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# Female Genital **Mutilation**

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

## A **Teacher's** Guide

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

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

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# FOREWORD

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

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

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

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

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

# INTRODUCTION

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

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

## Who is the Teacher's Guide for?

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

## How is the Teacher's Guide organized?

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

**Module 1: Introduction to FGM**

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

**Module 2: Community involvement in the prevention of FGM**

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

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

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

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

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

Each module is organized as follows:

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

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

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

## How should the modules be used?

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

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

### Teachers are advised to:

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

## Teaching/learning activities

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

**The lecture –**

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

**Small group discussions –**

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

**Buzz group discussions –**

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

**Plenary, or large group, discussions –**

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

**The summary –**

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

**Case studies –**

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

**Scenarios and situation analysis –**

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

**Role play and drama –**

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

**Story telling –**

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

**Simulation games and exercises –**

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

**Demonstration and return demonstration –**

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

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

**Field trips –**

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

**Clinical practice –**

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

**Assignments –**

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

## Evaluation

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

# SUMMARY OF SESSIONS

## Module 1: Introduction to Female Genital Mutilation

### Session 1 – Analysing and influencing traditions – 2 hours

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

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

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

## Session 3 – Complications of FGM – 1 hour

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

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

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

## Session 5 – Human rights and FGM practice – 3 hours

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

# Module 2:
# Community involvement in the prevention of FGM

## Session 1 – Beliefs, values and attitudes – 2 hours

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

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

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

(Session 3 continued overleaf)

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

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

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

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

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

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

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

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

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

## Session 3 – Using counselling skills – 4 hours

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

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

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

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

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

## Session 6 – Demonstrating referral skills – 2 hours

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# MODULE 1: INTRODUCTION TO FEMALE GENITAL MUTILATION

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

## Application of the module

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

## General objectives

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

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

## Background qualifications

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

## Essential competencies

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

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

## Suggested teaching/learning activities

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

## Teaching aids

The teaching aids may include:

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

## Reference materials


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


### Regional and national references, for example:

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

## The Sessions

Time in hours

Session 1:
Analysing and influencing traditions .....2

Session 2:
Description and background of FGM .....3

Session 3:
Complications of FGM .....1

Session 4:
Professional ethics and legal implications of FGM .....2

Session 5: Human rights and the practice of FGM .....3

# Session 1: Analysing and influencing traditions

## Session objectives

By the end of the session students are expected to:

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

## Key references

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

## Suggested teaching methods

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

## Teaching aids

The teaching aids may include:

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

## Setting the scene

As a warm-up exercise:

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

## The Sessions:

Introduce the session and its objectives

## Defining tradition

### Buzz:

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

### Agree on a definition, for example:

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

## Examination of traditions

### Small group discussion:

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

*Teacher's notes*

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

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

## Thinking about harmful tradition

### Story telling:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

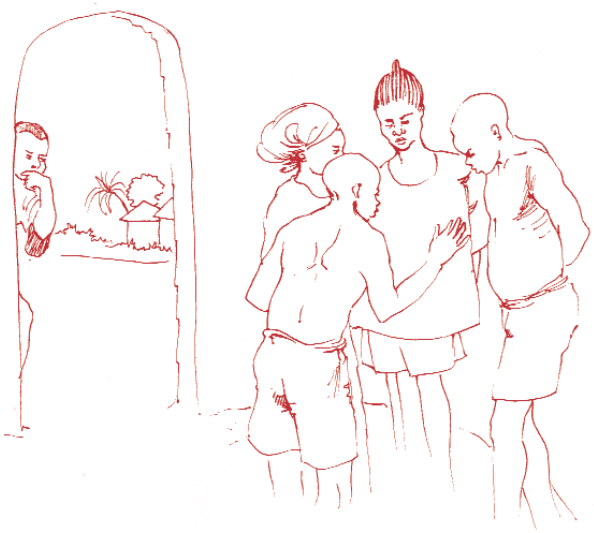
Then Mother Earth thought that perhaps the rulers of the land might take a lead in stopping this bad tradition. But alas even they were not prepared to do so! They were afraid of challenging such a deep-rooted tradition.

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

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

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

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



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

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

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

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

## After the story telling:

Discuss the following questions with the students:

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

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

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

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

## Summary interpretation of the story

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

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

### Small group discussion:

Ask each group to:

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

## Checklist for teachers

Constructive approaches to changing a harmful tradition include:

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

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

### Closing the session:

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

# Session 2: Description and background of FGM

## Session objectives

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

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

## Key references

See page 11 for teaching and learning resources

## Suggested teaching methods

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

## Teaching aids

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

## Setting the scene

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

## THE SESSION

Introduce the session and its objectives

## Anatomy of the female external genitalia

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

### Poster exercise:

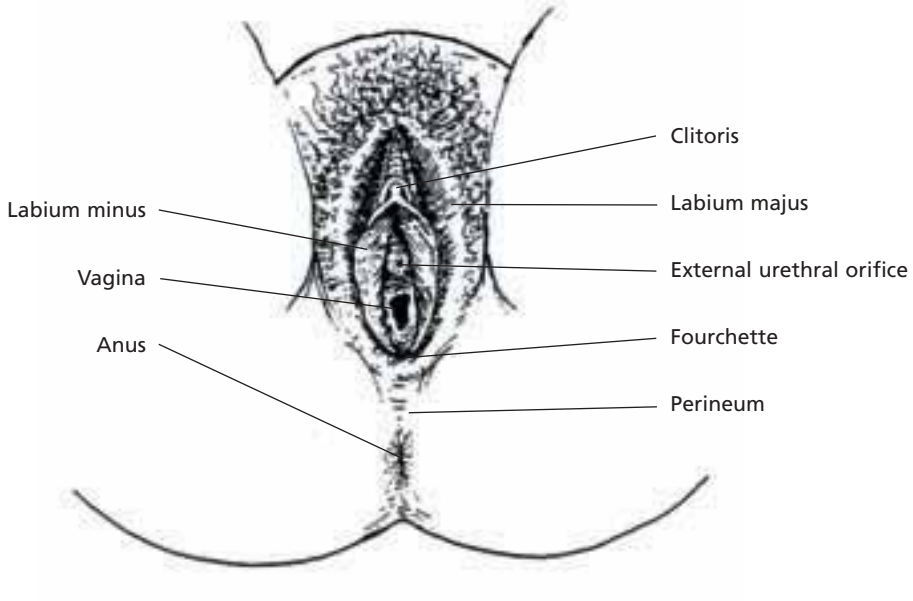
- Have a large poster with an unlabelled diagram of the female external genitalia.
- Give the students pieces of paper with, written on them, the names of the different structures and their functions.
- Ask the students to paste the pieces of papers on the appropriate structures on the poster.

### Summarise:

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

See figure 1.1: on next page

**Figure 1.1: Structure of normal external female genitalia**




## Structure and functions of External Female Genitalia

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

## Definition of female genital mutilation

- Ask students: what is female genital mutilation?

### Buzz:

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

### Summarise:

Summarise by giving the following definition:

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

## The procedures of FGM

(see Figures 1.2 to 1.6)

Ask students if they know what procedures are involved in FGM

### Buzz:

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

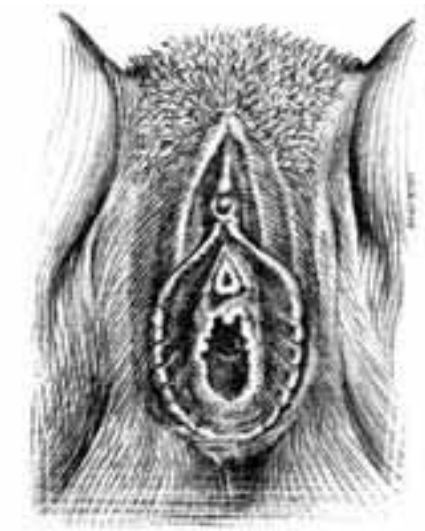
### Summarise:

- FGM is carried out using special knives, scissors, razors, or pieces of glass. On rare occasions sharp stones have been reported to be used (e.g. in eastern Sudan), and cauterization (burning) is practised in some parts of Ethiopia. Finger nails have been used to pluck out the clitoris of babies in some areas in the Gambia. The instruments may be re-used without cleaning.
- The operation is usually performed by an elderly woman of the village specially designated this task, who may also be a traditional birth attendant (TBA). Anaesthesia is rarely used and the girl is held down by a number of women, frequently including her own relatives. The procedure may take 15 to 20 minutes, depending on the skill of the operator the extent of the excision and the amount of resistance put up by the girl. The wound is dabbed with anything from alcohol or lemon juice to ash, herb mixtures, porridge, coconut oil or cow dung, and the girl's legs may be bound together until it has healed. Thorns may be used for pricking the prepuce and for holding the labia together.
- In some areas (e.g. parts of Congo and mainland Tanzania), FGM entails the pulling of the labia minora and/or clitoris over a period of about 2 to 3 weeks. The procedure is initiated by an old woman designated for this task, who puts sticks of a special type in place to hold the stretched genital parts so that they do not revert back to their original size. The girl is instructed to pull her genitalia every day, to stretch them further, and to put additional sticks in to hold the stretched parts from time to time. This pulling procedure is repeated daily for a period of about two weeks, and usually no more than four sticks are used to hold the stretched parts, as further pulling and stretching would make the genital parts unacceptably long.

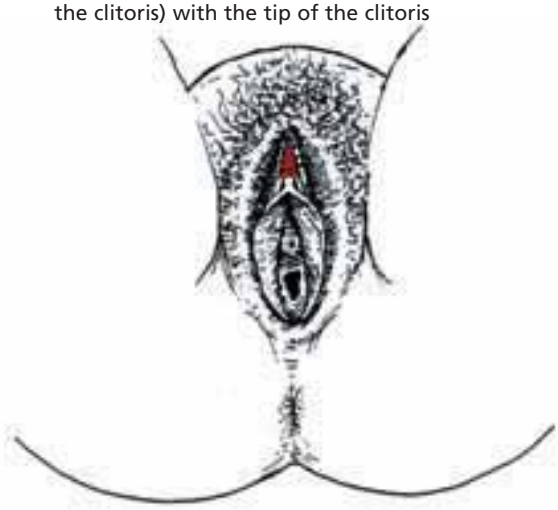
FGM includes the following operations:

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

Normal genitalia



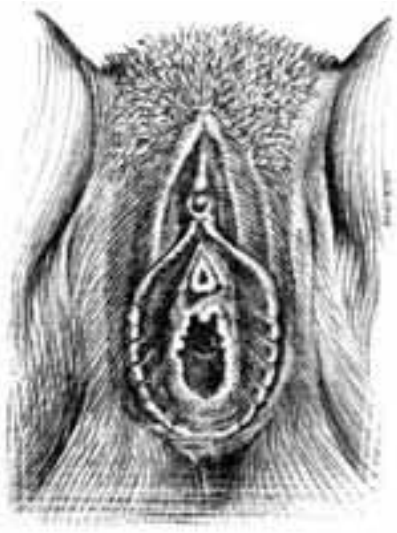
Excision of the prepuce (the fold of skin above the clitoris) with the tip of the clitoris



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

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

Normal genitalia



Excision of the prepuce and clitoris

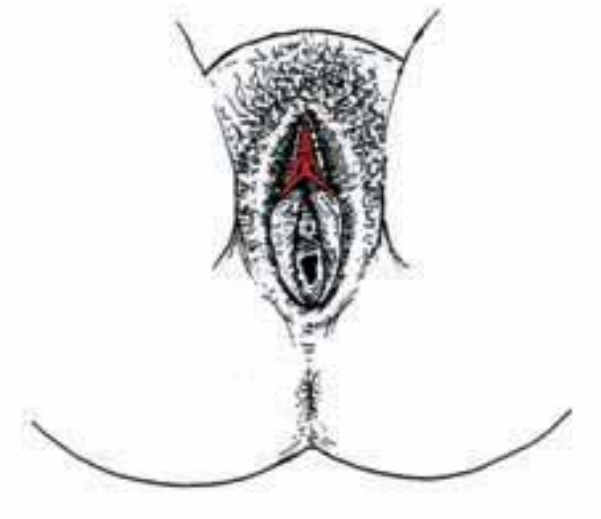
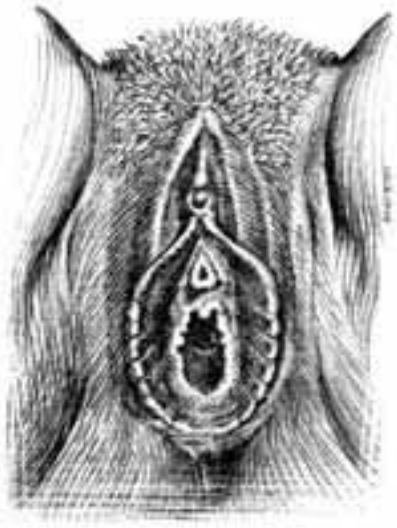


**Figure 1. 4: Normal female external genitalia and genitalia with excision of the prepuce, clitoris and labia minora (Type II)**

Normal genitalia



Excision of prepuce, clitoris and labia minora

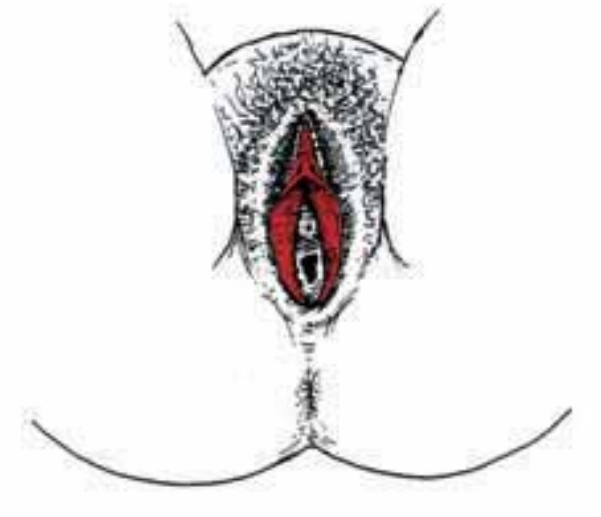
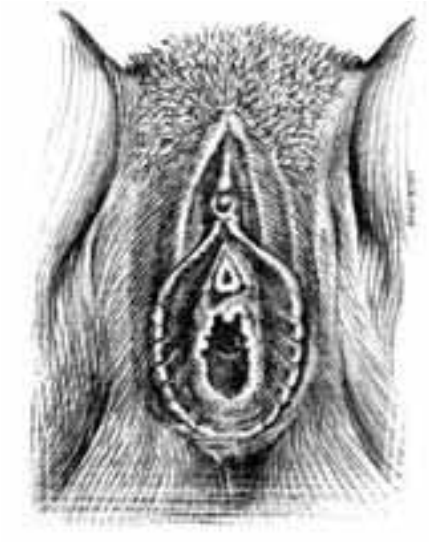


**Figure1.5: Normal female external genitalia and infibulated genitalia (Type III)**

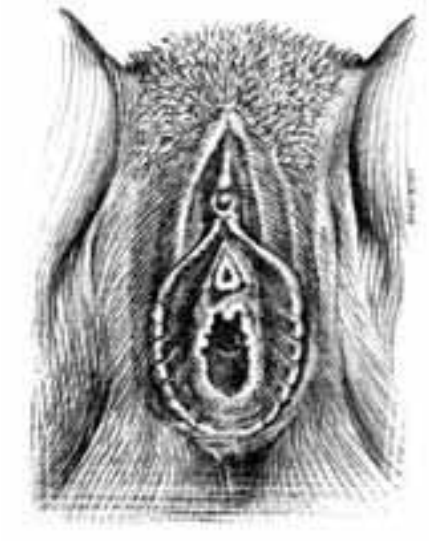
Normal genitalia



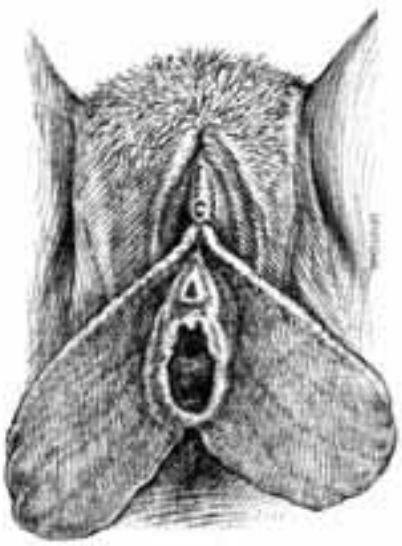
Infibulated genitalia

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

Normal genitalia



Pulled labia minora



### Small group discussion:

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

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

### Summarise:

Summarise in plenary session

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

## The age at which FGM is performed

(see Figures 1.7 to 1.12)

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

Figure 1.7: It is performed on babies

Figure 1.8: It is performed on children

Figure 1.9: It is performed on adolescents

Figure 1.10: It is performed on adult women at marriage

Figure 1.11: It is occasionally performed on pregnant women

Figure 1.12: It is performed during labour and delivery

## Who practises FGM?

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

## Who are the excisors?

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

## "Medicalization" of FGM

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

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

## The origins of female genital mutilation

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

## Reasons for performing FGM

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

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

### Socio-cultural reasons

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

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

### Hygienic and aesthetic reasons

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

### Spiritual and religious reasons

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

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

### Psycho-sexual reasons

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

## World Health Organization (WHO) classification of FGM

### Buzz:

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

### Lecture/Discussion:

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

### *Teacher's notes:*

WHO classifies FGM is as follows:

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

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

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

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

### Visual aids:

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

## The prevalence of FGM

### Brainstorming:

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

### Summarise:

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

### *Teacher's notes:*

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

# Table 1. Estimated prevalence of female genital mutilation

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

## Most reliable estimates: national surveys*

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

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

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

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

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

## Other estimates

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

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

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

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

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

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

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

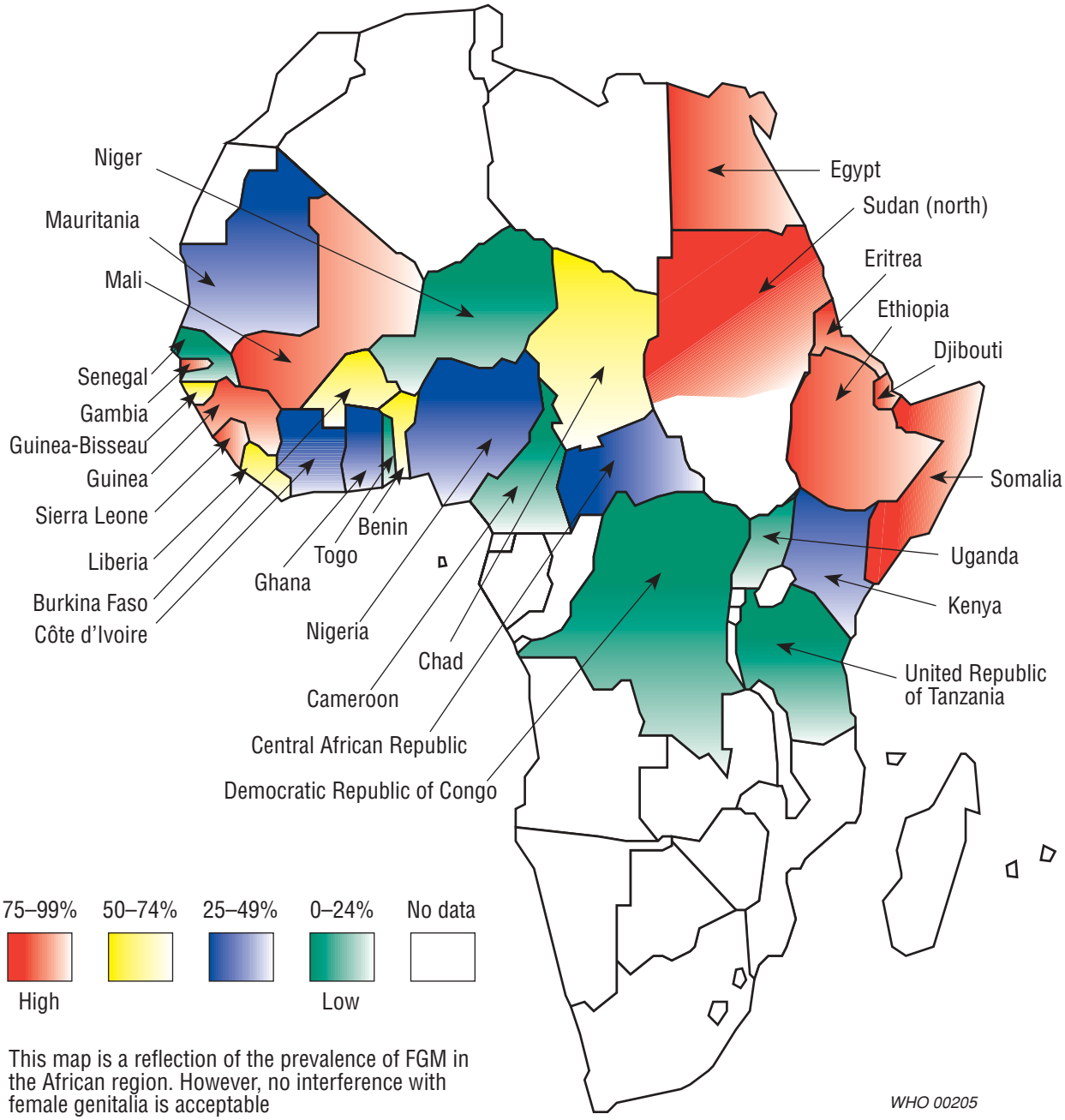
## Questionable estimates***

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

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

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

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




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

# Session 3: Complications of FGM

## Session objectives

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

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

## Key references

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

## Introduction

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

## Suggested teaching methods

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

## Teaching aids

Teacher's notes and student manual.

## Setting the scene

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

## THE SESSION

Introduce the session and its objectives

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

### Small group discussion:

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

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

- Allow one hour for group discussion.

## Plenary session or large group discussion:

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

## Summarise:

Summarise, using the following checklist:

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

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

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

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

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

## Closing the session:

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

# Session 4: Professional ethics and legal implications of FGM

## Session objectives

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

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

## Suggested teaching methods

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

## Teaching aids

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

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

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

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

## Setting the scene

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

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

## THE SESSION

Introduce the session and its objectives.

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

### Small group discussion:

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

## Plenary session:

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

## Summarise:

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

## *Teacher's notes:*

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

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

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

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

## Ethical principles:

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

## Small group discussion:

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

## Plenary session:

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

## Summarise:

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

## *Teacher's notes:*

**Legal implications of FGM –**

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

of either for themselves or their daughters.

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

**Laws and decrees against FGM –**

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

## Closing the session:

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

# Session 5: Human rights and FGM

## Session objectives

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

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

## Key references

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

## Suggested teaching methods

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

## Teaching aids

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

## Setting the scene

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

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

## THE SESSION

Introduce the session and its session objectives

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

### Small group discussion:

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

### Plenary session:

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

### Summarise:

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

## *Teacher's notes*

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

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

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

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

### Buzz:

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

### Small group discussion:

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

### Plenary session:

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

### Summarise

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

### *Teacher's notes*

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

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

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

### Student exercise:

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

## The regulatory bodies of nurses and midwives and FGM

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

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

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

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

## Closing the session:

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