure and function of female genitalia

See figure 1.1: on next page

Figure 1.1: Structure of normal external female genitalia



Structure and functions of External Female Genitalia

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

Definition of female genital mutilation

- Ask students: what is female genital mutilation?

Buzz:

- Let students buzz for 5 minutes.
- Ask for a few responses.

Summarise:

Summarise by giving the following definition:

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

The procedures of FGM

(see Figures 1.2 to 1.6)

Ask students if they know what procedures are involved in FGM

Buzz:

- Allow students to buzz for 5 minutes
- Ask for a few responses

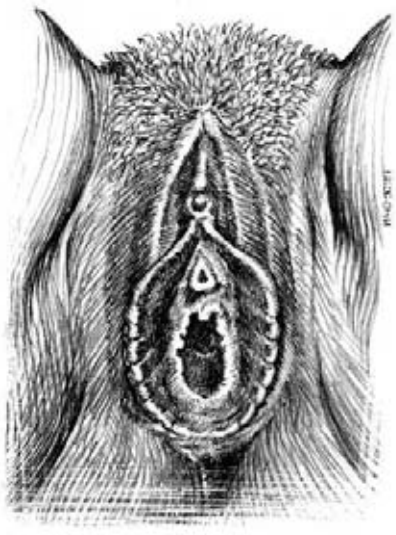
Summarise:

- FGM is carried out using special knives, scissors, razors, or pieces of glass. On rare occasions sharp stones have been reported to be used (e.g. in eastern Sudan), and cauterization (burning) is practised in some parts of Ethiopia. Finger nails have been used to pluck out the clitoris of babies in some areas in the Gambia. The instruments may be re-used without cleaning.
- The operation is usually performed by an elderly woman of the village specially designated this task, who may also be a traditional birth attendant (TBA). Anaesthesia is rarely used and the girl is held down by a number of women, frequently including her own relatives. The procedure may take 15 to 20 minutes, depending on the skill of the operator the extent of the 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, coconut oil or cow dung, and the girl's legs may be bound together until it has healed. Thorns may be used for pricking the prepuce and for holding the labia together.
- In some areas (e.g. parts of Congo and mainland Tanzania), FGM entails the pulling of the labia minora and/or clitoris over a period of about 2 to 3 weeks. The procedure is initiated by an old woman designated for this task, who puts sticks of a special type in place 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 put additional sticks in to hold the stretched parts from time to time. This pulling procedure is repeated daily for a period of about two weeks, and usually no more than four sticks are used to hold the stretched parts, as further pulling and stretching would make the genital parts unacceptably long.

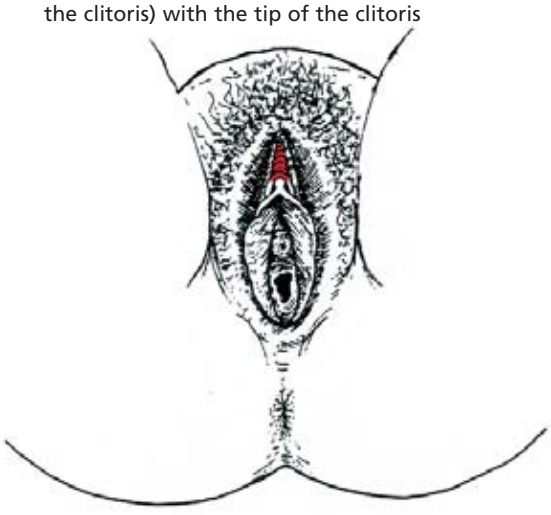
FGM includes the following operations:

Figure 1.2: Normal female external genitalia and female external genitalia with the tip of the clitoris excised (Type 1)

Normal genitalia



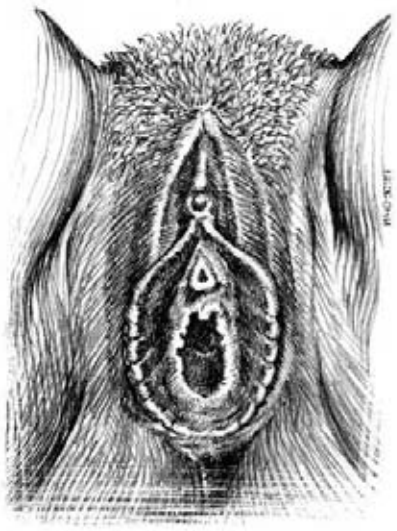
Excision of the prepuce (the fold of skin above the clitoris) with the tip of the clitoris



* Type I may consist of removal of the prepuce without damage to the clitoris

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

Normal genitalia



Excision of the prepuce and clitoris

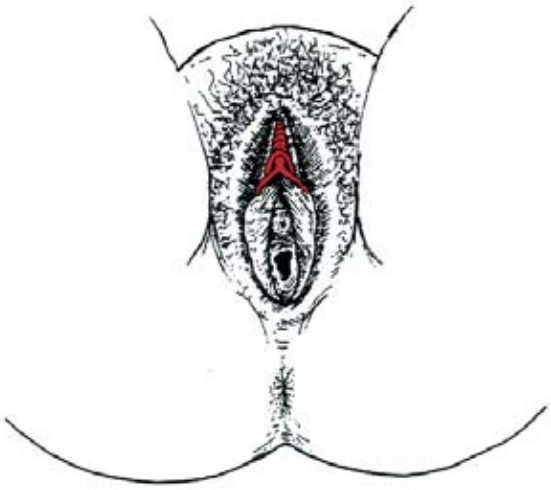
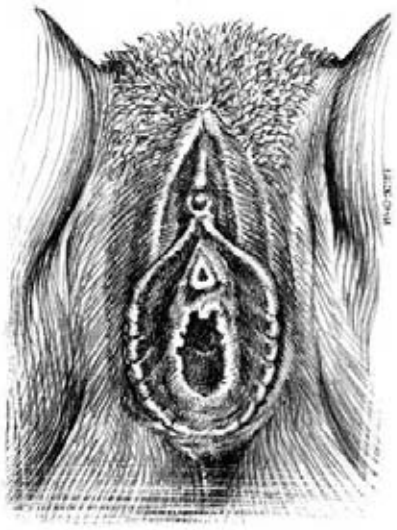


Figure 1. 4: Normal female external genitalia and genitalia with excision of the prepuce, clitoris and labia minora (Type II)

Normal genitalia



Excision of prepuce, clitoris and labia minora

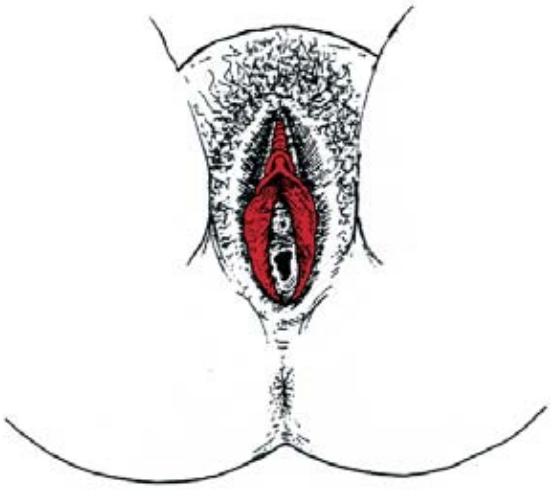
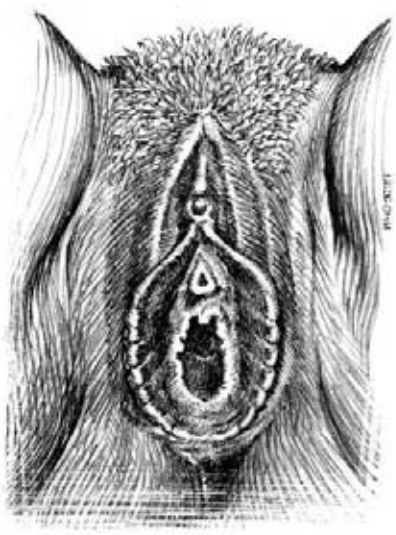


Figure1.5: Normal female external genitalia and infibulated genitalia (Type III)

Normal genitalia



Infibulated genitalia

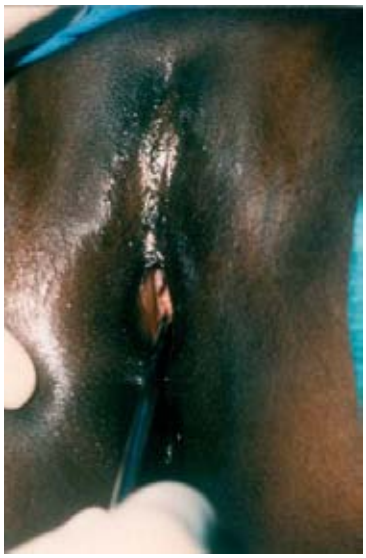
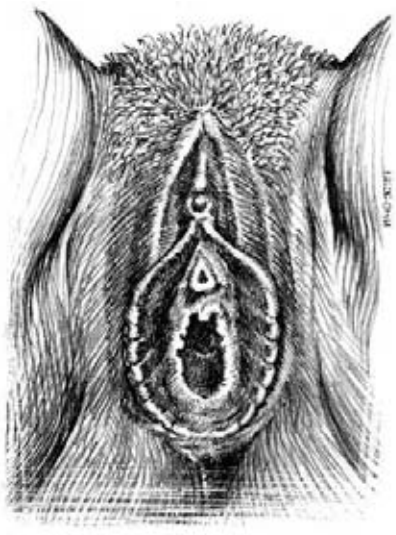
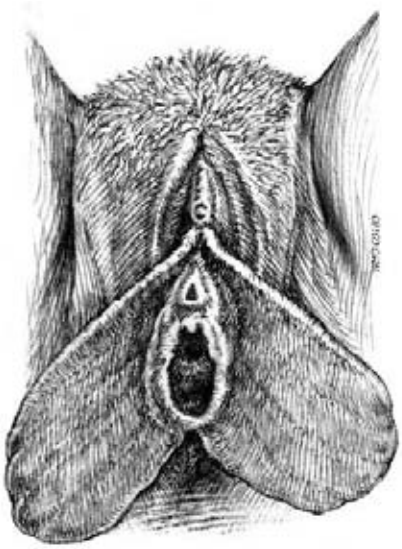


Figure 1.6: Normal female external genitalia and pulled labia minora (Type IV)

Normal genitalia



Pulled labia minora



Small group discussion:

- Divide students into groups of 6 to 8.
- Write the following questions down either on a chalkboard, or on transparencies, or on a poster, and ask each group to answer them:
  - who are the victims of FGM, or on whom is FGM performed?
  - what are the reasons for performing FGM?
  - who performs FGM?
  - how is FGM performed?

- Allow 20 to 30 minutes for the groups to discuss among themselves.
- Ask each group to select a chairperson, a secretary and one member to present their group work.
- Allow another 30 minutes for presentation and general discussion.

Summarise:

Summarise in plenary session

- Who are the victims of FGM?
  - Female genital mutilation is performed on girls and women, from birth to adulthood.

The age at which FGM is performed

(see Figures 1.7 to 1.12)

The age at which female genital mutilation is performed varies a great deal. It depends on the ethnic group or geographical location. In some ethnic groups it is performed on babies. In Eritrea, for example, baby girls are excised around the seventh day after birth. However it is more common for children to be excised between the ages of 4 and 10 years. Alternatively, FGM may be performed during adolescence, at the time of marriage (or subsequent marriages), during a first pregnancy or even during labour if it was not performed before.

Figure 1.7: It is performed on babies

Figure 1.8: It is performed on children

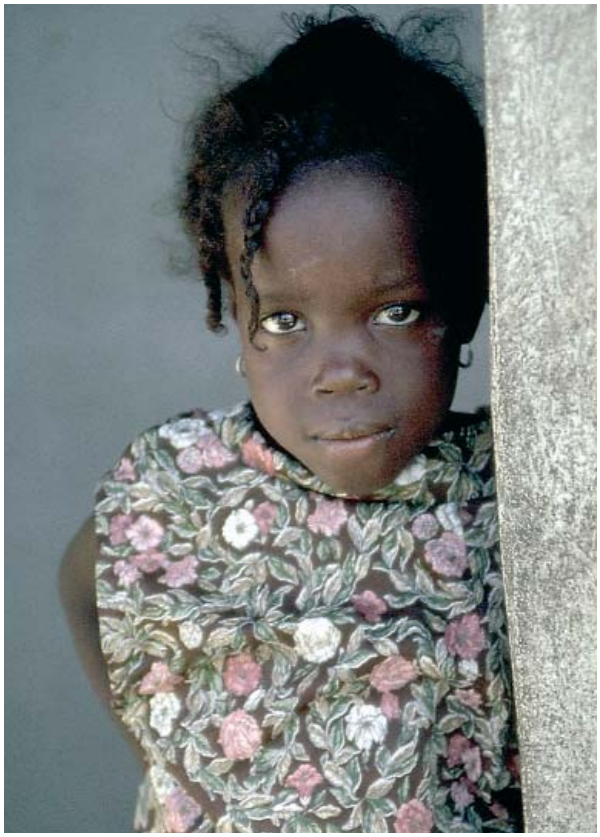


Figure 1.9: It is performed on adolescents

Figure 1.10: It is performed on adult women at marriage

Figure 1.11: It is occasionally performed on pregnant women

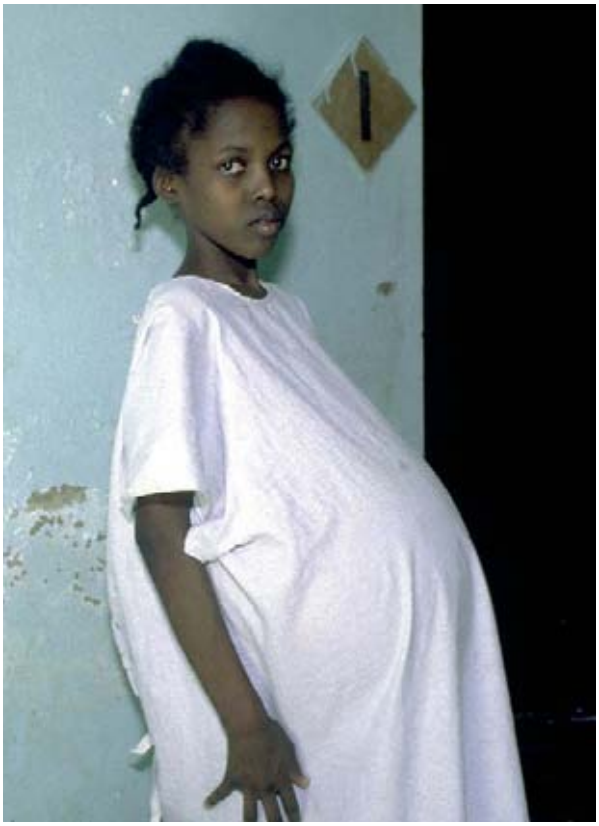
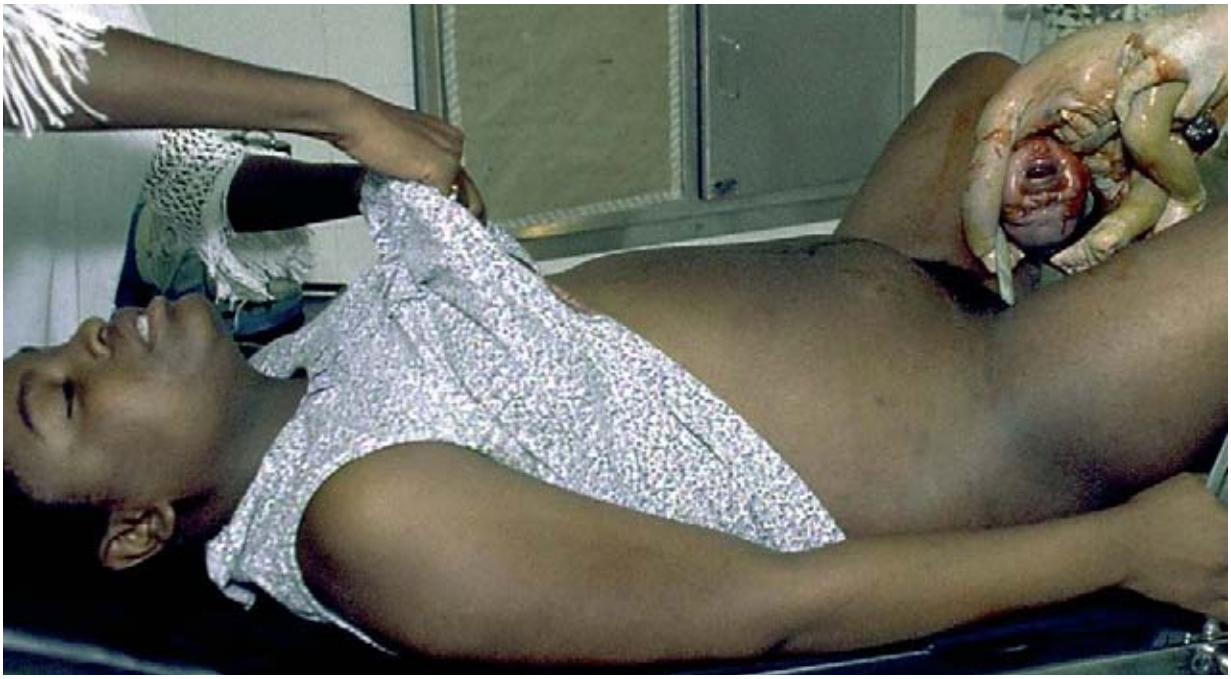


Figure 1.12: It is performed during labour and delivery



Who practises FGM?

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

Who are the excisors?

In cultures where FGM is the custom, the operation is performed by traditional excisors, commonly elderly women in the community specially designated for this task. Sometimes traditional birth attendants or village barbers perform this duty.

"Medicalization" of FGM

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

It is important to note that FGM, whether performed in hospital or any other modern setting, is willful damage to healthy organs for non-therapeutic reasons. It violates the injunction to "do no harm", and is unethical by any standards.

The origins of female genital mutilation

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

Reasons for performing FGM

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

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

Socio-cultural reasons

- Some communities believe that unless a girl's clitoris is removed, she will not become a mature woman, or even a full member of the human race. She will have no right to associate with others of her age group, or her ancestors.
- Some communities believe that a woman's external genitalia have the power to blind anyone attending to her in childbirth; to cause the death of her infant or else physical deformity or madness; and to cause the death of her husband.

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

Hygienic and aesthetic reasons

- In communities where FGM is a traditional practice, it is believed that a woman's external genitalia are ugly and dirty, and that they will continue to grow if they are not cut away. Removing these parts of the external genitalia is believed to make girls hygienically clean.
- FGM is also linked to spiritual purity.
- FGM is believed to make a girl beautiful.

Spiritual and religious reasons

- Some communities believe that removing the external genitalia is necessary to make a girl spiritually clean and is therefore required by religion.
- In Muslim societies which practise FGM, people tend to believe that it is required by the Koran. However, FGM is not mentioned in the Koran.

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

Psycho-sexual reasons

- The unexcised girl is believed to have an over-active and uncontrollable sex drive so that she is likely to lose her virginity prematurely, to disgrace her family and damage her chances of marriage, and to become a menace to all men and to her whole community. The belief is that the uncut clitoris will grow big and pressure on this organ will arouse intense desire.
- It is also believed that the tight opening of infibulation or narrowing of the vaginal orifice, enhance male sexual pleasure which prevents divorce or unfaithfulness.
- In some communities it is believed that mutilating the genitalia of a woman who fails to conceive will solve the problem of infertility.

World Health Organization (WHO) classification of FGM

Buzz:

- Ask students what types of FGM are being performed in their own areas.
- Allow time for responses.

Lecture/Discussion:

- Start by asking students if they are familiar with the WHO classification of FGM.
- Allow students to share what they know for few minutes.
- Clarify, correct misunderstandings, and provide information using the following notes.

Teacher's notes:

WHO classifies FGM is as follows:

Type I: Excision of the prepuce with or without excision of part or all of the clitoris.

Type II: Excision of the clitoris with partial or total excision of the labia minora.

Type III: Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation)

Type IV: Unclassified: Includes pricking, piercing or incision of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissues; scraping of the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding, into the vagina or for the purposes of tightening or narrowing it; and any other procedure that falls under the definition of female genital mutilation given above.

Visual aids:

- Show slides, charts, models or transparencies of types of FGM.
- Discuss with students how they feel about the visual aids.
- Let them share their feelings.

The prevalence of FGM

Brainstorming:

- Ask students: Is FGM a problem in our country?
- How big is the problem of FGM in our country? How big is it globally?
- Let students brainstorm and write down their responses.

Summarise:

- Emphasise that FGM is a health and human rights problem and that the problem is very large.
- Display a map of the world and give students small flags or cards and let them indicate countries on the map where they think FGM is practised.
- Display slides with figures giving the prevalence of FGM in the various countries worldwide; or show a map of the world on which the countries practising FGM are marked together with the figures for prevalence of FGM.
- Explain the figures to students.
- Inform students of any survey results or national research studies that give the prevalence of FGM, for example the country's Demographic Health Survey.

Teacher's notes:

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

Table 1. Estimated prevalence of female genital mutilation

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

Most reliable estimates: national surveys*

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

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

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

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

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

Other estimates

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

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

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

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

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

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

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

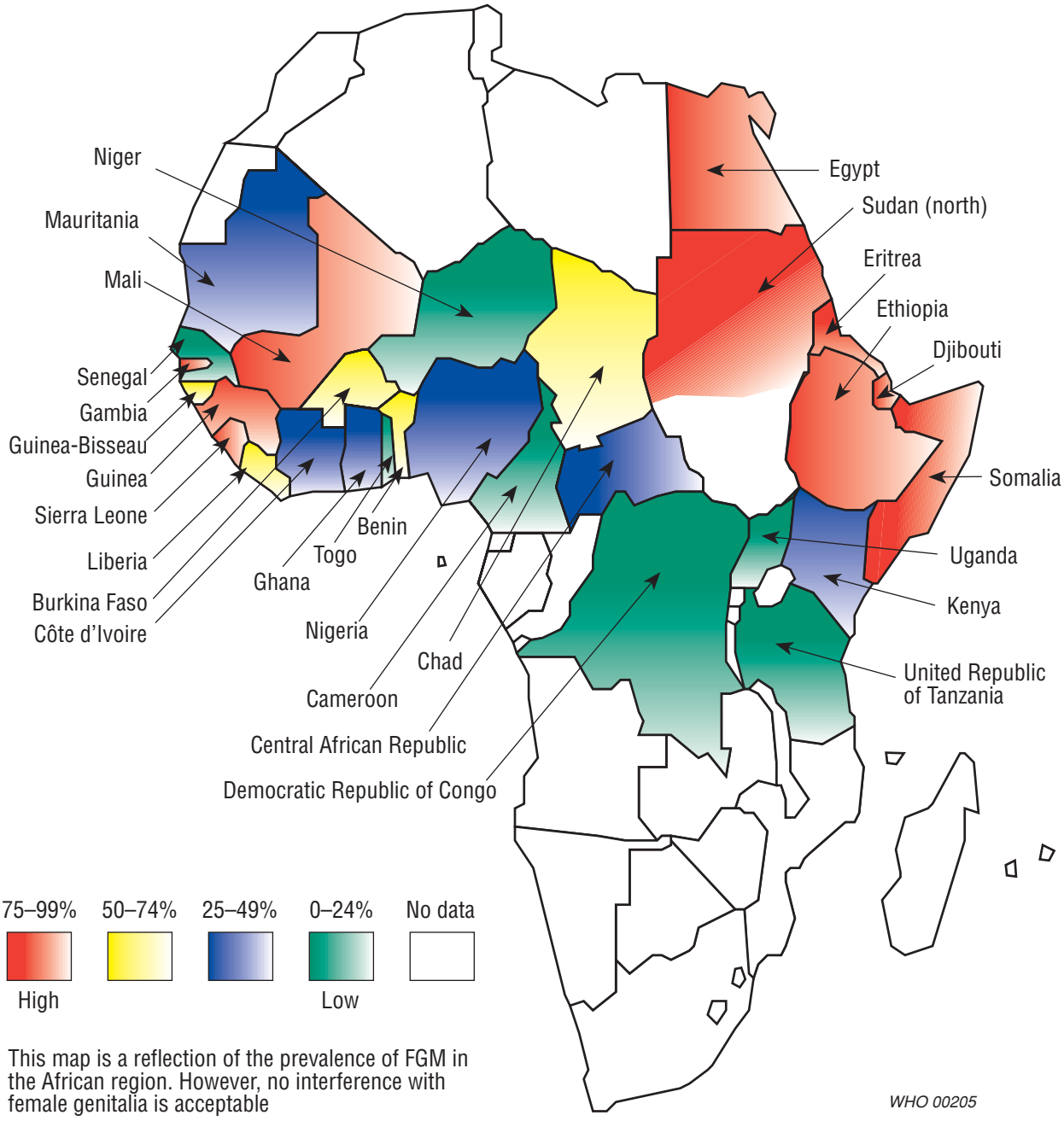
Questionable estimates***

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

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

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

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



This map is a reflection of the prevalence of FGM in the African region. However, no interference with female genitalia is acceptable

Session 3: Complications of FGM

Session objectives

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

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

Key references

- *A Systematic review of the complications of female genital mutilation including sequelae in childbirth.* WHO/FCH/ WMH/00.2 Geneva (2000).
- *Female Genital Mutilation: A Handbook for Frontline Workers.* WHO/FCH/WMH/00.5 Rev.1. WHO, Geneva (2000) .
- *Female Genital Mutilation: The Prevention and the Management of the Health Complications: Policy Guidelines for nurses and midwives.* WHO/FCH/ GWH/01.5. WHO, Geneva (2001)

Introduction

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

Suggested teaching methods

- Question and answer.
- Small group discussion.
- Lecture (illustrated where possible).

Teaching aids

Teacher's notes and student manual.

Setting the scene

Let students share feelings about a procedure which had good intentions but which went wrong.

THE SESSION

Introduce the session and its objectives

- Review knowledge about the structure and function of the female external genitalia covered in session 2.
- With reference to the chart used in session two (structure and functions), ask the students what they think would be the consequences of cutting each of the structures.

Small group discussion:

- Divide students into groups of 6 to 8.
- Let each group discuss and come up with answers of the following questions:
  - What are the physical complications of FGM?
  - What are the psychosocial problems of FGM?
  - What are the sexual consequences of FGM?
  - How can knowledge on the health complications on FGM be improved?

  - Where else within the health system can data on FGM be integrated?

- Allow one hour for group discussion.

Plenary session or large group discussion:

- Let students share their knowledge and thoughts on the above questions in a large group.
- Provide further information as required.

Summarise:

Summarise, using the following checklist:

- Short-term physical complications:
  - Severe Pain.
  - Injury to the adjacent tissue of urethra, vagina, perineum and rectum.
  - Haemorrhage.
  - Shock.
  - Acute urine retention.
  - Fracture or dislocation.
  - Infection.
  - Failure to heal.
- Long-term physical complications:
  - Difficulty in passing urine.
  - Recurrent urinary tract infection.
  - Pelvic infection.
  - Infertility.
  - Keloid scar.
  - Abscess.
  - Cysts and abscesses on the vulva.
  - Clitoral neuroma.
  - Difficulties in menstrual flow.
  - Calculus formation in the vagina.
  - Vesico-vaginal fistula (VVF), recto-vaginal fistula (RVF).
  - Problems in child birth.
  - Failure to heal.

- Psychosocial consequences:
  - For some girls, mutilation is an occasion marked by fear, submission, inhibition and the suppression of feelings. The experience is a vivid "landmark" in their mental development, the memory of which never leaves them.
  - Some women have sometimes reported that they suffer pain during sexual intercourse and menstruation that is almost as bad as the initial experience of genital mutilation. They suffer in silence. In Sudan an official day off from work every month is given to women to deal with the menstrual problems.
  - Some girls and women are ready to express the humiliation, inhibition and fear that have become part of their lives as a result of enduring genital mutilation. Others find it difficult or impossible to talk about their personal experience, but their obvious anxiety and sometimes tearfulness reflect the depth of their emotional pain.
  - Girls may suffer feelings of betrayal, bitterness and anger at being subjected to such an ordeal, even if they receive support from their families immediately following the procedure. This may cause a crisis of confidence and trust in family and friends that may have long term implications. It may affect the relationship between the girl and her parents, and may also affect her ability to form intimate relationships in the future, even perhaps with her own children.
  - For some girls and women, the experience of genital mutilation and its effect on them psychologically are comparable to the experience of rape.
  - The experience of genital mutilation has been associated with a range of mental and psychosomatic disorders. For example, girls have reported disturbances in their eating and

sleeping habits, and in mood and cognition. Symptoms include sleeplessness, nightmares, loss of appetite, weight loss or excessive weight gain, as well as panic attacks, difficulties in concentration and learning, and other symptoms of post-traumatic stress. As they grow older, women may develop feelings of incompleteness, loss of self-esteem, depression, chronic anxiety, phobias, panic or even psychotic disorders. Many women suffer in silence, unable to express their pain and fear.

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

- Sexual complications of FGM
  - Women who have undergone genital mutilation may experience various forms and degrees of sexual dysfunction.
  - Women who have undergone FGM may suffer painful sexual intercourse (dyspareunia) because of scarring, narrowing of the vaginal opening, obstruction of the vagina due to elongation of labia minora and complications such as infection. With the severe forms, vaginal penetration may be difficult or even impossible without tearing or re-cutting the scar.
  - Vaginismus may result from injury to the vulval area and repeated vigorous sexual acts.

Closing the session:

- Ask the students questions relating to the session to see how well they have understood.
- Allow students to ask questions for clarification.
- Let students share what they have learnt from the session, and write down what they say for example, on chalkboard or poster.
- Close the session.

Session 4: Professional ethics and legal implications of FGM

Session objectives

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

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

Suggested teaching methods

- Buzz groups.
- Small group discussion.
- Case study review.

Teaching aids

Reference: *Female Genital Mutilation. A joint WHO/UNICEF/UNFPA statement.* WHO. Geneva (1997).

Documents on professional ethics and code of conduct from International Council of Nurses (ICN), International Confederation of Midwives (ICM) and local resources (see annex of *Management of pregnancy, childbirth and the postpartum period in the presence of Female Genital Mutilation. Report of a WHO Technical Consultation. Geneva, 15 - 17 October 1997* WHO/FCH/WMH/01.02. Geneva).

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

Dorkenoo, E. (1994). *Cutting the Rose. Female Genital Mutilation: The practice and its prevention.* Minority Rights Publications, London.

Setting the scene

- Ask students to buzz in twos or threes for five minutes on the question: what are professional ethics?
- Write down their responses.

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

THE SESSION

Introduce the session and its objectives.

- Inform students that every country has a regulatory body which governs the practice of nursing and midwifery. At the international level we have the International Nursing Council (ICN) and the International Confederation of Midwives (ICM).
- Review international and local nursing and midwifery ethics.

Small group discussion:

- Divide students into groups of 6 to 8.
- Ask the groups to select a chairperson, a secretary and a presenter.
- Ask them to read and analyse the case studies in the appendix on pages 127 to 129, (you can devise your own case studies or use those provided).
- Allow groups up to one hour for their discussion
- The questions they should be discussing are:
  - what ethical principles and dilemmas are addressed in the case studies?
  - what actions would we have taken and why?

Plenary session:

- Allow group representatives to present their group's work.
- Allow discussion among students.

Summarise:

Summarise using the important points as in teacher's notes.

Teacher's notes:

The ethical implications of FGM – some nurses, midwives and other health personnel are reported to be performing FGM in both health institutions and private facilities. Aside from the economic aspect, the justification given for "medicalization" of the practice is that there is less risk to health if the operation is performed in a hygienic environment, with anaesthetics, and where pain and infection can be controlled. "Medicalization" of FGM offers the opportunity to encourage the less drastic forms of mutilation as a first step toward the elimination of the practice. But whether the procedure is performed in hospital or in the bush, the fact remains that FGM is the deliberate damage of healthy organs for no medical or scientific reasons.

Performing FGM violates the ethical principles "do no harm" and "do not kill".

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

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

Ethical principles:

- Respect, autonomy, beneficence, non-maleficent, justice, veracity and fidelity.
- Obligation, responsibilities and accountability

Small group discussion:

- Ask students to form into the same small groups as before.
- Ask them to discuss among themselves the following questions:
  - Is it practical and advisable to pass a law against FGM?
  - How are laws formed?
  - What issues should a law against FGM address?
- Allow students about 30-minute for discussion.

Plenary session:

- Allow group representatives to present their group's.
- Allow about 30 minutes for this activity.
- Open the discussion to everybody, and ask them to come to a consensus on the issues discussed.

Summarise:

Summarise using the important points in the teacher's notes.

Teacher's notes:

Legal implications of FGM –

- The enactment of a law to protect girls and women from FGM makes it clear what is wrong and what is right.
- Having a law in place gives the police, community committees, and health professionals the legitimacy to intervene in cases of threatened FGM.
  Individuals can also report to the law for protection

of either for themselves or their daughters.

- Passing laws is not enough on its own to protect girls and women from FGM. There is a danger that the fear of prosecution will inhibit people from seeking help for complications - thus laws must go hand in hand with community education to raise awareness of the harmful effects of FGM, its human rights implications and to change attitudes.
- A law against FGM will only be meaningful if it is put into practice. There are a number of countries which have laws against FGM; some implement them and some do not.

Laws and decrees against FGM –

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

Closing the session:

- Ask students if there is anything that needs clarifying.
- Let students share what they have learnt from the session.
- Write down what they say.
- Close session by informing them about the next session.

Session 5: Human rights and FGM

Session objectives

By the end of the session the students are expected to be able to:

1. Recognize how FGM violates human rights.
2. Identify international conventions and declarations for the promotion and protection of the health of the girl and the woman, including FGM.

Key references

- R. J. Cook (1994) *Women Health and Human Rights.* WHO, Geneva (1994).
- *Female Genital Mutilation: A Joint WHO/ UNICEF/UNFPA statement.* WHO, Geneva (1997)
- *Summary of international and regional human rights texts relevant to the prevention and redress the violence against women.* WHO/GCWH/WMH/ 99.3. WHO, Geneva (1999).
- *Female Genital Mutilation: The Prevention and the Management of the Health Complications: Policy Guidelines for nurses and midwives.* WHO/FCH/ GWH/01.5. WHO, Geneva (2001)
- Dorkenoo, E. (1994). *Cutting the Rose. Female Genital Mutilation: The practice and its prevention.* Minority Rights Publications, London.

Suggested teaching methods

- Small group discussion.
- Plenary sessions.
- Buzzing.
- Student exercises.

Teaching aids

Teachers notes, newspaper articles, overhead projector and transparencies, slides projector and slides.

Setting the scene

- Ask students what rights they have as human beings.
- Write their responses up on the board.

All human beings have the right to life, security, good health, and freedom of religion, protection, shelter, and education.

THE SESSION

Introduce the session and its session objectives

- Review human rights with the students, using locally available slides, transparencies, or newspaper articles.
- Explain that FGM is a human rights issue because it violates the rights of women and girls.

Small group discussion:

- Divide students into groups of 6 to 8.
- Ask the group to read and analyse case studies.
- Allow groups one hour for their discussion.
- The questions they should be discussing are:
  - what rights have been violated?
  - what recommendations would we have for preventing the practice of FGM?

Plenary session:

- Allow students to present their group work.
- Allow discussion among students for one hour.

Summarise:

- Explain to students how FGM violates human rights using important points in teacher's notes.
- Refer to national and any other regional and international human rights instruments.

Teacher's notes

- **How FGM violates human rights** – There is documented evidence that FGM damages the health of girls and women. Thus the practice infringes their right to the highest attainable standard of physical, sexual and mental health. FGM is also:
  - associated with gender inequalities
  - a form of discrimination against girls and women
  - torture, cruel, inhuman, or degrading treatment of children and women
  - an abuse of the physical, psychological and sexual health of children and women.
- **International Conventions and Declarations relevant to the elimination of FGM** – Several international as well as regional instruments protect the rights of women and children. The international human rights covenants oblige Member States of the United Nations to respect and to ensure the protection and promotion of human rights, including the rights to non-discrimination, integrity of the person, and to the highest attainable standard of physical and mental health.

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

- **The Universal Declaration of Human Rights (1948)** proclaims the right of all human beings to live in conditions that enable them to enjoy good health and health care. Article 3 of the Declaration states that everyone has the right to life, liberty and security of person. FGM leads to medical complications, which may result in death.
- **The International Covenant on Civil and Political Rights, and the International Covenant on Economic, Social and Cultural Rights (1966)** condemns discrimination on the grounds of sex and recognizes the universal right of a all persons to the highest attainable standard of physical and mental health.
- **The Convention on the Elimination of All Forms of Discrimination against Women (1979)** can be interpreted as obliging States to take action against female genital mutilation including:
  - to take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women (Art. 2.f)
  - to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices, and customary and all other practices which are based on the idea of the inferiority or superiority of either of the sexes or on stereotypes for men and women (Art.5.a).
- **The Convention on the Rights of the Child (1990)** protects the right to equality irrespective of sex (Art. 2), to freedom from all forms of mental and physical violence and maltreatment (Art.19.1), and requires States to abolish traditional practices prejudicial to health of the children(Art.24.3).
- **The Vienna Declaration and the Programme of Action of the World Conference on Human Rights (1993)**, expanded the international human rights agenda to include gender-based violations which include female genital mutilation.
- **The Declaration on Violence against Women (1993)** states that violence against women must be understood to include physical and psychological violence occurring within the family, including female genital mutilation and other traditional practices harmful to women.

- **The Programme of Action of the International Conference on Population and Development (1994)** included recommendations on female genital mutilation which commit governments and communities to take steps to stop the practice and to protect women and girls from unnecessary and dangerous practices.
- **The Platform for Action of the Fourth World Conference on Women, Beijing (1995)** urged governments, international organisations and non governmental organisations to develop policies and programs to eliminate all forms of discrimination against women and girls including female genital mutilation.

Buzz:

- Ask students: do children have rights?
- Let them buzz in twos or threes
- Let them respond to the question
- Inform the students that children do have rights.

Small group discussion:

- Divide students into groups of 6 to 8.
- Ask them to read and analyse case studies.
- Let each group discuss and come up with answers to the following questions:
  - in what ways have the rights of children been violated in the case studies?
  - what recommendations do we have for preventing these violations?

Plenary session:

- Allow groups to share their group work with everyone.
- Allow discussion among students.

Summarise

Summarise how FGM violates the rights of the child using the teacher's notes.

Teacher's notes

The Convention on the Rights of the Child protects the rights to equality irrespective of sex (Art. 2), to freedom from all forms of mental and physical violence and maltreatment (Art. 19.1), to the highest attainable standard of health (Art. 24.1), and to freedom from torture or cruel, inhuman or degrading treatment (Art. 37.a).

FGM violates all the rights mentioned above. FGM constitutes torture and inhuman treatment, and impairs the health of the child both in the short-term and for the rest of her life. Principle 2 of the Declaration of Rights of The Child states that: *'the child shall enjoy special protection… to enable (her) to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and integrity.'*

The rights of the child are important and must be protected. National and international laws protect the rights of children. However, these are only effective if they are observed and they are implemented.

Student exercise:

- Ask students, working in small groups, to write their own statements on human rights.
- Let each group post their statements on the wall.

The regulatory bodies of nurses and midwives and FGM

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

The International Confederation of Midwives (ICM) and the International Council of Nurses (ICN) are the international regulatory bodies in all matters concerning professional midwifery and nursing

respectively. Both the ICM and the ICN have policies against the practice of FGM. For example:

- Female genital organs are vital to the sexual response of women, and cutting or removal of even a few millimetres of highly sensitive tissue results in substantial damage. The experience of mutilation has a lasting psychological impact on girls and women. The memory of the pain and trauma remains with girls and women throughout their lives.
- Two of the most important ethical principles of health professionals are:
  - to do no harm, and
  - to preserve healthy functioning body organs at all costs unless they carry a life threatening disease.
- FGM entails the removal and or damage to healthy functioning body organs. There is no medical justification for the procedure. Reasons for performing FGM are mainly to comply with traditional ritual. **It is usually performed on children who have no awareness or power of consent.** The consent of parents or guardians is not valid when the act performed is damaging, rather than beneficial, to the child.
- It is also unethical for a health professional to damage a healthy organ in the name of culture. The argument put forward by health professionals that an operation performed by a skilled person in hygienic conditions poses less risk to health and is therefore less damaging is not valid. Any health professional taking such action would be guilty of misconduct and liable to disciplinary action being taken against him/her by the regulatory bodies for health professionals. Such action can vary from a warning to removal from the professional register, and denial of a license to practice. Health professionals can also be prosecuted under national laws against FGM.

Closing the session:

- Ask questions of the students to check their understanding of the session.
- Ask students to share what they have learnt from the session.
- Write down what they say, on a chalk board or flip chart.
- Close the session.

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

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

Application of the module

The material in this module may be added to existing courses, such as community health nursing or community midwifery. The module may also be used as a complete course in itself during in-service training of nurses and midwives.

General objectives

At the end of this module the students are expected to be able to:

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

Background qualifications

Students working on this module should already have the following:

- Basic knowledge of FGM (from Module 1)
- Knowledge of ethical, legal, policy, and professional conduct as regards FGM

Essential competencies:

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

- an understanding of the values, beliefs and attitudes that underpin the practice of FGM and how these are formed
- an ability to apply this knowledge in their work with communities
- an understanding of the rules and standards governing professional practice and behaviour in caring for women with FGM
- an understanding of, and ability to apply, ethical, human rights, and legal concepts to FGM prevention and care
- a knowledge of local, national and international organisations working on FGM
- an ability to identify key community groups/leaders who will be influential agents for change in FGM prevention
- an ability to develop effective and appropriate strategies in working with groups to bring about change
- an ability to apply information, communication, education (IEC) and advocacy skills when working with communities on the prevention of FGM.

Suggested teaching activities

- Lecture.
- Plenary sessions.
- Small group discussions.
- Buzzing.
- Brainstorming.
- Simulation games.
- Case analysis.
- Field visits.
- Individual and group assignment.

Teaching aids

The teaching aids may include:

- Films.
- Flip charts, posters, leaflets, writing boards.
- Overhead projector and transparencies.
- Models.

Reference materials

- *Female Genital Mutilation. Report of a WHO Technical Working Group*, Geneva, 17-19 July 1995. Geneva, World Health Organization, 1996. (WHO/FRH/WHD/96.10).
- *Female Genital Mutilation. A joint WHO/UNICEF/UNFPA Statement.* WHO. Geneva (1997).
- *A systematic review of the health complications of Female Genital Mutilation including sequelae in childbirth.* WHO/FCH/WMH/00.2 Geneva (2000).
- *Female Genital Mutilation: A Handbook for Fontline Workers.* WHO/FCH/WMH/00.5 Rev.1 Geneva (2000).
- *Female Genital Mutilation. Programmes to date: what works and what doesn't. A review.* WHO/CHS/WMH/99.5. Geneva (1999).
- *WHO Film: Female Genital Mutilation - "The Road to Change".* WHO, Geneva (2000).

Teachers are advised to read more on the following:

- WHO regional strategy for reproductive health.
- Regional plans of action for accelerating the elimination of FGM in Africa.
- National plans of action on the elimination of FGM.
- Effective communication.
- Effective teaching.
- Effective advocacy: mass media, campaigns and lobbying.
- Effective interpersonal skills.

Note: For case analyses, you can use storybooks as indicated earlier or use locally available relevant stories.

The Sessions

Time in hours

Session 1:
Beliefs, values and attitudes. 2

Session 2:
Traditional beliefs values and attitudes towards FGM. 2

Session 3:
Strategies for involving individuals, families and communities in the prevention of FGM. 4

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

Field trip to the community. 8

Session 1: Beliefs, values and attitudes

Session objectives

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

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

Suggested teaching methods

- Small group discussion.
- Feedback and discussion.
- Simulation games and exercises.
- Plenary session.
- Value clarification exercises and games.

Teaching aids

- Charts and pictures.
- Flip Charts.
- Teacher's notes.

Setting the scene

- Ask students to identify some beliefs and values.

Examples of beliefs:

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

THE SESSION

Introduce the session by recalling the definition of tradition. Explain that people are a complex mix of unique characteristics, which include physical characteristics as well as various beliefs, values and attitudes. Traditions are guided by beliefs, and the practice of traditions is based on values and attitudes.

Small group discussion:

- Divide students into groups of 6 to 8
- Ask them to discuss the following questions:
  - what do we mean by beliefs, values and attitudes?
  - what are the origins of beliefs?
  - how do people develop belief systems?
- Allow 30 minutes for discussion.

Plenary session / large group discussion:

- Allow another 30 minutes for feedback and discussion.
- Write down the results of the groups' discussions.
- Provide information using teacher's notes.

Teacher's notes

- **Meaning of beliefs:** The dictionary defines a belief as a conviction, a principle or an idea accepted as true or real, even without positive proof. There are many beliefs and belief systems – including religious beliefs, cultural beliefs, group and individual beliefs. People's beliefs guide their actions and behaviour.
- **Meaning of values:** The dictionary defines values as the moral principles and beliefs or accepted standards of a person or social group. Our values

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

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

Origins of beliefs, values and attitudes

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

The development of a value system

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

Steps in the development of a value system

Step 1: Knowing how one should behave, or what is expected of one.
This is the cognitive component.

Step 2: Feeling emotionally about it .
This is the affective component .

Step 3: Taking appropriate action.
This is the behavioural component.

Exploring personal beliefs, values and attitudes

Exercises:

The aim of these exercises is to enable students to explore their own values, and to look at them in relation to the different values of other people. Select one or more of the following:

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

"Walking Survey" exercise:

This is a group exercise

- Post two signs on the wall:
  - Agree.
  - Disagree.
- Read statements from a worksheet below designed to explore values. Ask participants to move to the sign "Agree" or "Disagree" that reflects their opinion.
- Repeat this process with all the statements.
- Ask representatives from each opinion group to explain the reasons behind their choices.

- Repeat the process as time permits.

WALKING SURVEY EXERCISE

LIST OF VALUE STATEMENTS ON FGM

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

Summarise:

Summarise the exercise by asking the students the following questions:

- What was the most striking experience for you when you did this exercise, both as regards to your own reaction to the questions, and that of others in the class?
- Were you surprised with the responses of your peers?
- How did you feel when others disagreed with you?

Value clarification

- Ask students what they understand by "value clarification".
- Allow time for a few responses.
- Give them information in the teacher's notes.

Teacher's notes:

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

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

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

The process of valuing

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

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

Exercise to clarify personal values:

- Ask students to pair up and the partners to sit facing one another but not speaking
- Instruct students to:
  - List three activities they think their partner would be most interested in doing after the session.
  - Rank these activities in order of importance to the partner.
  - List three activities they themselves would be most interested in doing after the session.

- Ask each student to read out the list she has made on behalf of her partner. Then ask the partner to read out the list she has made for herself. Continue this process until everyone has shared his or her lists.
- Ask students the following questions, as appropriate:
  - **A:** Why do you think you were able to identify the interests of your partner correctly?
  - **B:** Why do you think you were unable to identify the interests of your partner correctly?
  - **C:** How did you feel when your partner was identifying your interests?
  - **D:** How did you feel when you were prejudged or misjudged?

Possible explanation for the different responses:

A: The person was able to identify her partner's interests correctly because she had a lot of things in common with the partner, for example:
- a similar educational background
- the same sex
- same cultural background
- same religion
- they already knew each other
- they had discussed their interests already
- she had observed her carefully already.

B: The person was unable to identify her partner's interests correctly because she had not been allowed to talk to her or to observe her before the exercise.

C: You may have felt strange because even when two people know each other, it may be difficult for them to identify each other's real interests unless they have made a special effort to find out about these things.

D: You may have felt surprised and resentful at being misjudged by your partner.You may have felt devalued as a person, and felt the need to defend yourself. You may have found you lost respect for the person making such assumptions about you.

Summarise:

Summarise the exercise by making the following points to the students:

- If you had difficulty identifying a fellow student's real interests, think how much more likely you are to be mistaken in identifying the needs and problems of clients about whom you may know very little. Or in identifying the needs of a community of which you are not a member.
- This activity has demonstrated how difficult it is to make correct assumptions about someone else's interests. It underlines the fact that there has to be dialogue, and open minds, if one really wants to understand the beliefs and values of other people.

Name tag exercise:

- Inform students that this exercise is a value clarification exercise.
- Hand out the exercise sheets (see below).
- Ask them to read the instructions carefully.
- Give them time to do the exercise.
- Ask them to share what they have written and give them adequate time to do so.

Instructions to students:

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

3 Take a close look at your responses to the questions and to the ways in which you described yourself. What values do you think are reflected by your answers?

Pattern exercise:

- Hand out the exercise sheets (see below).
- Ask the students to read the instructions carefully.
- Give them time to do the exercise.
- Ask them to share their responses and give them adequate time to do so.

Instructions to students:

1. Look at the list of words above, and draw a circle around the seven words that best describe you as an individual.
2 Underline the seven words that most accurately describe you as a professional person. (You may circle and underline the same words).

Reflect on the following questions:

- What values are reflected in the patterns you have chosen?
- What is the relationship between these patterns and your personal values?
- What patterns indicate inconsistencies in your attitudes or behaviour.
- What patterns do you think would be most appropriate for health personnel, and that they should cultivate?

Ranking values exercise:

- Hand out to students lists of "value" statements regarding FGM (see below).
- Explain the exercise to the students.
- Give them time to complete the exercise.
- Ask them to share their responses.

Instructions to students:

1. Rank in order the following 12 actions that could be taken for the prevention of FGM, by using 1 to indicate the action you feel is most important, and 12 to indicate the action you feel is least important.

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

2. Examine the way in which you have ranked these options, and answer the following questions:

- What values can you identify based on your responses in this exercise?
- How do these values emerge in your behaviour?

Summarise:

Summarise the exercise using the teacher's notes

Teacher's notes

- Our attitudes, values and beliefs greatly influence the service we provide to clients and community regarding FGM.
- If we try to impose our own attitudes and values on others, it is unlikely we will be effective in our efforts to eliminate FGM .
- Our attitudes, beliefs and values are influenced by our cultural beliefs, social background, age, gender, education and other factors in life. We must not impose them on individual clients or communities.
- Even in a group of people from similar backgrounds, with similar educational levels and professions, there is likely to be a wide range of attitudes and values.
- If health workers can recognize their own biases and understand the roots of their own beliefs, they are most likely to be successful in working with communities.
- Listening to the community and to clients will give health workers a better idea of how best to communicate with them about the dangers of FGM.
- The best ways to find out what someone's real interest are is to talk directly with that person.

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

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

Closing the session:

- Summarise the important lessons of the session.
- Let students share what they have learnt from the session.
- Write down what they say.
- Close the session.

Session 2: Traditional beliefs, values and attitudes towards FGM

Session objectives

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

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

Suggested teaching methods

- Small group discussion.
- Large group discussion.
- Lecture.
- Community visit.

Teaching aids

- Teacher's notes.
- Student manual.

Setting the scene

- Ask students to reflect on the story of Tradition! Tradition! Ask them what conclusions they reached about the role tradition plays in perpetuating the practice of FGM.
- Write their response on a flip chart or chalk board and discuss.

THE SESSION

Introduce the session and its objectives.

- Emphasise to the students that it is not known when or where the practice of female genital mutilation originated, and that a variety of reasons are given for maintaining the tradition. These include social, cultural, psychological, hygiene, aesthetic and religious reasons.
- Emphasise also that traditional beliefs, values and attitudes have a strong influence on the practice of FGM.

Beliefs, values and attitudes and the practice of FGM

The practice of FGM is supported by traditional beliefs, values and attitudes. In some communities it is valued as a rite of passage into womanhood (For example in Kenya and Sierra Leone). Others value it as a means of preserving a girl's virginity until marriage, (For example in Sudan, Egypt, Ethiopia and Somalia). In each community where FGM is practised, it is an important part of the culturally defined gender identity, which explains why many mothers and grandmothers defend the practice: they consider it a fundamental part of their own womanhood and believe it is essential to their daughters' acceptance into their society. In most of these communities FGM is a pre-requisite to marriage, and marriage is vital to a woman's social and economic survival.

Small group discussion:

- Let students sit in small groups to discuss the question: how can we enable communities to change their beliefs, values and attitudes towards FGM?
- Let students present their group work to the whole class and allow discussion for a further hour.
- Provide information as required using teacher's notes.

Teacher's notes:

- Individuals, families and communities have their own reasons for valuing FGM. In discussing the

issue of prevention with them, one needs to help them to analyse their feelings and to clarify their values regarding FGM, before explaining to them the consequences of upholding these values.

- Nurses and midwives must appreciate that values and attitudes develop over a lifetime, and changing them is never an easy or quick process. But helping the community to examine their feelings about FGM will allow them to make conscious decisions about which of the values and attitudes that underpin the practice they wish to keep and which they think may no longer be valid.
- Only by fully understanding one's own values and their relative importance can one recognise which of one's behaviours are the result of rational choice and which may be the result of other influences.
- People must be allowed to change in their own way and at their own speed. Therefore they must be involved in all stages of the process.

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

Small focus group discussions are an effective means of assisting this process.

- The first step in assisting people to clarify their attitudes towards FGM is to find out from them the reasons why they support it, and what happens to those who do not go through it. The nurse/midwife can use the statements from the "exploring values" exercises as issues for the focus group discussions, if they wish.
- After they have shared their views, the nurse/midwife can then give information and education on the anatomy and physiology of the female reproductive system; the effects of FGM on women's physical, psychological, sexual and reproductive health, and the possible consequences for childbirth.
- The nurse/midwife should give groups an opportunity to discuss their own experiences of such health problems. She should then relate these problems to the practice of FGM (Often, women who have experienced such problems have not associated them with genital mutilation, but attributed them to God's will or witchcraft).
- The nurse/midwife should help people to identify good practice and dangerous practice, and to understand the implications of FGM on the health of girls and women.

Assisting in the process of change

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

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

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

Behavioural scientists have demonstrated that in changing any behaviour, an individual goes through a series of steps (see Figure 3 on page 65). These are as follows:

1. Awareness.

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

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

Summarise:

- inform students that FGM is a traditional practice, and that it is rooted in cultural and religious traditions.
- Share stories with participants and discuss the different beliefs people hold regarding FGM.
- Plan a community visit.
- Give students guideline for the community visit.

Community observation visit:

- It is the teacher's responsibility to make arrangements for the students to visit a community to observe a community meeting.
- The teacher is advised to enquire about the schedule of community meetings and seek permission for students to attend a meeting as observers.

Guidelines for students:

Purpose of the community visit:

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

Questions to guide the observation:

- What was the structure of the meeting? For example, who was present, and who led the meeting?
- What subjects were discussed?
- Who introduced the subjects for discussion?
- Who participated?
- What traditional beliefs, values and attitudes were displayed during the meeting?
- What decisions were made?
- How were they made?
- By whom?

Feedback from community observation visit:

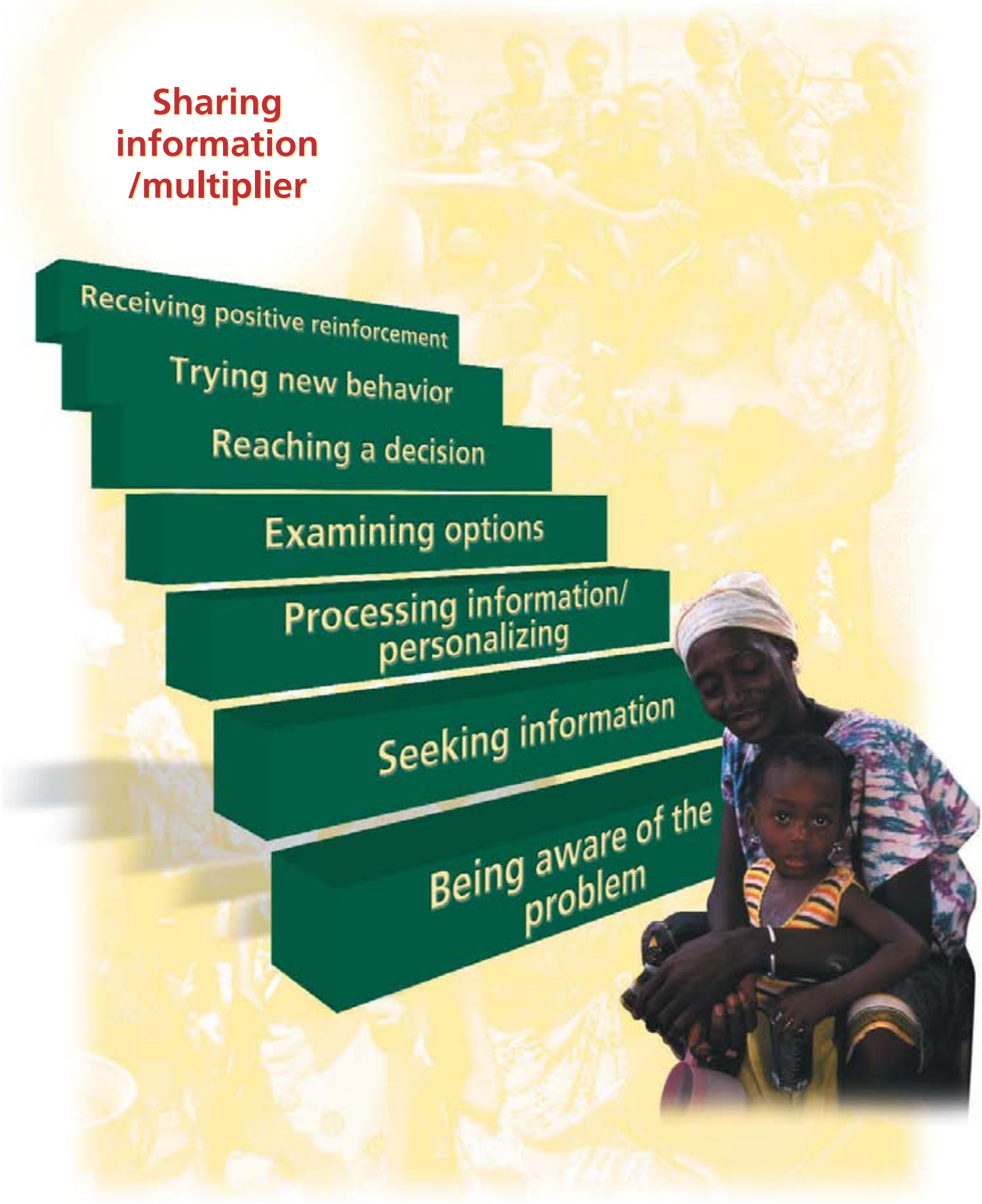
- Ask students to work in small groups and to compile a report of their observation.
- Ask students to share their reports with the whole class.
- Summarise key points learned concerning beliefs, values and attitudes.

Closing the session:

- Ask students questions relating to the session to see how well they have understood.
- Clarify points as necessary.
- Close the session.

Figure 3:

STAGES OF BEHAVIOUR ADOPTION



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

Session objectives

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

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

Key references

- *Female Genital Mutilation. Programmes to date: what works and what doesn't. A review.* WHO/CHS/WMH/99.5 Geneva (1999).
- *Female Genital Mutilation: A Handbook for frontline workers.* WHO/FCH/WMH/00.5 Rev.1. WHO Geneva (2000).
- *Towards the healthy women counselling guide: Ideas form the gender and health research group.* TDR, WHO, Geneva.
- *WHO Film: Female Genital Mutilation - "The Road to Change".* WHO, Geneva (2000).

Suggested teaching methods

- Buzzing.
- Short story.
- Small group discussion.
- Large group discussion.
- Plenary session.

Teaching aids

Teacher's notes.

Setting the scene

Set the scene with a short story and discussion, as follows:

- Suggest the following scenario to the students: An epidemic broke out in a community. Health personnel were called and they managed to stop the disease, but after six months the same disease broke out again. What is the problem?
- Allow a few students to respond to the question.
- Summarise by explaining to the students that the disease broke out again because the community itself had not been closely involved in setting up the prevention strategies. When the health personnel left, prevention activities gradually broke down.

THE SESSION

Introduce the session and its objectives.

- Ask students to define "community" and say what is meant by "community involvement".

Teacher's notes:

- ***Community.*** A community is an aggregation 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, 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.*** Community involvement means working with the people, rather than for them, to answer their needs and find solutions to their problems. It is a process whereby the

community is encouraged to take responsibility for its problems and make its own decisions as to how to solve them, using its own resources and mechanisms.

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

Strategies for involving individuals, families and communities in FGM prevention

Brainstorming:

- Ask student: who makes the decision in the family that FGM should or should not be carried out?
- Allow students to respond to the question.
- Write down their responses.

Small group discussion:

- Divide the students into four small groups.
- Allocate a section of the community to each group and ask them to discuss strategies for involving that particular section in the prevention of FGM.
- Allocate them as follows:
  - Group 1: the whole family.
  - Group 2: men.
  - Group 3: women.
  - Group 4: youth.
- Allow 15 minutes for discussion in small group.

Plenary discussion:

- All students to share their thoughts with the whole class.
- Allow 30 minutes for this discussion.

Summarise:

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

Health professionals are respected and listened to by individuals, families and communities and have a major role to play in promoting education against FGM. Some are already members of non governmental groups working to bring about change in their communities on the practice.

Explain to students that the first requirement is to learn about the practice and to be clear about the reasons given by people for practising it. Student should know that FGM is not just a health issue but a gender and human right issue, therefore the solution to the problem lies not just in giving information on health consequences of FGM but to advising on the various dimensions of the problem. The health workers role is to contribute to the change process

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

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

the rite of passage (Kenya) and teaching women problem solving skills (Tostan, Senegal)

- supporting individuals and families to cope with the problems of FGM and with adjusting to change.

Using the document cited in "key references" above, discuss with students the community involvement strategies that have been tried in the field – which ones have proved effective and which ones have not.

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

Strategies for involving men

Explain to students that, in order to involve men in the prevention of FGM, they should:

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

Strategies for involving women

Explain to students that, in order to involve women in the prevention of FGM, they should:

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

Discuss examples from the field of successful programmes, e.g. the programmes in Kenya where alternative initiation ceremonies have been developed for young girls to mark their rite of passage to adulthood without requiring excision.

Strategies for involving youth

Explain to students that, in order to involve youth in the prevention of FGM, they should:

- Identify appropriate forums for meeting with young people, such as in youth clubs, schools, colleges, and make contact with relevant people.
- Identify appropriate forums for meeting young girls separately, in order to address sensitive issues of direct relevance to them, including teaching basic life skills aimed at empowering girls.
- Give clear information about the health effects and

human rights implications of the practice, and identify misconceptions.

- Use participatory approach.
- Advocate for the issue of FGM to be addressed in school health programmes, and included in the curricula of schools.
- Provide special support to girls how have already undergone FGM.
- Establish peer education (i.e. youth to youth) programmes.

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

Communicating with target groups

Advise students that, in communicating with the various audiences, they should observe the following rules:

- **Assess and decide on appropriate ways of communicating**. For example:
  - One-to-one discussions.
  - Group discussions, such as with all members of a family; or a youth group.
  - Mass campaigns meetings.
  - Use of mass media including radio, television, magazines, news papers, journals.
  - Use of drama, dance, song, story telling.
- **Know their audience** – this means identifying the target group for example, individuals, family members, women or youth or men's groups, community leaders; and knowing their background such as education level, language and age.
- **Find out about the practice of FGM locally**. This means asking individuals or group the following:
  - what type of FGM is performed locally?
  - what are the reasons for practising FGM?
  - what problems or complications people experience during or after the procedure and how they are handled?
  - who performs FGM?
  - what happens to girls/ women who do not comply with this tradition?
- **Know their material** – have the information and materials well prepared and readily available, and know exactly what it is they mean to convey. This should include accurate information on reproductive health, and on the types of FGM and their health consequences.
- **Make contact with appropriate people** to set up meetings with community and religious leaders; health authorities and other influential people in the community.
- **Create and maintain trusting relationships.** This means:
  - establishing rapport with the target audience;
  - showing respect for people's beliefs and values regarding FGM
  - greeting people in a culturally accepted manner;
  - always introducing themselves and others accompanying them
  - making sure people are comfortable with them and with the setting before opening a dialogue with them
  - addressing people by their names and/or titles according to the accepted norm.
- **Present clear and appropriate information.** This means:
  - assessing the level of knowledge about FGM in the target audience
  - introducing the topic, and the objective of the discussion

- speaking slowly and clearly, using simple but accurate terms. Explain to students that most people prefers the term "circumcision" to "mutilation" when speaking in English, as the idea that they are "mutilated", or that their parents or society are "mutilators" can be offensive. The best way to refer to the procedure is to use the local terminology
- writing clearly, where appropriate, and always using words that are understandable to the audience
- using posters and pictures to illustrate a point as appropriate, since some of the people may be illiterate
- selecting the most important messages to be delivered, as too much information may confuse people
- giving out adequate information for reading e.g. posters, leaflets
- summarising what has been discussed at the end of a meeting
- ensuring people have understood the most important information
- giving ample time for people to ask questions and clarify points
- informing people where they can find more information if they wish
- inviting individuals with personal questions or who need counselling to come and discuss things privately.

Summarise:

In order to change behaviour, anti-FGM activists should:

- use a participatory approach in which the target community and as many interested parties as possible are involved in the design and implementation of the programme
- use a variety of activities which are carefully tailored to the target audience
- ensure that the IEC materials and messages used are soundly based on research
- ensure that positive community attitudes and values are identified and reflected in the programme activities
- identify who are the chief decision-makers in the community regarding FGM
- ensure that people who will be involved in implementing the programme are well trained.

Closing the session:

- Ask students questions to check that they have understood.
- Let students share what they have learnt from the session.
- Write down what they say.
- Close the session.

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

Session objectives

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

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

Suggested teaching methods

- Brain-storming.
- Small group discussion.
- Plenary sessions.
- Buzzing.

Teaching aids

- Teacher's notes.
- Students manual.

Setting the scene

- Ask students who are the political and government leaders in their own communities.
- Allow a few students to respond and write their responses on a flip-chart or chalk board.
- Explain to the students that political and government leaders are the decision - makers in society and they are therefore important players in any FGM-prevention programme.

THE SESSION

Introduce the session and its objectives.

Brainstorming:

- Ask students: what is the role of government and political leaders in prevention of FGM?
- Let students brain-storm on this question.
- Write down all their answers.

Summarise:

Summarise using the important points as in the teacher's notes.

Teacher's Notes:

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

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

In countries where FGM is practised:

- some national governments have made a clear and public commitment to eliminate female genital

mutilation through laws, professional regulations and programmes, and by signing international declarations that condemn the practice
- some have begun developing policies and plans of action for eliminating the practice, including setting targets for elimination and developing national-level and district-level indicators for monitoring and evaluating programmes
- there is a move towards integrating efforts to prevent female genital mutilation into mainstream health and education's programmes, and towards building partnerships with non-governmental groups and communities in order to bring about change
- the launching, in March 1997, of the WHO African Region's "Plan of Action" for speeding up efforts to eliminate female genital mutilation has given a boost to national government commitment.

Buzz:

- Ask students which political and government leaders in their countries could most appropriately be involved in FGM prevention.

Summarise:

Summarise by listing the appropriate leaders (Note: This will differ from one country to another, depending on how the political and civic structures are organised). Appropriate leaders might include:

- parliamentarians, who can be encouraged to advocate for laws and policies on FGM;
- women's leaders, youth leaders, heads of professional associations (e.g. lawyers, physicians, nurses, midwives) who can be encouraged to create pressure groups to lobby government
- influential people at community level such as chiefs, religious leaders, traditional healers, and traditional birth attendants. In most societies, the political structure starts at the village level, in which case the list will include village-level politicians
- the heads of state, such as the President and/or Prime Minister, and the First Lady, whose support for the elimination of FGM is very influential in guiding national opinion.

Small group discussion:

- Divide students into groups of 6 to 8.
- Ask them: how can we involve these leaders in the programme to prevent FGM?
- Allow discussion of the question for 30 minutes.
- Let the small groups prepare to present their thoughts.

Plenary discussion:

- Allow 30 minutes for the small groups to present their thoughts to the whole class.
- Let the whole class discuss this issue among themselves.
- Guide them and record all the small group responses.

Summarise:

Explain to students that, in order to involve political leaders in the prevention of FGM, they should:

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

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

Tips for effective communication

Advise students that, in communicating with the various leaders, they should always:

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

Advocacy

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

The most important strategies in advocacy are:

- **building coalitions** with people, e.g. NGOs or institutions with similar interest
- effective **use of mass media**
- **working with communities**.

Building coalitions.

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

Explain to students that, in order to build coalitions, they should:

- identify other individuals or groups interested in stopping the practice of FGM within their communities
- arrange for a meeting with the leaders to find out about their activities – e.g. how they work, who they work with, and what their objectives are. They should also be prepared to share this information about their own organization
- set up collaborative activities.

International organizations working to eliminate FGM include:

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

Working with mass media.

Articles published in newspapers or stories broadcast on radio and television spread the message far and wide. Thus building partnerships with media organizations is a valuable exercise. The first task of such a partnership is to educate relevant people in the media about FGM.

Inform students that when working with the media, writing skills may be necessary. Their messages

should be clear, concise and convincing, and delivered in such a way that they catch the attention of the reader, listener or viewer. Messages should be tested for their effect before being delivered to a wide audience.

Other forms of mass media, such as drama, song, and poster and leaflet campaigns, can also be used to disseminate information, and can be targeted at specific audiences, e.g. youth, women, if desired. Mass meetings and rallies may also provide useful forums for campaigning.

Working with communities.

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

Steps in the advocacy process:

- *Information gathering and analysis.* Before launching an advocacy programme it is necessary to collect reliable on FGM, including the extent of the practice locally and nationally, who performs it, the rationale for the practice, the age at which excision is performed, and what is known of the health and social consequences. Detailed background information is essential in formulating appropriate messages for the advocacy campaign.
- *Identification of target audiences, and key individuals, for advocacy.* Politicians, government officials, community leaders and parents are key in promoting, supporting or blocking the initiative in their positions as decision-makers or legislators. They should be targeted with appropriate messages.
- *The setting of objectives for each component of the advocacy programme.* This should include identification of the role of each target group in bringing about the desired change.
- *The development of an action plan*, identifying the target audiences, the activities to be carried out, their objectives, and who will be responsible for what.
- *Monitoring and evaluation.* The advocacy program must be monitored using clearly developed indicators and objectives.

Lobbying

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

Advise students that, for successful lobbying, they should:

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

Summarise:

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

- strong and capable anti-FGM programmes at the national, regional and local levels
- a committed government that supports FGM elimination with policies, laws and resources

- making FGM a mainstream issue – integrating FGM prevention into all relevant government and non-government programmes, e.g. health, family planning, education, social services, human rights, religious programmes etc.
- health care providers at all levels who are trained to recognize and manage the complications of FGM and to prevent the practice
- good coordination among governmental and non-governmental agencies
- advocacy that encourages a supportive policy and legal environment for the elimination of FGM, increased support for programmes, and public education
- empowerment of women.

Closing the session:

- Give students time to ask questions about the session.
- Ask them if there is anything that needs clarifying.
- Close the session.

MODULE 3: MANAGEMENT OF GIRLS AND WOMEN WITH FGM COMPLICATIONS

Module three is an intervention module. It is intended to prepare nurses and midwives to identify and to manage the physical, psychosocial, and sexual consequences of female genital mutilation.

Application of the module

The material in this module may be added to existing courses, such as child health, human growth and development, gynaecology, and reproductive health. The module may also be used together with the community module during in-service training of nurses and midwives.

General objectives

At the end of this module students are expected to be able to:

1. Recognise the complications due to FGM.
2. Manage women with FGM complications.
3. Demonstrate skills in opening up a tight introitus and type III FGM.
4. Demonstrate skills in counselling.
5. Refer clients for further management when the complications are beyond their competence.

Background qualifications

Students working on this module should already have the following:

- Basic knowledge of complications due to FGM: physical, psychosocial and sexual
- Basic knowledge and skills in family planing
- Basic knowledge and skills in information education and communication (IEC), health education and counselling

Essential competencies

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

- ability to carry out an interview with a girl or woman with FGM
- ability to perform physical assessment and identify complications resulting from FGM
- ability to conduct a pelvic examination to determine the type of FGM and its physical complications
- ability to adapt family planning methods to ensure effective family planning care to a woman who has undergone FGM
- ability to recognize and provide appropriate information, counselling, support, treatment and/or referral for further management of physical, sexual and psychosocial complications of FGM
- ability to manage the opening up of an infibulated girl or woman, including:
  - recognizing that this is necessary
  - making a referral, as appropriate
  - providing pre-operative care and counselling
  - performing the procedure where appropriate
  - managing post-operative care.

Suggested teaching methods

- Lecture.
- Plenary sessions.
- Small group discussions.
- Demonstrations.
- Simulation exercises.
- Case studies.
- Role play.

Teaching aids

The teaching aids may include:

- Models.
- Pictures.
- Charts.
- Overhead projector and transparencies.
- Media articles.
- Audio tape recorder.

Reference materials

- *A systematic review of the health complications of Female Genital Mutilation including sequelae in childbirth.* WHO/FCH/ WMH/00. 2. WHO, Geneva (2000).
- *Female Genital Mutilation. Report of a WHO Technical Working Group. Geneva, 17 - 19, July 1995.* WHO/FRH/WHD/96. 10.
- *Female Genital Mutilation. An overview.* WHO, Geneva (1998).
- *Management of pregnancy, childbirth and the postpartum period in the presence of Female Genital Mutilation. Report of a WHO Technical Consultation. Geneva, 15 - 17 October 1997* WHO/FCH/WMH/01.02. Geneva.
- *Female Genital Mutilation: The Prevention and the Management of the Health Complications: Policy Guidelines for nurses and midwives.* WHO/FCH/ GWH/01.5. WHO, Geneva (2001)
- *Counselling skills training in adolescent sexuality and reproductive health: A facilitators guide.* WHO/ADH/93. 3 WHO, Adolescent Health Programme. Geneva 1993.
- Toubia, N. (1999). *A practical manual for health care providers caring for women with circumcision.* RAINBO Publication, New York.

Note: You can also make use of any other appropriate material available locally.

The Sessions

Time in hours

Session 1:
Assessment to identify physical complications of FGM 2

Session 2:
Management of clients with physical complications of FGM 4

Session 3:
Using counselling skills 4

Session 4:
Identifying psychosocial and sexual problems 2

Session 5:
Management of psychosocial and sexual problems 3

Session 6:
Demonstrating referral skills 2

Session 7:
Family planning use in the presence of FGM 2

Session 8:
The procedure of opening up type III FGM 3

Practical work: 40

Session 1: Assessment to identify physical complications of FGM

Session objectives

By the end of the session the students are expected to be able to:

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

Suggested teaching methods

- Lecture.
- Role play.
- Plenary sessions.
- Simulation exercise.
- Demonstrations and return demonstrations.
- Large group discussion.

Key references

- Toubia, N. (1999). *A practical manual for health care providers caring for women with circumcision.* RAINBO Publication, New York.
- *A Systematic review of the health complications of female genital mutilation including sequelae in childbirth.* WHO/FCH/ WMH/00.2 Geneva (2000).
- *Female Genital Mutilation. A Handbook for Frontline Workers.* WHO/FCH/WMH/00.5 Rev.1. WHO, Geneva (2000).

Teaching aids

- Student manual.
- Teacher's notes.
- Audio tape recorder.

Setting the scene

- Review knowledge of physical complications of FGM covered in module 1, with everyone participating in the review exercise.

THE SESSION

Introduce the session and its objectives.

Buzzing:

- Ask the students what is meant by assessment?
- Let students buzz in twos or threes.
- Allow students to respond to the question.

Summarise:

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

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

Lecture:

Taking a history

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

They will have to find out by asking direct or indirect questions.

Explain to the students that the procedure is as follows:

- Greet the client in the culturally accepted manner. Ask her to sit comfortably near and facing you. Introduce yourself, and address the client by her name.
- Begin by asking general questions, such as: "How are you? How is the family? Do you have any information you would like to share with me?"
- When the patient is relaxed and seems ready to talk about personal matters, ask her tactfully about any operations she has had, including FGM. Use terminology which is familiar to the client. Ask her if she would like to share any information about the operation and any problems she may have due to FGM, and reassure her that you are comfortable dealing with her condition and that it is not a barrier to her getting services.
- Let the client express her feelings and give you the information she wants to share. If she starts crying, be patient and give support. Listen carefully and empathize with her. Show concern to the client and let her know you can help her.
- Encourage the client to talk by using facilitation skills, such as nodding, saying "ah, ah", and making eye contact when you look at her. Clients may be very slow in sharing information about excision; be patient and do not force her to speak. If the client is not ready to share information yet, make an appointment with her for another visit.
- Once it has been established that the woman has undergone excised, this information and the subsequent clinical examination should be handled with professionalism and discretion.
- The information (the type and the complications) should be recorded as required by the policy of the health institution.

Points to emphasise with students:

- For the purposes of history taking and clinical examination, it is essential that the service provider establish a trusting relationship with clients. This means:
  - Showing *empathy* – i. e. using interpersonal skills to create a rapport with client.
  - Ensuring *privacy.*
  - Maintaining *confidentiality.*
  - Showing *respect.*
  - Having *patience.*

- There are certain issues that the service provider should approach with caution and special sensitivity. They include:
  - the client's relationship with her husband or partner.
  - problems with sex, for example, painful intercourse, difficulty in penetration with the penis, and whether this necessitated cutting to open the vagina.
- Service provider should be prepared for the fact that the client may cry, and she should give support whenever necessary.
- Counselling of both the client and her partner is very important.

Simulation exercise:

- In front of the whole class, the teacher should simulate history taking from a client with FGM.
- For this exercise, select a volunteer from among the students or use a colleague to act as a client, and you, the teacher, should act as the service provider.
- Follow the history taking procedure set out in the lecture.
- After your simulation exercise, provide the opportunity for the students to simulate history taking themselves (return simulation):
  - Ask the students to work in groups, with one of them acting as a client and another as the interviewer while the rest of the group observes

the procedure using a checklist of the points made in the lecture.

– Allow two or three groups to simulate in front of the whole class.
– While students are doing the simulation exercise make sure you use the checklist to ensure they are following the procedure described in your lecture, and draw attention to the important points in history taking.
– Allow students who acted as clients and observers to discuss their observations and feelings about the interviews.
– Summarise by discussing the good and bad experiences.

Lecture:

The clinical examination

Important note

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

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

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

Women have reported that one of the most traumatic experiences they have had was during a pelvic examination by a health provider unfamiliar with the practice, they were found to be excised; and when the health provider called in the rest of the staff to look at her "mutilated" genitals.

The preparation for a clinical examination:

- Preparation of client – i. e. explain the procedure carefully and fully, and get her consent, and/or that of her partner if applicable.
- Preparation of equipment – it is essential to use sterile equipment and materials. i.e:
  – gloves
  – kidney dish with gallipot, sterile swabs and cleansing lotion
  – receptacle for used swabs.

The procedure:

- Explain procedure to client in detail and check that she has understood.
- Ask client's consent to examine her. If there is another member of the health staff present, explain the reason for his/her presence to the client and ask her permission for the person to be present. The client has the right to refuse and this must be respected. The nurse/midwife should emphasize that care is not conditional on the woman's consent to allow others to attend the examination.
- Ensure privacy and confidentiality.
- Instruct the client to take off her underwear and help her to lie down on the examination couch with her legs apart and flexed.
- Expose the necessary area for inspection and examination. Cover the client until you are ready for the examination.
- Wash your hands thoroughly and put on gloves.

- Expose the genitalia. Inspect the external genitalia to identify type of FGM, and to check for ulcers, infection, abscesses, or any abnormal swelling.
- Tactfully ask the client about her experiences of urination, menstruation, and sexual intercourse, if relevant.
- Most of the time there is no need to introduce fingers into the vagina, as most of the complications can be detected by inspection of the external genitalia. But if it is necessary, follow the steps indicated below. These are:
  - Try to introduce the tip of the index finger slowly, then introduce the whole finger very slowly if the introitus allows it. If there is room for more than one finger, introduce the second finger very slowly and observe the client's reaction, as this may cause pain.
  - Respect client's reactions.

- In cases of type III FGM (infibulation), the introitus may be very tight and may not allow the introduction of even the tip of a finger. In such cases, you should not attempt to introduce any fingers.
- After completing the procedure, thank the client for her cooperation.
- In cases where you have introduced fingers, look for abnormal vaginal discharge before taking off gloves.
- Take off gloves and wash your hands.
- Help the client to a sitting position; assist her with dressing, if appropriate, and seat her comfortably for next step of the procedure.
- Record your findings and share these with the client.
- All equipment used should be put to soak in disinfectant for half an hour before sterilization. (See WHO International precautions on prevention of hospital infections).

Practical work:

- Instruct the students to examine between 2 and 5 women with FGM during their clinical practice under supervision.
- Record details of their examination, using the notes above for guidance.

Closing the session:

- Summarise the two main lessons of the session which are history taking and clinical examination of a girl or woman with FGM.
- Review the issues that needed special emphasis.
- Ask students questions relating to important points to check that they have understood.
- Clarify any points which are not clear.
- Close the session.

Session 2: Management of clients with physical complications of FGM

Session objectives

By the end of the session the students are expected to be able to:

1. Manage girls and women with physical complication due to FGM.
2. Demonstrate skills in opening type III FGM.
3. Refer girls and women for further management to the next level of care.

Key references

- *A Systematic review of the health the complications of female genital mutilation including sequelae in childbirth.* WHO/FCH/ WMH/00.2 Geneva (2000).
- *Female Genital Mutilation. A Handbook for Frontline Workers.* WHO/FCH/WMH/00.5 Rev.1. WHO, Geneva (2000).
- *Female Genital Mutilation: The Prevention and the Management of the Health Complications: Policy Guidelines for nurses and midwives.* WHO/FCH/ GWH/01.5. WHO, Geneva (2001)
- Toubia, N. (1999). *A practical manual for health care providers caring for women with circumcision.* RAINBO Publication, New York.

Suggested teaching methods

- Large group discussion.
- Lecture.
- Question and answers.

Teaching aids

- Student manual.
- Teacher's notes.

Setting the scene

- Ask the students to share their experiences in caring for a woman with FGM.
- Allow time for a few responses.

THE SESSION

Introduce the session and its objectives.

- Prepare a detailed lecture using the teacher's notes following.

Teacher's notes:

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

Managing immediate and short term complications

Bleeding

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

Severe pain and injury to tissues

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

Shock

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

Managing long-term physical complications

Keloid formation

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

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

Cysts

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

- Inspect the site to assess the size and type of cyst.
- Small and non-infected cysts may be left alone after counselling client to accept the condition. Alternatively the client may be referred to have them removed under local or regional anaesthesia.
- However, before interfering with a small cyst it is important to find out if the procedure could result in further damage and scarring of existing sensitive tissue. If such a risk exists, the woman should be fully informed and allowed to choose for herself

whether to proceed with removal with full understanding of the risk involved.

- In the case of a large or infected cyst, the client must be referred for excision or marsupialization. The procedure is usually done under general anaesthetic. During the procedure, great care should be taken to avoid further damage to sensitive tissue or injury to the blood or nerve supply of the area.

Clitoral neuroma

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

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

Vulval abscesses

A vulval abscess may develop as a result of deep infection due to faulty healing or an embedded stitch. Instruct students that management is as follows:

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

Urinary tract infection (UTI)

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

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

Chronic pelvic infection

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

- Identify type of FGM and likely cause of problem.
- If the client has type III FGM, counsel her and/or her attendants on the need to open up the infibulation, and seek their informed consent.
- Take vaginal swab for culture and sensitivity.
- Give antibiotics that are appropriate and available locally, for example, tetracycline 500mg 6 hourly for 10 days, or doxycycline 100mg twice daily for 10 days.
- If the infection is fungal, Flagyl may be prescribed.

- If the client has a husband or partner, treat him also for the same infection.
- If symptoms persist, refer client for medical intervention.
- If the cause of the infection is obstruction due to stones or injury, refer client for surgical intervention.

Infertility

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

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

Fistulae and incontinence

Vesico-vaginal 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. Instruct students that management of these conditions is as follows:

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

Vaginal obstruction

Partial or total obstruction of the vagina may occur as a result of infibulation, vaginal stenosis, or the presence of a vaginal haematoma. The condition may be accompanied by haematocolpos (accumulation of trapped menstrual blood). Unmarried girls may be suspected of being pregnant because the amenorrhoea and swelling of the abdomen. There are reported cases where young girls have been punished for this condition. Instruct students that management is as follows:

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

Menstrual disorders

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

- Try to establish the cause of dysmenorrhoea by taking a history and performing a clinical examination of the client's genitalia.
- Counsel the client to find out how she feels and support her in dealing with the situation
- Give antispasmodic drugs to relieve pain.
- If dysmenorrhoea is due to the accumulation of menstrual flow as a result of infibulation, counsel the client on the need for opening up.
- If the condition is severe refer to a gynaecologist for further management.

Ulcers

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

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

Documentation of FGM

- Instruct students to record FGM type and complications.

Closing the session:

- Students should be instructed to document always the type of FGM and its associated complications
- Ask students questions relating to each complication and its management.
- Allow students to ask questions in order to clarify anything they are unsure of.
- Close the session.

Session 3: Using counselling skills

Session objectives

By the end of this session students should:

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

Suggested teaching methods

- Questions and answer.
- Lecture.
- Role play.

Key reference:

- *Counselling skills training in adolescent sexuality and reproductive health: A facilitators guide.* WHO/ADH/93. 3 WHO, Adolescent Health Programme. Geneva 1993.

Teaching aids

- Student manual.
- Audio tape recorder.

Setting the scene

- Ask students to define counselling.
- Allow a few responses and discuss.

THE SESSION

Introduce the session and its objectives

- Ask students individually to think about who they would go to in order to discuss a sensitive issue.
- Without mentioning any names, ask the students to identify the qualities which make them feel able to approach this particular person. These will include:
  - Good listener.
  - Experienced.
  - Genuine, trustworthy.
  - Observant.
  - Empathetic.
  - Broad minded.
  - Sympathetic.
  - Mature.
  - Respectful.
  - Quick witted.
  - Caring.
  - Calm.
  - Willing to help.
  - Understands the need for confidentiality.
  - Sense of humour.
  - Attentive.
  - Makes people feel special.

Note: Some qualities will be important to some students but not to others. Respect all responses.

Summarise:

These are good qualities, which are helpful in counselling. No one person has all the qualities, but it is good to be aware of them and to work towards developing them.

Counselling is an interaction between the client and the health care provider which is aimed at enabling the client to explore, understand, and make

her own decisions about how to deal with a problem.

In counselling a woman with FGM, the counsellor must create an environment which enables the client to speak openly by reassuring her about confidentiality, showing respect and answering her questions patiently and fully. The client must be given clear, accurate and specific information which will enable her to think about her situation and understand her own needs. The information provided must be tailored to the individual client's needs, and throughout the session she must be treated as an individual. The role of the counsellor is to help the client think through her situation and not to give her instructions or to pressurise her in any way to make certain choices.

Teacher's notes:

During the counselling session the aim is to build a trusting relationship with the client, so that she feels safe in discussing her concerns with the counsellor. Important factors for achieving this are:

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

Preparation for counselling session

In preparing for a counselling session, instruct students that they should:

- Find a suitable setting – this should be a room where you will not be disturbed by other people, which can be locked if necessary, and where privacy and confidentiality can be assured.
- Prepare the place – there should be comfortable seating.

- Confirm the appointment with your client, and make sure that you both have allowed adequate time for the discussion.

The counselling session

Explain to students that the procedure for a counselling session is as follows:

- Welcome the client (and her partner/husband if appropriate) and invite her to sit down.
- Greet her and introduce yourself in the culturally appropriate manner.
- Ask client her name and ask if you can help her with anything.
- Let the client talk and encourage her by nodding or saying "ah" from time to time.
- Give client information about the services available in your clinic, ward or centre and the staff who will care for her.
- Let client explain her concerns; be patient as she may find it hard to express her experiences and feelings.
- Listen carefully and observe non-verbal cues (e. g. body language; tone of voice) to enhance your understanding of the client's situation.
- Paraphrase the client's information from time to time to check that you have heard her correctly and avoid misunderstanding.
- Show concern throughout the session by being attentive and making eye contact from time to time.
- Empathize with client when she is describing a disturbing experience, which may make her weep.
- Explain to client how you can help
- If the purpose of counselling is to raise with the client the need for opening up her infibulated vulva after type III FGM, give her detailed information about the procedure, and advise her on how her genitalia will be changed by the operation. Give her information about her after care (see procedure for opening up type III FGM on page 104 to 108).
- If counselling is for psychosocial or sexual problems, ask questions as appropriate to draw out as much information from the client as possible about her problems. Advise her that there are various ways of conducting sexual relationships; teach her appropriate techniques by which both she and her partner may be aroused. If she expresses a wish for her partner to be involved in the discussion, draw him into the counselling session also. It is known that it is not in all cases that FGM lead to inability of a woman to achieve orgasm or enjoy sex women. It depends on the extent of the damage to the organs particularly the clitoris. Sexual problems may be due to fear of pain, rather than to any physical malfunction. However, if sexual intercourse is not possible as a result of infibulation or extensive scarring the issue of opening up the tight introitus should be addressed during counselling.
- Assist the client, and her partner where appropriate, to make an informed decision on the steps to be taken to solve the problem.
- Assist them to act on their decision by giving advice on how to proceed.
- Give client an appointment for another counselling or follow-up session to prepare for next step.
- If the proplem persists refer to a specialist.

Please note:

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

Role Play:

- Divide students into seven groups and provide each group with one of the following situations, which they should explore using role-play. In each group, one person should role-play the client and one the counsellor, while the others observe:
  1. A client with a vesico-vaginal fistula (VVF).
  2. A client with vulval keloids.
  3. A client with haematocolpos (obstructed menstrual flow).
  4. A client seeking counselling for infertility.
  5. A client who is experiencing dyspareunia (difficulty with sexual intercourse).
  6. A client who is having problems passing urine.
  7. A client who is very depressed.

Summarise:

After the role-play:

- Ask: how did the client feel?
- Ask: how did the counsellor feel?
- Discuss the qualities and skills which were demonstrated by the counsellor.
- Get feedback from all the groups.
- Acknowledge that it can be difficult to provide counselling, but assure students that, as counsellors, their anxiety will reduce with experience.
- Repeat for emphasis that the basis for managing psychosocial and sexual problems is counselling. Counselling of a girl or woman should be strictly confidential. If the client has a partner, he should be counselled separately if necessary, until the right moment arrives for them to be counselled as a couple. The aim of counselling is to help a client, a couple, or a family come to terms with, or solve a problem they have.

Closing the session:

- Allow students to ask questions for clarification of any issues.
- Close the session.

Session 4: Identifying psychosocial and sexual complications of FGM

Session objectives

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

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

Key references

- *Female Genital Mutilation. Report of a Technical Working Group. Geneva, 17 - 19, July 1995.* WHO/FCH/WHD/96. 10.
- *A systematic review of the health complications of Female Genital Mutilation including sequelae in childbirth.* WHO/FCH/ WHD/00. 2 Geneva (2000).
- *Female Genital Mutilation: A Handbook for Frontline Workers.* WHO/FCH/WMH/00.5 Rev.1. WHO, Geneva (2000).

Suggested teaching methods

- Lecture.
- Small group discussion.
- Plenary session.
- Simulation exercises.
- Case study analysis.

Teaching aids

- Writing board.
- Case studies with psychosocial and sexual situations.
- Stories.
- Charts.

Setting the scene

- Ask students to share personal experiences of adverse mental and social situations.
- Ask students to recall an incident where a client had come to them with a sexually related problem; and ask them how they felt.
- Allow a few responses.
- Remind students that it is not easy for a client to come forward with a sexual problem, as this is a very sensitive subject. Furthermore, in most communities that practise FGM, it is taboo to talk about sex. Dealing with sexual problems therefore requires special skills.

THE SESSION

Introduce the session and its objectives

- Ask students what is meant by psychosocial?
- Let students brainstorm and then allow a few responses.

Teacher's notes

"**Psychosocial**"refers to the psychological and social aspects of human experience – i. e. how a person feels about her or his relationships with others in society.

Psychosocial and sexual problems are identified by interviewing clients using interpersonal communication, observation and listening skills. Because of the sensitivity of the subject, a woman will rarely speak directly about a psychosocial problem, but will tend to present with some physical complaint. It is essential for the nurse/midwife to pick up non-verbal cues of psychosocial problems, by observing body language and listening carefully to the tone of voice,

which may give more meaning to what the client is saying and feeling. Sometimes a client may just cry, which tells a lot about how distressed she is. She should be given comfort and a shoulder to cry on.

Buzzing:

- Ask students:
  - what are the sexual problems a woman with FGM may experience?
  - how can psychosocial and sexual complications of FGM be identified?
- Let the students buzz in twos and threes.
- Allow them to share their thoughts.
- Write down their responses.

Summarise:

Summarise using information from teacher's notes, as follows.

Teacher's notes

Genital mutilation is commonly performed when girls are young and uninformed and is often preceded by acts of deception, intimidation, coercion, and violence by parents, relatives and friends that the girl has trusted. Girls are generally conscious when the painful operation is undertaken as no anaesthetic or other medication is used. In a lot of instances they have to be physically restrained because they struggle. In some instances they are forced to watch the mutilation of other girls. The experience of genital mutilation is associated with a range of mental and psychosomatic disorders. For example:

- Girls frequently report disturbances in their eating and sleeping habits, and in mood and cognition. Symptoms include sleeplessness, nightmares, loss of appetite, weight loss or excessive weight gain, as well as panic attacks, instability of mood, difficulties in concentration and learning, and other symptoms of post-traumatic stress. As they grow older, women may develop feelings of incompleteness, loss of self-esteem, depression, chronic anxiety, phobias, panic or even psychotic disorders.
- Girls may suffer feelings of betrayal, bitterness and anger at being subjected to such an ordeal. This may cause a crisis of confidence and trust in family and friends that may have long term implications. It may affect the relationship between the girl and her parents, and may also affect her ability to form intimate relationships in the future, even perhaps with her own children.
- Girls and women sometimes express feelings of humiliation, inhibition and fear that have become part of their lives as a result of enduring genital mutilation.

Sexual problems of FGM:

- Painful intercourse (dysparaenia), due to tight introitus as a result of infibulation vaginal stenosis, stimulation of the clitoral nerve or clitoral neuroma.
- Difficulty or impossibility of penetration by husband/partner due to narrowing of the vaginal orifice as a result of infibulation or scarring.
- Various forms and degrees of sexual dysfunction due to injury or removal of the clitoris, which is a key organ in female sexuality (The clitoris and labia minora are supplied with a large number of sensory nerves, which are connected to the brain and plays an important role in female sexual arousal).
- Inability to reach orgasm.

Identifying psychosocial and sexual problems

Instruct students that the procedure for identifying psychosocial and sexual problems is as follows:

- Take client into a room where privacy and confidentiality are assured and ask her if she has time to talk to you.
- If she has time, ensure she is comfortable and seated near to you. Counselling should never be

hurried: if either of you are pressed for time it could be better to make an appointment for another, mutually convenient, time.

- Make it clear by your body language, the way you are sitting, that you are ready to listen to her concerns, and that she should feel free to share anything she wishes with you. Encourage her to talk by using facilitation skills such as eye contact, nodding your head, saying "ah, ah", and listening attentively while also observing non-verbal cues.
- When the client has opened up to you, ask her about her eating and sleeping patterns. Ask about menstrual patterns and sexual relationships in a very tactful manner, because these questions may embarrass the client and result in communication breakdown.
- Use "open-ended" questions by asking questions that require more than a simple 'yes' or 'no' answer, and thus offer the client the chance to explain things in some detail.
- Use observation skills continuously to pick up non-verbal cues, and tell the client what you have observed to give her the chance to tell you more about the situation.
- Listen carefully and empathetically (showing concern).
- Use all your senses to try to understand the client's world. It may not be easy the first time you meet her, but arrange for subsequent visits to explore more.
- Support the client throughout the interview to give her psychological strength.
- Assess the client's intellectual status - that is her ability to understand information and comprehend a situation.

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

- Remember that, throughout the counselling session, the emphasis should be on:
  - Privacy and confidentiality.
  - Patience.
  - Creating a trusting relationship.
  - Remaining non-judgmental.
  - Understanding of non-verbal cues.
  - Using facilitation skills.

- Record your findings and share these with clients wherever appropriate.

Closing the session:

- Allow students to ask questions and clarify anything they have not properly understood.
- Emphasise to students that girls and women are seriously traumatised by genital mutilation, and that they generally have no acceptable means of expressing their fears and pain and thus suffer in silence. Therefore, support is extremely important.

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

Session objectives

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

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

Key references

- *A systematic review of the health complications of Female Genital Mutilation including sequelae in childbirth.* WHO/FCH/ WMH/00.2. Geneva (2000).
- *A practical manual for health care providers caring for women with circumcision,* by Toubia, N. A RAINBO Publication. New York, 1999.

Suggested teaching methods

- Lecture.
- Story telling.
- Group discussion.

Teaching aids

- Teacher's notes.

Setting the scene

- Ask students to share their experiences of caring for clients with psychosocial and/or sexual problems due to FGM.
- Allow for a few responses.

THE SESSION

Introduce the session and its objectives.

Briefly review the psychosocial and sexual problems associated with FGM as described in session 4, and using the teacher's notes.

Teacher's notes:

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

Key elements in managing psychosocial and sexual complications

The key elements in managing psychosocial and sexual complications are:

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

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

Managing psychosocial problems

- Psychosocial problems include: **chronic anxiety, feelings of fear humiliation, betrayal, stress, loss of self-esteem, depression, phobias, and panic attacks.** These may manifest as psychosomatic symptoms such as **nightmares, sleeping and eating disorders, disturbances of mood and cognition, loss of appetite, excessive weight loss or gain, and negative body image.** Instruct students that the procedure for managing psychosocial problems is as follows:
  - Assess client to identify the exact problem (take a detailed history) .
  - Counsel client, and partner where appropriate
  - If the client has type III FGM, counsel her on the need for opening up.
  - If she has other types of FGM, counsel her until she is relieved of her symptoms.
  - If symptoms are severe, refer client for further management.

Managing sexual problems

Painful intercourse (dyspareunia).

Instruct students that the procedure for managing this condition is as follows:

- Interview client to identify real problem.
- Assess client to identify the type of FGM.
- If opening up the introitus is indicated, counsel the client and her husband/partner about the need for this and obtain their informed consent. Follow the procedure for opening up and repair (see session 8).
- Give antibiotics and analgesics.
- Where opening up is not indicated, encourage foreplay to stimulate maximum arousal, and the use of lubricating jelly.
- Follow-up client to monitor progress.
- Counsel the client and her husband about the importance of discussing sexual matters.
- Invite them to come back whenever they have problems.
- Advise the couple of the changes to expect as a result of opening up operation – for example, changes in the urine flow and with sexual intercourse.
- If the sexual problem is severe and recurring refer to a specialist.

Other sexual problems

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

- Assess the type of FGM.
- Interview the client to find out what the problem is.
- Counsel the client and her husband/partner together.
- Obtain informed consent for opening up of introitus.
- Follow the opening up procedure (see session 8).

Documentation of FGM

- Instruct students to always document FGM type and complications presented

Story telling:

- Tell the students a story in which a woman's husband has to cut open her perineum in order to penetrate her.
- Ask the students who they think has the right to decide on opening her up?
- Ask them to give the reasons for their answers.
- Remind the students that this is an issue of human rights. The human rights involved in this incident are to be free from torture and the right to self determination.

Summarise:

Remind students that counselling is the basis for managing psychosocial and sexual problems, and that it should be given to both the client and her husband/partner.

Closing the session:

- Ask students questions about the management of clients with psychosocial and sexual problems associated with FGM to ensure they have understood the session.
- Clarify any points which have not been understood.
- Close the session.

Session 6: Demonstrating referral skills

Session objectives

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

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

Suggested teaching methods

- Lecture.
- Demonstration and return demonstration.
- Clinical practice.

Teaching aids

- Teacher's notes.
- Student manual.
- Locally used referral forms.

Setting the scene

- Ask students to recall their own experience of referring clients for further management.
- Ask them what procedure they followed.
- Let a few respond.

THE SESSION

Introduce the session and its objectives.

Lecture:

- Inform students that referral is not a simple matter, it is a skill. If clients are not well informed about where to go and why referral is necessary, the process may fail and the patient remain untreated. Besides, FGM is a sensitive issue, and a woman who has made initial contact with a health provider and has established a trusting relationship may find referral daunting.
- Ask students to identify FGM complications which a midwife will need to refer for further management. These must include:
  - Severe bleeding requiring blood transfusion.
  - Calculus.
  - VVF or RVF.
  - Dermoid cyst.
  - Clitoral neuroma.
  - Infertility.
  - Depression.
  - Obstructed labour.
- Explain to students that referral may be needed because:
  - the management of the complication is beyond the competence of the nurse/midwife
  - the health facility does not have the equipment or skills necessary for diagnosis or treatment.
- Inform students that a health facility qualifies as a referral unit if it has:
  - the necessary diagnostic and treatment facilities
  - the required expertise
  - a well equipped theatre
- It is important for the nurse or midwife to:
  - identify limitations of the health facility
  - know what services are available and which ones are appropriate for the different conditions.

  - perform a proper assessment of the client
  - provide necessary information and convince the client that referral is necessary
  - carefully document the findings from assessment, clinical findings, any measures taken before the referral.

- The referral note must include the following information:
  - client's demographic data including age, marital status and any other relevant information.
  - summary of health history
  - clinical findings
  - care given thus far
  - reason for referral.

Procedure for referral of clients

Inform students that the referral procedure is as follows:

- Usually you will have identified the need for referral while taking a history or performing a physical examination.
- Inform the client sensitively that she has a problem which needs further management.
- Give her the facts and reasons for referral.
- Check that she has understood what you have said. Involve others, such as her husband/partner, who will accompany her to the referral facility.
- Give them detailed information about what to expect and what to do at the referral point.
- Write and give the referral letter to the client or her attendants and give them detailed instructions about who to hand it on to at the referral point.
- Ask client to return for follow-up and monitoring of progress after she has received specialist treatment at the higher level facility.
- Ask client to repeat the important information she has been giving to check that she has understood.
- Wish her good luck and tell her you will see her when she comes back from the referral point.

Demonstration:

- Demonstrate the referral of a client for further management.
- Ask one student to act as the client, while you, the teacher, act as a nurse/midwife.
- After you have demonstrated the procedure, ask the students to demonstrate referrals (return demonstration).
- Ask them to do the exercise in pairs, taking turns to act the client or the nurse/midwife.
- Provide the students with scenarios to use for practice (e. g. VVF, severe depression, infertility etc).
- While they are doing the exercise, the teacher should pass around the class observing the demonstrations and guiding the students as necessary.

Summarise:

- Allow students to share their experiences of simulating referral skills and ask questions to clarify matters.
- Summarise the important points in the skill.

Closing the session:

- Ask students questions to check their understanding.
- Close the session.

Clinical practice:

- Place students in clinical settings to practise all skills.
- Supervise students while they are practising skills.
- Record skills gained by each student using a guideline.
- Compare skills at the beginning and at the end of the course.

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

Session objectives

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

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

Key references

- *A systematic review of the health complications of Female Genital Mutilation including sequelae in childbirth.* WHO/FCH/ WMH/00.2. Geneva (2000).
- *A practical manual for health care providers caring for women with circumcision,* by Toubia, N. A RAINBO Publication. New York, 1999.
- Robert A. et.al (1997). *The essentials of contraceptive technology: A Handbook for clinic staff.* Johns Hopkins Population Information Programme, Centre for Communication Programmes. The John Hopkins School of Public Health 111 Market Place, Baltimore MD 21202, USA.

Suggested teaching methods

- Lecture.
- Small group discussion.
- Large group discussion.
- Questions and answer.

Teaching aids

Teacher's notes.

Setting the scene

- Ask students if they have ever managed women with FGM in their family planning clinics, and if so, what problems they have encountered.
- Allow a few responses.

THE SESSION

Introduce the session and its objectives.

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

Lecture:

- Review family planning methods with students, especially those which need to be inserted vaginally, e. g:
  - Intrauterine device (IUCD).

– Female condom.
– Vaginal tablets, foams.
– Diaphragm.
– Vaginal rings.
– Vaginal sponge.

Small group discussion:

- Divide students into groups of 6-8 people.
- Ask students what problems a woman with FGM might have in finding a suitable family planning method.
- Allow students to discuss the question for 30 minutes.
- Ask groups, one by one, to share their thoughts with the whole class.
- Allow 40 minutes for this exercise.

Summarise:

- Inform students that the following problems may be encountered by women with FGM seeking family planning:
  – women with FGM may hesitate to seek advice about family planning because of embarrassment about the appearance of their vulva.
  – it may be difficult for the family planning adviser to perform a vaginal examination
  – it may be difficult to use a family planning method that has to be inserted vaginally
  – a client with FGM may be denied choice a wide range of family planning methods.

Teacher's notes:

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

Table 2: Family Planning Method and Type of FGM

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

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

Session objectives

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

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

Key reference

See page 17 teaching and learning resources.

Suggested teaching methods

- Simulation.
- Clinical observation.
- Clinical practice.
- Question and answers.

Teaching aids

- Models (if necessary, make your own with locally available material).

Setting the scene

- Ask students if they have seen a client with type III FGM.
- Ask them what problem the client presented with.

THE SESSION

Introduce the session and its objectives

- Review knowledge about type III FGM.
- Ask students if they have observed or undertaken an opening up procedure.
- Let students share their experiences.

Lecture:

Inform students that opening up an infibulation should only be done after the client has been thoroughly counselled. If the woman is married it is important to counsel the husband in separate sessions. Husbands need psychosexual counselling to assist them in dealing with the changes in sexual intercourse. The couple can be counselled together when it is necessary or appropriate to have them both in the same session.

Indication for the opening up procedure

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

- Urinary retention (common in children).
- Recurrent urinary tract infection and or kidney infections.
- Severe genital tract infection.
- Haematocolpos (especially in adolescents).
- Severe menstrual problems.
- Difficulty in penetration during sexual intercourse.
- Incomplete abortion.
- Termination of pregnancy.
- Childbirth.

- Gynaecological problems of the genital tract.
- Gynaecological diseases in elderly requiring manual or speculum examination or treatment vaginally.
- For the use of certain contraceptive methods for family planning.
- For certain religious/purification purposes.
- For cosmetic reasons.

Preparation of the client

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

- Educate her about the female external genitalia and make her aware of the difference between normal and infibulated genitalia.
- Provide information about complications associated with infibulated genitalia.
- Inform her of the legal status of FGM in their country.
- Give full and clear information about the procedure and make sure she has understood. Also inform her that the sides will be sutured separately, and not re-sutured together to create a small opening.
- Discuss carefully with the client and her partner and significant others the degree of opening required. Help them to reach an informed decision about this.
- Inform her of the physical changes that will result from the procedure. This information must be given to her partner also, if she is married, because the procedure will result in changes in:
  - urination
  - menstrual flow
  - sexual intercourse.
- If the family refuses to give consent for an adolescent or the woman to be opened up (because of fear of rejection by family and community members), the provision of a medical certificate may help to alleviate these concerns.
- Counsel the client on the procedure. Several sessions may be needed to prepare her psychologically for the procedure. Her partner and/or guardians should also be counselled where appropriate.
- Make it clear to the woman (and others as appropriate) why it is advisable that she has the procedure. Sometimes a woman may be in two minds about being opened up. For example, she may want it on one level, but be fearful of the consequences on another level. Counselling should aim to help her reach an informed decision about which she is confident.
- Reassure the client about privacy and confidentiality.
- If the client is an immigrant who speaks a different language from the health staff, make sure the interpreter is appropriate and is acceptable to her.
- Discuss pain relief options.
- Make sure you complete the required records and documentation accurately.

Preparation of equipment and materials

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

The procedure

- Make the client comfortable in bed or on a couch.
- Remember to use all the interpersonal skills (facilitation skills).
- Go over again what you have already discussed with her about the opening up. Emphasize that the main reason for the problems she has suffered is the infibulation and that opening the infibulation

will relieve these problems.

- Ensure total privacy and confidentiality.
- Wash hands, put on gloves, expose the genitalia and clean the perineal area with antiseptic swabs.
- Introduce index finger or forceps or dilator slowly and gently into the opening to lift the scar skin (see figures 4. 1 & 4. 2).

Figure 4. 1: Introducing finger(s) under the scar.

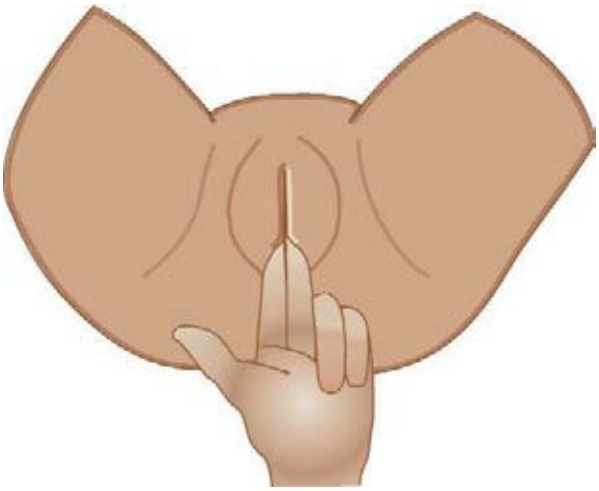
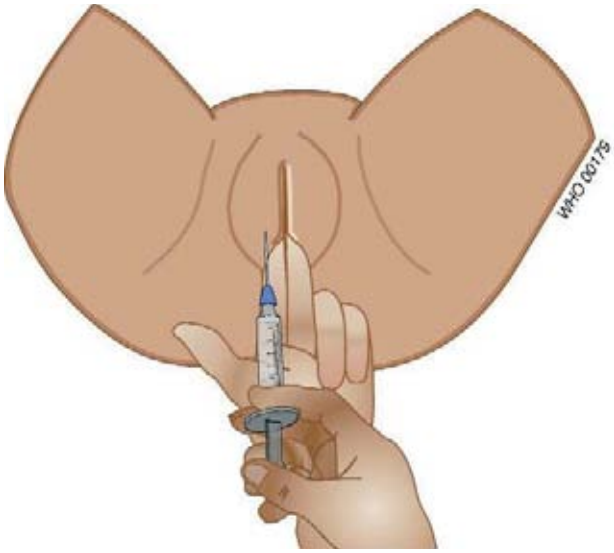


Figure 4. 2: Introducing a dilator under the scar.

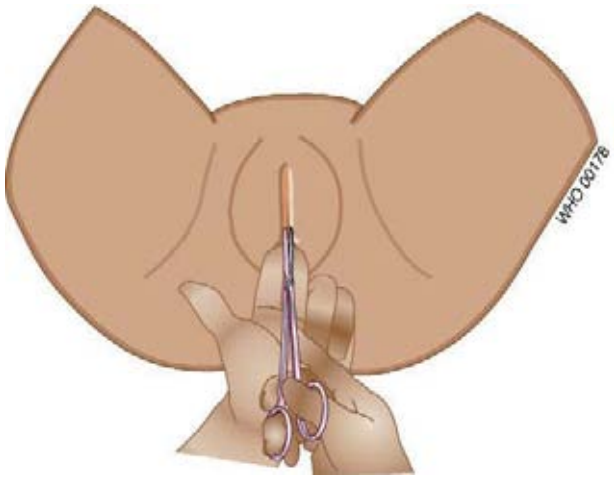
- Infiltrate 2–3 mls of local anaesthetic into the area where the cut will be made, along the scar and in both sides of the scar (see figure 4. 3).

Figure 4. 3: Infiltrating the scar area with local anaesthetic.



- With your finger or dilator inside the scar, introduce the scissors and cut the scar alongside the finger or fingers to avoid injury to the adjacent tissues (or to the baby, if the procedure is done during labour).
- The cut should be made along the mid-line of the scar towards the pubis.

Figure 4.4: Cutting open the scar.



- Take care that you do not cause injury to the structures underneath the scar (urethra, labia minora and clitoris). It is common with type III FGM to find the structures below the scar intact, e.g. clitoris and labia minora.

- Incise the mid-line to expose the urethral opening. Do not incise beyond the urethra. Extending the incision forward may cause haemorrhage, which is difficult to control. A cut of about 5-7cm towards the urethra is usually appropriate. Generally speaking there is little bleeding for the relatively avascular scar tissue.

Figure 4. 5: An opened infibulation.

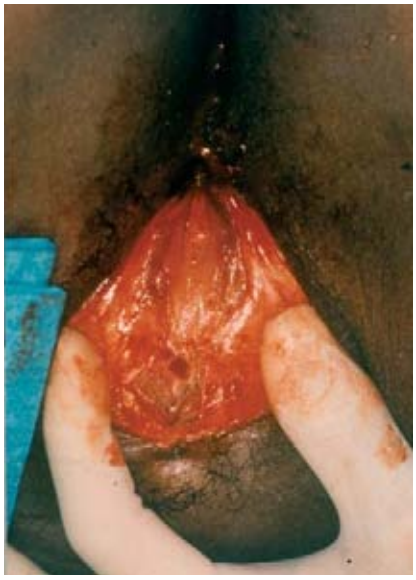
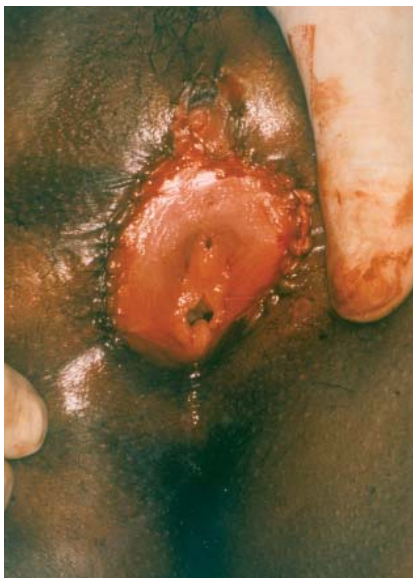


Figure 4. 6: Sutured sides of the opened scar.



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

Post operative care

- It is important to follow up clients who have undergone a de-infibulation procedure.
- Many women report increased sensitivity in the vulval area which was covered by the scar skin for 2 to 4 weeks following the procedure. They may also report discomfort about having wet genitals, and a feeling that air is entering the vulva.
- Prepare the woman for these experiences by explaining to her that there will be changes in appearance, and that she is likely to have increased sensitivity for a while. Reassure her that the sensitivity will disappear after a while and that she will get used to the feeling of wet genitals.
- Suggest that she takes sitz baths (warm water containing salt) three times a day followed by gentle drying of the area. Application of a soothing cream can be prescribed for the first 1-2 weeks.
- Advise her and her husband when to resume sexual intercourse. Typically this will be after 4 to 6 weeks to allow adequate time for the wound to heal. This may require counselling over several sessions. Advice and counselling regarding sexual matters require great sensitivity, and should be carefully tailored according to the needs of the client and her family and to what is culturally appropriate.
- Advise on the importance of personal hygiene.
- Make a follow-up appointment to monitor healing progress and to deal with any other issue that may have arisen concerning the genitals or sexual relationship.
- Home visiting is ideal because the client and her

family need further support and counselling in order to cope successfully with the many changes following the opening up of type III FGM. Male partners in particular need psychosexual counselling to help them understand and accept the changes in sexual intercourse and to ensure they do not try to persuade the woman to be re-infibulated.

- In cases where the client is referred to community services for follow-up, the nurse/midwife who performed the procedure must provide clear information to the health care provider who will be responsible for follow-up to ensure there is no lapse in support.

Simulation:

- Demonstrate the opening up procedure on a model*, using the lecture notes above for reference.
- Allow return demonstration from two or three students.

Summarise:

- Comment on the return demonstrations and clarify information and skills as necessary.
- Emphasise important points.

Clinical observation and practice:

- Make arrangements for clinical observation for the students.
- Make arrangements for supervised, clinical practice for each student.
- Assess each student for competence in the procedure, using the checklist in the appendix.

Closing the session:

- Ask students questions to ensure they have understood the lesson and clarify points as necessary.
- Close the session.

* 1 The Inter-African Committee on Harmful Practices has a model which demonstrates the different types of FGM
2 Pelvic models used for teaching and nursing/midwifery may be modified accordingly

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

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

Application of the module

The material in this module may be added to existing courses, such as midwifery or obstetrics. The module may also be used as a complete course in itself during in-service training of midwives and obstetricians.

General objectives

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

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

Background qualifications

Students working on this module should already have the following:

- basic midwifery skills (antenatal care, labour, delivery and postnatal care).
- basic life-saving skills.
- the essential competencies acquired from modules 1, 2, and 3.

Essential competencies

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

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

Suggested teaching activities

- Large group discussion.
- Small group discussion.
- Demonstrations.
- Simulation exercises.

Teaching aids

- Slides, charts, posters and pictures.
- Trays, scissors, swabs, catgut, dummies, and antiseptics.
- Clients with FGM.

Reference materials

- *A systematic review of the health complications of Female Genital Mutilation including sequelae in childbirth.* WHO/FCH/ WMH/00.2.Geneva (2000)
- *Female Genital Mutilation. A Handbook for Frontline Workers.* WHO/FCH/WMH/00.5 Rev.1. WHO, Geneva (2000).

- *Female Genital Mutilation: The Prevention and the Management of the Health Complications: Policy Guidelines for nurses and midwives.* WHO/FCH/GWH/01.5. WHO, Geneva (2001)
- *Management of pregnancy, childbirth and the postpartum period in the presence of Female Genital Mutilation. Report of a WHO Technical Consultation. Geneva, 15 - 17 October 1997.* WHO/FCH/WMH/00.7 Geneva.
- *Female Genital Mutilation. A joint WHO/UNICEF/UNFPA statement.* WHO. Geneva (1997).
- *A practical manual for health care providers caring for women with circumcision,* by Toubia, N. A RAINBO Publication. New York, 1999.

The Sessions

Time in hours

Session 1:
Assessment and management of woman with complications due to FGM during pregnancy ...3

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

Session 3:
Assessment and management of women with FGM complications during labour and delivery.....4

Session 4:
Management of women with FGM during the postpartum period..... 3

Session 1: Assessment and management of woman with complication due to FGM during pregnancy

Session objectives

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

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

Key references

- *A systematic review of the health complications of Female Genital Mutilation including sequelae in childbirth.* WHO/FCH/ WMH/00.2.Geneva (2000)
- *Management of pregnancy, childbirth and the postpartum period in the presence of Female Genital Mutilation. Report of a WHO Technical Consultation. Geneva, 15 - 17 October 1997.* WHO/FCH/WMH/00.7 Geneva (2000).
- *Female Genital Mutilation: The Prevention and the Management of the Health Complications: Policy Guidelines for nurses and midwives.* WHO/FCH/ GWH/01.5. WHO, Geneva (2001)

Suggested teaching methods

- Small group discussion.
- Plenary discussion.
- Lecture.
- Question and answer.

Teaching aids

- Teacher's notes.
- Student manual.

Setting the scene

- Ask students to share their experience regarding the care of women with FGM during pregnancy.

THE SESSION

Introduce the session and its objectives

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

Assessing problems associated with FGM

Remind students that in communities where FGM is a tradition, women coming to clinic may present with many types of FGM. FGM-associated complications during pregnancy can be identified through history taking and during pelvic examinations.

- Women with FGM often suffer great anxiety at

visiting a clinic when they are pregnant because of their genital mutilation. They may be fearful of being seen by a health care worker who is unfamiliar with FGM and who may advise unnecessary interventions, like Caesarean section. Women with FGM should be made to feel welcome and respected in these clinics. You should reassure them that you are comfortable with their condition and that they will get the services they need without being subjected to unnecessary interventions.

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

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

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

- Women with FGM require sensitive antenatal care. Type I, II and IV FGM can produce severe vulval and vaginal scarring which may cause obstruction during assessment and delivery. Infection and inflammation at the time FGM was performed may result in vulval adhesions which narrow or completely occlude the vaginal orifice. Insertion of herbs or other substances may also cause severe scarring and stenosis.
- Where type I, II, and IV FGM did not result in any particular complications, the woman will require no special management or treatment during pregnancy. Reassure the woman that she is not at risk because of her condition and invite her to ask any questions about her excision or any other issues relating to her pregnancy. Find time to counsel her about sexual relationship and to give her support. Provide more information by giving leaflets on FGM. During follow-up visits, ask the woman if she needs any special help. Do not ask about her excision unless she wants to discuss it.
- Pregnancy provides a good opportunity to give women education and information on:
  - basic health
  - normal and excised genitals
  - childbirth and postnatal care.
- Be aware that many women approach pregnancy and delivery with great fear of the outcome of pregnancy and delivery including fear of death. Special support and counselling is therefore required during this periods.

Women with vaginal infections

- Where infections are serious, send a vaginal swab for diagnosis, if laboratory facilities are available.
- Give antibiotics according to policy.
- Contact partner and give same treatment.
- Counsel woman and partner about the problem, and monitor the situation closely.

Women with abscess

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

Women with cysts and keloids

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

Management of women with type III FGM during pregnancy

- Perform assessment to confirm type III FGM. Remember that there is great need for sensitivity during history taking and pelvic examination. It is not necessary to perform a vaginal examination to confirm infibulation, as this condition can be identified by visual inspection.
- In some communities type III FGM may not be the prevalent form of FGM and only a minority of women may be affected. Where type III FGM is common, the vulval area should be inspected at first antenatal visit as a matter of routine.
- Women with tight introitus (i.e. opening of 1 cm.or less) are at special risk of major perineal damage during labour. As a general rule, if the urinary meatus is visible, (i.e. if there is no barrier from the urinary meatus downwards), or if two fingers can be introduced into the vagina without discomfort, the mutilation is unlikely to cause major physical problems at delivery. If the woman has been pregnant before, her previous experiences during delivery will help to indicate whether she is likely to have problems this time.
- Because of the need to seek sensitive information, it is important to create a rapport with the client and to gain her confidence and trust. You should obtain her consent before conducting a genital examination.
- Making a record of the appearance of the vulva may help to avoid unnecessary examinations in future.
- Give client factual information about the effects of type III FGM on pregnancy and delivery. Give her information on the anatomy and physiology of the female reproductive system.
- Counsel the client and her husband (and/or other family members where appropriate) on the importance of opening up her infibulation before delivery. Discuss with them the importance of not re-suturing after delivery. Give the client and her husband detailed information about the changes that will occur in such functions as urination and sexual intercourse.

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

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

after the opening up surgery the woman may blame the surgery for her abortion and word may spread in the community that the opening up procedure is a dangerous one.

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

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

Summarise:

- Summarise using the checklist of complications described at the beginning of the session.
- Summarise main points in management of complications.
- Highlight the importance of documenting the FGM type and the complications presented.

Closing the session:

- Allow students to ask questions, and clarify points as necessary.
- Close the session.

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

Session objectives

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

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

Key references

- *A systematic review of the health complications of Female Genital Mutilation including sequelae in childbirth.* WHO/FCH/ WMH/00.2.Geneva (2000)
- *Management of pregnancy, childbirth and the postpartum period in the presence of Female Genital Mutilation. Report of a WHO Technical Consultation. Geneva, 15 - 17 October 1997.* WHO/FCH/WMH/00.7 WHO, Geneva (2000).
- *Female Genital Mutilation: The Prevention and the Management of the Health Complications: Policy Guidelines for nurses and midwives.* WHO/FCH/ GWH/01.5. WHO, Geneva (2001)
- *A practical manual for health care providers caring for women with circumcision,* by Toubia, N. A RAINBO Publication. New York, 1999.

Suggested teaching methods

- Question and answer.
- Small group discussion.
- Large group discussion.
- Case study.

Teaching aids

- Case study.

Setting the scene

- Ask students if any of them have seen a woman with FGM in labour.
- Ask those that have to share their experiences.

THE SESSION

Introduce the session and its objectives

- Ask students what complications may arise during labour for a women with FGM.
- Allow students to respond.

Small group discussion:

- Divide students into small groups.
- Give them the following case study to discuss.

Case Study

Mrs. Piego is a 20-year-old primigravid who comes to the labour ward with a family member complaining of contractions for the last five hours. From her antenatal records you note that she is full-term and also that she has undergone type III FGM. It is your responsibility to admit her and conduct a complete assessment of her condition and to monitor her labour. You need to develop a care plan for Mrs. Piego that takes account of the importance of reducing the risk of complications during labour and delivery associated with type III FGM.

- Ask students to analyze the case study and determine what complications they might expect

for Mrs. Piego and her newborn under the circumstances.

- Ask the students to analyze the causes of these complications.
- Allow 30 minutes for discussion.

Large group discussion:

- Allow students to share their group work with the whole class.
- Allow one hour for presentation and discussion.

Summarise:

Use the following checklists with the students to ensure that all possible conditions are considered:

Complications of FGM during labour and delivery

- Reduced vaginal opening, which will present a direct mechanical barrier to delivery and will interfere with other procedures required for both assessment and management during labour. A tight introitus may, for example, prevent vaginal examination, and result in mistakes being made in assessing the degree of cervical dilatation, and monitoring the stage of labour and fetal presentation.
- Labour may be obstructed as a result of scarring of the external genitalia which prevents the normal stretching of the perineum to allow the passage of the baby.
- Prolonged second stage due to scarring of the perineum and a tight vaginal opening.
- Tears during delivery due to rigidity of the perineum as a result of scarring of the tissues around the introitus.
- Development of obstetric fistulae as a result of prolonged labour, during which the foetal head presses against the bladder or rectum.
- Death as a result of rupture of the uterus due to obstructed labour.
- Need for Caesarean section because infibulation has not been opened up during pregnancy.

Possible effects on newborn

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

Closing the session:

- Allow students to ask questions and clarify points for them as necessary.
- Ask students questions to check that they have understood the lesson.
- Close the session.

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

Session objectives

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

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

Suggested teaching methods

- Buzzing.
- Discussion.
- Simulation and demonstration.
- Question and answer.

Teaching aids

- Teacher's notes.
- Models.

Setting the scene

- Ask students if any of them has cared for a woman with FGM during labour.
- Ask students how they ascertain that a woman is progressing well in labour.
- Allow them to share their experiences.

THE SESSION

Introduce the session and its objectives.

Buzzing:

- Ask students how a woman with FGM should be assessed during labour.
- Allow them to buzz in twos or threes.
- Allow them to share their thoughts with the class.

Teacher's notes:

Inform students that the procedure for assessment of a woman with FGM arriving on the labour ward is as follows:

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

Physical examination

Inform students that the procedure for a physical examination entails the following:

- Head to toe assessment.
- Abdominal examination, inspection, palpation and auscultation.
- Palpation of the bladder (also, ensure that bladder is emptied regularly).
- Examination of the genitalia to identify type of FGM (follow the procedure and principles of genital examination in women with FGM described earlier in this manual)
- If introitus is tight:
  - explain to the woman the problems associated with having a tight opening during labour and delivery
  - inform her that an episiotomy will need to be performed during delivery to increase the opening, and explain carefully what is involved. If she has type III FGM, explain that she will

need to have the infibulation opened up, and explain what is involved.

Monitoring progress of labour

Inform students that the procedure for monitoring labour is as follows:

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

Demonstration:

- Ask students to demonstrate assessment of women with FGM during labour
- Give guidance to the students and emphasise the key principles of history taking and physical examination of a woman with FGM.

Assessment of the introitus during labour

Inform students that it is important to inspect the introitus carefully during second stage of labour to assess whether it is going to be able to stretch sufficiently during delivery of the baby. The procedure is as follows:

- Prepare the client psychologically for this procedure by telling her what you are going to do and why such an assessment is needed.
- Ask her permission to examine her genitalia.
- Prepare equipment: a tray with antiseptic, sterile swabs and gloves.
- Prepare the client by putting her into a lithotomy position; expose only the necessary parts of the body - do not expose unnecessarily.
- Wash hands with soap and water; put on gloves.
- Clean the external genitalia with antiseptic swab.
- Instruct the client to relax by taking a deep breath while you are introducing a finger into the introitus.
- Try slowly and carefully to introduce first one finger into the vagina to measure the tightness of the introitus. If it allows one finger, try to move the finger upward and downward, and left to right. If there is space for a second finger, try to widen the two fingers and check the resistance.
- If it is impossible to introduce a finger, or even the tip of a finger, the introitus is extremely tight – equivalent to type III FGM.
- If it is possible to introduce a finger but 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 client and perform the procedure following the guidelines described earlier in the guide.

Summarise:

- In a plenary session, summarise the important points of history taking and physical examination.
- Allow students to ask questions for clarification.

Important note

Emphasise to students that, when progress is slow, they should anticipate a difficult delivery and make appropriate arrangements in good time:

- **If it is clear an episiotomy would facilitate delivery, it should be performed skillfully.**
- **If there is a need for opening up the infibulation, the woman should be prepared and the procedure should be undertaken.**
- **If a caesarean section is required, the woman should be referred in plenty of time to a health centre with appropriate facilities.**

Management of woman with types I, II and IV FGM during labour

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

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

Demonstration:

Using a dummy as a model, demonstrate the performance of an episiotomy to the students:

- Prepare the client.
- Prepare a tray with antiseptic swabs, an episiotomy scissors, sterile gloves, a 5ml syringe and local anaesthetic.
- Inform the client 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 into the area where the cut will be made, along the fingers to avoid injuring the baby.
- 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 your are right handed, cut towards the mother's right buttock. If left handed, cut towards the mother's left buttock.
- Usually after cutting, the baby is 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 client on how to keep the perineum clean.
- Wash hands and clear equipment.

Management of women with type III FGM during labour and delivery

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

Demonstration:

- Ask one student to volunteer to act as a client with a tight introitus due to FGM.
- You, the teacher, will act as the service provider.
- Make the client comfortable in bed.
- Recall all the interpersonal skills.

- Introduce yourself to the client if you have not already done so.
- Inform the client that her labour is making good progress.
- Inform the client that during examination you identified a tight passage which may prevent the baby from being delivered.
- Inform her that in order to increase the size of the passage to allow delivery, she will need to have her infibulation opened up, or an episiotomy performed (whichever is appropriate in the circumstances).
- If the need is for an episiotomy to open up a tight introitus due to type I or type II FGM, give the client this information and tell her what the procedure entails.
- If the need is to open up infibulation from type III FGM, inform the client that the scar will be cut to allow passage of the baby. Also inform her that afterwards the sides of the wound will be sutured separately; the intention is not to recreate a small opening. Also inform her about the changes this will mean in terms of urination, menstrual flow a sexual intercourse.
- Thank the client for her co-operation.

Closing the session:

- Ask students to share what they have learnt from the session.
- Write down what they say for future reference.
- Close the session.

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

Session objectives

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

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

Key references

- *Management of pregnancy, childbirth and the postpartum period in the presence of Female Genital Mutilation. Report of a WHO Technical Consultation. Geneva, 15 - 17 October 1997.* WHO/FCH/WMH/00.7. WHO,Geneva (2000).
- *Female Genital Mutilation: The Prevention and the Management of the Health Complications: Policy Guidelines for nurses and midwives.* WHO/FCH/GWH/01.5. WHO, Geneva (2001)
- *A Systematic review of the complications of female genital mutilation including sequelae in childbirth.* WHO/FCH/ WMH/00.2 Geneva (2000).

Suggested teaching methods

- Buzzing.
- Plenary sessions.
- Demonstrations.
- Clinical practice.

Teaching aids

- Writing boards.
- Charts, flip-charts.
- Posters, pictures.
- Overhead projector and transparencies.
- Models.

Setting the scene

- Ask a few students to share their personal experiences of being very tired.
- Ask them how they felt at that time.

THE SESSION

Introduce the session and its objectives.

Buzzing:

- Ask students what the procedure is for assessing a woman with FGM after delivery.
- Allow them to discuss this question by buzzing in twos or threes.
- Allow 10 minutes for buzzing.

Summarise:

Summarise the discussion as follows:

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

Immediate assessment of mother and baby

Inform students that immediately after delivery, the mother should be assessed as follows:

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

Inform students that immediately after delivery, the baby should be assessed as follows:

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

Subsequent assessment of mother and baby

Inform students that they should:

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

Buzzing:

- Ask students what complications women with FGM may experience after delivery.
- Allow students to buzz in twos or threes for 10 minutes.
- Allow students to share their thoughts in discussion with the whole class.
- Allow half an hour for discussion.

Complications after delivery

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

Large group discussion:

- Ask students what care should be given to a woman with complications of FGM during the postpartum period?
- Allow students to discuss.

Management of a woman with FGM after delivery

Inform students that the management of women with FGM during the postpartum period is the same as for any other women. However, these women will

need more psychological care in cases where the vulva has been opened up and not closed to restore the genitalia to the condition they were in before pregnancy and delivery. Such women will have to learn to accept dramatic changes to the vulva from what they have known all their lives. The opened vulva will be different in both appearance and function from the infibulated vulva.

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

Immediate care

In cases of haemorrhage:

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

In cases of neonatal asphyxia:

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

Postpartum follow-up

- Women with type I, II and IV with no complications after delivery should be advised like any other woman.
- Assure client that you are available to answer any queries she might have about her own care or that of the baby, or concerns about sexual matters.
- Perform the usual postpartum care for the mother and the baby.
- Women with type III FGM need the same kind of postnatal care as other women, but they will need additional information, counselling and support to help them adapt to the changes following de-infibulation, and to discourage them from seeking re-closure after discharge from the health unit. Discuss with her the feeling of wetness and increased sensitivity in her opened vulva, which she might not have experienced before. Advise her to wear loose underwear to reduce discomfort caused by friction.
- Provide psychosexual counselling to the husband separately to make him aware of the importance of not closing the opened up infibulation, and to help him deal with sexual changes.
- A women with any type of FGM who delivers a baby girl should be counselled about the consequences of allowing her daughter to be excised. The husband and other family members who are influential in decisions about FGM, e.g. mothers and mothers-in-law, should also be counselled about the same issues.
- Like any other woman in the postpartum period, those with FGM should be advised about the importance of personal hygiene, good nutrition, adequate rest, and about care of the new-born including breast feeding. They should also be given family planning advice and counselling like any other newly delivered mother.

- Information on FGM type and complications should be recorded.

Closing the session:

- Review major points.
- Ask the students questions to check their understanding.
- Close the session.
  - Prepare students for skill practice in practicum.
  - Provide opportunity to practice in clinical areas.

APPENDIX 1: CASE STUDIES

CASE 1

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

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

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

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

CASE 2

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

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

girl. He says it is hard to keep challenging his mother but he will persist.

CASE 3

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

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

CASE 4

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

Meda went back to work, but she was unable to find a maid to look after the children while she was out of the house. Since her mother-in-law lives in the same town, she decided to leave the girls with her during the week and to fetch them on Friday evenings to take them home for the weekends. One Friday evening when she went to fetch the girls, she was surprised not to find them playing outside as usual. Her mother-in-law explained that they could not come out because they were not well. Meda thought perhaps they just had a fever. But as she entered the room, the girls cried out: "Mum it hurts!" It did not occur to her immediately that the girls had been genitally mutilated, but then her mother-in-law announced proudly: " I have excised my grand-daughters; I have done what is right for them".

CASE 5

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

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

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

CASE 6

Ella is a 19 year old woman married to a soldier. She has a 2 year old daughter who was infibulated 7

days after birth. The child has been admitted to hospital several times because of urinary tract infections. During discussions with Ella she reveals that she also was mutilated when she was a child, and that she has lived with the pain all her life. She explains that she was opened during delivery and stitched up again afterwards to create a small opening. She did not want her daughter to undergo the procedure, but says there was no way she could persuade her mother-in-law to accept the idea that the little girl should not be excised.

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

APPENDIX 2: TAKING HISTORY OF A WOMAN OR GIRL WITH FGM

CHECKLIST

ITEM	OBSERVED	NOT OBSERVED	NOT APPLICABLE
1. Welcomes and greets the client in a culturally acceptable manner.			
2. Makes the client comfortable by providing a chair			
3. Sits at the same level with the client			
4. Introduces herself and ask for the name of the client			
5. Addresses the client by name			
6. Starts by asking general questions like: "How are you?", "How is your family?"			
7. Ensures that the client is relaxed and ready to open up before asking about FGM			
8. When the client is ready to open up, tactfully asks about FGM using the culturally acceptable terms for the surgery			
9. Observes client's non verbal cues			
10. Reassures the client that she is comfortable dealing with the client's condition			
11. Empathises and use facilitation skills to enable the client express herself			
12. Maintains eye contact			
13. Lets the client express herself freely			
14. Is patient and does not force client to talk if she is hesitant			
15. If the client starts crying is patient and gives support			
16. Does not give false promises			
17. Once established that the client is mutilated, informs her about physical examination which will include examination of her genitalia.			
18. Reassures the client			
19. Records findings			
20. If the client is not yet ready to share, arranges for another visit			

APPENDIX 3:
PHYSICAL EXAMINATION OF A WOMAN OR GIRL WITH FGM

CHECKLIST

ITEM	OBSERVED	NOT OBSERVED	NOT APPLICABLE
1. Prepares the required equipment			
2. Explains the procedure to the client			
3. Asks client's permission to examine her			
4. Reassures client about confidentiality			
5. Ensures privacy			
6. If there is another person, asks permission of that person to be present and respects client's wishes			
7. Asks the client to empty bladder			
8. Asks the client to take off her underwear and assists her to lie comfortable on the examination bed or couch			
9. Exposes the genitalia			
10. Washes hands thoroughly and puts on gloves			
11. Inspects the external genitalia to identify type of FGM			
12. Tactfully asks the client about urination patterns, menstrual flow, and coitus if relevant			
13. If there is need to introduce finger cleans the genitalia with antiseptic lotion			
14. Where applicable lubricates the finger and tries to introduce the tip of index finger slowly observing client's reaction then introduces whole finger and second finger if necessary			
15. Respects client's reactions			
16. Before taking off the gloves checks for abnormal discharge			
17. After the procedure thanks the client for co-operation			
18. Takes off gloves and washes hands			
19. After the procedure helps the client off the bed and ensures comfort			
20. Records findings and shares with the client			
21. Soaks used instruments in disinfectant ready for sterilisation.			

APPENDIX 4: COUNSELLING A WOMAN OR GIRL WITH FGM

CHECKLIST

ITEM	OBSERVED	NOT OBSERVED	NOT APPLICABLE
Preparation for counselling			
1. Prepares a setting which is private, preferably a room: - with a locking door - where they will not be disturbed - which is well ventilated and light			
2. Confirms the time available with the client			
The counselling session:			
1. Greets and welcomes the client in a culturally acceptable manner			
2. Invites her to sit			
3. Makes the client comfortable			
4. Introduces self to the client.			
5. Asks for the client's name			
6. Sits facing the client and on the same level			
7. Thanks the client for coming and briefly explains the services provided at the facility			
8. Starts with easy and general questions			
9. Helps the client to explain why she came			
10. Listens carefully and observes non verbal cues			
11. Demonstrates patience, allowing the client to express her feelings and concerns freely			
12. Empathises with the client when she is describing a distressing situation			
13. Paraphrases the client's information to avoid misunderstanding			
14. Explains to the client how he/she can help			
15. With sensitive issues such as sexual problem, probes tactfully to discover the actual problem			
16. Provides accurate information related to the problem			
17. Refrains from giving instructions			
18. Assists the client and partner/guardian to reach informed decision			
19. Assists clients to implement the decision			
20. Plans for follow up with the client			
21. Thanks the client for coming			

APPENDIX 5:
THE PROCEDURE FOR OPENING UP TYPE III FGM (INFIBULATION)

CHECKLIST

ITEM	OBSERVED	NOT OBSERVED	NOT APPLICABLE
Preparation of the client (and partner/guardian):			
1. Educates about the normal and infibulated genitalia			
2. Educates about legal status of FGM in the specific country			
3. Gives full information about the procedure for opening up the infibulation			
4. Informs the client that after the opening up, the vulva will not be re-sutured to recreate a small opening, but the two sides will be sutured separately			
5. Informs the client of the physical changes following opening up:			
- changes in the appearance			
- changes in urination			
- changes in sexual intercourse			
- increased sensitivity of opened area			
- increased wetness			
6. Reassures the client about confidentiality			
7. Explains that local anaesthetic will be used			
8. Discusses clearly about the degree of opening up and reaches a consensus with client			
Preparation of equipment			
- Tray with antiseptic swabs			
- Gauze swabs			
- Straight scissors			
- Sterile gloves			
- 2 artery forceps			
- Haemostat forceps			
- Tissue forceps			
- Syringe and needle			
- Stitching needle and needle holder			
- Antiseptic lotion			
- Lidocaine			

CHECKLIST continued

ITEM	OBSERVED	NOT OBSERVED	NOT APPLICABLE
Preparation of equipment cont			
- Lubricant			
- Sterile towel, mackintosh			
- Soap - Receptacle for disposal			
The procedure:			
1. Makes the client comfortable			
2. Assembles all the required equipment at the bedside			
3. Introduces self to the client and asks or confirms client's name			
4. Ensures privacy and reassures the client about confidentiality			
5. Reflects on the initial discussion and reminds the client of the results of the physical examination and the indication for opening up			
6. Exposes genitalia and washes hands			
7. Puts on gloves			
8. Cleans the genitalia with antiseptic			
9. Introduce finger, forceps or dilator slowly and gently in the opening to lift the scar			
10. Infiltrates 2- 3 mls of local anaesthetic, as appropriate, along the scar and both sides of the scar where cuts will be made			
11. With fingers inside the scar, introduces scissors and cuts along the scar to avoid injury to the adjacent structures, or to the baby if opening up is done during labour			
12. Cuts along the midline towards the pubis to expose the urethral opening. Does not cut beyond the urethral opening			
13. Provides information about post operative care of the perineum:			
– advises on sitz bath three times a day or oat oil			
– gentle drying after sitz baths			
– advises on application of soothing cream			
14. Gives antibiotics depending on the situation			
15. Provides follow up after a week			

APPENDIX 6:
TEACHING AND LEARNING RESOURCES

Films and videos

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

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

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

Printed materials from WHO

- *Female Genital Mutilation. A joint WHO/UNICEF/UNFPA Statement.* WHO. Geneva (1997).
- *Female Genital Mutilation. Information Kit.* WHO. Geneva (1996). WHO/FRH/WHD/99.11.
- *Female Genital Mutilation. Report of a WHO Technical Working Group*, Geneva, 17-19 July 1995. Geneva, World Health Organization, 1996. (WHO/FRH/WHD/96.10)
- *Female Genital Mutilation. An overview.* WHO, Geneva (1998).
- *Management of pregnancy, childbirth and the postpartum period in the presence of Female Genital Mutilation. Report of a WHO Technical Consultation. Geneva, 15 - 17 October 1997.* WHO/FCH/GWH 01.2. WHO, Geneva (2000).

- *A systematic review of the health complications of Female Genital Mutilation including sequelae in childbirth.* WHO/FCH/WMH/00.2. Geneva (2000).
- *Female Genital Mutilation. A Handbook for frontline workers.* WHO/FCH/WMH/00.5 Rev.1. WHO, Geneva (2000).
- *Female Genital Mutilation. Programmes to date: what works and what doesn't. A review.* WHO/CHS/WMH/99.5. Geneva (1999).
- *Summary of international and regional human rights texts relevant to the prevention of violence against women.* WHO/GCWH/WMH/99.3. Geneva (1999).
- *Counselling skills training in adolescent sexuality and reproductive health: A facilitator's guide.* WHO/ADH/93.3. Geneva (1993).
- R. J. Cook (1994) *Women Health and Human Rights.* (WHO, Geneva 1994)
- *The right path to health: Health education through religion. Islamic ruling and female circumcision.* WHO, regional office for Eastern Mediterranean (1996)

Books and booklets

- *Tradition! Tradition! A story of Mother Earth,* by Dorkenoo, E. published by FORWARD Ltd. London, 1992.
- *Yimmer's story.* Published by The National committee on Traditional Practices in Ethiopia, 1995.
- *Alia's story.* Published by The National committee on Traditional Practices in Ethiopia, 1995.
- *Fatoumata's story.* Published by Turin centre regional programme. AIC/AIDOS/ILO (1995).
- *Female Genital Mutilation: The Unspoken Issue.* Published by The Royal College of Nursing, London, 1994.
- Dorkenoo, E. (1994). *Cutting the Rose. Female Genital Mutilation: The practice and its prevention.* Minority Rights Publications, London.
- Toubia, N. (1999). *A practical manual for health care providers caring for women with circumcision.* A RAINBO Publication. New York.
- Smith, J. (1995). *Visions and discussions on genital mutilation of girls: An international survey.* Published by Defense for Children International, Netherlands,
- Johns Hopkins Population Information Program (1997). *The Essentials of contraceptives Technology: A Handbook for Clinic Staff. Publisher of Population Reports.* WHO, Geneva

Human rights charters

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

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