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MANUAL FOR THE MANAGEMENT
AND PREVENTION OF
FEMALE GENITAL MUTILATION/CUTTING
FOR HEALTH PROFESSIONALS
KENYA

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FOREWORD

The Kenyan government recognizes that Female Genital Mutilation/Cutting (FGM/C) is a rapid growing public health problem and poses severe threat to the Kenyan women and girls, with major physical, psychological, social and economic impact on individuals, households, communities and the society as a whole.

Moi University signed a Memorandum of Understanding (MOU) with Wassu-UAB Foundation in 2012 with the aim of reducing the prevalence of FGM/C in Kenya by prevention, through training and awareness of Kenyan Nursing, Midwifery, Medicine and Public Health students and professionals. It is hoped that these stakeholders will participate in training health care workers, institutions and community health workers in rural settings where FGM/C is practiced. Availability of an FGM/C manual to other health training institutions will be used alongside advocacy for positive cultural change, in all areas practicing FGM/C in Kenya.

The introduction of FGM/C into the academic curriculum of the Health Schools has been already developed and implemented in The Gambia, which has been pioneer on the issue. The framework of this action is the *Transnational Observatory of Applied Research to New Strategies for the Prevention of Female Genital Mutilation/Cutting* under the Wassu-UAB Foundation, with two research centres: one in The Gambia, through the NGO Wassu Gambia Kafo, and one in Spain, through the *Interdisciplinary Research Group for the Prevention and Study of Harmful Traditional Practices* at the Department of Social and Cultural Anthropology of the Autonomous University of Barcelona.

Moi University is the second public University in Kenya formed by an act of parliament and came into operation in 1984. It is situated in Uasin Gishu County at the Rift Valley. The Moi University vision is to be the University of choice in nurturing innovation and talent in Science, Technology and development. Inherent to the vision, the university has an institute of gender, equity, research and development (IGERD), whose key mandate is to mainstream gender issues including FGM/C into all its curricula. It is from this aspect therefore that the Moi University, College of Health Sciences, School of Nursing has taken the lead to integrate this unique program into its curriculum and develop a manual. This manual will be used to train students and other stakeholders and thereafter offer support to other universities and Health Care training institutions in the introduction and implementation of FGM/C into their curricula.

Proper implementation of this curriculum will require capacity building of both students and professionals, hence the need for standard learning protocols for providing guidance on the highest quality and cost effective health care delivery models for prevention of FGM/C in Kenya.

With the publication of this FGM/C manual, the collaborating institutions will be in the frontline in disseminating education that addresses global challenges that will help create healthy and socio-economically stable communities for the current and future generations. It will also help support education, research and extension activities which will contribute towards achievement of the United Nations (UN) Millennium Development Goals 4 and 5 “reducing child mortality” and “improving maternal health” respectively.

It is our expectation therefore that, the university will find the FGM/C manual useful and that, we will continue joining hands together with Wassu-UAB Foundation in rolling out the FGM/C manual into other health academic programs.

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I

INTRODUCTION

Female Genital Mutilation/Cutting (FGM/C) is an ancient practice that remains a deeply rooted tradition in 29 countries of Sub-Saharan Africa, part of the Middle East (Iraqi Kurdistan, Yemen) and Asia (Indonesia, Malaysia). Today, the local becomes global, and the practice is also widespread within the African diaspora worldwide.

Kenya is among the countries with “moderately low prevalence”, with 27% of the women over 15 years old cut (UNICEF, 2013). In absolute numbers, it is the fifth country, sharing the position with Burkina Faso, where more women have undergone FGM/C: 9.3 millions. It is also one of the countries with the biggest decline in former years. Total prevalence has decreased from 38% in 1998 to 32% in 2003 and 27% (DHS 2008-09). The change is even more visible if we compare generations: women aged 45 to 49 are approximately three times more likely to have been cut than girls aged 15 to 19.

However, prevalence is still driven by deep-seated traditional beliefs. Mothers and grandmothers insist on excising their daughters and grand-daughters to prepare them for eligibility of marriage, sometimes the only social security within the community. It is out of love and care for the future of their daughters that this rite of passage is perpetuated. The socializing process which moulds the attitudes of girls and women prepares them to accept pain and suffering as an inevitable part of women's life, and as an obligation to be observed for acceptance by their respective societies, giving ethnic and gender identity.

Women living with FGM/C can suffer its consequences throughout their lives and it is a violation of human rights.

FGM/C is currently a national concern in Kenya, with a significant effort to improve the law with the enactment of the *Prohibition of Female Genital Mutilation Act* in 2011 and several cases taken to court. Numerous players are involved addressing the problem, from national and international organisations to local NGOs.

However, health professionals are yet to play an active role. There is still much to be achieved in terms of providing quality health services to those affected, and to prevent other girls to undergo the practice. Bringing FGM/C into mainstream education for health professionals will increase the pressure for abandonment.

In 2008, a Reference Manual for Health Services Providers on the *Management of complications, pregnancy, childbirth and the postpartum period in the presence of FGM/C* was published by the Ministry of Health of the Republic of Kenya, becoming the first and excellent contribution to the field, but had a limited dissemination throughout the country.

The present Manual and its 10 modules aim to be part of the Academic Curriculum for the faculties and schools where health students are trained. It is based on the *Manual on Female Genital Mutilation/Cutting for Health Professionals (2010)* published for The Gambia, integrated in all health studies in the country. For example, in Medicine, the FGM/C issue was integrated into six subjects: anatomy, physiology, psychology, G&O, paediatrics and community medicine. The project follows the scientific methodology developed and implemented by *The Transnational Observatory of Applied Research to New Strategies for the Prevention of Female Genital Mutilation/Cutting* under the Wassu-UAB Foundation, with two research centres: one in The Gambia, through the NGO *Wassu Gambia Kafo*, and one in Spain, through the *Interdisciplinary Research Group for the Prevention and Study of Harmful Traditional Practices* at the Autonomous University of Barcelona. Qualitative and clinical knowledge is generated through applied research and transferred to key social actors (governmental and non-governmental institutions; health, social and educative services; health professionals and students; community and religious leaders, traditional birth attendants and circumcisers). The outcome is to empower them to be the ones who transfer this knowledge to their communities, promoting preventive actions for the abandonment of the practice.

It is also designed to set the stage for the active participation of medical doctors, graduate nurses and graduate Public Health officers for the promotion of the prevention, care and abandonment of FGM/C, as well as for the management of its consequences. It is important that these gaps in professional training and education are addressed adequately in the societies where FGM/C is performed. The training gives health professionals the skills needed to identify and manage the complications. Advanced training prepares midwives and those involved in caring for women during pregnancy, labour, delivery and the postpartum period. Training also enables medical professionals to open up type III FGM/C. Integrating FGM/C into mainstream training of health professionals in Kenya will increase the pressure for the elimination of the practice. Training of practitioners in interpersonal communication skills, including counselling, is crucial to their role in its prevention. Health education of communities, civil society organisations, organized community groups, families and individuals on FGM/C issues in a participatory manner, is equally important. The aim is empowering through information and education. If health professionals do not recognize FGM/C as a major public health issue, there is little hope of convincing communities to abandon the practice.

In 2012, Memorandums of Understanding have been signed with Universities in Kenya and Tanzania, in order to replicate this methodology, promoting South-South cooperation. This Manual is one of the first outcomes of this collaboration.

In this common endeavor for the abandonment of FGM/C, the role of health professionals is crucial as they win respect and confidence from the population, becoming effective agents of change. This Manual wants to be a contribution to this attempt. It wants to add efforts to this strategy based on research, awareness, prevention and empowerment in order to be women and their communities the ones who take alternative proposals to avoid FGM/C. It seeks to safeguard the fundamental right of women to physical and mental integrity, reconciling this perspective with respect to tradition, the right to privacy and the free movement of persons.

Prof. Adriana Kaplan Marcusán

Chair of Knowledge Transfer

Director Wassu-UAB Foundation

Autonomous University of Barcelona (UAB)



1

Origin and definition

The origins of FGM/C

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

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

Ancient history of the Dogon culture in Mali relates an incident of significance to the origin of FGM/C¹. According to the myth, Amma, God of the Sky, was alone and wanted to have intercourse with the Earth, whose form was like that of the female body. The Earth's sexual organs were like ants' nest and her clitoris was raised like a termite mound. Amma drew close but the termite mound rose up, blocking penetration. It so happened that the Earth had the same sex as Amma, causing discord in the Universe. Amma, angry at being thwarted, cut down the termite mound and successfully coupled with the Earth. Amma consorted many times with his wife and harmony was restored to the universe once the termite mound had been removed. Nowadays, there are still cultures that believe that if the clitoris is not removed it will grow to the same size as the penis and, once erect, will prevent a man penetrating a woman's vagina.

The historian Carlos Castañeda¹ places the origin of FGM/C in the V century A.C. Probably it was a rite of passage performed by Egyptian, Phoenician, Hitites and Ethiopians. From Egypt, the practice may have travelled to Sudan and the Horn of Africa. The first references in papyrus are from the II century A.C., where they mention a girl in the age of undergoing an Egyptian circumcision. From here, researchers link the practice with African groups who had contact with Egyptians. It seems the girls' parents organized a feast in her honour, called *therapeuteria*. That was common in the Roman Era, proved by documents from Oxirrinco (III century A.C).

FGM/C is also linked to camito-semita groups and Afro-asiatic languages. The excision could initially has been practised by the Masaai in Kenya, from Cushitic groups coming from Ethiopia. The Kikuyu, influenced by Cushitic groups, could have adopted it as a result of having Bantu influence. The Harris Papyrus mentions that goddesses Anat and Astarté had to have their vulvas closed. Horus sealed them and Set opened them. Thus, goddesses could conceive but not give birth. The tradition may have come from Asia, as those goddesses are from there.

The Lidyas in Greece were the first women to develop this practice called *ευνουχισμο*. It could be associated to a ritual for adolescents in the temples, performed within the menarche or before marriage. Perhaps, it arrived in this way to Egypt.

Castañeda considers that the Egyptian contact with inland Africa had a remarkable Nubia influence (matriarchal community with feminine leadership) and it came in the last dynasties (XXIV and XXV), with the Peys conquer.

It has also been written that the *leitmotif* to perform FGM/C is the belief that the *feminine soul* of men is located in the prepuce, while the masculine soul of women is located in the clitoris. With the excision, both become real men and women. This convention may have come from the androgyny of Egyptian gods, and it has last until nowadays as one of the reasons explaining the survival of this harmful traditional practice.

Definition of FGM/C

Female Genital Mutilation/Cutting (FGM/C) is defined as “all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons”². Prior to the adoption of “female genital mutilation”, the practice was referred to as female

circumcision. This term is still used in societies where FGM/C is practiced. In those communities it is perceived as an equivalent of male circumcision. *“Only this terminology [FGM/C] reflects the full seriousness and the extent of the damage caused by these practices and captures the element of violence and physical assault which mutilations entail”*³. FGM/C is practiced for social and cultural reasons.

Classification

Different types of FGM/C are known to be practiced today:

Type I: “Partial or total removal of the clitoris and/or the prepuce. In medical literature this form of FGM/C is also referred to as ‘clitoridectomy’⁴. In Islamic culture, this type is known as “Sunna” (“tradition”) and is compared to male circumcision.

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

Type III: “Narrowing of the vaginal orifice by cutting and bringing together the labia minora and/or the labia majora to create a type of seal, with or without excision of the clitoris. In most instances, the cut edges of the labia are stitched together, which is referred to as ‘infibulation’⁴. This type is sometimes referred to as ‘Pharaonic’, and its name comes from the Latin word “infibulare” (“fasten with a clasp”).

Type IV: “All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization”⁴. Detailed examples include:

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

Current estimates indicate that around 90% of FGM/C cases included types I or II and cases where girls’ genitals were “nicked” but no flesh removed (type IV), and about 10% are type III⁵. FGM/C is mostly

performed on girls between the ages of 0 to 15 years, prior to the onset of menstruation. However, adult and married women are also occasionally subjected to the procedure⁴.

Prevalence of FGM/C

Distribution of FGM/C

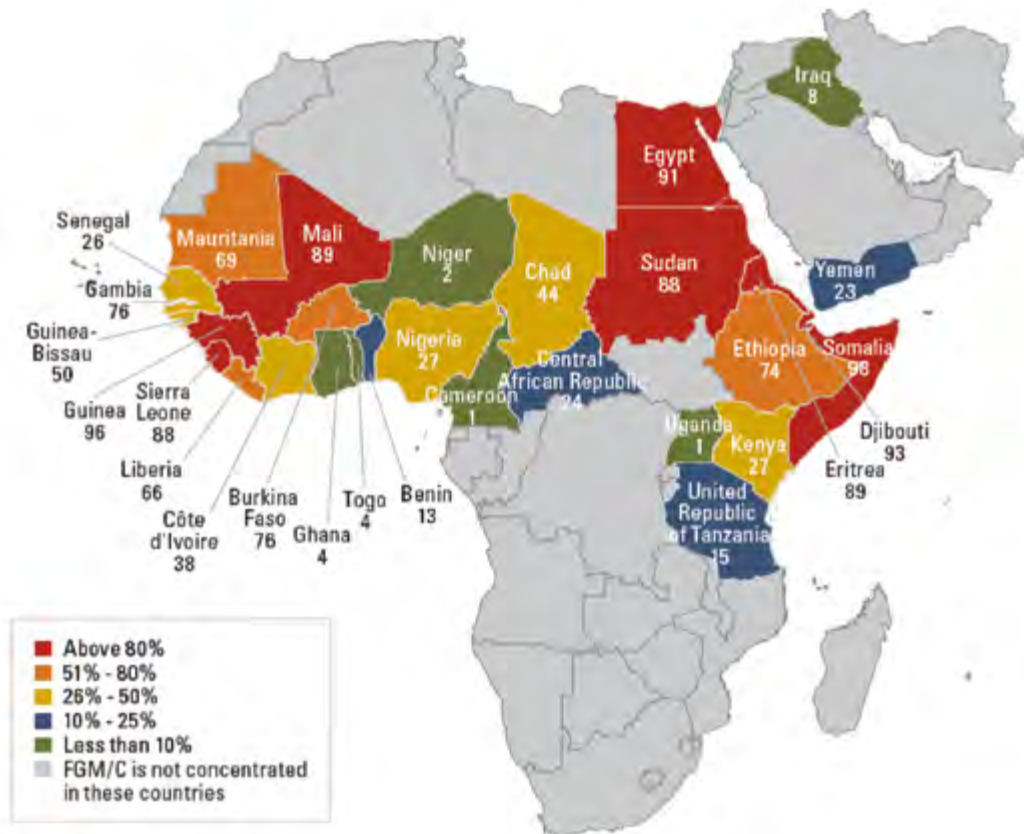
The prevalence of FGM/C has been estimated through surveys asking women aged 15 to 49 years of age whether they had been cut. It is predominantly practiced in 29 countries in Sub-Saharan Africa and the Middle East (Iraqi Kurdistan, Yemen) and Asia (Indonesia, Malaysia)⁶. Due to the migration of people who follow this tradition, FGM/C is today found in Europe, Australia, Canada, and the United States of America, mainly among migrants from Sub-Saharan Africa.

This prevalence varies considerably, both between and within regions and countries. Ethnicity is the most decisive factor. In eight countries the national prevalence is almost universal, over 85% (Somalia, Guinea Conakry, Djibouti, Egypt, Eritrea, Mali, Sierra Leone and Sudan); five countries have high prevalence, 60–80% (Gambia, Burkina Faso, Ethiopia, Mauritania, Liberia); medium prevalence, 25–60%, is found in six countries (Guinea-Bissau, Chad, Côte d'Ivoire, Kenya, Nigeria and Senegal); and low prevalence ranging from 1% to 24% is found in the remaining ten countries (Central African Republic, Yemen, United Republic of Tanzania, Benin, Iraq, Ghana, Togo, Niger, Cameroon, Uganda). However, national averages hide marked variations in prevalence in different parts of most countries⁶.

In 1997, the World Health Organization (WHO), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), United Nations Economic Commission for Africa (UNECA), United Nations Programme on HIV/AIDS (UNAIDS), United Nations Development Programme (UNDP) and United Nations Educational, Scientific and Cultural Organization (UNESCO) issued an interagency statement on FGM/C². It describes the implications of the practice for public health and human rights and declared support for its abandonment. According to the statement, between 125 and 140 million girls and women in the world are estimated to have undergone the procedure and 3 million girls are calculated to be at risk every year.

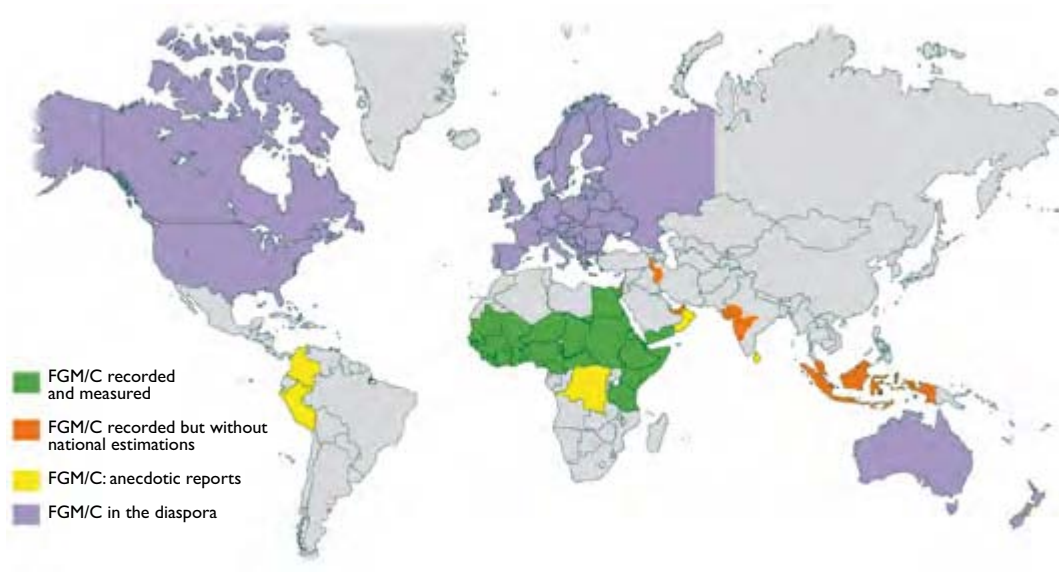
Map 1. Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, by country

Source: UNICEF (2013)⁶



Map 2. FGM/C world map

Source: Interdisciplinary Group for the Prevention and the Study of Harmful Traditional Practices (IGPS-HTP) of the Autonomous University of Barcelona, 2012.



References

1. CASTAÑEDA REYES, J.C. (2003) *Fronteras del placer; fronteras de la culpa. A propósito de la mutilación femenina en Egipto*. México. Primera edición.
2. WHO (2014) Female Genital Mutilation <http://www.who.int/mediacentre/factsheets/fs241/en/> [Accessed 15th July 2014]
3. WHO, UNICEF, UNFPA (1997) *Female Genital Mutilation. A Joint WHO/UNICEF/UNFPA Statement*. Geneva.
4. WARZAZI, H.E. (2005) *Ninth report and final report on the situation regarding the elimination of traditional practices affecting the health of women and the girl child E/CN.4/Sub.2/2005/36*, 11 July 2005, p. 35.
5. WHO (2008) *Eliminating female genital mutilation: an interagency statement UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNIFEM, WHO*. Geneva.
6. YODER, S.; KHAN, S. (2007) *Numbers of women circumcised in Africa: The production of a total*.

Other references

- UNICEF (2009) *Global and regional perspectives on Female Genital Mutilation/Cutting*. New York.
- UNICEF (2013) *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*. New York.



2

Procedures, decision-making and age

FGM/C procedures

FGM/C is usually carried out using blades or razors¹. Other instruments used include special knives, scissors or pieces of glass. On rare occasions sharp stones have been reported to be used, for instance in Eastern Sudan. Cauterisation, or burning, is practiced in some parts of Ethiopia. Finger nails have been used to pluck out the tip of the clitoris of babies in some areas in The Gambia. Instruments used for cutting may be re-used without being cleaned. Anaesthesia is rarely used and the girl is held down by a number of women, often including her own relatives. The procedure may take 15 to 20 minutes, depending on the skills of the exciser; the extent of excision and the amount of resistance put up by the girl. The wound is dabbed with anything from alcohol or lemon juice to ash, herb mixtures, porridge or cow dung, and the girl's legs may be bound together until healing is completed. In certain countries scalpels are used for cutting in local health clinics.

Decision to perform FGM/C

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

Age at which FGM/C is performed

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

In half of the countries with data available, the majority of the women experience it before five years old¹, when girls are young and uninformed. They are generally conscious when the painful operation is undertaken as no anaesthetic is used and have to be physically restrained because they struggle. Sometimes, they are forced to watch the mutilation of other girls, increasing the probabilities of psychosocial problems as a consequence.

Excisers and medicalisation of FGM/C

Description of the excisers

In cultures where FGM/C is a tradition, the operation is performed by excisers, usually elderly women in the community specially designated for this task. In most societies, the practice is handed down through family lineage. Traditional Birth Attendants (TBAs) are known to be involved in the practice in many societies. Excisers are powerful and well-respected members of the community, who keep the tradition alive.

“Medicalisation” of FGM/C

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

by health professionals, mainly doctors, and in Kenya there is nowadays a substantial proportion of FGM/C performed by health professionals, the majority nurses, midwives or others, no doctors¹. In Tanzania, almost all FGM/C are performed by traditional practitioners. Egypt is unique in having had a period in which the government gave its consent for FGM/C when performed by health personnel. In other countries, government policies have either been absent or actively opposed to healthcare providers performing the procedure. In Kenya, for instance, the Ministry of Health issued a policy in 2001 making illegal to perform FGM/C in healthcare facilities¹.

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

According to the World Medical Association Declaration of Helsinki (1964) the physician's mission is to safeguard people's health. Trained health professionals who perform FGM/C are violating girls' and women's right to life, to physical integrity and health. Yet, in some countries and societies, health professionals have performed it and continue performing it². Evidence shows the trend to be increasing in many of them. In addition, FGM/C in the form of reinfibulation has been documented as being performed as a routine procedure after childbirth in some countries. Reports also indicate that among groups that have immigrated to Europe and North America reinfibulation is occasionally performed even where it is prohibited by law.

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

There are serious risks associated with the medicalisation of FGM/C. Its performance by health personnel may wrongly legitimise the practice as beneficial for girls' and women's health. It can also further institutionalise the procedure, as health professionals often hold power, authority, and respect in society. In Egypt, the issue of medicalisation was intensely debated but the tradition has now become almost legitimised.

Regulatory Bodies

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

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

The International Federation of Gynaecology and Obstetrics (IFGO) passed a resolution in 1994 at its General Assembly opposing the performance of FGM/C by obstetricians and gynaecologists. The Federation “recommends strong opposition to any attempt to medicalise the procedure or to allow its performance under any circumstances in health establishments or by health professionals”³.

Customs and traditions underpinning FGM/C

All human behaviour has an explanation and FGM/C is no exception. In societies where FGM/C is practiced, it is entrenched in the traditional beliefs, values and attitudes of the people. Traditions are the customs, beliefs and values of a community which govern and influence people’s behaviour. Traditions constitute learned habits which are passed on from generation to generation.

In some communities, FGM/C is valued as a rite of passage into womanhood (e.g. Kenya, The Gambia and Sierra Leone). Others value it as a means of preserving a girl’s virginity until marriage (e.g. Sudan, Egypt and Somalia). In each community where FGM/C is practiced it is an important part of gender identity, which explains why many mothers and grandmothers defend the practice. They consider it a fundamental part of their own womanhood and believe it is essential to their daughters’ acceptance into their society. In most of these communities, FGM/C is a pre-requisite to marriage, and marriage is vital to a woman’s security.

Discussion on Tradition

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

Beliefs:

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

Values:

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

Attitudes:

Attitude is a mental view or disposition. They are largely based on personal values and perceptions.

Examples of Beliefs, Values and Attitudes with regard to FGM/C:

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

People develop a unique set of values and attitudes that guide them through life and give them their cultural identity. By understanding their own values and how they were formed, healthcare providers can gain understanding and respect to the values and belief systems of communities with which they work.

The role of men

The data on boys' and men's opinions of FGM/C is generally less up to date than data on girls and women, and may not reflect recent attitudinal changes¹. The most recent data show that the level of support for the continuation of FGM/C among boys and men varies widely across countries. In four countries with high prevalence (Mauritania, Mali, Egypt and Guinea Conakry), the majority of boys and men report that they wanted the practice to continue. By contrast, in the rest of the countries, the majority of them favour stopping the practice. In Egypt and Eritrea, almost twice as many older men think the practice should continue compared to adolescents. This is similar to the findings for girls and women in those countries¹.

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A study conducted in a rural area of Sudan along the Blue Nile in March-May 1997 was focused on the role of men regarding FGM/C⁴. A total of 59 young men and grandfathers were interviewed. Male complications resulting from FGM/C, such as difficulty in penetration, wounds/infections on the penis and psychological problems were cited by the majority of respondents. The first and second responses came up most frequently in chronological order. They also mentioned decreased sexual desire and enjoyment of the woman. Many of them also felt that the man 'hurts' the woman during sexual intercourse. Most of the subjects were also aware of the female complications of FGM/C. Interestingly, a majority of men said they would have preferred to marry a woman without FGM/C. There was a high level of awareness that FGM/C has negative health consequences for women. The study revealed that even the majority of grandfathers answered that the practice negatively affects the health of girls and women.

Acknowledging the gap on the role of men in FGM/C, a new line of research is emerging interested in exploring how men position themselves on the matter, with the objective of assessing their potential inclusion in preventive actions and programmes. The study by Kaplan et al. (2013)¹³ intends to contribute to this field, by exploring the knowledge and attitudes of Gambian men towards FGM/C, as well as practices in their family and household. The study was integrated in the Practicum of Community Medicine of the School for Enrolled Community Health Nurses and Midwives at Mansakonko, Lower River Region. The survey was implemented through face-to-face questionnaires in three regions of

the country. The overall sample was composed by 993 men with a mean age of 36.5 years old with Muslim affiliation (96.2%). Seen through men's eyes, the secret world of women remains embedded in cloudy concepts shaped by culture and influenced by religion. The practicing ethnic groups considered FGM/C as a religious injunction or as "Sunna", finding justification for its continuation. Almost all those from traditionally non-practicing groups, deny that the practice is mandatory from Islam. Even within traditionally practicing groups, the support towards the practice is highly dependent on ethnic identity. Amongst older men, FGM/C is seen as mandatory by religion, but a window of opportunity for change is found amongst younger generations. Men between 31 and 45 are the less supportive towards the practice and have the lowest intention to perform it to their daughters. Although few men are active participants in the decision-making of the practice, in a patriarchal society, men are still decision-makers and can promote a positive change to the secret world of women.

Reasons for FGM/C existence and persistence

There is a wide variety of reasons why FGM/C continues to be practiced. The reasons given by practicing communities are as follow:

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

Socio-cultural reasons

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

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

Some communities believe that a woman's external genitalia have the power to blind anyone attending her during delivery. Others believe that the external genitalia have the power to cause the death of an infant or bring about physical deformity or madness.

In some societies, it is believed that being uncircumcised can cause the death of one's husband or harm his penis. FGM/C is believed to ensure a girl's virginity. In many traditional societies, virginity is a prerequisite for marriage, which is necessary to maintain a family's honour. The societies practicing FGM/C are largely matrilineal. Women's access to land and security is through marriage, and only excised women are considered suitable for that purpose.

Spiritual and religious reasons

Some communities believe that removing the external genitalia is necessary to make a girl spiritually clean and is therefore required by religion. In some Muslim societies where FGM/C is practiced, people believe that it is required by the Qur'an or Sunna, even though the practice is not mentioned in the Holy Book. It is noteworthy that neither the Bible nor the Qur'an subscribe to the practice of FGM/C, although it is carried out in many societies with Muslim, Coptic-Christian and Jewish Falasha communities (e.g. Egypt and Ethiopia).

The practice pre-dates both Christianity and Islam. The response of religious leaders to FGM/C varies. Those who support it tend either to consider it a religious act or to see efforts aimed at eliminating it as a threat to culture and religion. Other religious leaders support and participate in efforts to eradicate it. When such leaders are unclear or avoid the issue, they may be perceived as being in favour of FGM/C.

Hygienic and aesthetic reasons

In FGM/C practicing communities it is believed that a woman's external genitalia are ugly and dirty. Removing these structures makes a girl clean and smart. In many societies it is believed that eating food prepared by an unexcised girl is taboo. This is considered true in many communities in The Gambia.

Psycho-sexual reasons

The uncut girl is believed to have an overactive and uncontrollable sex drive and is thus likely to lose her virginity prematurely, and girls who have lost their virginity before marriage are a disgrace to their families. The belief of FGM/C as means of controlling sexual urge still persists in The Gambia and Kenya. In some communities, uncut girls have slim chances of marriage. The belief is that the uncut clitoris will grow big and the slightest touch of the organ will arouse intense sexual desire.

It is also believed that the tight vaginal orifice of an infibulated woman or a woman who has had chemicals placed in the vagina to narrow it will enhance male sexual pleasure, thus preventing divorce or unfaithfulness. In some communities it is believed that excising a woman who fails to conceive will solve the problem of infertility.

Why FGM/C continues to be practiced

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

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

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

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

FGM/C is also considered to make girls “clean” and beautiful. Removal of genital parts is thought of as eliminating such “masculine” elements as the clitoris. It is also felt that infibulation is performed in order to make the genitalia ‘smooth’ thereby making a woman/girl beautiful. A belief sometimes expressed by women is that FGM/C enhances men’s sexual pleasure.

The practice is often upheld by influential people and local structures of power such as traditional and religious leaders, circumcisers, elders, and even some health professionals.

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

Preservation of ethnic identity to mark a distinction from non-practicing groups is also an important factor. For example, it is carried out by immigrant communities living in countries that have no tradition of the practice. FGM/C is also occasionally performed on women and their children from non-practicing groups when they marry into groups/societies in which it is widely practiced.

Religion and FGM/C

Is the voice of religious leaders heard?

In Africa, the practice of FGM/C is driven significantly by religious misperceptions. The ordinary people in African countries, where the practice is common, have little knowledge of the fundamental teachings of Islam. In particular, women have less chances of learning the fundamental teachings of Islam because they have less access to education in general. Moreover, misconceptions like the uncertainty regarding the origins of the practice lead to link the practice with religion. Many Islamic academics and authorities in these countries however demonstrate a positive position on the issue and condemn the practice when they are given the opportunity to articulate their views. Despite these attitudes among Islamic religious scholars, the practice still persists on a large scale. Perhaps the explanation for this phenomenon needs further research.

In July 1998, a symposium for religious leaders and medical personnel was held in Banjul, The Gambia. Participants came from 15 countries in Africa. Also in attendance were delegates from the Inter-African Committee (IAC) on Practices Affecting the Health of Women and Children, international NGOs and representatives from several UN agencies. The participants made strong declarations at the meeting. They declared "We, the participants at the symposium for Religious Leaders and Medical Personnel on FGM/C as a Form of Violence, organised by the IAC in collaboration with The Gambia Committee on Traditional Practices (GAMCOTRAP) declare as follows:

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

- (I) Hereby strongly condemn the continuation of FGM/C;
- (II) Prohibit the misuse of religious arguments to perpetuate FGM/C and other forms of violence;
- (III) Commit ourselves to clarify the misinterpretation of religion and to teach the true principles of Islam and Christianity with regard to violence against women, including FGM/C¹⁹.

In October 2007, the Fourth Symposium for African Religious Leaders on Human Rights, Gender and Violence against Women was held in Abidjan, Ivory Coast. Thirty-six (36) participants from 25 African countries attended. A strong declaration and a string of recommendations were made at this symposium too¹⁰. The spirit and letter of the declaration and recommendations are very similar to those made at the Banjul symposium in July 1998.

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

Ethics, legal implications and rights in FGM/C

Ethical Implications

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

In some countries physicians, nurses, midwives and other health personnel are reported to be performing FGM/C in both health institutions and private facilities. The WHO and most governments have expressed their unequivocal opposition to the "medicalisation" of the practice. The WHO position is that under no circumstance should FGM/C be performed by health professionals or in health institutions. The practice of FGM/C by medical professionals is a serious betrayal of professional ethics, since it involves causing harm without therapeutic reasons.

Legal implications of FGM/C

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

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

Table 1. Countries with laws against FGM/C¹

COUNTRY	LEGISLATION
BENIN	2003
BURKINA FASO	1996
CENTRAL AFRICAN REPUBLIC	1966, 1996
CHAD	2003
COTE D'IVOIRE	1998
DJIBOUTI	1995, 2009
EGYPT	1996, 2008
ERITREA	2007
ETHIOPIA	2004
GHANA	1994, 2007
GUINEA	1965, 2000, 2006
GUINEA BISSAU	2011
KENYA	2001, 2011
MAURITANIA	2005
NIGER	2003
NIGERIA (some states)	1999-2006

COUNTRY	LEGISLATION
SENEGAL	1999
SOMALIA	2012
SUDAN (some states)	2008-2009
TANZANIA	1998
TOGO	1998
UGANDA	2010
YEMEN	2001

In other countries, national laws make provisions for protection against injury, even if FGM/C is not specified. Laws and decrees have a variety of stipulations that can be used to regulate or ban the practice of FGM/C. In the United Republic of Tanzania and some non-African countries FGM/C is illegal only among minors¹. In 2011, Kenya expanded the 2001 ban on FGM/C among minors to apply to adult women and added an extraterritoriality clause, extending restrictions to citizens who commit the crime outside the country's border¹.

Human Rights and FGM/C

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

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

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

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

The rights of the child

Because of children's vulnerability and their need for care and support, human rights law grants them special protection. One of the guiding principles of the Convention on the Rights of the Child is the primary consideration of "the best interests of the child". Parents who take the decision to subject their daughters to FGM/C perceive that the benefits to be gained from this procedure outweigh the risks involved. However, this perception cannot justify a violation of the fundamental human rights of girls and women.

The Convention on the Rights of the Child refers to the capacity of children to make decisions regarding matters that affect them. Even in cases where there is an apparent desire by girls to undergo the procedure, in reality it is the result of social pressure, community expectations and girls' aspiration to be accepted as full members of the community. That is why a girl's decision to undergo FGM/C cannot be called 'free'.

The FGM/C is nearly always carried out on minors and is therefore a violation of the rights of the child. The practice also violates the rights to health, security and physical integrity of the person, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life, as the procedure may result in death.

Legal instruments for the protection of children's rights call for the abolition of traditional practices damaging to their health and lives. The Convention on the Rights of the Child makes explicit reference to harmful traditional practices. The Committee on the Rights of the Child, as well as other United

Nations Human Rights Treaty Monitoring Bodies have frequently raised FGM/C as a violation of human rights. They have called on State Parties to the Convention to take all effective and appropriate measures to abolish the practice.

Treaties and consensus

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

The Committee on the Elimination of All Forms of Discrimination against Women issued its General Recommendation on Female Circumcision. It calls upon states to take appropriate and effective measures with a view to eradicating the practice. It also requests them to provide information about measures being taken to eliminate FGM/C in their reports to the Committee¹².

International Treaties of direct relevance to FGM/C include:

- Universal Declaration on Human Rights, 1948;
- Convention for the Suppression of the Traffic in Persons and of the Exploitation of Others, 1949;
- Convention on Consent to Marriage, Minimum Age for Marriage and Registration of Marriages, 1964;
- International Covenant on Civil and Political Rights, 1966;
- International Covenant on Economic, Social and Cultural Rights, 1966;
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and its Optional Protocol, 1981;
- Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, 1987;
- Recommendation 19 of the Committee on the CEDAW, 1992;
- Vienna Declaration and Plan of Action (VDPA Vienna), 1993;
- United Nations Declaration on Violence Against Women, 1993;
- Declaration and Programme of Action of ICPD (International Conference on Population and Development), 1994;
- The Beijing Declaration and Platform for Action, 1995;
- The Geneva Conventions and their Additional Protocols, 1949 and 1977;
- Convention on the Rights of the Child (1989) and its two Optional Protocols (2000);

- Convention against Transnational Organized Crime and its Optional Protocols, 2000;
- African Charter on Women's Right, Maputo Protocol, 2005;
- UNESCO Universal Declaration on Cultural Diversity, 2001;
- United Nations Economic and Social Council (ECOSOC), Commission on the Status of Women. Resolution on the Ending of Female Genital Mutilation, 2007;
- United Nations General assembly first resolution calling on States to intensify efforts to eliminate FGM/C, 2012.

The Convention on the Rights of the Child (1990)

This Convention provides for:

- Protection of all fundamental rights irrespective of sex;
- The right to the highest attainable levels of health;
- Freedom from all forms of mental and physical violence and maltreatment.

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

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

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

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

Regional treaties

- African Charter on Human and Peoples' Rights (the Banjul Charter) and its Protocol on the Rights of Women in Africa, 2005;
- African Charter on the Rights and Welfare of the Child, 1999;
- European Convention for the Protection of Human Rights and Fundamental Freedoms, 1956..

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

The ACRWC was adopted in July 1990 by Heads of State and Governments of the African Union and entered into force in November 1999. The Charter has 48 Articles covering a wide range of issues affecting children. Article 21 is specifically committed to 'Protection against Harmful Social and Cultural Practices'. It states that "State Parties to the Charter shall take all appropriate measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child and in particular (a) those customs and practices prejudicial to the health or life of the child and (b) those customs and practices discriminatory to the child on the ground of sex or other status".

Article 16 provides "Protection against Child Abuse and Torture. State Parties to the Charter shall take specific legislative, administrative, social, economic and educational measures to protect the child from all forms of torture, inhumane or degrading treatment and especially physical and mental injury or abuse, neglect or maltreatment including sexual abuse, while in the care of the child". The spirit and intent of these two articles clearly run against the practice of FGM/C. Seen from a human rights perspective, the practice reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women.

Violence against women

Definition of violence against women

Article 1 of the UN Declaration on the Elimination of Violence against Women, proclaimed by the UN General Assembly in its resolution 48/104 of 20 December 1993, defines the term “violence against women” as: “Any act of gender-based violence that results in, or is likely to result in physical, sexual or psychological harm or suffering to women”. The Article further states that violence includes “threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life”. Three contexts of violence are differentiated in Article 2 of the Declaration – family, community and state. The forms of violence are classified as follows:

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

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

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

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

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

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

References

1. UNICEF (2013) *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*. New York.
2. UNICEF (2005) *Changing a harmful social convention: Female Genital Mutilation/Cutting*. Geneva, Innocenti Digest.
3. COOK, R.J.; DICKENS, B.M.; FATHALLA, M.F. (2002) "Female genital cutting (mutilation/circumcision): ethical and legal dimensions". *International Journal of Gynecology & Obstetrics* 79(3): 281-287.
4. ALMROTH, L.; ALMROTH-BERGGREN, V.; HASSANEIN, O.M.; AL-SAID, S.S. et al (2001) "Male complications of female genital mutilation". *Social Science and Medicine* 53(11): 1455-60.
5. WHO (1996) *The right path to health: Health education through religion. Islamic ruling and female circumcision*. Regional Office for Eastern Mediterranean.
6. SYMPOSIUM FOR RELIGIOUS LEADERS AND MEDICAL PERSONNEL ON FEMALE GENITAL MUTILATION (1998) "Banjul declaration on violence against women". *Women's International Network News* 24(4):27.
7. IAC (2007) *Report on the 4th Symposium for African Religious Leaders on Human Rights, Gender and Violence against Women*. Abidjan, Ivory Coast. October 23-25 2007.
8. UNECA (2009) *A Fifteen year Review of the Implementation of the Beijing Platform for Action in Africa – Main Report 1995-2009*. The Gambia, UNECA.
9. UN WOMEN (1987-1999) General recommendations made by the Committee on the Elimination of Discrimination against Women [Accessed the 1st April 2014]: www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm.
10. KAPLAN, A.; CHAM, B.; NJJE, L.; SEIXAS, A.; BLANCO, S.; UTZET, M. (2013) "Female Genital Mutilation/Cutting: The Secret World of Women as Seen by Men", in *Obstetrics and Gynecology International*, vol. 2013, Article ID 643780. [Accessed the 15th July 2014]

Other references

- BOURDIN, M.-J. (2006): *L'Excision, une coutume à l'épreuve de la loi*. Editions A-3, Paris.
- KAPLAN, A.; PÉREZ JARAUTA M.J. (Coord.) (2006) *Mutilació Genital Femenina: Prevenció i Atenció. Guia per a professionals*. Institut Català de la Salut, Barcelona.
- KAPLAN, A.; CANO, F.; MORENO, J. y PÉREZ JARAUTA, M.J. (2008) "From local to global: Female Genital Mutilation in Diaspora", in *Journal of FGM/C and other harmful traditional practices* n° 1, IAC, Geneva/Addis Abeba.
- KAPLAN, A.; TORÁN, P.; BERMÚDEZ, K.; BOLIBAR, B. y MORENO, J. (2008) "Conocer y actuar: un proyecto interdisciplinar de prevención de las mutilaciones genitales femeninas en Gambia y España", en *Studia Africana*, Centre d'Estudis Africans-Barcelona. # 19. pp. 42-52.
- KAPLAN, A.; TORÁN, P.; MORENO, J.; CASTANY, M.; MUÑOZ, L. (2009) "Perception of primary health professionals about Female Genital Mutilation: from healthcare to intercultural competence". *BMC Health Services Research* 2009, 9:11
- LEVIN, T. & ASSAH, A. (Eds.) (2009) *Empathy and Range. Female Genital Mutilation in African Literature*. Ayebia Clarke Publishing Ltd. England.
- SHELL DUNCAN, B.; HERNIUND, Y. (2006) "Are there 'Stages of Change' in the Practice of FGM/C? – Qualitative Research Findings from Senegal and The Gambia", in *African Journal of Reproductive Health*, Vol. 10, No.2 August 2006.
- THE DONORS WORKING GROUP ON FEMALE GENITAL MUTILATION/CUTTING (2008) *Platform for Action: Towards the abandonment of FGM/C. A matter of gender equality*.
- TOUBIA, N. (1999) "Evolutionary cultural ethics and the circumcision of children", in G. C. Deniston et al. (Eds), *Male and female circumcision: Medical, legal, and ethical considerations in pediatric practice*. New York: Plenum. Pp. 1-7.
- UNFPA (2008) *Global Consultation on FGM/C. Technical Report*, N.York
- WHO (1998) *Female Genital Mutilation. An overview*. Geneva.
- WHO (2001) *A WHO Student Manual prepared for use by students in response to needs expressed in a proposal on female genital mutilation (FGM/C)*, WHO Department of Gender and Women's Health, Department of Reproductive Health and Research, Family and Community Health, Geneva.



3

Country profile

The Republic of Kenya is situated on the Indian coastline of Eastern Africa between Somalia and Tanzania in equatorial latitudes. It has a total land area of 569,140 square kilometers and there is an important climatic diversity. Rainy (March to May) and dry seasons alternate in the tropical coast, western plateau, highlands and Rift valley. The climate is arid and semi-arid in the majority of the area bordering Ethiopia and Somalia¹.

Kenya gained its independence from Britain on December 12, 1963, more than ten years after the Mau Mau Rebellion started opposing the British colonial rule. Up to 1991, the country was a –first de facto, later legally- one-party state and the political power was mainly in hands of the president. In August 2010, the Constitution adopted by referendum supposed significant devolution of power and resources to the local governments, from then organized into 47 counties (Map 3). Previously, Kenya was divided into 8 provinces^{1,2}.

Map 3. Counties of Kenya
Source: Geocurrents Map



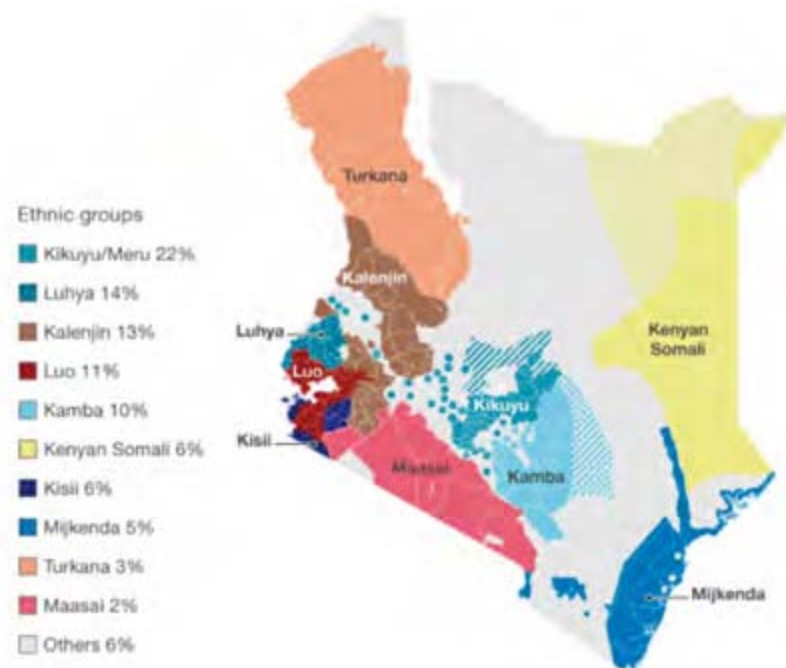
According to the 2009 Population and Housing Census, the population was 38.61 million people³. For 2013 the estimated population is 44.04 million, with a population growth rate of 2.27%, and the estimated life expectancy at birth for men and women is 61.8 and 64.8 years respectively¹. Infant mortality rate is 42.2 deaths per 1,000 live births, and maternal mortality rate is 360 deaths per 100,000 live births¹.

Kenya is a cultural diverse country, and interethnic relations keep playing an important role in the country's everyday life and politics. There are 67 living languages, most of them associated to different ethnic groups⁴. According to KNBS 2010, the main ethnic groups, with more than 800,000 people are: Kikuyu (17.2%), Luhya (13.8%), Kalenjin (12.9%), Luo (10.5%), Kamba (10.1%), Kenyan Somali (6.2%), Kisii (5.7%), Mijikenda (5.1%), Meru (4.3%), Turkana (2.6%) and Masai (2.18%)³ (Map 4; note that the percentages from both sources vary slightly).

Map 4. Main ethnic groups in Kenya

Source: BBC 2013

Kenyan Embassy delegated to the UN
Kenya National Bureau of Statistics 2009



The UNDP Human Development Index for 2013, locates Kenya among countries ranking 145 out of 187⁵. Its estimated 2012 GDP per capita is 1,800 USD ranking 198 out of 229 countries¹. The main sources of national income include the exports of tea, horticultural products, coffee, petroleum products, fish and cement; and an important tourism sector¹.

FGM/C situation

Prevalence

In Kenya, about 9.3 million women have undergone the practice⁶. Although there is 27% prevalence in the country, it is the fifth African country in absolute numbers of women affected, and there are important differences between regions and ethnic groups⁶. It ranges from 98% prevalence amongst Kenyan Somalis in the North East to 1-10% prevalence amongst the Luo in the West. The Kisii and the Masai have 96% and 73% prevalence respectively, while the Kikuyu and the Turkana have 21% and 12%. Kenya appears also as one of the countries with the biggest decline in former years, from 38% in 1998 to 27% in 2008-2009^{7,8,9}. Furthermore, a majority of Kenyan women stated that they do not see any benefits in FGM/C, do not associate it to religion, and think that the practice should be stopped⁶.

FGM/C is four times more prevalent in rural than in urban areas⁶, it is also more prevalent among those with no education, and women in the lowest wealth quintile⁷.

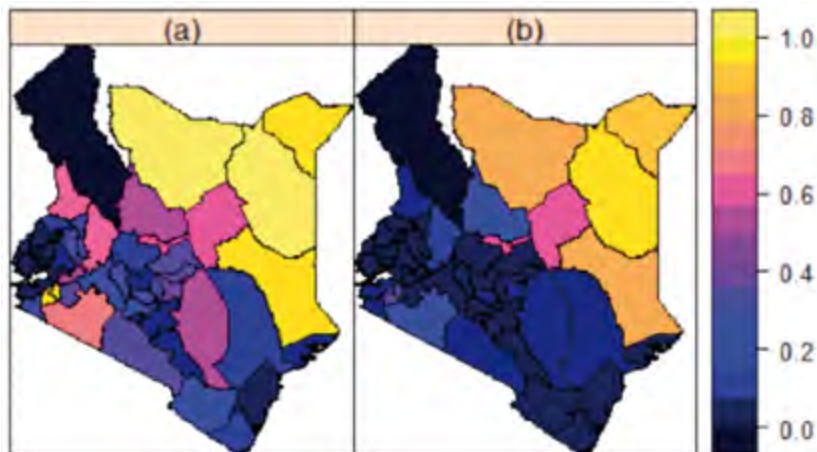
Achia (2013) has developed a spatial modelling and mapping of FGM/C in Kenya¹⁰. Using the 2008 KDHS data, the following variables were found to be significantly associated with FGM/C: age, region, rural-urban, classification, education, marital status, religion, socioeconomic status and media exposure. The current FGM/C status of a woman was also a significant predictor of support for the continuation of the practice. The study has demonstrated both geographical heterogeneity in the practice and support for the continuity of it in Kenya. The counties located in the North Eastern and South Western parts of the country are identified as FGM/C 'hotspots' and are areas in need of urgent attention. The study finds a linear negative relationship between a woman's level of education and the view that FGM/C should continue. It also adds to the general body of knowledge on the subject of women's support for FGM/C by documenting and mapping prevalence and identifying high risk clusters. The study did not find significant clusters of support for the continuation of FGM/C in counties where the Meru (Meru North, Taraka), Kikuyu (Muranga, Thika, Kirinyaga, Kiambu County), Kamba (Mwingi County) and Taita

(Taita/Taveta County) ethnic groups live. The results of this study indicated clustering of FGM/C in the North Eastern part of Kenya where Islam is the dominant religion. The practice was nearly universal among the Kisii and Masai, and very common among Kalenjin, Taita/Taveta, Embu/Mere, and to a lesser extent among the Kikuyu, Kamba, and Mjikenda/Swahili. The results of the present study concur with these findings, but also indicate a possible high prevalence of the practice amongst Somali, Rendile, Borana and Omoro community in the North Eastern region of Kenya.

In the following map (Map 5), we observe the differences between FGM/C prevalence per counties (a) and the proportion of women in support of the continuation of the practice (b).

Map 5. Observed (crude) County FGM/C Prevalence

(a) Prevalence of FGM/C and, (b) Proportion of women in support of FGM/C continuation
Source: Achia (2013)¹⁰



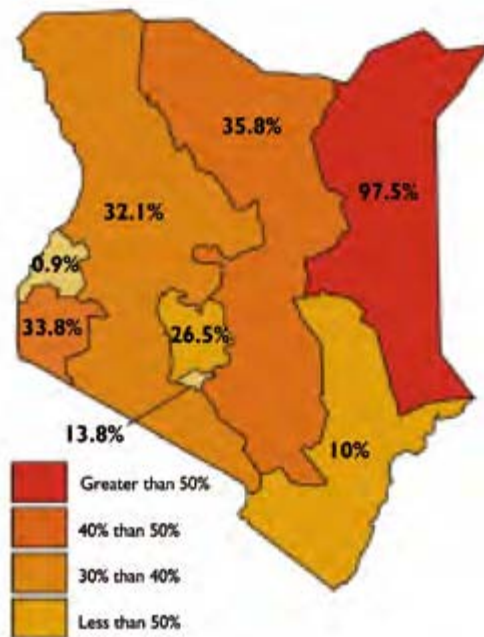
The ethnic factor

There are important differences in the prevalence of FGM/C between regions (Map 6; see also Map 2 for the current county division of Kenya) and between ethnic groups (Table 2). The proportion of women circumcised ranges from 1% in Western Province to 98% in North Eastern Province. Around one out of three women experienced FGM/C in the Eastern, Nyanza and Rift Valley Provinces, and around one out of four in the Central Province. The proportions in Nairobi and the Coast were smaller; 14% and 10% respectively^{7,10}.

Map 6. FGM/C by province

Source: 28 Too Many, 2013.

Country Profile. Kenya. Data from DHS 2008-09



This intra-country discrepancy is related to the fact that FGM/C is closely tied to ethnic affiliation. In Kenya, the highest prevalences are found among the Kenyan Somalis (98%), mostly located in the North Eastern part, and whose prevalence is very similar to those of the Somalia and Ethiopia Somalis⁶, and the Kisii (96%), mainly living in the Eastern part. The lowest correspond to the Luo (0.1%) in the East, and the Luhya (0.2%), mostly located in the Western part of the country. Other groups with an important number of cut women are the Massai (73%), Embu (51%), Kalenjin (40%) and Meru (40%)⁷.

FGM/C decline is also related to ethnicity. The practice diminished steadily among certain ethnic groups where it was once almost universal: in the 15-19 age cohort, the practice has become rare among the Kalenjin and Kikuyu, and has almost disappeared among Meru. At the same time, it has remained over 95% among Somali and Kisii girls⁶.

Table 2. FGM/C per ethnic group main characteristics

Sources: DHS 2008-09 a, Turkana DHS 2003 b,c, 28TOOMANY (2011) d, KNBS (2010).

Ethnic Group	Prevalence FGM/C^a	FGM/C Main Type^b	FGM/C Age^c	% Kenya population^d
K. Somali	98%	III	6-10	6.2%
Cushitic (like Borana, Gabra, El Molo and Rendille). Mostly Muslims. FGM/C is linked to tradition, virginity and religion.				
Kisii	96%	I	6-10	6.2%
Bantu (also known Abagusii o Gusii). Mostly Christians. FGM/C continues because of tradition and sense of community.				
Massai	73%	II	12-14	2.2%
Nilotic pastoralists. FGM/C is part of the rite of passage, important for community respect and marriage. Slight reduction 2003-2008.				
Embu	51%	Flesh removed	Puberty	0.8%
Bantu (related to Kikuyu and Meru). Mostly Christians. There seem to be a generational FGM/C attitude change.				
Kalenjin	40%	Flesh removed	12-18	12.9%
Nilotic (include Pokot). Mostly Christians. Women not cut are seen as promiscuous, immoral and imitators of Western culture.				

Ethnic Group	Prevalence FGM/C^a	FGM/C Main Type^b	FGM/C Age^c	% Kenya population^d
Pokot	Subgroup of the Kalenjin	Flesh removed	12-18	1.6%
Nilotic. Part semi-nomadic pastoralist, part are agriculturalist. Traditional religion is dominant, there is a Christian minority.				
Meru	40%	II	Puberty	4.3%
Bantu (related to Kikuyu and Embu). Mostly Christians. FGM/C related to adulthood and marriage.				
Taita/ Taveta 32%	Flesh removed	Infants	0.8%	
Bantu in the interior of the Coast Region bordering Tanzania. Mostly Christians, 10% Muslims.				
Kamba	23%	Flesh removed	12-18	10.1%
Bantus, important trading activities. Mostly Christians. FGM/C is rarely practiced in this ethnic group.				
Kikuyu	21%	I	12-18	17.2%
Bantu main population group. Mostly Christians. Big descent in FGM/C from 1998				
Turkana	12%	III	6-10	2.6%
Nilotic pastoralist. Contradictory FGM/C reports: either they have practiced type III, either they have voluntary stopped the practice.				
Mijikenda/ Swahili	23%	Flesh removed	12-18	10.1%
Bantu agriculturalist. Mostly Christians, but more than one third of the population remain traditionalist.				
Luhya	0.2%	-	-	13.8%
Bantu. Mostly Christians. FGM/C is rarely practiced in this ethnic group.				
Luo	0.1%	-	-	10.5%
Lake Nilotes fishing. Mostly Christians, but more than one third of the population remain traditionalist.				
Others	39%	Flesh removed	14-18	7.8%
Heterogeneous				

Type of FGM/C

Types I and II of FGM/C are the most prevalent in Kenya⁷. Nevertheless there is a 13.4% of women who reported to have undergone type III, mainly pertaining to the Kenyan Somalis, other Cushitic groups such as the Rendille and the Borana, and Nilotic groups such as the Samburu and the Turkana^{7,11,12} (note that there are contradictory reports that suggest Rendille people practice a “less extreme form”¹³ and Turkana do not practice circumcision “whether male or female”¹⁴). Type I is performed by groups such as the Kisii and the Kikuyu, and type II by the Maasai and the Meru¹². There are reports from different groups, including the Kenyan Somalis, Kisii and Nandi (a subgroup of the Kalenjin), that the amount of tissue cut has been reduced in the last decades¹².

Age at which FGM/C is performed

Traditionally, in most ethnic groups in Kenya, FGM/C was linked to puberty and its associated rites of passage from childhood to womanhood, and thus, it was generally practiced between 12 and 18 years old. The main exceptions were the Kenyan Somalis, for whom FGM/C plays no role as a rite of passage and normally perform it between 6 and 10 years old¹⁵, and the Taita / Taveta who practice it in infants¹¹. Nevertheless, DHS surveys demonstrate a general trend to circumcise girls at younger ages, especially in urban settings⁷. In the case of the Kisii, the diminution in the age for FGM/C has been accompanied with the loss of importance of the ritual associated, and the medicalization of FGM/C, all in the context of important socioeconomic changes and the first anti FGM/C legislation in 2001¹⁶.

Yearly, communal FGM/C schedules are still active in other ethnic groups such as the Maasai^{17,18} and the Kuria¹⁹ (an ethnic group closely related to the Kisii). Among the Maasai, some families perform FGM/C in younger daughters when the oldest come to age in order to save ceremony costs¹⁷.

Decision-making

As in other countries, FGM/C has traditionally been a women’s affair. Decisions and preparations have been taken predominantly by mothers and elderly women, with no information given to the girl. In some communities, where important expenses are needed to afford the ceremonies associated or the medicalization of the practice, women emphasize the relevance of men’s opinion in order to organize the process, as in the case of Kenyan Somalis¹⁵.

Although this is not the most frequent situation, peer pressure can sometimes be stronger than family desires. Given the changes in the social context and meaning of FGM/C in Kisii communities, in some occasions the demand and pressure for FGM/C was found to be more linked to the adolescents themselves than to their grandmothers, who considered that the new ways have made the practice lose most of its former meaning¹⁶. Among the Kikuyu, given the political –ethnic identity reaffirmation-content that the practice was given in the pre-independence period (see below “efforts aimed at eradication”) and now in some outlawed sects such as the Mungiki¹¹, the decision may (had) come from the woman herself and the pressure of her sects’ colleagues, opposing family religious (Christian) views²⁰.

Procedures

In the Maasai community, and in others where the practice is included as part of the rite of passage from childhood to womanhood, it is generally organized for a group of adolescents in the community, and performed by traditional excisers, older women with a lot of experience. Traditionally, a ceremonial knife was used for all the girls, but now different hygienic measures have been adopted, including the use of disposable razors, plastic gloves and plastic sheet for the girl to lie. Anesthesia is not used and some of the different women present hold the girls during the procedure. The girls are treated with a paste after the cut to stop the bleeding and accelerate healing –among the Maasai the paste is traditionally made of cow dung and milk fat^{16,17}.

Kenyan Somalis have a different traditional procedure. The girl is generally cut alone, and not within a group and no ceremony is held. Most of the times a traditional exciser goes to her home (although it can also be done in the traditional exciser’s house) and the girl is held by three women during the procedure. The clitoris is cut first, followed by the labia minora and sewed, nowadays generally with catgut sutures, but formerly with acacia thorns. A traditional paste, called *malmal*, is used to stick the sutured tissues together. Some excisers, who have had contact with the health care system, may use local anesthesia¹⁵.

The seclusion period

After FGM/C there is usually a seclusion period. In those cases when FGM/C is part of the rites of passage, the seclusion period is part of the ritual and includes learning about the girl’s new roles as woman and future wife³⁵. It generally ends with a big ceremony and party^{16,17}. Nevertheless, it seems to be a general tendency in the country to diminish seclusion periods, ceremonies and their costs²¹.

Among the Kenyan Somalis, there is also a seclusion period of seven days, during which the girls are isolated, not allowed to walk, with their legs tied together. After this period, they are checked to see if the infibulation has been successful¹⁵. There is no party / ceremony to end the period.

Perceptions of the need for FGM/C

Nowadays, a majority of Kenyan women stated for the DHS 2008-09⁷ that they do not see any benefit in female circumcision (81%), do not associate it to religion, and that they think the practice should be stopped (82%) (see also Map 4). Remarkably, more than half of girls and women who have been cut do not see any benefits⁶. The exception is the North Eastern part, with a Kenyan Somali majority, where they associate it to religion (87%) and consider it should continue (80%)⁷. The level of education is also a key factor to explain the support to FGM/C practices: the differences among women with no education versus women with secondary education were above 30 percentage points⁶.

The perceptions of the need for FGM/C vary between ethnic groups and can be summarized as follow¹²:

- It is a rite of passage necessary to become a woman, and thus be socially accepted by the community in the new role (Maasai, Kalenjin, Meru, Embu).
- It ensures marriageability and increases the bride price (Samburu, Maasai, Kuria, Kisii, Kenyan Somalis)
- It is associated with family honour, like the virginity it preserves (Somali)
- It helps controlling women's sexuality (Somali, Kisii)
- It is a religious requirement (the main Islamic groups, mainly Somalis, but also Borana, and others)
- It is part of the cultural and ethnic identity, and women who fail to perform it are considered Western imitators (Kisii, Meru, Embu, Kalenjin, Maasai, Somali, Kikuyu, and others). Men in these communities prefer to marry women who have been circumcised and thus women fear to be ostracized by the community if they don't undergo the practice.

However, the perceptions of the people are changing because of increased awareness of its effects brought about by education, religion and legislation.

Cutting without ritual and medicalization – an emerging phenomenon

As in other countries, for many groups in Kenya there has been a tendency to diminish and even suppress the rituals associated to FGM/C. Some of the reasons for it include: migration to urban areas, lowering the age of FGM/C, unaffordable ceremony expenses, schooling, and illegality of the practice from 2001.

There is substantial evidence that health professionals are increasingly performing FGM/C, both in hospitals and health clinics as well as in community settings, sometimes, but not always, using medical supplies. The justification given for having health professionals performing FGM/C is that it reduces the pain and the risks to the girl's health, as the operation is performed hygienically. Whether the practice is performed in the village or in a clinical setting, it is willful damage to healthy organs for non-therapeutic reasons. It violates the expectation of medical staff not to harm, and it is unethical and unacceptable. It also contravenes the policies of the Ministry of Health in Kenya (2001) banning FGM/C by all health workers and in all facilities³⁰.

In the case of the Kisii communities, and also in that of Kenyan Somalis there has been a tendency to medicalize the practice, especially in urban settings. The overall percentage of Kenyan daughters that had FGM/C performed by a health professional increased from 34% in 1998 to 41% in 2008/2009. In most of the cases the intervention was performed by nurses⁶.

For Kisii communities, the medicalization has been accompanied by a new practice called by the nurses "psychological circumcision". Health professionals report that in these cases the clitoris is pricked, cut, but no tissue is removed, the girl bleeds and so the psychological effect is declared to be the same for the girl. Only if the family insists there will be a partial removal of tissue²¹. The medicalization of the practice also involves an increase in its cost, and its commodification (a more commercial approach)^{15,16,22}.

Scientific knowledge on FGM/C

There is a growing scientific bibliography on statistical and qualitative analysis on FGM/C in Kenya. It allows a good differentiation among ethnic groups, although no conclusive information is available for some ethnic groups or sub-groups that seem to have specific approaches to FGM/C such as the Taita/Taveta or the Pokot (subgroup of the Kalenjin).

Part of the latest biomedical discussion on FGM/C is centered in its relation with HIV. Whilst medical trials have shown that adult male circumcision reduces the risk of HIV acquisition in men by about 60%^{23,24} and may provide some long term benefit to women²³, the relation between FGM/C and HIV seems to be positive and mediated by different social practices associated with FGM/C. These include having older or same age/younger partners, starting sexual life earlier or having less extramarital relations^{25,26}.

Other studies in male circumcision have shown the openness of some ethnic groups to change their circumcision practices if the benefit perceived is high. For instance, the Luos would accept male circumcision in order to prevent HIV infection²⁷.

Legislation

From 1966, Kenya has signed several international human rights conventions that oppose FGM/C¹¹:

- 1966: International Covenant on Economic, Social and Cultural Rights (ICESR)
- 1979: Convention on the Elimination of Discrimination Against Women (CEDAW)
- 1981: African Charter on Human and People's Rights ('Banjul Charter')
- 1989: Convention on the Rights of the Child (CRC)
- 1990: African Charter on the Rights and Welfare of the Child
- 2003: Maputo Protocol to the African Charter on Human and Peoples' Rights on the Rights of the Women in Africa
- 2003: Sexual Offences Act
- 2010: The Kenya Constitution: Bill of Rights
- 2011: Female Genital Mutilation Act
- 2012: UN resolution calling on countries to eliminate FGM/C

Kenya has passed two anti-FGM/C Acts¹¹. The first one in 2001 –the Children's Act- made FGM/C illegal for girls under 18. However, there were few reported cases and it was criticized for failing to curb FGM/C as it was offering inadequate protection, not applying to adult women, and being poorly implemented¹¹.

The Prohibition of Female Genital Mutilation Act 2011, has been a significant effort to improve the law. It criminalizes all forms of FGM/C performed on anyone, regardless of age or status, bans the stig-

matization of a woman who has not undergone the practice, and illegalizes to aid someone who has performed it. It also criminalizes to do FGM/C in Kenya or abroad and to fail to report the performance of it to the authorities. Punishments are more severe and apply to a wider range of perpetrators than the previous 2001 Act. Capacity-building of those responsible for up-holding the law has taken place, and in less than 2 years there have been 3 successful prosecutions¹¹.

Efforts aimed at eradication

FGM/C became a major national concern for the first time in the late 1920s when Western missionaries sought the help of the colonial government to fight the rite. They found a profound resistance from Africans, especially from the Kikuyus, to protect their culture from Western imperialism, including the first President of Kenya, who supported this cultural view²⁹. Even if Kenya started signing international human rights conventions that oppose FGM/C in 1966, it was not until 1976-1985, during the UN Decade for Women, that the efforts to eradicate FGM/C were renewed¹¹.

In 1982, the then President publicly condemned the practice of FGM/C in Baringo district and continued to make public appeals to stop the practice throughout the 1980s and the 1990s in the whole country.


In the same year, the Director of Medical Services instructed the government and mission hospitals to stop performing FGM/C⁶. After the ratification of the Convention on the Rights of the Child and the establishment of the Kenya National Council on Traditional practices in 1990, NGOs effort to eradicate the practice started with a national grassroots women's organization⁶. Later in the decade, questions on FGM/C were included in the DHS (1998) and a National Plan of Action for the Elimination of FGM/C (1999-2019) was launched by the Ministry of Health⁶.

After the first Anti-FGM/C Act, a new National Action Plan for Accelerating the Abandonment of FGM/C in Kenya (2008-2012) was launched by the Ministry of Health to support legislation, advocacy, public education, media communication and other activities in the fight against FGM/C¹¹. It included the publication of a reference manual for health service providers on "Management of complications during pregnancy, childbirth and the postpartum period related to FGM/C"³⁰.

In 2011, the Female Genital Mutilation Act prohibiting FGM/C was enacted. The government updated the national action plan on FGM/C in light of this Act⁶.

In Kenya, there are more than 150 organizations involved in the efforts for the eradication of FGM/C ranging from multi-national and bi-lateral agencies to local NGOs. These organizations have used various methodological approaches in the eradication of FGM/C which can be summarized as follow¹¹:

- **Health risk and harmful traditional practices approach:** Informing about the health risks of traditional practices is one of the most frequent approaches. However, this approach can lead to the medicalization of the practice unless it is combined with other activities¹¹.
- **Alternative rites of passage (ARPS):** This includes both cultural information on the roles of women, sexual education and promotion of education in the whole community. For example, in Nyanza Region, it is better accepted by Kisii community – who have separated FGM/C from rites and ceremonies - than by the Kuria community –who still hold traditional rites of passage including FGM/C^{19,21,32,33}.
- **Religious-oriented approach:** Used both in Muslim and Christian communities. It searches debate and consensus among religious scholars regarding FGM/C in their traditions and public information of the religious views not supporting FGM/C. It has been used by organizations working with Kenyan Somalis³⁴ [Population Council 2009], and also in Kisii community¹¹.
- **Legal approach:** The lack of effectiveness of the first Kenyan Anti- FGM/C Act shows that this approach is not enough unless social and religious consensus is also achieved in order to eradicate FGM/C^{1,31}.
- **Human Rights approach:** It emphasizes public declarations but proceeds in a supportive, non-judgmental manner. It wants women and communities to take their own decisions being aware of all the information available. It promotes public affirmation of abandoning FGM/C, and diffusion of those cases to other communities. It has been used in different communities such as the Kisii, Pokot (Kalenjin), Maasai and Meru¹¹.
- **Promoting girls' education:** Given that many women stop education after FGM/C rituals to prepare for marriage (for example in Maasai and Pokot communities), this approach encourages girls to continue education. In some occasions, it also encourages the girls to speak out against the practice, and it is generally accompanied by the use of rescue centers¹¹.

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- **Supporting girls escaping from FGM/C and child marriage:** It generally includes the use of rescue centers, children informing the police about their FGM/C status and their willingness to avoid it, meeting and intermediating between the girls and the parents/families or asking church members to intermedate. The organizations applying this approach with Maasai and Pokot communities are also supporting ARPS¹¹.
 - **Media influence:** Messages informing and advocating against FGM/C in TV, radio – which is considered a highly effective media - , press, films and social media¹¹.
 - **Intergenerational dialogue:** It is organized by facilitators that promote and guide the exchange of ideas about values, customs, traditions and expectations, as well as the discussion of the ideal conditions to make a change in the practices¹¹.

In Kenya, with many actors addressing the problem, multiple methodological approaches and an important cultural diversity, the main challenge nowadays is to achieve the integration of different methodologies, and the coordination of the multiple actors in a context-focused, cultural sensitive approach¹¹. Therefore, there is a need to employ a multidimensional approach to achieve this end.

References

1. CENTRAL INTELLIGENCE AGENCY (2013) *The world fact book. Kenya*. <https://www.cia.gov/library/publications/the-world-factbook/geos/ke.html> [Accessed 25th November 2013]
2. GETTLEMAN, J. (2010) "Kenyans approve new constitution" *New York Times* 5/08/2010. <http://www.nytimes.com/2010/08/06/world/africa/06kenya.html> [Accessed 25th November 2013]
3. KENYA NATIONAL BUREAU OF STATISTICS (KNBS) (2010) *Population and Housing Census 2009. Summary of Results*. <http://www.knbs.or.ke/censussummary.php> [Accessed 25th November 2013]
4. SIL INTERNATIONAL (2013) *Ethnologue. Languages of the World. Kenya*. <http://www.ethnologue.com/country/ke> [Accessed 25th November 2013]
5. UNDP (2013) *Human Development Report. The rise of the South*. <http://hdr.undp.org/en/reports/global/hdr2013/> [Accessed 25th November 2013]
6. UNICEF (2013) *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*. New York.
7. KENYA NATIONAL BUREAU OF STATISTICS (KNBS) (2010) *Kenya Demographic and Health Survey 2008-9*. Nairobi, KNBS.
8. KENYA NATIONAL BUREAU OF STATISTICS (KNBS) (2004) *Kenya Demographic and Health Survey 2003*. Nairobi, KNBS.
9. NATIONAL COUNCIL FOR POPULATION AND DEVELOPMENT (1998) *Kenya Demographic and Health Survey 1998*. Nairobi, Central Bureau of Statistics.
10. ACHIA, T.N.O. (2014) "Spatial modeling and mapping of female genital mutilation in Kenya. *BMC Public Health* 14:276. <http://www.biomedcentral.com/1471-2458/14/276> [Accessed 11th July 2014]
11. 28 TOO MANY (2013) *Country Profile. Kenya*. Nairobi, 28 Too Many.

12. POPULATION COUNCIL (2007) *Contributing towards efforts to abandon Female Genital Mutilation/ Cutting in Kenya. A situation analysis*. Nairobi, Ministry of Gender, Sports, Culture and Social Services
13. SHELL-DUNCAN, B. (2001) "Understanding a controversial rite of passage". *A&S Perspectives*, Winter-Spring 2001. University of Washington. <http://www.artsci.washington.edu/news/Winter-Spring01/ShellDuncan.htm> [Accessed the 25th November 2013]
14. FINKE, J. (2006) *Traditional music and cultures of Kenya*. <http://www.bluegecko.org/kenya/tribes/turkana/society.htm> [Accessed 25th November 2013]
15. JALDESA, G.W.; ASKEW, I.; NJUE, C.; WANJIRU, M. (2005) *Female Genital Cutting among the Somali of Kenya and management of its complications*. Nairobi, Population Council.
16. CHRISTOFFERSEN-DEB, A. (2005) "Taming tradition: medicalized female genital practices in Western Kenya". *Medical Anthropology Quarterly* 19(4): 402-418.
17. IRIN (2005) "In-depth: razor's edge – the controversy of Female Genital Mutilation. FGM among the Maasai community of Kenya". Irin news. <http://www.irinnews.org/indepthmain.aspx?InDepthId=15&ReportId=62470> [Accessed 25th November 2013]
18. EQUALITY NOW (2011) *Protecting girls from undergoing Female Genital Mutilation. The experience of working with the Maasai communities in Kenya and Tanzania*. Nairobi, Equality Now.
19. OLOO, H.; WANJIRU, M.; NEWELL-JONES, K. (2011) *Female Genital Mutilation practices in Kenya: the role of alternative rites of passage. A case study of Kissi and Kuria districts*. Nairobi, Feed the minds.
20. ESHO, T.; VAN WOLPUTTE, S.; ENZLIN, P. (2011) "The socio-cultural-symbolic nexus in the perpetuation of female genital cutting: a critical review of existing discourses". *Afrika focus* 24(2):53-70.
21. GACHIRI, E (2006) *Christian Initiation for Girls*". Nairobi Paulines Publications Africa.
22. NJUE, C.; ASKEW, I. (2004) *Medicalization of Female Genital Cutting among the Abagusii in Nyanza Province, Kenya*. Nairobi, Population Council.
23. WEISS, H.A.; DICKSON K.E.; AGOT, K.; HANKINS, C.A. (2010) "Male circumcision for HIV prevention: current research and programmatic issues". *AIDS* 24:S61-S69.

24. BAILEY, R.C.; MOSES, S.; PARKER, C.K.; AGOT, K. et al. (2007) "Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomized controlled trial. *The Lancet* 369(9562): 643-656.
25. YOUNT, K.M.; ABRAHAM, B.K. (2007) "Female Genital cutting and HIV/AIDS among Kenyan women". *Studies in Family Planning* 38:73-88.
26. MASLOVSKAYA, O.; BROWN, J.J.; PADMADAS, S.S. (2009). "Disentangling the complex association between Female Genital Cutting and HIV among Kenyan women". *Journal of Biosocial Sciences* 41: 815-830.
27. BAILEY, R.C.; MUGA, R.; POULUSSEN, R.; ABICHT, H. (2002) "The acceptability of male circumcision to reduce HIV infections in Nyanza Province, Kenya". *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV* 14(1): 27-40.
28. WAMALWA, L. (2012) "Pokot community reverts back to male circumcision after 60 years of suspension". West FM 2012-08-05. Nairobi, Kenya. <http://westfm.co.ke/index-page-news-bid-6341.htm> [Accessed 25th November 2013]
29. PEDERSEN, S. (1991) "National bodies, unspeakable acts: the sexual politics of colonial policy-making". *The Journal of Modern History* 63(4): 647-680.
30. REPUBLIC OF KENYA MINISTRY OF HEALTH (2009) *Management of complications in pregnancy, childbirth and the postpartum period in the presence of FGM/C. A reference manual for Health Service Providers*. Nairobi, Ministry of Health.
31. WHO (2011) *Female Genital Mutilation programmes to date: what works and what doesn't*. Geneva, WHO/RHR/11.36.
32. CHEBET, S. (2007) *A curriculum of Tumndo Ne Leel: A coming of age concept*. Moi University Press, Eldoret, Kenya.
33. GACHIRI, E. (2000) *Female Circumcision: With Reference to the Agikuyu of Kenya*. Nairobi Paulines Publications Africa.
34. ABDI, M.S.; ASKEW, I. (2009) *A religious oriented approach to addressing Female Genital Mutilation/Cutting among the Somali community of Wajir, Kenya*. Nairobi, Population Council.
35. GACHIRI, E. (2006) *Christian Initiation for girls*. Nairobi, Paulines Publications Africa.



4

COMPLICATIONS OF FGM/C

FGM/C violates the integrity of the female reproductive organs and is almost always practiced with rudimentary instruments such as glass, knives and razor blades. It causes multiple complications both in the short and in the long term and some girls die because of bleeding or due to infections after the cutting. Circumcised women have more problems during delivery than those not circumcised. FGM/C can also lead newborns to death. The practice currently affects around 140 million women and girls around the world.

The complications caused by FGM/C can be classified into: immediate physical complications, long term physical complications, psychosocial complications, sexual complications and dangers of FGM/C to childbirth¹.

Overview of the female genitalia

The normal external female genitalia comprise the following parts²:

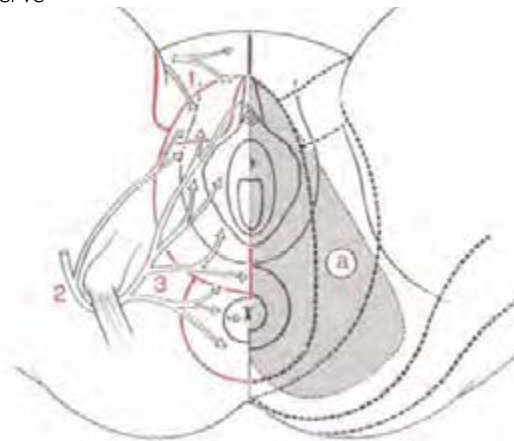
- Skene's and Bartholin glands: lubrication of the vagina;
- Vaginal orifice: allows menstrual flow, sexual intercourse and delivery of baby;
- Urethral meatus: allows emptying of the bladder within a few minutes;
- Clitoris: assists the woman to achieve sexual satisfaction;
- Perineum: supports the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

Figure 1. Female genitalia



Figure 2. Innervation of the vulva

a. pudendal nerve area; 1. iliohypogastric, ilioinguinal and genitofemoral nerves; 2. posterior thigh cutaneous nerve; 3. pudendal nerve



Immediate complications

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

Pain

Severe pain is one of the immediate physical complications and is produced by two fundamental aspects: first, by the extensive innervations of female genitalia (Figures 1 and 2), and second, because this operation is practiced with inappropriate instruments and without anaesthetics. Sometimes the pain is so intense that it can cause shock.

Haemorrhage

Excision of the clitoris involves cutting the clitoral artery which has a strong blood flow at high pressure. Packing, tying or stitching to stop bleeding may not be effective and this can lead to haemorrhage. Secondary haemorrhaging may occur after the first week as a result of sloughing of the clot over the artery due to infection. Cutting of the labia causes further damage to blood vessels and Bartholin glands. Haemorrhage is the most common and life-threatening outcome of FGM/C.

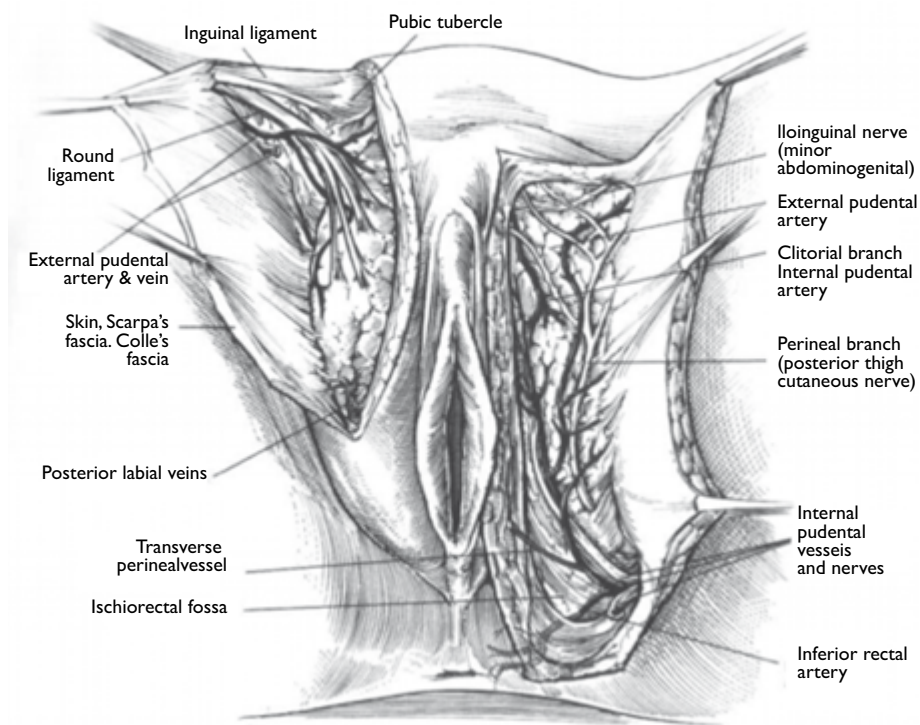
Shock

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

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

In Figure 3, we can observe the irrigation of the female reproductive system. The variety of small, medium and large blood vessels available at that level, illustrates the potential damage that may be life threatening to their integrity.

Figure 3. Irrigation and Innervation of the Femenine Reproductive Tract



Injury to tissue

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

Acute urine retention

Urine retention can result from swelling and inflammation around the wound, the girl's fear of the pain when passing urine on the raw wound, or injury to the urethra. Retention is very common and it may last for hours or days. This condition can lead to urinary tract infections.

Fracture or dislocation

Fractures of the clavicle, femur or humerus, or dislocation of the hip joint can occur if heavy pressure is applied to restrain the struggling girl during the cutting. It is common that several adults hold a girl down during the mutilation/cutting.

Infection

Infection is very common as a result of the following:

- Unhygienic conditions;
- Use of unsterilized instruments;
- The application of substances such as herbs or ashes to the wound, which may act as a growth medium for bacteria;
- Binding of the legs following FGM/C type III (infibulation), which prevents wound drainage;
- Contamination of the wound with urine and/or faeces.

Infections may prevent the wound healing, and may result in an abscess, fever, ascending urinary tract infection, pelvic infection, tetanus, gangrene or septicaemia. Severe infections can be fatal. Group mutilations, in which the same unclean instruments are used on several girls may pose a risk of transmission of blood-borne diseases such as HIV and hepatitis B. Nevertheless, there have been no confirmed cases of such transmission to date.

Failure to heal

The wounds may fail to heal quickly because of infection, irritation from urine or rubbing when walking. This can lead to a purulent, weeping wound or to a chronic infected ulcer.

Long-term complications

Long-term physical complications may include the following:

- **Difficulty in passing urine**

This can occur as a result of damage to the urethral opening or scarring of the meatus.

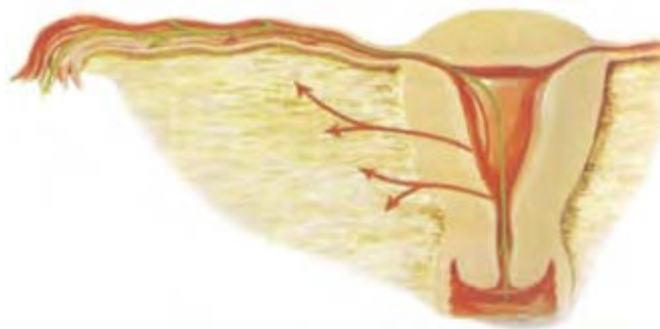
- **Recurrent urinary tract infection**

Infection near the urethra can result in ascending urinary tract infections. This is particularly common following FGM/C type III, when the normal flow of urine is affected and the perineum remains constantly wet and susceptible to bacterial growth. Stasis of urine resulting from difficulty in micturition can also lead to bladder infections. These infections can spread to the urethra and kidneys.

- **Pelvic infections**

They are painful and may be accompanied by a discharge. Infections may spread to the uterus, fallopian tubes and ovaries, and may cause infertility (See Figure 4).

Figure 4. Spread of the Infection



- **Infertility**

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

- **Keloid scar**

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

- **Abscess**

Deep infection resulting from defective healing or an embedded stitch which may require surgical intervention (See Figure 5).

Figure 5. Abscess on the vulva



- **Cysts on the vulva**

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

- **Clitoral neuroma**

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

- **Difficulty in menstruation**

Difficult menstruation can occur as a result of partial or total occlusion of the vaginal opening.

- **Occlusion of the vagina**

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

- **Calculus formation in the vagina**

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

- **Fistulae**

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

- **Dyspareunia (painful sexual intercourse)**

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

- **Sexual dysfunction**

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

- **Problems in childbirth**

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

Psychosocial complications

Various circumstances related to this practice can lead to psychosocial problems. FGM/C is commonly performed when girls are young. It is often preceded by acts of deception, intimidation, coercion and violence by people surrounding the child. Girls are generally conscious when the painful cutting occurs. They are often physically restrained because they struggle. In some instances they are also forced to watch the mutilation of other girls.

For some girls, mutilation is an occasion marked by fear, ambivalence and suppression of feelings. The experience leaves a scarring memory that can affect their mental development. They suffer in silence.

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

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

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

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

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

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

Sexual complications

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

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

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

Findings from a study conducted in the Ismailia Governorate in the Suez Canal area of Egypt reveal that over 80% of women who were circumcised complained of some form of psychosexual impact of the practice. Their complaints included: dysmenorrhoea (80.5%); vaginal dryness during intercourse (48.5%); lack of sexual desire (45%); less frequency of sexual desire per week (28%); less initiative during sex (11%); being less pleased by sex (49%); being less orgasmic (39%); less frequency of orgasm (25%); having difficulty reaching orgasm (60.5%)³.


Dangers for childbirth

Findings from a WHO multi-country study, in which more than 28,000 women participated, confirm that women who had undergone FGM/C had significantly increased risks for adverse effects during childbirth. Higher incidences of caesarean section and post-partum haemorrhage were found in the women with type I, II and III compared to those who had not undergone FGM/C, and the risk increased with the severity of the procedure⁴.

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

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

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



In The Gambia, two clinical studies have been carried out by Kaplan et al. about the health consequences of FGM/C (2011, 2013)^{5,6}. The first, proved that 299 of 871 patients (34,3%) presented complications due to having undergone the practice, specially infections. Even with type I, 1 out of 5 women examined presented complications. The second clinical study focused on the long term consequences and complications during delivery and for the newborn. Women with type I and II had a significantly higher prevalence of long term health problems (dysmenorrhea, vulvar or vaginal pain), problems related to anomalous healing (fibrosis, keloid, synechia), and sexual dysfunction. Women with FGM/C were also much more likely to suffer complications during delivery (perineal tear, obstructed labour, episiotomy, caesarean, stillbirth) and complications associated with anomalous healing after FGM/C. Similarly, newborns were found to be more likely to suffer complications such as fetal distress and caput of the fetal head.

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

References

1. WHO (2000) *A systematic review of the complications of female genital mutilation including sequelae in childbirth*. Geneva, WHO/FCH/WMH.
2. RIGOL RICARDO, O. (2006) *Obstetricia y Ginecología*. La Habana, Ciencias Médicas.
3. HASSIB EL-DEFRAWI, M.; LOTFI, G.; ELMETWALLY MEGAHED, H.; SAKR, A.A. (1996) "Female circumcision in Ismailia. A descriptive study". *Egypt. J. Psychiat.* 19: 137-145.
4. WHO (2006) "Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries". *The Lancet* 367:1835-1841.
5. KAPLAN, A.; HECHAVARRÍA, S; MARTÍN, M.; BONHOURE, I (2011) "*Health consequences of female genital mutilation/cutting in The Gambia, evidence into action*", in *Reproductive Health* 2011 8:26.
6. KAPLAN, A; FORBES, M; BONHOURE, I; UTZET; M; MARTÍN M; MANNEH, M; CEESAY, H. (2013) "*Female Genital Mutilation/Cutting (FGM/C) in The Gambia: long-term health consequences and complications during delivery and for the newborn*", in *International Journal of Women's Health*, 2013:5, pp 323-331.

Other references

- WHO (2000) *Female Genital Mutilation. A manual for frontline workers*. Geneva, WHO/FCH/WMH/00.5 Rev.1.
- WHO (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*. Geneva, WHO/FCH/WMH/00.7.
- WHO (2001) *Female Genital Mutilation. The prevention and management of the health complications: policy guidelines for nurses and midwives*. Geneva, WHO/FCH/GWH/01.5.
- WHO (2001) *Female Genital Mutilation. Integrating the prevention and the management of the health complications into the curricula of nursing and midwifery. A teacher's guide*. Geneva, WHO/FCH/GWH/01.3.
- WHO (2001) *Female Genital Mutilation. Integrating the prevention and the management of the health complications into the curricula of nursing and midwifery. A student's manual*. Geneva, WHO/FCH/GWH/01.4.
- WHO (2008) *Effects of female genital mutilation on childbirth in Africa*. Geneva, WHO.



5

MANAGEMENT OF WOMEN WITH PHYSICAL COMPLICATIONS OF FGM/C

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

Management of immediate physical 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/C. 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.

Health professionals 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 vital signs and transfer her immediately to a secondary level facility for blood transfusion if necessary.

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

Severe pain and injury to tissues

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

Health professionals 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 patient or her attendants to keep it dry.
- If the patient is in shock, see instructions under shock.
- If there is no relief from pain, refer patient for medical attention.
- If injury is very extensive refer patient for surgical intervention.

Shock

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

Health professionals should observe the following procedure:

- Assess the severity of shock by checking vital signs.
- Treat the shock by raising the client's extremities above the level of the 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 I.V. are not available, fluids may be given rectally).
- Check vital signs and record every 15 minutes.
- If client's condition does not improve, refer her to the hospital.

Infection and septicaemia

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

Health professionals should manage the condition as follows:

- Take a vaginal swab and a urine sample to test the presence of infection and identify the organisms involved.
- Inspect the vulva carefully for signs of an infected wound, and to check for anything that might be contributing to the infection, such as urine obstruction.
- Any obstruction found should be removed, and the 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 to the hospital.

Urine retention

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

The management of this condition is as follows:

- Carry out an assessment to determine cause.
- Use appropriate nursing skills and techniques to encourage the 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.

The management of this condition is as follows:

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

Management of long-term physical complications

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

Their management should be carried out as follows:

Keloid formation

- Inspect patient genitalia to assess size of keloid;
- If the keloid is small, advise the woman to leave it undisturbed, and reassure her that it will not cause harm;
- If the keloid scar is large, causing difficulty during intercourse or possible obstruction during delivery, the woman should be referred to a specialist experienced in removing keloid scars;

- The presence or appearance of a keloid may cause excessive distress to a woman, in which case you should consider referring her for surgery for psychological reasons.

Cysts

- Inspect the site to assess the size and type of cyst;
- Small and non-infected cysts may be left alone after counselling the woman about her condition. Alternatively the woman may be referred to have them removed under local or regional anaesthesia;
- However, before interfering with a small cyst it is important to find out if the procedure could result in further damage and scarring of existing sensitive tissue. If such danger exists, the woman should be fully informed and allowed to choose for herself whether to proceed with removal, with full understanding of the risk involved;
- In the case of a large or infected cyst, the patient must be referred for excision or marsupialisation; the procedure is usually performed under general anaesthetic. During the operation, great care should be taken to avoid further damage to sensitive tissue or injury to the blood or nerve supply of the area.

Clitoral neuroma

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

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

Vulval abscesses

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

Chronic Urinary Tract Infection (UTI)

UTIs are a common complication of women who have undergone FGM/C in any of its forms. Practitioners should manage UTI as follows:

- Examine the vulva carefully for any anatomical abnormalities that may establish a link with FGM/C;
- If infibulation is the cause, counsel the woman on the need to open up the infibulation (see section on defibulation);
- Carry out urine analysis and vaginal swab for discharges to identify causative organisms and for appropriate antibiotics;
- Give antibiotics and/or urinary antiseptics as required (a mixture of potassium may also be prescribed);
- Advise the patient on adequate fluid intake and on vulva hygiene;
- If UTI is recurring, refer patient for further medical attention.

Chronic pelvic infection

- Examine the woman. Identify type of FGM/C based on history and exam;
- Establish the connection between FGM/C and the infections;
- If the woman has type III, counsel her and/or her attendants on the possible need to open up the infibulation and seek her/their informed consent;
- Take vaginal swab for culture and sensitivity;
- Give antibiotics that are appropriate and locally available;
- If the cause of the infection is obstruction due to stones or injury, refer the woman for surgical intervention.

Infertility

Infertility can be primary or secondary. It is usually a complication of pelvic infection. In some cases it may be due to failure of penetration because of a very tight vaginal opening. Medical practitioners should manage infertility as follows:

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

Fistulae and incontinence

Vesico-vaginal fistula (VVF) or recto-vaginal fistula (RVF) – fistula resulting in incontinence – occur as a result of injury to the external urethral meatus or obstructed labour. Practitioners should manage the condition as follows:

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

Vaginal obstruction

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

Menstrual disorders

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

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

Ulcers

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

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

References

- WHO (2001) *Female Genital Mutilation. Integrating the prevention and the management of the health complications into the curricula of nursing and midwifery. A teacher's guide.* Geneva, WHO/FCH/GWH/01.3.
- WHO (2001) *Female Genital Mutilation. Integrating the prevention and the management of the health complications into the curricula of nursing and midwifery. A student's manual.* Geneva, WHO/FCH/GWH/01.4.

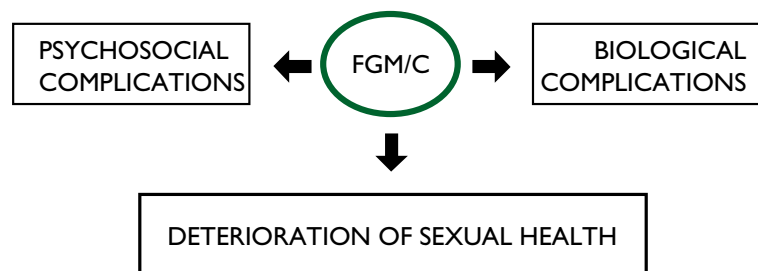


6

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

All medical practitioners should remember that counselling is the principal tool used in managing psychosocial and sexual problems. Counselling of a girl or woman should be strictly confidential. If the patient has a partner, he should be counselled separately if necessary, until the right moment arrives for them to be counselled as a couple (see Module 9: Counselling).

The woman who has undergone FGM/C frequently presents psychosocial and sexual complications that will easily develop in biological complications having negative consequences in her sexual health.



Managing psychosocial complications

Psychosocial problems include:

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

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

Psychological problems are managed as follows:

- Assess woman to identify the exact problem (take a detailed history);
- Counsel woman, and partner where appropriate;
- If she has type III FGM/C, counsel her on the need for opening up;
- If she has other types of FGM/C, counsel her until she is relieved of her symptoms;
- If symptoms are severe, refer patient for further management.

Managing sexual problems

The manifestation of these complications is influenced by several factors ranging from the type of FGM/C that was practiced on the woman, to the preparation for the sexual life that she (and her sexual partner) have had. Each girl or woman should be treated as a unique individual with distinct needs. It is very important to take into account that sexual complications are a delicate matter to be dealt with high care and sensitivity (see also chapter 9 - Counselling). To illustrate this, the following paragraph describes a case treated by an Ob-Gyn with a Master's degree in Sexology.

Mr. Mj, 27 years young, is a businessman married to two wives. He has been married to his second wife for two months but has not yet been able to have sexual penetration with her, so he goes to ask the doctor to check her out and operate on her, because "she was closed when she was a child". When examining Mrs. Mj, the doctor finds a type I FGM/C. This should readily allow the passage of the penis, but the hymen is intact.

It is decided to call Mr. MJ to be examined, but a very large penis that might have difficulty in penetrating any virgin woman is ruled out. Upon further questioning it is discovered that attempts to penetrate were frustrated because of pain in the woman, even though Mr. MJ said they had engaged in prior sexual games. The physician suggests focusing on the couple's sexual games and using a gel lubricant for penetration, as well as Mr. MJ being patient and gentle when penetrating. A week later, Mr MJ called to thank him because the problem had been resolved. In this case the influence of the FGM/C practiced is clear, producing long-lasting fears and psychological problems in the woman, an additional factor being the couple's lack of preparation to approach sex.

Management of painful intercourse (dyspareunia)

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

Health practitioners should manage sexual problems as follows:

- Interview the woman to identify the real problem;
- Assess her to identify the type of FGM/C;
- If opening up the introitus is needed, counsel her and her husband/partner about the need for this, obtaining their informed consent. Follow the procedure for opening up and repair by giving antibiotics and analgesics, or refer to the appropriate facility for the procedure;
- Where opening up is not necessary, encourage foreplay to stimulate maximum arousal, and the use of appropriate lubricating jelly;
- Follow-up the patient to monitor the progress;
- Counsel the patient and her husband/partner about the importance of discussing sexual matters;
- Invite them to come back whenever they have problems;
- Advise the couple of the changes to expect as a result of the opening up operation – for example, changes in urine flow and during sexual intercourse. If the sexual problem is severe and recurring, refer patient to a gynaecologist;
- Offer psychological support and ongoing counselling.

Other sexual problems

Failure or difficulty in penetration by husband/partner is a common form of sexual problem. This is managed as follows:

- Assess the type of FGM/C;
- Interview the patient to find out what the problem is;
- Counsel the woman and her husband/partner together;
- Obtain informed consent for opening up of the introitus;
- Follow the opening-up procedure as explained elsewhere in this material.

Referral procedures

- Perform a proper assessment of the woman;
- Provide necessary information and offer counselling on the importance of referral;
- Carefully document the findings of the assessment, the clinical findings and any measures taken before the referral;
- Check that she has understood what you have said;
- Involve others, such as her husband/partner, who will accompany her to the referral facility;
- Give them detailed information about what to expect and what to do at the referral point;
- Write and give the referral letter to the patient, or escort when appropriate, and give detailed instructions about who to give the letter to at the referral point;
- Ask the woman to return for following-up and monitoring of progress after she has received specialist treatment;
- Evaluate counselling and assess patient's understanding.

A referral note must include the following information:

- Woman's demographic data including age, marital status and any other relevant information;
- Summary of health history;
- Clinical findings;
- Management, including both medical and surgical care given to patient prior to referral;
- Reason for referral;
- Contact for feedback.

The surgery to correct complications is performed in a hospital where appropriate conditions exist with qualified medical personnel. This procedure is used primarily for the process of opening women with type III, sometimes having difficulty and pain during penetration.

Opening up of type III²

The surgical procedure required is usually simple. The majority of de-infibulation can be done under local anaesthesia, but this could not be appropriate for elective reversal when the patient is apprehensive. Deinfibulation may bring back memories of the original infibulation and be psychologically traumatic. For this reason, a short general anaesthesia or spinal anaesthesia may be more appropriate. Any skilled health care provider who can perform and repair episiotomy in normal maternity settings can perform de-infibulation.

Minimum clinical equipment

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

Step One:

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

Step Two:

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

the opening, behind the closed scar tissue for any dense adhesions. Usually the finger slides easily under a free flap of skin. If the opening is too small to allow passage of one finger the closed points of an artery forcep can be inserted and opened to allow initial division from the posterior part of the closed flap for a centimeter or so which will then allow entry of a finger. Palpate the clitoral region to ascertain if a buried clitoris is present below the scar.

Step Three:

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

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

Step Four:

After dividing the fused labia majora, an intact clitoris and labia minora have sometimes been found concealed by scar tissue. However this operation is more complex and requires careful dissection in good light and with good anaesthesia; it should only be carried out in a health facility/ hospital setting. A more extensive opening up of the fused labia majora may not be culturally acceptable to all women, but could be considered in specialized centres. Appropriate counselling and the consent of the women are essential before proceeding with more extensive de-infibulation. Suture the raw edges using absorbable interrupted sutures to secure heamostasis and prevent adhesion formation. Healing should take place within one week.

Opening beyond the urethra

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

Post operative care

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

Many women report increased sensitivity in the vulval area that was previously covered by the scar skin for 2 to 4 weeks following the procedure. They may also report discomfort about having wet genitals and a feeling that air is entering the vulva. Prepare the woman for these experiences by explaining to her that there will be changes in appearance and that she is likely to have increased sensibility. Reassure her that the sensibility will disappear after a while and that she will get used to the feeling of wet genitals.

Suggest that she takes sitz bath (warm water containing salt) three to four times a day followed by gentle drying of the area. As this will not be possible for many women who do not have access to water or bath, discuss alternatives that would also assist in the healing and recuperation process. Application of a soothing cream can be prescribed for the first 1-2 weeks. Advise her and her husband when to resume sexual intercourse- typically this will be after 4 to 6 weeks to allow adequate time for the wound to heal. Counselling regarding sexual matters requires great sensitivity, and should be carefully tailored according to the needs of the client and her family and to what is culturally appropriate. It may also require over several sessions.

Advise the client on the importance of personal hygiene. Make a follow-up appointment to monitor healing progress and to deal with any other issue that may have arisen concerning the genitals or sexual relationship. In the months following surgery, vulval hypertrophy often occurs, presumably due to some erectile tissue remaining in the base of the residual vulva. In favourable cases, by six months, the vulva is indistinguishable from normal.

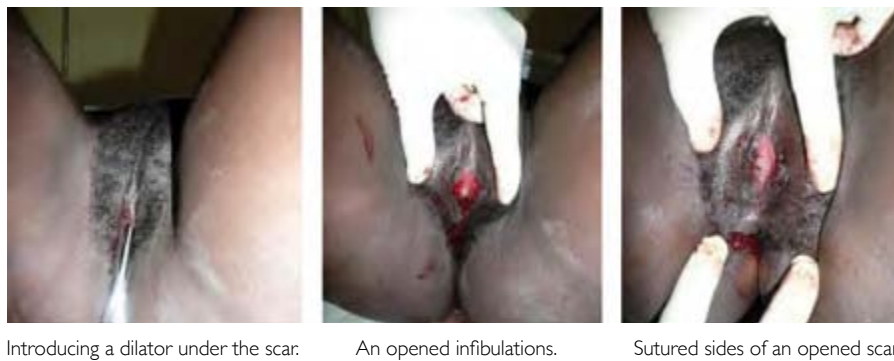
It is important to be aware of women's expectations surrounding sexuality after surgery, and to provide appropriate counselling. Some women have very high expectations and have consequently been disappointed. Traditionally, in some communities, intercourse occurs immediately after the woman has been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

In the following images, we can observe the procedure for the opening up of type III (see Figure 6 and 7).

Figure 6. Procedure for opening up type III'



Figure 7. Surgical intervention of opening up type III



References

1. WHO (2001) Female Genital Mutilation. Integrating the prevention and the management of the health complications into the curricula of nursing and midwifery. A student's manual. Geneva, WHO/FCH/GWH/01.4.
2. REPUBLIC OF KENYA MINISTRY OF HEALTH (2009) *Management of complications in pregnancy, childbirth and the postpartum period in the presence of FGM/C. A reference manual for Health Service Providers*. Nairobi, Ministry of Health.



7

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

Women with FGM/C require sensitive antenatal care. Types I, II and III can produce severe vulval and vaginal scarring which may cause obstruction during labour and delivery. Infection and inflammation at the time FGM/C was performed may result in vulva adhesions which narrow or completely occlude the vaginal orifice. Insertion of herbs or other substances may also cause severe scarring and stenosis.

Where FGM/C did not result in any particular complications (did not limit the space or skin turgor of the introitus, and did not lead to any chronic complications), the woman will require no special management or treatment during pregnancy. Some women do not require any special management during pregnancy other than emotional/social support and anticipatory guidance for the delivery. Reassure the woman that you do not expect any FGM/C-related complications and invite her to ask any questions related to FGM/C or other issues.

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

Management of women with FGM/C during pregnancy

The woman who has undergone FGM/C is at risk of complications during this period. The consequences of FGM/C in the female genital tract hinder the required accurate examinations for proper antenatal care. Sometimes, insertion of the vaginal speculum and bimanual vaginal exam is difficult because of stenosis or narrowing of the vaginal introitus. This makes it difficult for a proper examination and specimen collection for diagnosis of diseases such as vaginal infections, urinary tract infections and sexually transmitted infections. Furthermore, the lack of proper diagnosis causes inadequate treatment of the above-mentioned infections, increasing the risk of premature rupture of membranes, chorioamnionitis, preterm birth and dystocic delivery (caesarean).

In case of type III, defibulation will have to occur prior to delivery. It is recommended that defibulation is done in the second trimester of pregnancy, but can also be done just prior to delivery (See Module 6 of the present Manual and/or reference 5 of the bibliography).

Management of women with FGM/C during labour and delivery

Procedure

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

- If there is a problem with assessment such as a tight introitus making vaginal examination impossible, the scar can be opened along the midline. The incision should be made at the height of a contraction, and usually after the administration of a local anaesthetic. Use of episiotomy may be preferred. There tends to be little bleeding from the relatively avascular scar tissue and suturing of the incision can be delayed until after delivery. If the situation allows, labour can be assessed using other parameters such as contractions, descent of the presenting parts, and foetal heart rates.
- Observe the woman closely and monitor vital signs as condition requires;
- Give clear and simple information to the patient about what she should expect during delivery, and allay anxiety/fear;
- Record all observations in the partograph.

Assessment of the introitus during labour

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

The procedure is as follows:

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

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

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

In many cases, the doctor decides to perform caesarean section on patients in labour and delivery for various reasons. In the cases when the problem is due to stenosis caused by FGM/C, it may be hard to introduce the Foley catheter. In these cases, the patient is subjected to caesarean section without a bladder catheter, which presents as a challenge to the surgeon and a great risk of injury to the bladder during surgery.

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

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

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

- If FGM/C has caused a tight introitus there is a need to increase the vaginal opening by performing an episiotomy. This is usually performed during the second stage of labour, when the presenting part is pressing on the vulva.
- Usually a tight introitus will have been identified during the first stage of labour, and the woman should have been prepared for the performance of episiotomy at that time.
- If the woman has arrived at the ward already in the second stage of labour, explain to her the need to increase the opening by performing an episiotomy, and inform her of when and how this will be done.

If a woman presents with type III and Caesarean section is more appropriate than defibulation and vaginal delivery, explain the need for the operation and ask her consent to perform it, or refer her to a major health center.

The performance of an episiotomy is as follows:

- Prepare the patient;
- Prepare a tray with antiseptic swabs, episiotomy scissors, sterile gloves, a 5 ml syringe and local anaesthetic;
- Inform the patient that you are going to cut open the perineal area to increase space for the baby to pass easily;
- Wash hands, put on gloves, clean the perineal area;
- Introduce one or two fingers (they should go in easily), positioning them where you are going to administer the anaesthetic. This protects the baby's head;
- Infiltrate 2-3 ml of local anaesthetic along the fingers to avoid injuring the baby and into the area where the cut will be made;
- With your finger or fingers inside the vagina – they should be between the scissors and the baby's head – introduce the scissors and cut along the fingers to avoid injury to the baby. Start at the centre of the perineum and angle (slant) your scissors out at a 60 degree angle. If you are right-handed, cut towards the mother's right buttock. If left handed, cut towards the mother's left buttock. Following cutting, the baby is usually delivered slowly;
- Press a gauze firmly over the cut area while the woman continues to push;
- Immediately after delivery, the cutting and any tears must be sutured;
- Take care of the mother and the baby;
- Educate patient on vulva hygiene and keeping the perineum clean;
- Wash hands and clear equipment.

References

- WHO (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.* Geneva, WHO/FCH/WMH/00.7.
- WHO (2001) *Female Genital Mutilation. The prevention and management of the health complications: policy guidelines for nurses and midwives.* Geneva, WHO/FCH/GWH/01.5.
- WHO (2001) *Female Genital Mutilation. Integrating the prevention and the management of the health complications into the curricula of nursing and midwifery. A teacher's guide.* Geneva, WHO/FCH/GWH/01.3.
- WHO (2001) *Female Genital Mutilation. Integrating the prevention and the management of the health complications into the curricula of nursing and midwifery. A student's manual.* Geneva, WHO/FCH/GWH/01.4.
- REPUBLIC OF KENYA MINISTRY OF HEALTH (2009) *Management of complications in pregnancy, childbirth and the postpartum period in the presence of FGM/C. A reference manual for Health Service Providers.* Nairobi, Ministry of Health.





8

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

Management of women with FGM/C following delivery

Procedures for assessment

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

- Check for retained products and make sure uterus is well contracted. Check the bladder and empty it if necessary, or administer oxytocic drugs;
- If you have delivered the baby, change gloves for another sterile pair;
- Check for tears on the vulva and inside the birth canal;
- Clean the vulval area to enable you to look into the external genitalia;
- Use good light to assess for tears in the vaginal wall and on the cervix if you are unable to visualise a speculum maybe required;
- If necessary, introduce the speculum very slowly as this may cause pain to the woman;
- Look along the inside of the vaginal wall and at the cervix;
- If there is bleeding or tears, take appropriate action immediately.

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

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

Complications after delivery

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

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

Remember that the management of women with FGM/C during the postpartum period is the same as for any other woman. However, these women will need more psychological care in cases where the vulva has been opened up and not closed to restore the genitalia to the condition they were in before pregnancy and delivery.

Immediate care in cases of haemorrhage:

The medical practitioner should do the following:

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

In cases of neonatal asphyxia resuscitate the newborn and send for specific medical attention.

References

- WHO (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.* Geneva, WHO/FCH/WMH/00.7.



9

COUNSELLING

Counselling is defined as helping someone to explore a problem so that they cope more effectively and make an informed choice or decision. It is an important element in the prevention of FGM/C and in the management of complications. Counselling of a girl or woman with FGM/C complications should be strictly confidential. If the patient has a partner, he should be counselled separately until the right moment for them to be counselled as a couple. The aim of counselling is to help a woman, couple, or family to come to terms or solve problems. During a counselling session it is important to build a trusting relationship with the patient so that he/she feels safe in discussing her/his concerns with you as the counsellor.

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

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

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



This is usually the most suitable, taking into account the ethical and human aspects of the FGM/C issue. There are alternatives, such as using email or telephone to provide information, but the final choice depends, among other factors, on the actual conditions and the subject matter being addressed.

Who provides the counselling service?

People who are previously trained in the subject and experienced in this type of professional help. They should be characterised as being sensitive, tolerant, unbiased, sincere, trustworthy, discreet, understanding and willing to self-train.

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


Important elements to consider are:

- **Reception** - Receive the patient warmly and greet her;
- **Privacy and confidentiality** – make sure that counselling is carried out in a room where nobody can come in without permission, and where the discussion cannot be overheard by other people;
- **Patience** – you should be relaxed and not pressed for time;
- **A carefully considered seating plan** – counsellor and patient should be on the same level and seated opposite to each other, with no barriers between them so that the counsellor can lean towards the patient to demonstrate attentiveness and support during the discussion;
- **Eye contact** – it is important to look at the patient directly and to observe her carefully so that you become aware of her facial expressions (body cues), as these may tell a different story from her words. You should not look her straight in the eye all the time, but observe the whole person and her actions;
- **Attentive listening** – observe the patient's tone of voice as well as what she is saying as this may tell you more than her words. You should allow the patient to do most of the talking, but try to summarise what has been said from time to time to confirm that the information shared is well understood by both;
- **Show concern** (empathising) – try to put yourself in the patient's position and show that you care;

- **Appropriate facial expressions** – you should be aware of your facial expression and ensure it is appropriate to what is being said. Smile when you greet the patient, but if she cries during the session your facial expression should show sympathy and concern;
- **Respect** – you should always show respect for your patients as dignified human beings with their own values and religious and cultural beliefs;
- **A non-judgmental attitude** – it is very important not to be judgmental. As a counsellor you need to be aware of your prejudices so that they do not interfere with the counselling process.

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

- Welcome the patient (and her partner/husband if appropriate) and invite her to sit down;
- Greet her and introduce yourself in the culturally appropriate manner;
- Ask the patient her name and ask if you can help her with anything;
- Let the patient talk and encourage her by nodding or saying “yes” from time to time;
- Give the patient information about the services available (e.g. management of FGM/C complications) in your clinic or centre and the staff who will care for her;
- Let the patient explain her concerns;
- Be patient, as she may find it hard to express her experiences and feelings;
- Listen carefully and observe non-verbal clues (e.g. body language, tone of voice) to enhance your understanding of the patient’s situation;
- Summarise the patient’s information from time to time to check that you have heard her correctly and avoid misunderstanding;
- Show concern throughout the session by being attentive and making eye contact from time to time;
- Empathise with the patient when she is describing a disturbing experience, which may make her weep;
- Explain to the patient how you can help if the purpose of counselling is to discuss the need to manage an FGM/C related complication;
- Give her detailed information about the problem and the procedure you will use to address it;
- Give her information about any operations that may be necessary and the post-operative care;
- If counselling is for psychosocial or sexual problems, ask such questions as may be appropriate to draw out as much information from the patient as possible about her problems;
- Assist the patient, and her partner where appropriate, to make an informed decision on the steps to be taken to solve the problem;

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- Assist them to act on their decision by giving advice on how to proceed;
 - Give the patient an appointment for another counselling or follow-up session to prepare for the next step, if necessary;
 - If the problem persists, refer to a specialist.

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

References

- INFOMED Information on counseling. Website of the Cuban Health Network. <http://www.sld.cu/servicios/sida/temas.ph.idev>. [Accessed 15th April 2014]
- MIGALI, J. *Sanamente*, website about psychological counselling. <http://www.sanamente.com.ar/n-autoestima.html>. [Accessed 15th April 2010]
- WHO (2008) *Towards the healthy women counselling guide: ideas from the gender and health research group*. Geneva, TDR.



10

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

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

A **community** is a social unit of any size that shares common values. The community may share beliefs, resources, preferences, needs and risks, and may have cultural, ethnic, religious or other characteristics in common. In the context of FGM/C, the community is a group of people (including individuals and families) who either live in an urban or rural area and who tend to share beliefs, values and attitudes regarding this practice. Community involvement means working with the people to address their needs and find solutions to their problems. It is a process where community members take the lead.

Community Health Education

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

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

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

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

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

Strategies and means

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

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

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

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

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

Setting the stage for Community Health Education

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

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

- **Know the target audience:**
 - Identify the participant group (individuals, families or groups);
 - Decide who to reach (women, youth, men or mixed);
 - Know the background of the intended participant group (educational level, language, age, socio-economic status, level of exposure).

- **Find out about the practice of FGM/C locally. Explore the following:**
 - What type of FGM/C is performed locally?
 - What are the reasons for practicing FGM/C?
 - What perceived problems or complications do people experience during or after the procedure and how they are handled?
 - Who performs FGM/C?
 - Perceptions about girls who are not cut.

- Identify who the chief decision-makers are in the community regarding FGM/C;
- Ensure that people who will be involved in implementing the Community Education programme are well trained.

- **Prepare yourself very well:**
 - Have all the information and materials you need;
 - Organise your materials and equipment;
 - Make sure the intended programme participants are well informed and prepared before any session;
 - Ensure that any communication materials and messages used are based on research.

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

Strategies for involving specific community groups

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

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

Advocacy

Concept and definition

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

Advocacy includes tools to facilitate the active participation of people involved in the processes of social and political management and resource mobilisation in the different fields, at regional, national and international levels. It is a strategy to influence policy that includes several sectors of the population. In the case of FGM/C it contributes to bringing together women and girls and building of a new vision in defending their rights.

Over the last decade numerous organizations and individuals have become involved in community-based activities aimed at the elimination of FGM/C. These efforts have raised awareness of FGM/C worldwide and brought the issue to the attention of influential people at all levels of those societies where FGM/C is practiced. Elimination of the practice depends on the concerted effort of everyone with an interest in protecting the health of women and girls.

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

Steps

Information gathering and analysis

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

- Prevalence of the practice locally and nationally;
- Who the excisers are;

- Rationale and reasons given for the practice;
- Age at which excision is performed;
- Factors that motivate the community and individuals to maintain the practice;
- Those who make the decisions;
- Perceptions of girls who are not cut;
- Current knowledge of the health and social consequences of the practice;
- Responses of the community to past efforts directed at preventing the practice.

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

Identification of target audiences and key individuals for advocacy

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

The setting of advocacy objectives

The change sought on the part of each target audience for advocacy should be clearly spelt out. For instance, advocacy could be aimed at legislation against the performing of FGM/C or at establishing penalties for health professionals who engage in the practice. A variety of positive responses is needed from political leaders, legislators and key policy and decision-makers in both the public and private sectors, as well as in civil society.

Monitoring and evaluation

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

Essence of advocacy in FGM/C

Advocacy should be aimed at achieving the following:

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

Advocacy strategies

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

The most important strategies in advocacy include:

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

Building coalitions

Building partnerships with other active organizations or individuals in the same field has several advantages. It allows for the sharing of experience and expertise, and the pooling of resources. Besides, there is strength in numbers. Well-briefed pressure groups can be a key ally in a coalition which intends to push for changes in policies, laws and programmes or services and to influence major decisions. Examples of pressure groups include trade unions, student unions, communities, consumer groups and professional bodies.

Working with the mass media

Both the electronic and print mass media can be used to reinforce advocacy activities. The media is a powerful tool and can provide significant impact if used properly. The media may be employed to articulate the views of advocates and those affected by an issue. Articles published in newspapers or stories broadcast on the radio and television spread the message far and wide. Building partnerships with media organisations is therefore a valuable exercise and the first task in establishing such a relationship is to educate relevant people in the media about FGM/C.

Working with communities

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

Lobbying

This means canvassing support 'behind closed doors' and applying pressure to try to influence people's opinions and actions. It is usually a slow process, requiring great patience and persistence on the part of the lobbyist, and can take the form of one to one direct personal contact.

Conferences

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

Advocacy kits

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

Public events

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

References

- UNFPA (2008) *Promotion and Education on Sexual and Reproductive Health. Basic concepts and case studies*, La Habana.
- WHO (1999) *Female Genital Mutilation. Programmes to date: what works and what doesn't. A review*. Geneva, WHO/CHS/WMH/99.5
- WHO (2011) *Female Genital Mutilation programmes to date: what works and what doesn't*. Geneva, WHO/RHR/11.36.

