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Distribution: General

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*



Department of Gender, Women and Health
Department of Reproductive Health and Research

Family and Community Health
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1 INTRODUCTION

A WHO Technical Consultation on the Management of Pregnancy, Childbirth and the Postpartum Period in the Presence of Female Genital Mutilation, organized by the Women's Health and Development Programme in collaboration with the Department of Reproductive Health Technical Support, was held in Geneva from 15 to 17 October 1997. The Consultation was opened by Dr A. M. D'Almeida, Director of Programme Management, WHO Regional Office for Africa (WHO/AFRO), and was also addressed by Dr T. Türmen, Executive Director, Family and Reproductive Health, WHO Geneva, and Dr E. M. Samba, WHO Regional Director for Africa.

Dr D'Almeida highlighted the grave consequences of female genital mutilation (FGM) for the physical and psychological health and well-being of women and young girls, and the need for these to be addressed in order to meet the social, health and economic needs of women. He also noted that, in communities where FGM is a traditional practice, it is paradoxically performed as an indication of love and care for a daughter and, unlike other public health problems, may not be seen as a health issue. Great efforts will therefore be required, in terms of developing a dialogue and negotiating with the communities concerned, to eliminate the practice.

FGM encompasses all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or any other non-therapeutic reasons. The different types of female genital mutilation known to be practised are as follows:

WHO CLASSIFICATION OF FEMALE GENITAL MUTILATION

Type I - Excision of the prepuce, with or without excision of part or all of the clitoris

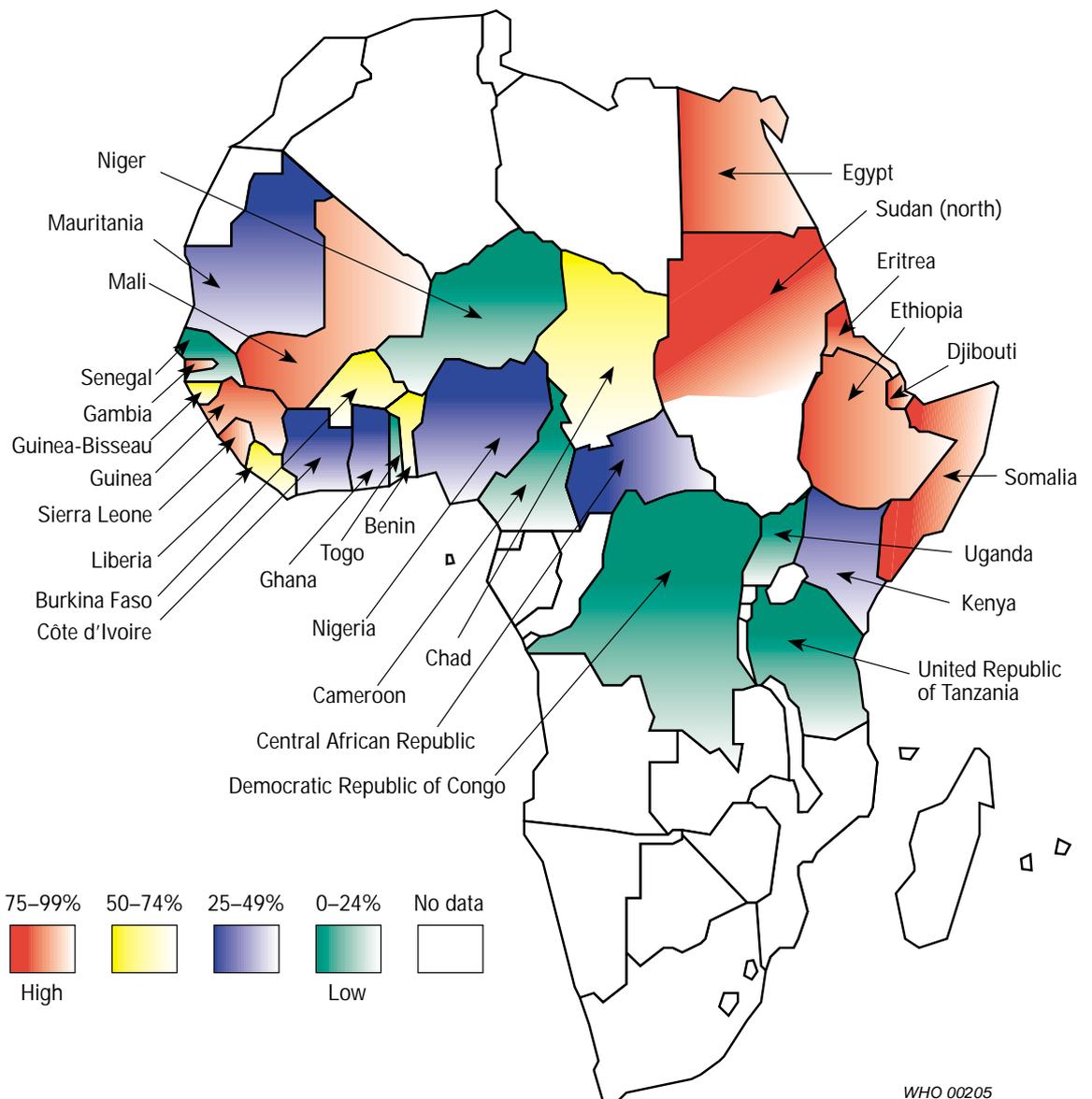
Type II - Excision of the clitoris with partial or total excision of the labia minora

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

It is estimated that between 100 - 140 million girls and women have experienced FGM and that at least two million girls undergo some form of the procedure every year. Most of these girls and women live in 28 African countries although some live in Asia. They are also increasingly found among the immigrant population groups in Europe, the United States of America, Canada, Australia and New Zealand.

Fig. 1 Prevalence of female genital mutilation in Africa



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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. New sources of information and corrections to the estimates will be posted on the Department of Women, Gender and Health's website (<http://www.who.int/frh-whd/FGM>) as they become available.

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

² 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.

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

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

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

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

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

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

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

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

Excision of the prepuce with part or all of the clitoris or excision of the clitoris and labia minora (types I and II) account for approximately 80% of all cases of FGM, while the most extreme form, type III, is found in around 15% of cases. The incidence of type III is widespread in Djibouti, Somalia and Northern Sudan, with a consequent higher rate of complications in these areas. Type III is also reported in southern Egypt, Eritrea, Ethiopia, northern Kenya, and in Mali.

Type III FGM often (but not always) involves the complete removal of the clitoris, together with the labia minora and the inner surface of the labia majora. The two sides of the vulva are stitched across the mid-line, leaving only a small posterior opening to allow the passage of urine and menstrual blood. This opening is often preserved during healing by the insertion of a foreign body.

The barrier of scar tissue resulting from type III FGM clearly presents major problems during sexual intercourse. The remaining orifice may be dilated as a result of forcible intercourse - a painful process which does not always result in full penetration. In some communities, notably northern Sudan, the opening is generally incised at the time of marriage to allow intercourse to take place.

There has been no systematic research into the magnitude of the immediate health effects or long-term morbidity following FGM.¹ Urinary problems, difficulty with menstruation, coital and psychosexual problems, infertility, vaginal infections and problems during labour have all been mentioned, but their frequency and severity have not been studied in any depth.

WHO is committed to the protection of women and girls, and has emphasized the need to advance and protect their health - which includes psychological, reproductive and sexual health. The Organization has adopted a number of resolutions urging Member States to establish clear national policies to end traditional practices harmful to the health of women and children and is committed to strengthening its technical support to countries in this regard (Annex 3). WHO has a special responsibility for equipping health care workers with the appropriate knowledge and skills to prevent and eliminate FGM and to manage the health complications that result from the practice.

Existing training materials for health professionals at all levels contain little information relating to the prevention of FGM or the management of women and girls suffering health complications as a consequence of the procedure. The Technical Consultation, which was attended by obstetricians and midwives from areas with a high prevalence of FGM, was convened primarily to begin the process of improving education and training for health care providers.

¹ See page 31.

OBJECTIVES

The objectives of the Technical Consultation were:

- to outline the major health complications of FGM associated with pregnancy, childbirth and the postpartum period, and to define the essential package of care required to manage and/or prevent these complications in settings where resources are limited
- to discuss service barriers and other problems in providing this essential package of care and to make recommendations as to how they may be overcome
- to determine future research and training needs in relation to the management of pregnancy, childbirth and the postpartum period in the presence of FGM.

It was expected that the recommendations arising from the Technical Consultation in these three areas would be issued in a technical document. This report constitutes that document.

3 BASIC PRINCIPLES

In addition to an overview of issues related to the management of pregnancy, childbirth and the postpartum period in the presence of FGM, the Technical Consultation considered reports on: the practical experience gained in the clinical management of women with FGM in hospital and at the community level in Northern Sudan, at a clinic in Sierra Leone and at a community clinic in Northern Ghana; innovative approaches to the clinical management of women with FGM in Burkina Faso and London; holistic care; the role of health workers in community health promotion in Nigeria; and ethical and legal aspects of opening up women who have undergone type III FGM (“de-infibulation”) and subsequent restitching (“re-infibulation”).

The recommendations focus on the work of peripheral health workers, particularly in resource-poor settings where most women will be delivered, and where hospitals are the last port of call - as highlighted in the classification of obstetric services shown below in Table 2.

Table 2. Classification of obstetric services

Levels	Type of service
Village	Trained traditional birth attendant, community health worker
District health centre	Health centre midwife
Hospital or clinic	Essential obstetric services, referrals, emergencies

The discussions were based on five general principles:

1. Recommendations should be realistic and pragmatic, within attainable resources, and based on an ethical framework for the prevention and elimination of FGM established by WHO, international human rights standards, and resolutions and codes of conduct of associations of health professionals.
2. Emphasis should be placed on essential services for the management of complications of FGM.

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3. The management of the complications of FGM during pregnancy, childbirth and the postpartum period should be integrated into existing reproductive health services.
4. Interventions should be known to be effective, to empower women and to ensure their rights to health, and should involve the community in interventions that seem promising and can be recommended for implementation.
5. Recommendations should be based on scientific data. Where data do not exist, research needs should be identified.

The discussions took into account the ways in which FGM affects the existing guidelines set out in WHO safe motherhood documents on antenatal, delivery and postpartum care.

4 THE IMPACT

OF FEMALE GENITAL MUTILATION ON THE MANAGEMENT OF PREGNANCY, CHILDBIRTH AND THE POSTPARTUM PERIOD

Background

With increasing ease of travel, migration and movement of refugees both regionally and globally, FGM is no longer a localized issue but has become a matter of global concern, even though in epidemiological terms its major impact remains in developing countries. An open discussion of FGM is therefore timely, although it is important to recognize the cultural sensitivity associated with the problem.

The type of procedure, the age when it is performed, the prevalence in the community and the socio-cultural and economic factors which support its continuation vary widely across the communities that practise FGM. In addition, formal health service provisions and the availability of trained health professionals also vary widely. Measures to combat FGM that will prove effective and practical at the local level are therefore essential.

In a systematic review of research on the health complications of female genital mutilation, which included the sequelae in childbirth, sixty-seven studies (published and unpublished) with primary data relating to childbirth outcome and FGM were identified.² A summary of the findings of the review are presented below.

Type III FGM causes a direct mechanical barrier to delivery. However, it is also recognised that type I, II and IV can produce severe, although perhaps unintentional vulval and vaginal scarring that can act as an obstruction to delivery. Infection and inflammation at the time that type I or II FGM are performed may lead to vulval adhesions which effectively narrow or completely obliterate the vaginal opening. Many of the women affected will never become pregnant but those that do may experience prolonged or obstructed labour. Vaginal inflammation resulting from type IV in the form of the insertion of herbal pessaries as treatment for gynaecological conditions, or the use of rock salt after previous pregnancies to reduce the vagina to its nulliparous state, may result in severe scarring and stenosis.

² *A Systematic Review of the Health Complications of FGM including Sequelae in Childbirth.* WHO, 2000 (WHO/FCH/WMH/00.2)

The reduced vaginal opening affects not only delivery but appears to be the main factor responsible for other obstetric problems caused by FGM, making antenatal assessment, intrapartum vaginal examination or catheterisation difficult or impossible. Inadequate assessment at these times as a result of FGM may compromise mother and fetus physically. Fear of labour and delivery is also noted in women due to the small size of the introitus, as well as reports of women with type III FGM with tender vulval scarring antenatally. Urine retention in labour has also been observed in women with FGM type III. Prolonged labour and/or obstruction appears to be one of the most frequent obstetric outcomes of FGM, identified by twenty-nine studies in the review. Overall, the obstruction described by the studies relates to soft tissue dystocia. Many cases of such obstruction are described as being easily overcome by episiotomies. In all but one study, the delayed labour relates to the second stage only; the other study describing the effects of FGM on delay in the first stage of labour.

Episiotomies and perineal tears are by far the most common complications. There is substantial evidence to show that women with FGM suffer more perineal damage as a result of delivery than those without FGM. Pain from anterior episiotomy of women with type III has been noted and this may result in “secondary inertia”, taken to mean reluctance to push in the second stage of labour. It is also reported that women experience increased pain at the time of repair of the anterior episiotomy. Postpartum haemorrhage is shown in the preliminary results of the review to be significantly more common among women with types I, II and III FGM. Most commonly, the cause for the increased haemorrhage is from the extra incisions made and perineal tears experienced as a result of scarring from FGM.

Seven studies in the review describe FGM as either a contributory or causal factor in maternal death following FGM. Most cases appear to describe unattended and/or inappropriately treated obstructed labour caused by the vulval scarring from type III FGM. Three maternal deaths are attributed to FGM. The observational studies (no frequencies are stated) suggest that many more may occur, or suggest that FGM is a significant contributory factor in many maternal deaths.

Ten studies describe stillbirth or neonatal death as a complication of FGM. Postpartum genital wound infection following FGM and fistulae as a possible obstetric complication of FGM are also identified in the systematic review.

Clinical Issues

It is important to relate clinical problems to each type of FGM and to distinguish between pregnancy complications due either totally or in part to the presence of the various forms of FGM and those that are just as common in pregnant women who have not undergone FGM. For example, obstruction of the introitus as a result of type III FGM creates a physical barrier to gynecological examination, treatment and delivery; the presence of types II or IV FGM, which result in the formation of rigid inelastic tissue or narrowing of the vagina, may also hinder or prevent appropriate investigation and treatment.

MODIFICATION OF ANTENATAL CARE IN WOMEN WITH TYPE III FEMALE GENITAL MUTILATION

Women who have undergone type III FGM require sensitive antenatal care. They may be apprehensive about pelvic examination, particularly when the introitus is very tight and digital vaginal examination may be uncomfortable. It is important for health workers to be knowledgeable about FGM and its different types so that they do not ask women embarrassing questions, blame them for FGM, or convey any signs of misapprehension to their clients. Health workers should relate to the women in a sensitive, empathic manner. A rapport should be developed with clients and information provided about the appropriate care during pregnancy, and after childbirth. Careful explanations should be given about any intimate examination considered necessary and consent should be obtained. In some cultures, it is usual for a husband to give consent before his wife undergoes any form of treatment or investigation. In such situations, there may be a need to involve husbands or other relevant family members in pre-examination discussions.

In areas where type III FGM does not involve the majority of the population, the health worker needs to establish whether or not the pregnant woman has undergone this type. Where type III FGM is common, the vulval area must be inspected at the first antenatal visit. In women having their first baby, this will establish the extent of the damage, and the degree of physical barrier presented. Women with a tight introitus following FGM (opening 1 cm or less) are at greater risk of major perineal damage during labour than those who have not been sewn so tightly or whose mutilation has been partly reversed (“opened up”) on marriage to allow the marriage to be consummated. As a general guideline, if the urinary meatus can be observed or if two fingers can be passed into the vagina without discomfort, the mutilation is unlikely to cause major physical problems at delivery, wherever this occurs. Digital assessment is not always needed, as the visual appearance may provide all the information required. Making a record of the appearance of the vulva may help to avoid unnecessary examinations in the future, or to highlight when specific procedures may be difficult to carry out.

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

In areas where type III FGM is not common, a tight introitus (opening 1 cm or less) should be regarded as a major risk factor, especially if the scar is thick. Women with this condition should be required to deliver in hospital where skilled supervision of labour should reduce the incidence of major perineal trauma - although problems may still arise if the woman presents late in labour or if the baby is born on the way to the hospital. Examples of suitable referral patterns are shown in Fig. 2. Flow charts for referral patterns should be developed locally, taking into account existing resources and experience. Colour coding could be used to overcome problems of literacy at village level.

In those countries where type III is virtually universal, hospital delivery is often not an option. There are no reliable data concerning levels of trauma and long-term morbidity in such women delivered in their village under the supervision of traditional birth attendants (TBAs).

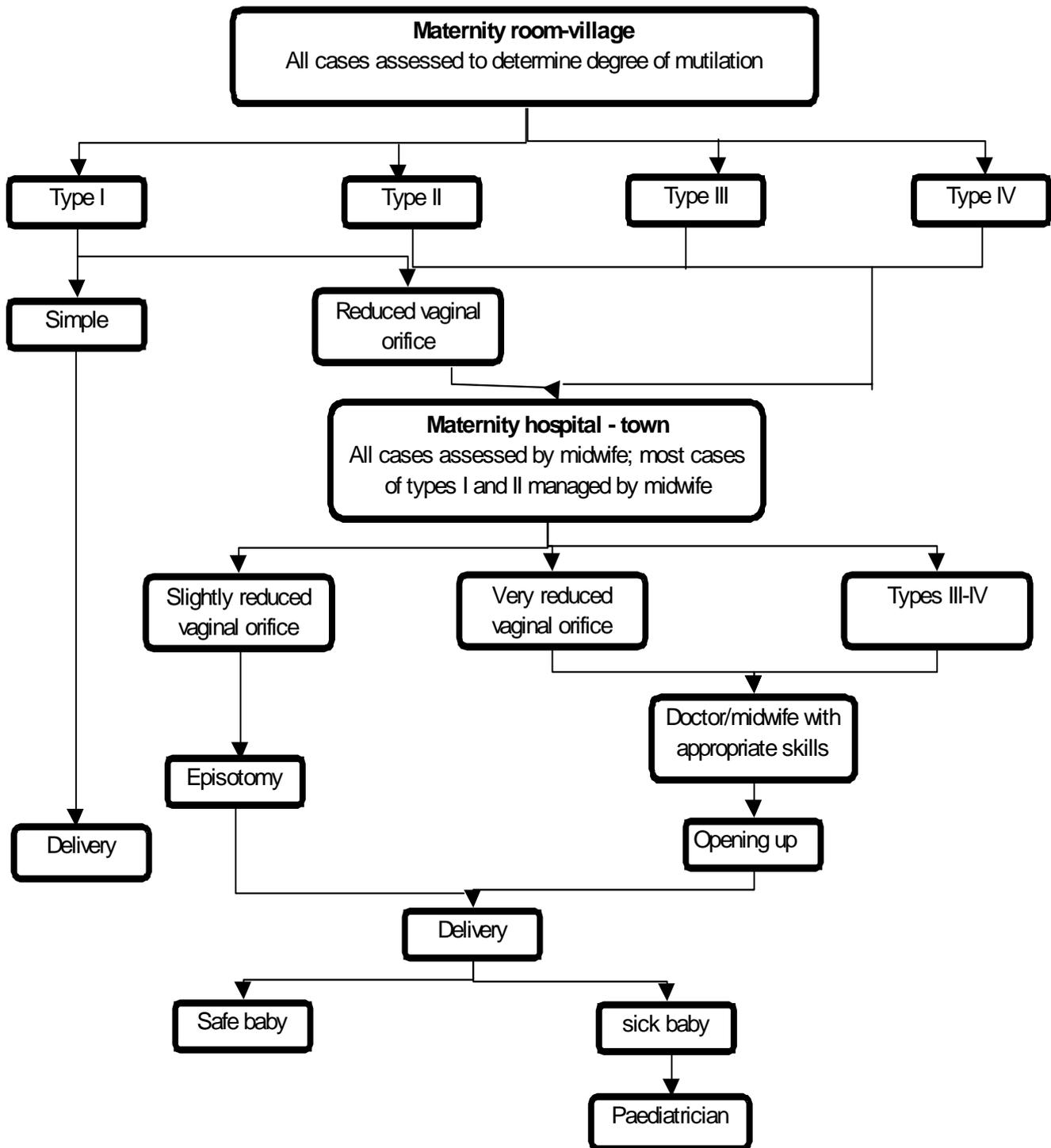
OPENING UP OF TYPE III FEMALE GENITAL MUTILATION

One hospital unit in the Middle East dealing with refugees from Sudan has been attempting to perform antenatal opening up of the closed vulva (reversal of FGM or “de-infibulation”) in the middle trimester of pregnancy (20-28 weeks). The aim is to remove the physical barrier created by the genital mutilation and allow the area to heal well before labour. The subsequent risk of trauma in labour is thus reduced, obviating the need for prolonged hospital confinement. This intervention needs further testing; so far, it has only been used in one area for women who live a considerable distance from hospital. Pilot testing could establish whether the procedure is suitable for wide application in the prevention of major perineal trauma. It would have to prove culturally as well as medically acceptable if its use is to spread to district health centre level and possibly village level (see Table 2)..

There are clearly logistic obstacles to widespread implementation of antenatal opening up of the closed vulva in resource-poor areas where type III FGM is almost universal. There is therefore an urgent need to gather reliable information about complications related to FGM to assess the cost-effectiveness of such an approach.

Fig. 2 Two examples of flow charts for the referral of pregnant women in the presence of FGM

(a) Care of pregnant women with FGM in areas where types III and IV are uncommon



The antenatal period provides an ideal opportunity for health workers to promote education on the health consequences of FGM. This should help to discourage women/couples from submitting their own daughters and granddaughters to FGM, as well as reducing demands for resuturing after delivery. Education and counselling of women and their partners will help to dispel myths around the need for “tightness” to enhance a husband’s sexual pleasure and to explain the risks of repeated surgery to open up the vulva for each birth, followed by closure after the birth. Good practice to prevent restitching may involve follow-up support during the postpartum period. This is an area where community midwives and TBAs could play a major role. Co-opting women role models within the family to assist with counselling and providing support to women in this area has, in some instances, proven to be useful in preventing restitching.

The operation to open up type III FGM consists of the following steps:

1. Observe an aseptic technique (washing hands thoroughly, wearing gloves etc.)
2. Locate the remaining opening and clean the surrounding area.
3. Raise up the scar tissue from the underlying tissues using a finger or dilator.
4. Incise in 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.
5. Suture the raw edges to secure haemostasis and prevent adhesion formation. Healing should take place within one week.

For further explanation of the above steps, see Fig. 3 (a-e on page 16).

Sometimes after dividing the fused labia majora, an intact clitoris and labia minora have been found concealed by scar tissue. However this operation is more complex and requires careful dissection in good light and with good anaesthesia; it should only be carried out in a **hospital** setting. A more extensive opening up of the fused labia majora may not be culturally acceptable to all women, but could be considered in specialized centres - together with appropriate counselling and consent procedures for women and/or couples who request it.

Fig. 3. Safe incision for the opening up of type III female genital mutilation (FGM), which, with appropriate training and support, can be carried out by health care staff at all levels, including birth attendants.

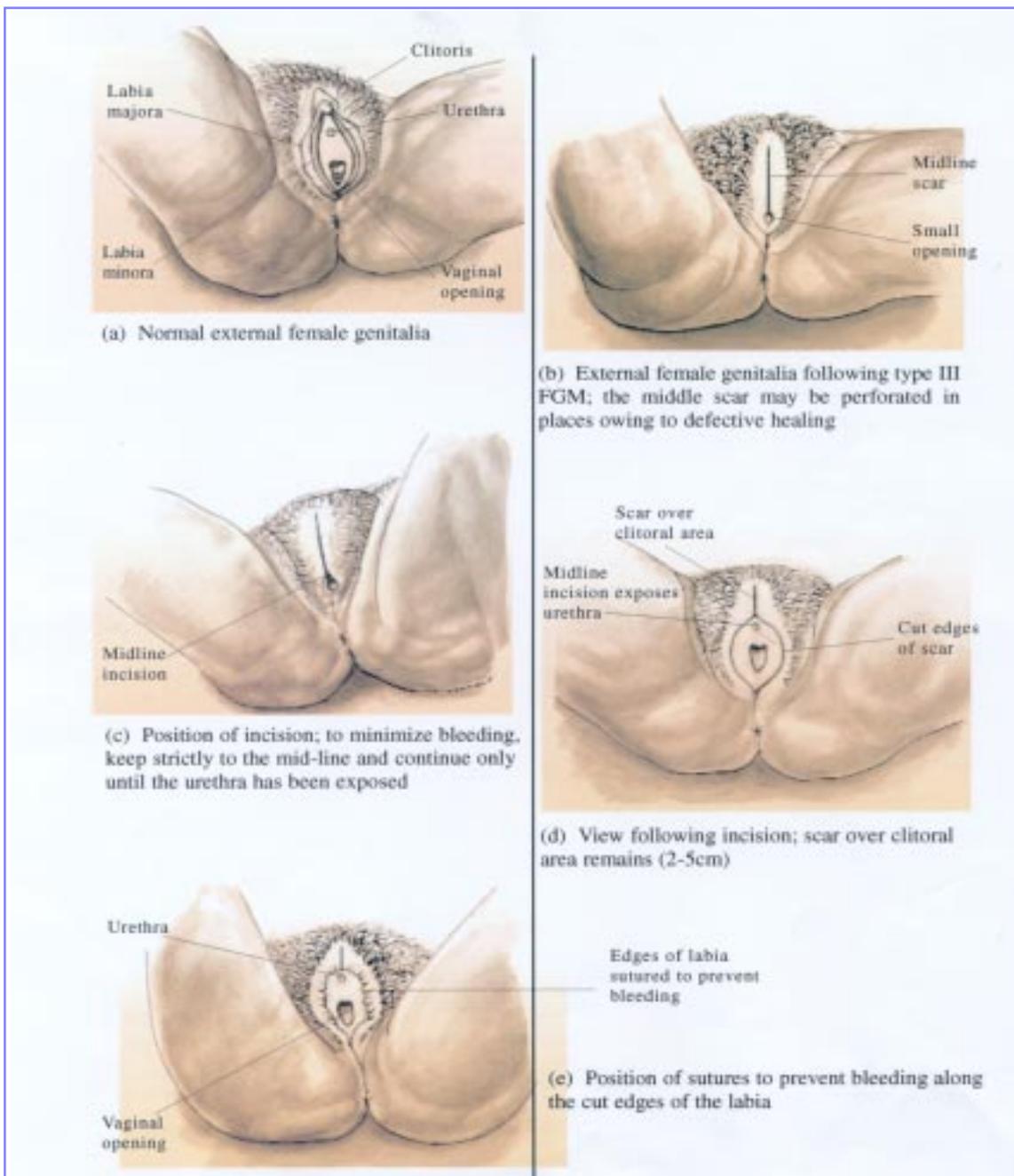


Fig. 4. The procedure for opening beyond the urethra is shown below.



a) A typical type III female genital mutilation



(b) It can be seen, by using a dilator, that the scar has perforated areas related to inadequate healing; this is a common finding.



(c) Careful dissection anterior to the urethra reveals an intact, normal clitoris.

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- d) The raw edges are then sutured with fine 3/0 plain cat-gut to prevent any adhesion formation. Plain cat-gut dissolves rapidly and the whole area is healed within a week.

The above procedure is readily carried out on a day care basis. The choice of anaesthetic is important. For the non-pregnant, fear of pain and memories of the mutilation procedure make it advisable to select general anaesthesia. Post operative analgesia is also important and this can be provided by infiltrating under the wound with 0.5% bupivacaine, followed up with analgesia for the first 48 hours.



- (e) This shows a much thicker scar



- (f) The final result restored to near normality

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

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

ANTENATAL COMPLICATIONS IN THE PRESENCE OF FGM

Vaginal infection

While it is often assumed that vaginitis and urinary tract infections are more common in women with type III FGM, the extent of the added risk is poorly documented. What is certain is that a tight opening (1 cm or less) will hinder pelvic examination, as well as hamper efforts to obtain appropriate samples for testing (e.g. clear urine samples). A tight opening may also prevent appropriate therapy (e.g. with pessaries). Treatment initially may be empirical - for example, if there is itching, assume a monilial infection and treat with clotrimoxazole (e.g. Canesten) cream and pessaries. Oral metronidazole (e.g. Flagyl) could be used for other symptomatic discharges; however, this drug should not be given in the first three months of pregnancy. If the infection discharge continues despite empirical treatment, antenatal surgery to open up the introitus ("de-infibulation") is indicated to facilitate a full assessment, including speculum examination. Vaginitis and bacterial vaginosis have received special attention because of their association with premature labour; adequate management may therefore be cost-effective, even in resource-poor areas.

Spontaneous abortion

Retention of products in the vagina due to a tight introitus may lead to serious infection. An incomplete abortion cannot be managed if the introitus is too narrow to allow a speculum to pass. Where there is pain and bleeding in early pregnancy, opening up of type III FGM may be required to help establish the diagnosis.

Antepartum haemorrhage

Again the same principles apply - if the FGM interferes with appropriate assessment and management, it will be necessary to open up the closed vulva.

Urinary tract infection

Urinary tract infections are common in pregnancy. They may be more common in women with type III FGM, but there is no good evidence on this point. There is, however, clearly a difficulty in obtaining a clean sample of urine for investigation. A catheter sample cannot be obtained and other urine samples are contaminated by vaginal secretions. Where the diagnosis cannot be established with certainty, where urinary infections are recurrent, or where there has been an attack of severe pyelonephritis, the introitus should be opened up.

Pre-eclampsia

When hypertension develops in pregnancy, and the patient is referred to hospital, important decisions may depend on the degree of proteinuria. In women with type III FGM, the urine is always contaminated with vaginal secretion and may therefore show false proteinuria. Where this is a serious problem, the scarring should be opened up.

LABOUR IN THE PRESENCE OF TYPE III FGM

Where the introitus is tight, it is difficult to assess the degree of cervical dilatation. If there is a problem of assessment, the scar can be opened in the mid-line as described previously. Ideally, this should be performed under a local anaesthetic, but in resource-poor areas without access to anaesthesia, the cut should be made at the height of a contraction. Topical analgesic ointments have so far proven ineffective in providing any significant pain relief, although recent research by the pharmaceutical industry suggests that effective anaesthetic creams may soon be available, providing a useful alternative to local anaesthesia. Usually there is little bleeding from the relatively avascular scar tissue. In these circumstances, suturing should be delayed until after delivery.

With a wider opening, normal assessment is possible, and a decision about anterior division of the scar, often combined with episiotomy, can be delayed until the second stage of labour. The second stage of labour may be complicated if the fetal head is held up on the scar tissue. This is dangerous to both the mother and baby and this is the time when uncontrolled tears can occur, as well as fetal asphyxia. There should be no delay in performing a mid-line cut in the anterior scar to minimize trauma. To avoid unnecessary bleeding, the incision should not be extended beyond the urethra - no extra space is created by doing so. On average, this will leave 4-5 cm of the old scar unopened as the mutilation always extends to the clitoral area.

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

POSTPARTUM CARE

It is the period immediately following delivery that major problems may occur - extensive lacerations and haemorrhage from tears are added to the usual puerperal difficulties. Extensive uncontrolled lacerations result if the woman has delivered through an intact scar, or if an anterior incision has been incorrectly performed. Tears may involve the urethra and bladder anteriorly and the rectum posteriorly. In ideal circumstances, e.g. in a hospital setting with skilled attendants and experienced surgeons, the damage can be limited. At the village level, good results can still be obtained by applying a pressure dressing to reduce blood loss and then transferring the patient to hospital. However, in resource-poor areas, communication and transfer may be difficult or impossible, and the absence of available expertise almost certainly contributes to a high level of fistula formation, although the extent to which type III FGM adds to the fistula risk is very poorly documented.

Improvements in overall results will depend on developing a policy specific to resource-poor areas, which in the absence of midwives, must include training of TBAs in safe practice, such as safe techniques for incision of vulval scars performed at a sufficiently early stage in labour.

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

OTHER PROBLEMS RELATED TO TYPE III FEMALE GENITAL MUTILATION

Girls and women who have undergone FGM suffer serious problems from the time of mutilation onwards. The age at which FGM is performed varies, but where type III is almost universal, it is most commonly carried out in childhood, between 5 and 8 years of age.

Although the rates of morbidity and mortality immediately following FGM are poorly documented, the morbidity from haemorrhage, sepsis and shock appears to be considerable and mortality significant. More reliable data would provide powerful ammunition in the battle to eliminate FGM.

It is not known whether FGM procedures (especially where several children undergo FGM at the same time) contribute significantly to the spread of HIV and hepatitis. Following FGM, painful intercourse (dyspareunia) and psychosexual problems are common. Intercourse and conception may not be easy to achieve in women with type III FGM as penetration can be hindered by the tough fibrotic skin closing the vaginal introitus; thick scars - the result of repeated infections and opening up and resuturing in successive pregnancies - are common. The extent to which type III contributes to infertility is unclear; management of infertility due simply to physical obstruction by FGM type III consists of opening up the introitus as described previously.

Counselling of women with these complications and their partners is essential, and health workers should receive adequate training in this respect. Cultural attitudes to sex vary widely and in many communities where FGM is a traditional practice, women are reluctant to discuss sexual matters with health personnel and are shy to complain of painful intercourse or inability to consummate marriage. Health workers should take the time to find out how women are suffering. Sometimes fear of intercourse, vaginismus and psychological disturbances may be due to flashbacks to the actual childhood FGM procedure. Psychosexual counselling sessions with couples will help clarify the underlying issues before appropriate therapy can commence. Reliable data are required on the impact of FGM on sexual health in order to guide management of painful scars and painful intercourse and to facilitate the design of a suitable protocol for research in this area.

As well as creating a physical barrier, type III FGM, in common with other types of FGM, is associated with the development of epidermal cysts (implantation dermoids). These may reach a large size and may become infected. Occasionally, they may increase in size and become painful as a result of internal haemorrhage. They require removal if they become symptomatic - but the dissection can be tedious and difficult and should only be attempted in hospital. In pregnancy, these cysts are best left alone, as attempted removal may provoke considerable haemorrhage. If acute problems develop (e.g. abscess formation) simple remedies such as incision, with or without marsupialization (suturing so that the incision remains open) can be used.

OTHER FORMS OF FEMALE GENITAL MUTILATION AND THEIR INFLUENCE ON PREGNANCY

It is noted previously that infection at the time that FGM types I and II are performed, as well as scraping around the vaginal orifice and the use of herbs and corrosives in type IV, can produce a tight fibrotic barrier in the lower vagina which can prevent delivery unless extensive episiotomy (occasionally bilateral) is carried out.

Best practice should ensure that all women who have undergone FGM type I and type II are examined at their first antenatal attendance to assess the degree of damage. Without this examination, serious problems may become apparent only during labour, when it may be too late to obtain the skilled assistance needed for safe delivery.

5 OTHER ASPECTS

OF THE PREVENTION OF HEALTH COMPLICATIONS RESULTING FROM FGM

Training and education

There have been several anecdotal reports of health workers not seeing FGM as a health issue - this indicates clearly the importance of education. If health workers are not convinced that FGM is a major public health issue, then there is little hope of convincing communities to eliminate the practice. Health workers have an important role to play, not only in the care of women affected by FGM, but also in the provision of education about FGM. They are in a unique position to provide this education, owing to their medical status, the respect in which they may be held, the relevance of health issues to FGM and the frequency with which they are likely to interact with affected communities. Education provided by health workers can give strong support to arguments against FGM, as information in a health context provides a non-threatening and objective criticism of FGM, particularly when backed up by tangible evidence of the health consequences. The way forward must include improved training for all health workers.

TRAINING OF NURSES, MIDWIVES AND DOCTORS

There is growing evidence that nurses and midwives are ill-prepared to deal with FGM at the level of prevention, management and counselling. FGM should be included as a specific topic in nursing and midwifery curricula in all countries where FGM is a problem. Nurses and midwives are well placed to document the health consequences and a relatively modest financial outlay in basic training could therefore yield handsome dividends. Similar adjustments should be made to the curricula for medical undergraduate and post-graduate training.

TRAINING OF TRADITIONAL BIRTH ATTENDANTS

TBAs play a key role, especially in resource-poor settings, where fewer than 30% of pregnant women have access to formal health care (for further information see Annex 4). Their training should be re-assessed. Training, updating and supervision currently vary from area to area; the situation should be reviewed in each area in light of the needs of the community and the existing health care resources. Consideration should be given to the provision of rewards to encourage good practice and the institution of some form of disciplinary code to discourage poor performance.

PUBLIC HEALTH EDUCATION

Public education in the broadest sense is one of the most important factors in producing change; the battle against FGM will only be won at this level. Health professionals and their associations should, as a group, assert a leadership role in public education on FGM. They are in key positions to brief policy-makers and liaise with community, religious, traditional and women's organizations in mobilizing the public for education.

Nurses, midwives and doctors involved in caring for women who live in areas where FGM is prevalent have a major role to play in the primary prevention of FGM. They should increase their knowledge about FGM and raise the awareness of colleagues, other professionals and the communities concerned. The building of partnerships with relevant community groups, agencies and professional groups will help in gaining insights into the issues involved as well as in bringing health promotion to a wider public.

All avenues to raise public awareness should be explored. Information, education and communication (IEC) programmes on FGM should be designed and tested at community level. Community education should incorporate information on the immediate and direct health complications of FGM in girls and on the subsequent health complications that may occur during pregnancy, childbirth and the postpartum period in the presence of FGM. Education on FGM for women and couples should also be integrated into management during pregnancy, childbirth and the postpartum period.

Education about FGM prevention should be encouraged in schools. Reproduction and FGM-related problems should be integrated into science, biology and hygiene lessons, personal social education, gender and religious education. Nurses, midwives and doctors can facilitate and assist teachers with such education. Young people should receive sound, reliable sex education to prepare them for a healthy future life as men and women. Only in this way is it possible to correct erroneous ideas or advice which they receive outside school. Factual understanding of physiology and sex and the emotions surrounding relationships will lay a basis for mutual understanding and communication between marriage partners which is currently all too frequently lacking. Sex education should also be placed within the general development of life skills. It is important to involve parents too in sex education so that they and their children do not come into conflict (parents versus school) over what is right.

Innovative programmes certainly merit funding, especially if they take into account the low level of female literacy in resource-poor areas where FGM is especially prominent.

Legal and ethical issues

The Technical Consultation endorsed existing policy statements on FGM (Annex 5). International agreements (Annex 6) and national laws are important as they reflect commitment and support. However, laws emanating from the community and which are based on respect for the integrity of the person and protection of human rights are likely to be more influential in matters related to FGM.

Laws should be seen to be protective rather than punitive and should be designed to prevent harm to children. The latter aspect should be emphasized at community level so that the law comes to be seen as providing protection and support to the individual.

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

FGM should be resisted because it violates the rights of girls and women to their natural sexuality and bodily integrity. Suggestions that type III FGM should be replaced by types I and II should also be resisted on both medical and ethical grounds.

The agreed definition of the term “infibulation” (type III FGM) is that it is a “stitching together of the labia”. In this context, the terms “de-infibulation” and “re-infibulation” for the opening up procedures of cutting for childbirth and subsequent restitching are thought to be inappropriate as they may be construed by the general public as endorsing the practice. The Technical Consultation recommended the use of “opening up” and “repair” or “reconstruction” as suitable replacements when addressing the general public.

When an obstetrician or midwife is faced with the repair of the vulva of a woman who has delivered a baby vaginally following previous type III FGM, it is unethical to carry out the procedure intentionally in such a way that intercourse and vaginal delivery are made difficult or impossible. Nurses, midwives and doctors should be guided by national and international laws on FGM, ethics and the codes of practice of their professional associations in this regard. Clearly, in this situation, counselling is needed for women/couples and appropriate family members on the long-term health complications of repeated opening up and reconstruction, in particular the implications for psychosexual and gynecological health.

6 CONCLUSIONS & RECOMMENDATIONS

Antenatal care

- Prevention of FGM and management of its complications should be included in antenatal care.
- During the antenatal period, women and couples should be provided with appropriate information about the timing of opening up the scar tissue of type III FGM, and possible complications in labour and at delivery.
- It is essential to develop a rapport with clients and obtain consent before attempting to undertake a physical examination.
- The introitus should be examined at the first antenatal visit to establish the extent of mutilation.
- Local guidelines for antenatal opening up of type III FGM should be established, taking into account the prevalence of type III, the travelling distances involved and access to medical and midwifery services.
- Midwives and doctors should receive adequate training in safe techniques for opening up the scar tissue of type III FGM and a tight introitus.
- Midwives and doctors should receive training in psychosexual counselling and communication skills so that women and couples can be given education and counselling on the health consequences of FGM.

Delivery

- Delivery strategies, including the timing of opening up procedures, should be designed to reduce trauma to the perineum.
- TBAs, midwives and doctors should receive adequate training in safe techniques to open up the scar tissue of type III FGM or any other barrier to delivery resulting from FGM, if this has not been performed during the antenatal period.
- Staff at levels I and II (see Table 2) should be trained to recognize complications requiring medical attention/transfer.

Postpartum care

- Local guidelines should be established for suture of lacerations and perineal incisions.
- Local guidelines should be established for transfer from levels I and II (see Table 2) to hospital for cases of severe damage.
- Local guidelines should be established for dealing with infected perineal wounds, with special emphasis on simple, inexpensive remedies.
- The number of follow-up visits during the postpartum period should be increased to provide support to women and ensure prompt identification and management of complications.

Education by health workers

- Nurses, midwives and doctors should integrate health promotion on FGM into routine antenatal and postnatal care.
- Nurses, midwives and doctors should liaise with other partners (ministries of health, women's affairs and information, nongovernmental organizations, traditional and religious leaders, schools, the media) to organize outreach education for young people, adults and communities.

Research

Studies are needed:

- to establish the true incidence of complications during pregnancy, childbirth and the postpartum period related to the different types of FGM - especially type III
- to establish the timing (antenatal, during labour or at delivery) and safe techniques for the opening up of type III FGM, placing emphasis on reduction of perineal trauma, especially for use in resource-poor areas
- to investigate the local traditional practices undertaken during the antenatal period to prepare women for childbirth and delivery and to assist in the preparation of appropriate educational programmes on FGM tailored to specific local needs
- to examine and document the use made of TBAs in health provision in resource-poor areas with a view to testing schemes for expanding their role; extensive involvement of trained and supervised TBAs may be the only viable means of reducing maternal mortality and morbidity in some of the most deprived areas
- to assess the knowledge, attitudes, practice and beliefs of health workers with respect to FGM at all levels

- to seek appropriate ways of studying and documenting psychosexual problems caused by FGM in order to establish a well-designed protocol for research in this area
- to improve means of pain relief in resource-poor settings where provision of anaesthesia is difficult
- to develop innovative information, education and communication programmes for use at community level.

Specific research projects on topics from the above list should be designed and funded.

Because of local variations in existing conditions, each project may need to be implemented in more than one geographical area in order to ensure that results are widely applicable. One research project, a multi-country study on the obstetric sequelae of FGM, is being carried out by WHO's Department of Reproductive Health and Research (RHR), with the following objectives: (i) to evaluate the relationship between different types of FGM and obstetric complications; (ii) to estimate the incidence of obstetric complications among women with FGM giving birth in hospital; and (iii) to obtain clinical information relevant to the prevention and treatment of obstetric complications in women with FGM.

Two proposals by the Technical Consultation are set out in Annex 7.

Implementation of recommendations

Networks of key groups should be established nationally and regionally and given adequate support to assist with the implementation of the above recommendations. Periodic assessment of all interventions is essential and should include the development of verifiable indicators to monitor and evaluate all aspects of FGM programmes.

Resource List

WHO. *Female genital mutilation: An Overview*. Geneva, World Health Organization, 1998.

WHO. *Female genital mutilation. A joint WHO/UNICEF/UNFPA statement*. Geneva, World Health Organization, 1997.

WHO. *Female genital mutilation (information kit)*. Geneva, World Health Organization, 1999 (WHO/CHS/WMH/99.11).

WHO. *Female genital mutilation. Programmes to date: What works and what doesn't*. Geneva, World Health Organization, 1999 (WHO/CHS/WMH/99.5).

WHO. *A systematic review of the health complications of female genital mutilation, including sequelae in childbirth*. Geneva, World Health Organization, 2000 (WHO/FCH/WMH/00.2).

WHO. *Female genital mutilation: A handbook for frontline workers*. Geneva, World Health Organization, 2000 (WHO/FCH/WMH/00.5).

WHO. *Regional plan of action to accelerate the elimination of female genital mutilation*. Brazzaville, World Health Organization Regional Office for Africa, 1996 (AFR/WAH/97.1).

WHO. *Islamic ruling on male and female circumcision*. Alexandria, World Health Organization Regional Office for the Eastern Mediterranean, 1996.

WHO. *Integrating the prevention and the management of the health complications of female genital mutilation (FGM) into nursing and midwifery curricula - a teacher's guide*. Geneva, World Health Organization, 2001 (WHO/FCH/GWH/01.3 - WHO/RHR/01.16).

WHO. *Integrating the prevention and the management of the health complications of female genital mutilation (FGM) into nursing and midwifery curricula - a student manual*. Geneva, World Health Organization, 2001 (WHO/FCH/GWH/01.4 - WHO/RHR/01.17).

WHO. *Integrating the prevention and the management of the health complications of female genital mutilation (FGM) into nursing and midwifery curricula - a policy guideline*. Geneva, World Health Organization, 2001 (WHO/FCH/GWH/01.5 - WHO/RHR/01.18).

Video: *The Road to Change: A Film on Female Genital Mutilation*

2000, VHS, 45 minutes, English and French editions

Sw.fr.35.-/US \$31.50 (In developing countries: Sw.fr.24.50) Order no. 1650103

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World Health Assembly Resolution Related to Female Genital Mutilation

Resolution WHA47.10

Forty-seventh World Health Assembly, May 1994

Maternal and child health and family planning: traditional practices harmful to the health of women and children

The Forty-seventh World Health Assembly,

Noting the report by the Director-General to the Executive Board on maternal and child health and family planning: current needs and future orientation;¹

Recalling resolutions WHA32.42 on maternal and child health, including family planning; WHA38.22 on maturity before childbearing and promotion of responsible parenthood; and WHA46.18 on maternal and child health and family planning for health;

Reaffirming its support for the United Nations Convention on the Rights of the Child, and United Nations Economic and Social Council resolution 1992/251 on traditional practices affecting the health of women and children;

Recognizing that, although some traditional practices may be beneficial or harmless, others, particularly those relating to female genital mutilation and early sexual relations and reproduction, cause serious problems in pregnancy and childbirth, and have a profound effect on the health and development of children, including child care and feeding, creating risks of rickets and anaemia;

Acknowledging the important role that nongovernmental organizations have played in bringing these matters to the attention of their social, political and religious leaders, and in establishing programmes for the abolition of many of these practices, particularly female genital mutilation,

1. WELCOMES the initiative taken by the Director-General in drawing international attention to these matters in relation to health and human rights in the context of a comprehensive approach to women's health in all countries, and the policy declarations to the United Nations Special Rapporteur on traditional practices by governments in countries where female genital mutilation is practised;

2. URGES all Member States:

(1) to assess the extent to which harmful traditional practices affecting the health of women and children constitute a social and public health problem in any local community or sub-group;

¹ See document EB93/1994/REC/1, Annex 5.

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(2) to establish national policies and programmes that will effectively, and with legal instruments, abolish female genital mutilation, childbearing before biological and social maturity, and other harmful practices affecting the health of women and children;

(3) to collaborate with national nongovernmental groups active in this field, draw upon their experience and expertise and, where such groups do not exist, encourage their establishment;

3. REQUESTS the Director-General:

(1) to strengthen WHO's technical support to and cooperation with Member States in implementing the measures specified above;

(2) to continue global and regional collaboration with the networks of nongovernmental organizations, United Nations bodies, and other agencies and organizations concerned in order to establish national, regional and global strategies for the abolition of harmful traditional practices;

(3) to mobilize additional extrabudgetary resources in order to sustain the action at national, regional and global levels.

The Traditional Birth Attendant

Definition of a traditional birth attendant

A traditional birth attendant (TBA) is a person who assists the mother during childbirth and initially acquired her skills by delivering babies herself or through apprenticeship to other traditional birth attendants.

A family TBA is a TBA who has been designated by an extended family to attend births in the family.

A trained TBA is a TBA or family TBA who has received a short course of training through the modern health care sector to upgrade her skills. The period of training is normally not more than one month, although this may be spread over a longer time.

Joint WHO/UNFPA/UNICEF Statement, 1992

TBAs are often older women, respected in the community for their knowledge and experience. They are often illiterate and learn their skills through working with other, more experienced TBAs. These women work mainly in rural areas distant from health facilities and in poor, periurban areas with limited access to health services.

The number of births attended by a TBA each year varies widely. In large extended families, a family TBA may deliver up to 24 babies in a year, although 5 or 6 births is more usual. Some TBAs are assisting regularly, for example, conducting over three deliveries a month, while others may have long intervals, such as a year, in between deliveries. The frequency of practice has important implications for TBA training programmes, such as selection of trainees and retention of new knowledge by trainees; if techniques learned are not practised within a reasonable time, they may be forgotten.

TBAs are private practitioners at the community level and may perform a mix of services ranging from assistance at birth and immediate postpartum care, to conducting female genital mutilation, unsafe abortion and ritual practices such as “certifying” virginitv at marriage (Egypt). TBAs usually receive some remuneration for their services. It may be in cash or in kind, depending on the customs of the community and the financial resources of the family.

Potential loss of income must be kept in mind as TBAs are integrated in the formal health system or displaced by it. In some cases, for example, once TBAs have received training, communities have perceived them as employees of the health system and refused to pay them as before. In order to promote timely referral by TBAs and to develop their links with the formal health system, consideration may be given to paying TBAs a fee for their referral services.

Policy Statements Related to Female Genital Mutilation

World Health Organization

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

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

International Federation of Gynecology and Obstetrics

The International Federation of Gynecology and Obstetrics (FIGO) adopted the following resolution on female genital mutilation at its General Assembly on 27 September 1994 in Montreal, Canada.

The FIGO General Assembly,

CONSIDERING that female genital mutilation (female circumcision) is a harmful traditional practice which is still prevalent in over 30 countries of the world, including areas of Africa, Asia and the Middle East;

CONCERNED about the serious adverse effects of the practice on the physical and psychological reproductive health of children, adolescents and women;

RECOGNIZING that female genital mutilation is a violation of human rights, as a harmful procedure performed on a child who cannot give informed consent;

RECALLING the 1994 World Health Assembly resolution WHA47.10 welcoming the policy declarations to the United Nations Special Rapporteur on traditional practices by governments in countries where female genital mutilation is practised;

1. INVITES Member Societies to:

(1) URGE their governments to ratify the Convention on the Elimination of All Forms of Discrimination Against Women, if they have not already done so, and to ensure the implementation of the articles of the Convention, if the Convention has already been ratified.

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(2) URGE their governments to take legal and/or other measures to render this practice socially unacceptable by all sectors and groups in society.

(3) COLLABORATE with national authorities, non-governmental and inter-governmental organizations to advocate, promote and support measures aiming at the elimination of female genital mutilation.

2. RECOMMENDS that obstetricians and gynaecologists:

(1) EXPLAIN the immediate dangers and long-term consequences of female genital mutilation to religious leaders, legislators and decision makers.

(2) EDUCATE health professionals, community workers and teachers about this harmful traditional practice.

(3) SUPPORT those men and women who want to end the practice in their families or communities.

(4) ASSIST in research for the documentation of the prevalence of the practice and its harmful consequences.

(5) OPPOSE any attempt to medicalize the procedure or allow its performance, under any circumstances, in health establishments or by health professionals.

International Confederation of Midwives

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

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

In keeping with this belief:

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

International Council of Nurses

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

Elimination of female genital mutilation¹

Female Genital Mutilation (FGM) and other harmful traditional practices are a reflection of gender discrimination and violence practised against women and children in both public and private life and constitute a violation of basic human rights. FGM is an issue for all nurses, as girls and women who have undergone FGM are likely to suffer a wide range of physical, mental and psychological problems. The World Health Organization estimates that between 85 to 115 million women and girls have suffered FGM throughout the world and each year a further 2 million girls are at risk of the practice².

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

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

Approaches to the eradication of FGM also include collaborating with national groups³ specifically working in this field; promoting the inclusion of FGM awareness, counselling and treatment into health services for women and children and primary health care programmes; and working with nurse educators to ensure that educational programmes include adequate knowledge of FGM and prepare nurses to provide culturally sensitive care and counselling to parents, women and children suffering the effects of FGM.

¹ This issue concerns all countries given the present patterns of immigration.

² Female Genital Mutilation (information kit). (WHO/CHS/WMH/99.11)

³ Examples of NGOs with national groups addressing FGM include: The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) has a headquarters in Addis Ababa, National Committees in 24 African countries, a Liaison Office in Geneva and a group working among immigrant communities in France; Foundation for Women’s Health, Research and Development (FORWARD) in London; International Planned Parenthood Federation.

Medical Women's International Association

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

Between 85 and 114 million girls and women throughout the world are the victims of the traditional practice of Female Genital Mutilation. Each year a further 2 million girls are at risk.

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

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

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

Therefore:-

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

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

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

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

International Agreements Relevant to the Elimination of Female Genital Mutilation

International human rights covenants underscore the obligations of Member States of the United Nations to respect and to ensure the protection and promotion of human rights, including the rights to non-discrimination, to integrity of the person and to the highest attainable standard of physical and mental health. In this regard, most governments in countries where female genital mutilation is practised have ratified several United Nations Conventions and Declarations that make provision for the promotion and protection of the health of girls and women, including the elimination of female genital mutilation as indicated below.

- 1948 The **Universal Declaration of Human Rights** proclaims the right of all human beings to live in conditions that enable them to enjoy good health and health care and the entitlement in motherhood and childhood to special care and attention.
- 1966 The **International Covenant on Civil and Political Rights** and the **International Covenant on Economic, Social and Cultural Rights** condemned discrimination on the grounds of sex and recognized the universal right to the highest attainable standard of physical and mental health.
- 1979 The **Convention on the Elimination of All Forms of Discrimination against Women** can be interpreted to require State Parties to take action against female genital mutilation, namely:
- “to take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women” (Article 2f)
 - to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or superiority of either of the sexes or on stereotyped roles for men and women” (Article 5a).
- 1990 The **Convention on the Rights of the Child** protects the right to equality irrespective of sex (Article 2), to freedom from all forms of mental and physical violence and maltreatment (Article 19.1), to the highest attainable standard of health (Article 24.1), and to freedom from torture or cruel, inhuman or degrading treatment (Article 37a). Article 14.3 of the Convention explicitly requires States to take all effective and appropriate measures to abolish traditional practices prejudicial to the health of children.
- 1993 The **Vienna Declaration** and the **Programme of Action of the World Conference on Human Rights** expanded the international human rights agenda to include gender-based violations which include female genital mutilation.

1993 The **Declaration on Violence against Women** expressly states:

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

1994 The **Programme of Action of the International Conference on Population and Development** included recommendations on female genital mutilation which commit governments and communities to:

- “urgently take steps to stop the practice of female genital mutilation and to protect women and girls from all such similar unnecessary and dangerous practices”.

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

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

Training and Education on Female Genital Mutilation - Two Proposals

The WHO Technical Consultation on Management of Pregnancy, Childbirth and the Postpartum Period in the Presence of Female Genital Mutilation, held in Geneva in October 1997, submits the following proposals for consideration.

1. Proposal for the development and implementation of information, education and communication programmes on female genital mutilation at community level.

Rationale

Female genital mutilation (FGM) is a complex traditional practice associated with severe social, psychological and health problems. Efforts to combat FGM have been largely directed at health personnel, researchers, policy-makers, etc. Little has been done at the community level to address the matter and there are very few culturally sensitive information, education and communication (IEC) materials currently available for use at this level. Urgent action is needed to remedy the situation.

FGM is a ritual that is deeply embedded in the societies where it is practised. Careful study is therefore required to develop strategies related to FGM that are effective and culturally acceptable in the communities where they are to be implemented.

Objectives

To develop culturally acceptable IEC materials for communities where FGM is practised in order to effect appropriate changes at the grass roots level.

Development of materials

Preliminary research will be undertaken in a suitable community or communities by a multidisciplinary team using qualitative and quantitative methods. This will involve participation by members of the community and will include:

- in-depth discussions
- focus group discussions
- narratives
- role play
- surveys.

In collaboration with the community, the findings will subsequently be used in developing and designing culturally acceptable IEC materials which will be pre-tested by trained field workers to ensure that they are appropriate for use in the target population (e.g. youth, women's and men's groups, traditional healers, secret societies, etc.). Any necessary modifications to the materials will then be made.

Implementation

Use of the pre-tested IEC materials will be administered by trained field workers. Information will be disseminated by all possible existing and appropriate channels: the mass media, songs, puppet shows, entertainment, education institutions, health care facilities, etc.

Evaluation

The IEC programmes will be evaluated after 12 months to determine their level of effectiveness.

Duration of study

The study will last 18-24 months.

2. Proposal for introducing education on female genital mutilation into mainstream nursing and midwifery curricula

Rationale

Female genital mutilation (FGM) is a health and human rights problem. Although its prevalence varies from country to country, it is significant in several countries in Africa.

Although there have been no systematic studies of the magnitude of the health consequences of FGM, the procedure is strongly implicated in infant and maternal mortality and morbidity and is an important cause of morbidity throughout life. Apart from the suffering and disruption that FGM causes, it has considerable implications for the use of human, material and financial resources for health.

Health professionals are ill-prepared to deal with FGM in terms of prevention, management and the provision of appropriate and timely information and counselling. Nurses and midwives are well placed, especially through primary health care services, to contribute to the elimination of the practice and to alleviating the burden of ill health resulting from the effects of FGM.

Objectives

1. To develop guidelines to assist in the introduction of education on FGM into mainstream nursing and midwifery curricula that can be adapted to specific contexts; the guidelines should cover:
 - content, to include as a minimum, knowledge (theoretical and management approaches), strategies and skills for giving health education and counselling, and ethical and legal issues (including current international and professional instruments and positions related to FGM)
 - guidance on how to integrate FGM education into existing curricula
 - principles for adapting education programmes to specific contexts
 - listing of accessible teaching/learning resources.
2. To identify existing materials that can be used in developing these guidelines and supporting teaching/learning materials.

Methodology

1. Collection of existing suitable relevant materials.
2. Development of a preliminary outline of the content and approaches to be followed in the guidelines.
3. Establishment of a small technical group (of no more than 4-5 persons) to work on the first draft of the guidelines. Membership could include representatives of the International Council of Nurses, the International Confederation of Midwives and national groups such as the Federation of Female Nurses and Midwives of Nigeria. WHO should provide technical support.
4. Testing of the guidelines and revision in accordance with feedback.
5. Preparation of final draft for distribution.

Note

This project addresses only the first phase of the process of introducing FGM education into nursing and midwifery curricula. For there to be any prospect of implementation, there needs to be a follow-up phase targeting educators/trainers. They will need to be sensitized to the issues involved and assisted in developing strategies for integrating FGM education into their existing education programmes.