

FEMALE GENITAL MUTILATION

TEACHING MODULE

Background Information for Midwifery, Nursing and Medical Students

The Female Genital Mutilation Teaching Module
has been produced by the FGM Education Programme
for the New Zealand Ministry of Health.

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1 Purpose

The purpose of the *Female Genital Mutilation (FGM) Teaching Module* is to provide tertiary education providers a guide to use when discussing FGM with their midwifery, nursing and medical students. This teaching module provides an overview of clinical information relating to FGM and is intended for use in conjunction with the comprehensive manual *Female Genital Mutilation in New Zealand – a manual for health and child protection professionals* (2004).

2 Definition and Background

2.1 Definition

Female genital mutilation comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or other non-therapeutic reasons. (WHO, 1996)¹

CLASSIFICATION

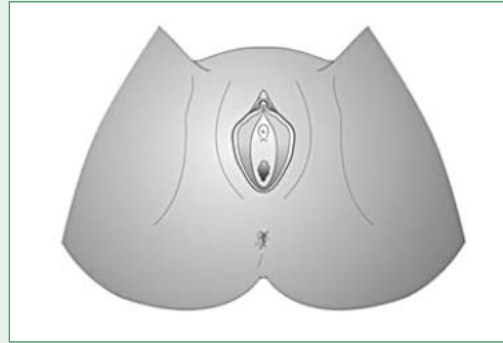
The different types of female genital mutilation known to be practised are as follows:

- Type I** Excision of the prepuce, with or without excision of part or all of the clitoris.
- Type II** Excision of the clitoris with partial or total excision of the labia minora.
- Type III** Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).
- Type IV** Unclassified: includes pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterisation by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vagina (gishiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purposes of tightening or narrowing it; and any other procedure that falls under the definition of female genital mutilation given above.²

Table 1: Types of Female Genital Mutilation and Normal Female Genitalia³

Normal Female Genitalia

Clitoris, labia minora and labia majora intact.



FGM Type I

Excision of the prepuce, with or without excision of part or all of the clitoris.



FGM Type II

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



FGM Type III

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



Images supplied by The Royal Women's Hospital, Victoria, Australia.

2.2 Background

PREVALENCE

It is estimated that between 100 and 140 million girls and women worldwide have been affected by FGM Type I, II or III with an estimated 3 million girls at risk of undergoing FGM every year.⁴

The majority of affected girls and women live in 28 countries in Africa and the Middle East. There are also reports but no clear evidence, of a limited incidence in Jordan, Oman, the Occupied Palestinian Territories (Gaza) and certain Kurdish communities in Iraq. The practice has also been reported among certain populations in India, Indonesia and Malaysia.⁵

Despite decades of prevention work undertaken internationally by local communities affected by FGM, Governments and NGOs, the overall rate of decline in the prevalence of FGM has been slow.⁶

Listed in Table 2 (page 8) are the countries in which FGM Types I, II, III and IV have been documented as a traditional practice. The prevalence is derived from the national survey data (the Demographic and Health Surveys (DHS) published by Macro, or the Multiple Cluster Indicator Surveys) published by UNICEF.

HOW THE PRACTICE IS CARRIED OUT

FGM is most commonly performed by midwives, birth attendants and traditional circumcisors. The procedure is carried out using crude tools and instruments such as razors, knives and scissors. Anaesthetics or antiseptics are not generally used, however in urban areas FGM is being performed more frequently in hospitals by trained doctors and midwives.

AGE FGM IS PERFORMED

The age at which FGM is performed varies widely, depending on ethnic group and geographical location. Among some groups FGM is performed as early as infancy, in other groups it doesn't occur until adolescence, or occasionally in adulthood. The most common age for infibulation is between 4 and 8 years.⁷

WHY FGM IS PERFORMED

FGM is deeply rooted in a complex social and economic framework. It is seen as a very beneficial custom and is supported by a wide range of beliefs, customs, values and sociological pressures. Some of the main reasons supporting the practice include:

- **Psychosexual reasons** - Reduction or elimination of the outer genital organs is believed to reduce sexual desire in a girl/woman, maintain her chastity and virginity before marriage, maintain faithfulness during marriage, and increase male sexual pleasure.⁸
- **Sociological reasons** - FGM is commonly linked with identification with the cultural heritage, initiation of girls into womanhood, social integration, the maintenance of social cohesion, and family honour.⁹
- **Hygiene and aesthetic reasons** - The external female genitalia are often considered by many groups to be dirty and unsightly and are removed to promote hygiene and provide aesthetic appeal.¹⁰
- **Myths** - FGM is believed to promote fertility, the child's good health and child survival. It is also commonly believed that the clitoris is dangerous and unless removed it will poison a child at birth or grow long and dangle down.¹¹
- **Religious reasons** - FGM is practised by Muslims, Christians (Catholics, Protestants and Coptics), animists and nonbelievers. It has frequently been carried out by some Muslim communities in the genuine belief that it is demanded by the Islamic faith, however, the practice of FGM predates Islam and there is no substantive evidence that it is an Islamic religious requirement.¹²

Table 2: Countries where FGM has been documented

Country	Year	Estimated prevalence of FGM in girls/women 15-49 years (%)
Benin	2001	16.8
Burkina Faso	2005	72.5
Cameroon	2004	1.4
Central African Republic	2005	25.7
Chad	2004	44.9
Cote d'Ivoire	2005	41.7
Djibouti	2006	93.1
Egypt	2005	95.8
Eritrea	2002	88.7
Ethiopia	2005	74.3
Gambia	2005	78.3
Ghana	2005	3.8
Guinea	2005	95.6
Guinea- Bissau	2005	44.5
Kenya	2003	32.2
Liberia*		45.0
Mali	2001	91.6
Mauritania	2001	71.3
Niger	2006	2.2
Nigeria	2003	19.3
Senegal	2005	28.2
Sierra Leone	2005	94.0
Somalia	2005	97.9
Sudan, northern (approx 80% of the total population in survey)	2000	90.0
Togo	2005	5.8
Uganda	2006	0.6
United Republic of Tanzania	2004	14.6
Yemen	1997	22.6

The estimate is derived from a variety of local and sub-national studies. (UNICEF, 2005).

3 FGM in New Zealand

3.1 Prevalence

Since the 1990s, increasing numbers of women have been settling in New Zealand from countries where FGM is practiced, in particular from Africa.

In New Zealand, the main communities affected by FGM are the Somali, Ethiopian, Egyptian, Eritrean and Sudanese communities. International reports indicate FGM is also practiced amongst some Muslim communities in India, Malaysia and Indonesia, and women and girls from these communities living in New Zealand may also have undergone FGM prior to arrival.

The largest and most significant group affected by FGM in New Zealand is the Somali community. Almost 98% of Somali women have undergone FGM, and of this number, an estimated 80% have Type III / infibulation¹³ – the most severe form of FGM.

It is important to note that women affected by FGM may present more frequently to women’s health services due to the larger number of children commonly born to African women and the complications associated with FGM requiring medical assistance.

Table 3: Origins of women affected by FGM living in New Zealand

Country	% of Women Affected	Type of FGM
Somalia	97.9	Type II and III
Ethiopia	74.3	Type I and II
Eritrea	88.7	Type I and II
Northern Sudan	90	Type III
Egypt	95.8	Type I
Indonesia	No documented prevalence	Type I or II
Malaysia	No documented prevalence	Type I or II
India	No documented prevalence	Type I or II

3.2 Attitudes Toward FGM in New Zealand

Attitudes toward FGM among the African communities in New Zealand vary greatly. The degree of knowledge about FGM also varies but is growing steadily as education programmes are initiated and health care professionals introduce FGM education into their routine care. Overall, there has been a steady decrease in support for the practice among the Somali community in Auckland. Regional (Auckland) FGM health surveys held in 1997 and then in 2008 have highlighted this decline, with 76% of the sample group supporting FGM in 1997 compared with only 43% in 2008. The survey indicated the two key factors for the decrease were an increased understanding that FGM is not a religious requirement and increased knowledge of the harmful health effects of FGM. Younger women also reported exposure to New Zealand cultural norms had influenced their attitudes towards FGM.¹⁴

When considering the support for FGM amongst some families, it is important to be aware that FGM is a complex multifaceted practice deeply rooted in a strong cultural, social and religious framework. It is endorsed by the community and supported by loving parents with the intention of making girls eligible for marriage and acceptable in their community. Despite its harmful physical effects – FGM provides women with many social and cultural benefits and is believed to be performed with the best interests of a young girl at heart.

Another important aspect to consider is that many Africans affected by FGM settling in New Zealand are refugees and few aspects of their life have not been threatened or lost with civil war and resettlement. Most have lost their homes, their social role and status, their family unit, their profession, their cultural identity, their religious structure, and many family members. For some members of the community faced with so much loss, FGM - a ritual that reinforces such important cultural values as chastity, purity and fidelity, often assumes even greater importance while settling in New Zealand.

It is important for health professionals to be aware that for almost all Somali families in New Zealand, it is a difficult time of transition as they question long held beliefs about FGM and learn how to let go of the practice - while still upholding some of the good cultural values and beliefs behind it. Many mothers may feel torn between their new knowledge of the consequences of FGM and the pressure from older members of the community to continue the practice. While they may not want FGM performed on their young daughters, they fear rejection from their families and community. In addition, FGM is commonly seen as the safeguard of a girl's virginity and as virginity is so essential to marriage and family honour, many mothers fear for their daughter's future.

Sensitive counselling and support from health professionals is therefore vital for communities affected by FGM, as they struggle with the changes inherent in giving up the practice. Counselling for mothers and adolescents in particular may be necessary on issues relating to FGM and beliefs surrounding sexuality, virginity and marriage.

4 Health Consequences

Female Genital Mutilation commonly causes damage to girls and women and may result in long term health complications. The effects on health depend on the extent of cutting, the skill of the operator, the cleanliness of the environment, and the physical state of the girl or woman concerned. The most detrimental health consequences occur with infibulation.

4.1 Short Term Complications

HAEMORRHAGE

This is one of the most common complications of FGM, as excision of the clitoris involves cutting across the high pressure clitoral artery and attempts to stop bleeding may not be effective. Acute extensive bleeding can lead to haemorrhagic shock or even sudden death in the case of severe uncontrolled haemorrhage.

SHOCK

This may occur because of blood loss and the severe pain and trauma of the procedure. Both haemorrhagic and neurogenic shock can be fatal.

PAIN

The majority of mutilation procedures are performed without anaesthetics and cause the girl severe pain. Even if a local anaesthetic is used, multiple insertions of the needle are often required.

URINARY RETENTION

This is very common and may last for hours or days. It is commonly due to pain, tissue swelling, inflammation, injury to the urethra, and fear of passing urine on the raw wound.

INJURY TO ADJACENT TISSUE

Injury to the urethra, vagina, perineum and rectum can result from the use of crude instruments, poor light, careless techniques, and/or from the struggles of the girl.

INFECTION

Infection commonly occurs for a number of reasons; unhygienic conditions, the use of unsterilized instruments, applications of traditional herbs or ashes to the wound, contamination of the wound with urine and/or faeces, or binding of the legs following infibulation which prevents wound drainage. Septicaemia and tetanus may also develop.

FRACTURE OR DISLOCATION

Fracture of the clavicle, femur, humerus or hip joint can occur if heavy pressure is applied to a struggling girl during the procedure - as often occurs when several adults hold her down.

FAILURE TO HEAL

Wounds may fail to heal quickly because of infection, irritation from urine, underlying anaemia or malnutrition.

4.2 Long Term Complications

DIFFICULTIES WITH URINATION

This can occur due to damage to the urethral opening (meatus), obstruction of the urinary opening, or scarring of the meatus - and can lead to chronic incontinence or difficulty passing urine. For many infibulated girls, passing urine can take up to 20 minutes when they are still virgins due to the narrow introitus.

RECURRENT URINARY TRACT INFECTIONS

Partial occlusion of the vagina and urethra means the normal flow of urine is deflected and the perineum remains constantly wet and susceptible to bacterial growth. Retrograde UTI's therefore can occur, affecting the bladder and kidneys. Damage to the lower urinary tract during the procedure can also result in urinary tract infections.

CHRONIC PELVIC INFECTIONS

Partial occlusion of the vagina and urethra increases the likelihood of infection and ascending pelvic infections can occur. The infections are often painful and may be accompanied by a noxious discharge spreading to the uterus, fallopian tubes and ovaries - and frequently become chronic.

INFERTILITY

This can occur due to chronic pelvic infections causing irreparable damage to the reproductive organs.

VULVAL ABSCESSSES

These can develop due to infection resulting from faulty healing or an embedded stitch.

NEURINOMA

This can develop when the dorsal nerve of the clitoris is cut or trapped in a stitch or in scar tissue. The surrounding area becomes hypersensitive and unbearably painful.

KELOID SCARS

These can result from slow and incomplete healing of the wound and the production of excess scar tissue. The scars may obstruct the vaginal opening and be so extensive that they prevent penile penetration.

DERMOID CYSTS

These can result from inclusion of the epithelium during healing, leading to swelling or pockets producing secretion. The cysts vary in size, are extremely painful and can prevent sexual intercourse.

CALCULUS FORMATION

These can develop due to menstrual debris or urinary deposits in the vagina or in the space behind the bridge of the scar tissue.

FISTULAE

Vesico-Vaginal or recto-vaginal fistulae can form as a result of injury during mutilation, deinfibulation, re-infibulation, sexual intercourse, or obstructed labour. Urinary and faecal incontinence may be lifelong with severe social consequences.

DIFFICULTIES WITH MENSTRUATION

Partial or total occlusion of the vaginal opening commonly results in dysmenorrhoea or amenorrhoea. Haematocolpos (accumulation of menstrual blood in the vagina) occasionally occurs from the retention of menstrual blood due to the almost complete coalescence of the labia.

INCREASED RISK OF HIV TRANSMISSION

There is an increased risk of HIV transmission due to the use of the same unsterile instruments in group mutilations, repeated cutting and stitching during labour, and the higher incidence of lacerations and abrasions during intercourse.

4.3 Complications in Pregnancy, Labour and Birth

Problems during pregnancy and childbirth are very common, particularly following infibulation. The extent of the complications varies depending on factors such as the size of the opening, parity, and the nature of the scar tissue. The following complications can occur following infibulation and will impact on the provision of pregnancy, labour and birth care:

DURING PREGNANCY

- In the event of a miscarriage the fetus may be retained in the uterus or the birth canal, and performing a dilation and curettage may be difficult.
- Inability to provide adequate vaginal examinations if required - for example, for high head at term or for infection screening.
- If an induction of labour is indicated - it may not be possible to perform the induction with prostaglandins due to the very narrow introitus.

DURING LABOUR AND BIRTH

- Incorrect assessment of the stage of labour, cervical dilation and fetal presentation due to inability to perform vaginal examinations.
- Difficulty identifying some obstetric emergencies such as cord prolapse, due to an inability to easily perform vaginal examinations.
- Prolonged and obstructed labour due to tough scar tissue causing partial or total occlusion of the vaginal opening. This can lead to increased risk of uterine inertia, rupture or prolapse, tearing to the perineum, haemorrhage, and fistula formation. The baby may have an increased risk of suffering neonatal brain damage or death as a result of birth asphyxia.
- Difficulties applying a fetal scalp electrode or performing a fetal blood sample due to the very narrow introitus. An inability to provide adequate fetal monitoring in the case of a compromised baby may hasten the decision to perform a caesarean.
- Increased risk of bleeding, wound infection and damage to surrounding tissues due to repeated deinfibulation - particularly if it is not performed correctly.
- Repetition of deinfibulation and re-infibulation weakens the scar tissue and at the beginning of menopause, a woman can be left with a mass of fibrous tissue. Incontinence and prolapses of the vaginal wall may result.

4.4 Sexual Consequences

Very little research has been conducted on the sexual consequences of FGM – and anecdotal evidence is conflicting. Some women who have undergone FGM state that they are not able to experience any sexual pleasure, while others testify that they experience complete sexual functioning.¹⁵ In the absence of any comparison between sexual experience before and after FGM, it is difficult to assess the real impact of FGM on women's sexual fulfilment. However it is reported, and most authors confirm, that FGM decreases the sexual pleasure and fulfilment of women, and many women who have undergone FGM experience various forms and degrees of sexual dysfunction.¹⁶ Factors such as the degree of mutilation and the amount of tissue removed, the extent of scarring, the experience of the initial procedure, cultural and social expectations, and affection and bonding in the sexual relationship will affect each individual woman with FGM differently, and will impact directly on her sexuality and sexual functioning.

PAIN AND FEAR ASSOCIATED WITH INITIAL SEXUAL INTERCOURSE

For infibulated women initial sexual intercourse through the damaged genital scar tissue can be difficult or impossible without further tissue damage. Often, re-cutting or de-infibulating the scar site is necessary. In most communities the husband is expected to penetrate the opening with his penis, which can be extremely painful for the woman. Consummation of marriage may take months if the scar tissue is not cut open. For most women, initial sexual intercourse is therefore a very frightening and painful ordeal and is associated with significant fear and anxiety.

ABSENCE OF ORGASM

The few studies that have addressed the area of FGM and sexuality report the absence of orgasm in women with FGM to be common. Injury to, or removal of the clitoris results in damage to the concentrated nerve complex responsible for clitoral erection and erection of a partially mutilated clitoris can be very painful - or simply not possible.¹⁷ However, despite such evidence, other smaller local studies and anecdotal evidence suggest that some women with FGM experience complete sexual fulfilment and orgasm is still possible.¹⁸ The reasons given to support this include the belief that clitoral tissue is able to regenerate¹⁹ and that arousal and sexual fulfilment is largely psychological. Recent deinfibulation surgery being performed in Western countries also indicates that a number of infibulated women still have their clitoris intact.²⁰

ONGOING DYSpareunia

Ongoing painful sexual intercourse is common amongst some infibulated women. This can be caused by the following factors; the narrow and tight introitus, keloid scar tissue, excessive scar tissue of the vulva and perineum with subsequent tenderness and hypersensitivity, sebaceous and inclusion (dermoid) cysts, neuroma or damage to nerve tissue during the initial mutilation, the absence of vaginal lubrication due to lack of physiological arousal, and the psychological pain and fear associated with intercourse.

VAGINISMUS

Vaginismus (prolonged contraction of vaginal muscles) may affect some women with FGM. It can result from the trauma associated with FGM performed in childhood, the fear associated with initial intercourse, the pain associated with intercourse, and in some cases the anxiety associated with repeated and unsuccessful attempts at penetrating the scar tissue.

4.5 Psychological and Social Consequences

For many girls FGM is an experience marked by fear, submission, and inhibition and suppression of feelings. The experience becomes a vivid landmark in their mental development, with feelings of deep anger, fear, bitterness and betrayal at having been subject to such severe pain. Some older women have reported that nothing they have subsequently gone through (e.g. childbirth) equals the painful experience of FGM.²¹

FGM is commonly performed when girls are young and uninformed and the procedure is often preceded by acts of deception and coercion by trusted parents and relatives. In most cases an anaesthetic is not used and girls are conscious and need to be physically restrained as they struggle against the pain. For some girls and women, the physical and psychological experience of genital mutilation is extremely traumatic and its aftermath is similar to that following rape.

It needs to be emphasized however, that despite the severe physical and emotional trauma of the practice FGM also has an important psycho-social role in the lives of young girls in their communities. FGM is often shrouded in mystery and magic rituals and celebrations with special clothes, food and gifts for the girl. The ritual marks the young girl's entry into womanhood and she carries a new and vital sense of 'identity' after the procedure. An uninfibulated girl is often despised, alienated, and made target of ridicule, thus facing severe psychological anxiety of another nature.

5 Responding to Health Care Needs

Women affected by FGM have very specialised health care needs, and yet have been vulnerable to difficult experiences within New Zealand health services. This vulnerability is related to the reactions of some health professionals unfamiliar with FGM, the overall lack of FGM knowledge, cultural barriers, and communication problems. In order to provide the most effective services for women with FGM, New Zealand health professionals must develop specialised and appropriate clinical skills - based on a deep understanding of the issues and beliefs surrounding FGM.

5.1 Obstetric Care

The obstetric care of women with FGM should always be provided by an experienced Lead Maternity Carer (LMC) familiar with the labour and birth care and complications of FGM. Special attention should be given to the following areas;

ANTENATAL EXAMINATIONS

All women affected by FGM should undergo a genital and/or vaginal examination (if indicated) during the antenatal period in order to identify the type of FGM and size of the introitus. Findings should be documented in detail to minimise the need for repeat examinations and so that any potential labour and/or birth difficulties can be anticipated. See *FGM Clinical Care Antenatal Guidelines*.

DIET

Many women affected by FGM in New Zealand have presented with low iron stores, commonly due to poor diet following extended periods in refugee camps. Because of the fear of a complicated labour, birth or a caesarean section, many pregnant women also begin to eat less in their last trimester. - in the hope that their baby will not gain weight and they will have an easier labour and birth. It is important to discuss diet with the women, highlighting the importance of a balanced and iron enriched diet - particularly in the last trimester.

INDUCTION OF LABOUR

Many women affected by FGM (in particular Somali women) are opposed to induction of labour, and some may not turn up for 40 week antenatal appointments for fear of being induced. It is beneficial to explain to women the local DHB recommended practice with regards to induction, and consideration should be given to close fetal monitoring post term instead of routine induction.

CAESAREAN SECTIONS

Many women affected by FGM (in particular Somali women) are strongly opposed to caesarean sections and even in emergencies will not readily agree to them. There are many beliefs and myths surrounding caesareans that support this view. These include the belief that a baby will die if it is born “through the stomach”, a woman’s uterus may rupture during caesarean, that a woman won’t be able to lift or carry heavy things again, and that the number of children a woman can have may be restricted with each caesarean.

LABOUR AND BIRTH CARE

An experienced practitioner familiar with the complications of FGM should always be involved in the labour and birth care of women with FGM - particularly in the case of primigravidas, as almost all primigravidas will need to be deinfibulated to allow for delivery of the fetal head. A comprehensive birth plan should always be written prior to labour, documenting when the woman wishes to be deinfibulated and her choices regarding re-suturing the genital scar tissue. See *FGM Clinical Care Labour and Birth Guidelines*.

RESUTURING

Women’s expectations surrounding re-suturing the scar tissue (infibulation site) post birth should be discussed in detail during the antenatal period. In New Zealand fully re-infibulating a woman is not permitted. The importance of keeping the scar tissue as open as possible to allow for sexual intercourse and the exit of urine and menstrual blood should be explained, and the woman’s requests documented clearly in her notes.

POSTPARTUM

The postpartum period is an important time for most women affected by FGM and traditionally the women are closely cared for during the first six weeks following the baby’s birth. Many women living in New Zealand subsequently feel quite isolated over this time, as their traditional support network is not accessible to them here. It is important for health professionals to be aware of this and that women may also need special support and information relevant to the care of perineal, vulval or vaginal wounds.

PSYCHOSOCIAL ISSUES

Most of the women affected by FGM are refugees who, in addition to the enormous trauma experienced fleeing their homeland, may be struggling with challenges inherent in resettlement into a new country. These may include language barriers, housing and income difficulties, culture shock, and feelings of isolation. Some of these issues may be heightened with pregnancy and childbirth, and referral to appropriate refugee and support services may be necessary.

5.2 Gynaecological Care

DEINFIBULATION

Deinfibulation (reversal of infibulation) may be requested by women affected by FGM prior to marriage in order to allow for penile penetration, or in preparation for childbirth. Most large New Zealand hospitals now have practitioners familiar with deinfibulation and the procedure should always be accompanied with education and counselling. Women may present to health services only days before marriage requesting deinfibulation and it is important the request is treated as urgent. See *FGM Clinical Care Deinfibulation Guidelines*.

GYNAECOLOGICAL COMPLICATIONS

Many women and adolescent girls affected by FGM have a subsequent range of related gynaecological complications. Some of the most common problems include difficulties with menstruation, difficulties with urination, painful sexual intercourse, recurrent UTI's, pelvic infections, and infertility. Health professionals should be aware of these potential complications and the appropriate clinical care.

5.3 Sexual Health

SEXUALITY

Sexuality is traditionally a very taboo subject among women affected by FGM, however once trust has been established women can be very open about their experiences. Areas that have been raised and may need follow up include problems with initial sexual intercourse, the need for deinfibulation, painful sexual intercourse and sexual dysfunction.

SEXUAL HEALTH SCREENING

Most women affected by FGM in New Zealand have had little or no previous sexual health screening. Performing vaginal examinations on infibulated women prior to childbirth is often very difficult and screening for some STI's and cervical smear taking may not be possible. In general, women's health screening and health promotion is welcomed and should be promoted - however, sensitivity is required surrounding performing vaginal examinations.

FAMILY PLANNING

Many women affected by FGM in New Zealand have never accessed family planning services before and have little or no knowledge of their reproductive cycle and the types of contraception available. Providing comprehensive family planning education is important, however, for women who have been infibulated some methods of contraception such as diaphragms and IUD's may be precluded.

5.4 Health Education

HEALTH EDUCATION

Some women affected by FGM in New Zealand may have had limited access to health education. Specific areas of need that have been identified include reproduction, sexual health, pregnancy, childbirth, family planning, and menopause.

FGM EDUCATION AND PREVENTION

Health professionals have a key role in the prevention of FGM. They are in a unique position to provide FGM education because medical professionals are often well respected and may frequently interact with women affected by FGM or their children. Education provided by health professionals can provide convincing support against FGM as information in a health context is not seen as threatening and provides an objective view of FGM.

Health professionals should also consider that most women affected by FGM are refugees and may be struggling with various resettlement issues such as language barriers, housing and income difficulties, culture shock and feelings of isolation. Therefore prevention and education initiatives focusing solely on FGM may be inappropriate.

All community education, child protection and prevention initiatives should be undertaken in collaboration with community members who are actively involved in the design and delivery of each education initiative, policy or relevant FGM guidelines. Men, women, youth and religious leaders opposed to FGM should be encouraged to provide teaching on FGM from a health and, if appropriate religious perspective.

6 Appendix

6.1 Further Reading and Websites

FURTHER READING

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WEBSITES

FGM Education Programme

www.fgm.co.nz

This website provides comprehensive information and resources relating to FGM in New Zealand and internationally. This information includes definitions of FGM, where FGM is practiced, background to the practice, beliefs sustaining the practice, complications of FGM, issues relating to FGM in New Zealand, frequently asked questions about FGM and information relating to the New Zealand FGM Education Programme. In addition resources relating to FGM in New Zealand and internationally are available to order.

IAC - Inter- African Committee (IAC)

www.iac-ciaf.ch

The IAC promote health of women and children in Africa by addressing harmful traditional practices including female genital mutilation (FGM). This website contains detailed information about FGM and fieldwork undertaken in Africa.

WHO – World Health Organisation

www.who.int/reproductive-health/fgm/

This website provides a comprehensive range of FGM educational resources, technical and legal material.

FARREP - Family and Reproductive Rights Education Programme, Australia

www.thewomens.org.au

FARREP works with refugee/migrant communities and provides support and education for health professionals working with women affected by FGM. This website contains a range of FGM resources for communities and health professionals.

The Centre For Reproductive Rights

www.reproductiverights.org/

The Centre For Reproductive Rights uses the law and policy to secure reproductive freedom as a fundamental right. This website provides current data on international FGM law and related legal issues.

Amnesty International

www.amnesty.org

Amnesty International's central goals are human rights campaigning, advocacy and education. This website contains resources relating to FGM and human rights.

Stop FGM

www.stopfgmkurdistan.org

Stop FGM is a campaign which draws international attention to the human rights violations of FGM. This website has resources in English, French and Arabic.

Women & Gender – FGM

www.afrol.com/Categories/Women/FGM/

Afro.com contains links to relevant FGM news articles and related FGM issues in Africa.

FGM and Islam

www.religioustolerance.org/fem_cirm.htm

This site presents a number of papers discussing the practice of FGM by Islamic scholars and Muslim women.

6.2 Resources

NEW ZEALAND FGM RESOURCES FOR HEALTH CARE PROFESSIONALS

Female Genital Mutilation: Understanding and Responding, by Nikki Denholm, FGM Education Programme

A comprehensive manual for health and child protection professionals working with women who have undergone FGM. The manual looks in-depth at health problems commonly linked with FGM and provides practical guidelines for effective health care.

2004

FGM Clinical Care Deinfibulation Guidelines

Guidelines on Deinfibulation

2009

FGM Clinical Care Antenatal Guidelines

Guidelines on recommended antenatal care

2009

FGM Clinical Care Labour and Birth Guidelines

Guidelines on recommended labour and birth care

2009

FGM Clinical Care Postnatal Guidelines

Guidelines on recommended postnatal care

2009

Childbirth Picture Books, WIN NEWS

Somali childbirth picture books to be used by all health professionals.

1995

FGM Information for Health Care Professionals, pamphlet

FGM health information for health professionals including information on FGM and the New Zealand law.

2004

NB: Clinical Care Videos and DVDs are available on request.

NEW ZEALAND FGM RESOURCES FOR CHILD PROTECTION PROFESSIONALS

FGM and New Zealand, pamphlet

FGM health information for child protection professionals including information on FGM and the New Zealand law.

2004

FGM Child Protection Strategies and Pathways of Care

Guidelines for child protection services in the case of suspected imminent FGM and if FGM has occurred.

2009

FGM Child Protection Resource Kit

A comprehensive manual containing FGM information and pathways of care when FGM is suspected imminent or has occurred.

2004

Female Genital Mutilation: Understanding and Responding, by Nikki Denholm, FGM Education Programme

A comprehensive manual for health and child protection professionals working with women who have undergone FGM. The manual looks in-depth at child protection issues linked with FGM and provides practical guidelines for effective pathways of care.

2004

NEW ZEALAND FGM RESOURCES FOR COMMUNITIES

FGM and New Zealand, pamphlet (available in Somali and English)

FGM information including FGM and the New Zealand law.

2004

FGM Flipchart (Somali)

A flipchart designed for use by FGM Community Educators during education sessions

2005

Islamic Ruling on Male and Female Circumcision Booklet

A guide to Islamic beliefs as they relate to circumcision

2004

Let's Talk Video

A discussion about FGM

1998

Ma Gudnii DVD

A re-enactment of communities addressing FGM issues

2006

FGM Discussion Video

Discussions about FGM amongst Somali experts

2004

My Sis Will Be Safe DVD

Youth initiatives against FGM in the Netherlands, Ethiopia and Burkina Faso

2009

6.3 FGM Clinical Care Guidelines

The following FGM Clinical Care Guidelines are available on request from info@fgm.co.nz

- **Female Genital Mutilation Clinical Care Antenatal, Labour & Birth and Postnatal Guidelines** (2009)
- **Female Genital Mutilation Deinfibulation Guidelines** (2009)
- **Female Genital Mutilation Child Protection Recommended Guiding Principles** (2009)

6.4 Linkages to National and Local Policies

This section describes the wider context for the 2009 FGM Clinical Care Guidelines.

Sexual and Reproductive Health Strategy (2001)

The vision for the Sexual and Reproductive Health Strategy is “good sexual and reproductive health for all New Zealanders” This strategy needs to be considered alongside the FGM Guidelines.

Auckland Regional Settlement Strategy (2006)

The Auckland Regional Settlement Strategy highlights migrants and refugees from culturally and linguistically diverse backgrounds face the greatest challenges and barriers to settling and being able to contribute economically and socially in Auckland. This strategy identifies aims to ensure healthcare services are accessible and responsive to the physical and mental health needs of migrants and refugees, and do not create health inequities.

Refugee Young Persons Strategy (2007)

The vision for the Refugee Young Persons Strategy is “to create opportunities that allow refugee young people to achieve their potential – a bright future in New Zealand” Health objectives identified in this strategy are to improve health of refugee young people, improve access to health prevention and promotion messages and activities and create programmes that reflect the concerns of refugee young people.

Youth Health: A Guide to Action (2002)

This document recognises young people from minority ethnic communities have complex needs which must be considered when planning youth health initiatives. Many women under twenty four years old who have undergone FGM, access maternity health care. This document is particularly relevant to FGM clinical care guidelines.

Maternity Action Plan (2008 – 2012) Draft for consultation

This Action Plan contains key information relevant to all maternity health guidelines.

6.5 References

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