

IPPF Medical Bulletin

Contents

IMAP Statement on the elimination of female genital mutilation (FGM)	1
Women Deliver conference – London	2
Obstetric fistula and the challenge to maternal health care systems Joseph K. Ruminjo	3

IMAP statement on the elimination of female genital mutilation (FGM)

This statement was prepared by the International Medical Advisory Panel (IMAP) in October 2007

Female genital mutilation (FGM) comprises all procedures involving partial or total removal of the external female genitalia, or other injury to the female genital organs, for non-medical reasons. Female genital mutilation violates a series of well-established human rights principles, norms and standards, including the principles of equality and non-discrimination on the basis of sex, the right to bodily integrity, the right to life if the procedure results in death, and the right to the highest attainable standard of physical and mental health.

Given the fact that children are subjected to this procedure, FGM also violates the rights of the child. The intense pressure many parents and communities exert on girls to accept it means that a child's decision to undergo female genital mutilation cannot be called free, informed and uncoerced. The Convention on the Rights of the Child makes explicit reference to harmful traditional practices, calling upon all countries to take effective and appropriate measures to abolish them.

FGM is a harmful practice that negates IPPF's vision of "a world in which all women, men and young people have access to the information and services they need; a world in which sexuality is recognized both as a natural and precious aspect of life and as a fundamental human right". The Federation will continue to uphold this belief through sustained efforts, in partnership with other stakeholders, to eliminate FGM.

The practice of FGM

WHO estimates that between 100 and 140 million girls and women worldwide have been subjected to FGM and every year about three million girls and women are at risk of undergoing the procedure. FGM has been documented predominantly in Africa and a few countries in Asia and the Middle East. Women who have had the procedure are increasingly seen in Europe, Australia, Canada and the USA, primarily among immigrants from countries where FGM is practised.

Many justifications are given for the practice of FGM; the reasons are complex, and vary from country to country, even within communities. It is entrenched in social, economic, cultural and political structures and understood as a social convention that is often accepted without question. Some of the social justifications include the preservation of virginity and ensuring fidelity, as well as a right of passage to womanhood. The practice is thus an important part of the cultural identity of girls and women. Religious justifications across Christian, Jewish, Muslim and certain indigenous African groups are often invoked for the practice, although none of the Holy Scriptures in any of these religions prescribes female genital mutilation. Understanding these cultural and societal beliefs is a critical element in any work designed to eliminate the harmful practice.

The World Health Organization has classified FGM as follows:

Type I: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).

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

Type III: Narrowing of the vaginal orifice by creating a covering seal through the cutting and apposition of the labia minora and/or labia majora, with or without excision of the clitoris (infibulation).

Type IV: Unclassified: All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incision, cauterization and scraping.

In many countries the age of the female undergoing FGM has been reduced as a direct reaction to FGM laws. Additionally, while the norm is for the procedure to be carried out by traditional practitioners, many medical personnel are now performing the interventions in response to raised awareness of the negative health impact of FGM. The medicalization of FGM is strongly condemned, and health care providers must be dissuaded from performing the procedure.

Adverse outcomes

All types of FGM have adverse health consequences. Once removed, genital tissues cannot be replaced, resulting in a life-long physical change irrespective of any other complications. The mutilation is often carried out by a traditional practitioner or a family member, under unhygienic conditions, without anaesthesia, and using non-surgical, unsterilized instruments such as razor blades, knives, or broken glass.

Immediate complications include **pain and bleeding**, during and after the procedure. Swelling and oedema cause acute retention of urine, painful urination, and also painful or difficult defaecation. Healing may take up to eight weeks, depending on the extent of the FGM procedure.

Long-term or delayed complications can occur at any time in the lifespan of a woman who has undergone FGM.

- Unprotected nerve endings may give rise to severe pain and tenderness over the scar tissue, leading to pain during intercourse (dyspareunia), even if the vaginal opening is sufficient to allow penetration—i.e., it can also occur in FGM types I and II. Penetration attempts through the narrowed vaginal opening may cause laceration and haematoma, requiring medical intervention.
- **Infections** such as perineal abscesses and genital ulcers are common, and may lead to fatal septicaemia, tetanus, or gangrene. Recurrent pelvic infections can cause chronic pelvic and back pain. FGM increases the risk of urinary tract infections, which can ascend to the bladder and kidneys, and can lead to life-threatening renal failure and septicaemia. FGM may also result in urinary incontinence, sexual dysfunction and infertility.
- FGM may pose a risk of increasing HIV transmission, and other **blood-borne infections** such as Hepatitis B and C. This risk could arise from the use of unsterilized instruments for FGM procedures, the management of FGM-related obstetric complications, or from genital tract trauma associated with intercourse.
- Chronic local irritation and inflammation may worsen scarring and narrowing, resulting in decreased urine flow, **retention of urine** and also **retention of menstrual blood** in the vagina (haematocolpos). The resultant anatomical abnormalities cause **difficult childbirth**, increasing both maternal and neonatal morbidity and mortality. Women who have undergone any form

of FGM are at significantly higher risk of obstetric complications such as perineal tears, and in some cases a surgical procedure may be necessary to open the lower genital tract (defibulation). Complications can make a Caesarean section necessary, or induce a postpartum haemorrhage, requiring an extended stay in hospital. Additionally, the infants of mothers affected by FGM types II and III have an increased risk of dying at birth.

- The cutting of highly sensitive genital tissue, especially the clitoris, excessive scar formation (keloid) and pain can adversely affect sexual sensitivity and pleasure. The negative impact of the procedure upon a girl's **psychological and psychosexual development** can last into womanhood. Anxiety, depression and fear of sexual intercourse have been observed.

IPPF endorses the joint statement by the World Health Organization and other United Nations agencies on the elimination of the harmful practice of FGM.¹

What can Member Associations do?

Member Associations have an important role to play in the elimination of FGM at the community and national levels. These practices have deep cultural roots. Sustained action is necessary to achieve a permanent impact, as behaviour change is a complex process. Member Associations should obtain all possible information on the prevalence, dynamics and characteristics of FGM in their own countries. In the context of their social and cultural background, they should then review their current activities, familiarize themselves with the available resources for FGM, and develop strategies to eliminate the practice. Actions the Member Associations can undertake to eliminate the practice of FGM should include the following key elements:

Advocacy

- The IPPF Charter on Sexual and Reproductive Rights should be used as an advocacy tool to lobby for changes in legislation that protect the human rights of women and girls, and eliminate all harmful and/or discriminatory practices.
- Efforts to encourage the elimination of FGM require the clarification and enforcement of existing laws, and training for service providers to increase their understanding of the human rights and health consequences of the practice.
- Strategic efforts should be made at all levels from the community to the region. Member Associations should collaborate with other governmental and non-governmental organizations working on the issue, such as professional medical associations and parliamentarians, to achieve optimum contributions towards the elimination of the practice through advocacy, information, education and research.
- Religious and secular community leaders should be involved in order to secure a supportive environment for change in the community. These leaders can generate social support for change by providing strong arguments against the practice of FGM.
- In countries where FGM is practiced within immigrant communities, such communities should be mobilized and involved in the process of behaviour change through the provision of accurate information and education related to the practice of FGM.
- Participation of women in discussions about FGM issues should be encouraged, and should include female health workers and women representatives from local communities.
- Men are equally important to bring about a change in a deep-rooted cultural practice. Social dialogue provides the opportunity to educate the whole community on women's human rights and the application of FGM laws.
- Where appropriate, broader programmes aimed at improving the reproductive health of women should include discussion of FGM and actions to stop the practice. Service providers should use every opportunity to counsel women and their partners, and parents of young children, about the harmful effects of perpetuating the practice.

Services

- Member Associations have a key role to play in counteracting the tendency towards the medicalization of FGM. Medical ethics standards for health professionals should include a

strong condemnation of the harmful practice of FGM. These standards should be implemented, to ensure that no health care professional performs any type of FGM.

- In countries where FGM is widely practised, Member Associations should be equipped to provide sympathetic counselling about, and care for, the physical and psychological complications of FGM. Women who have been subjected to FGM and are suffering from chronic complications may require specialist counselling and, or, surgical treatment. An appropriate referral system should be in place if comprehensive care is not possible at the service delivery point. Procedures requested after delivery that are associated with FGM, such as reinfibulation (reinstatement of the mutilation), should be strongly condemned.
- Member Associations should ensure that all women, including those who have been mutilated, have access to comprehensive sexual and reproductive health services, including testing for reproductive tract infections and sexually transmitted infections (RTI/STIs), contraception and sexuality education.
- Information should be provided, to all clients seeking care at the service delivery point, about the serious risks during childbirth for women who have undergone FGM. Pregnant women who have been mutilated should be advised to deliver in a clinical setting, where possible complications can be properly managed.
- Psychosexual complications should be identified so that appropriate counselling and support can be provided. Young women and their partners may require pre-marital counselling to address complications commonly associated with FGM.
- After the counselling of the woman, and with her informed consent, health professionals with the appropriate training should, whenever possible, try to repair the abnormal anatomical condition caused by FGM. If available, appropriate referrals should be made for defibulation services.
- Member Associations should report all FGM-related services in IPPF's global service statistics. Data about the prevalence and health consequences of FGM victims should be collected from the clinical services, for use as an advocacy tool to support policy change.

1. "World Health Organization. Joint inter-agency statement on the elimination of female genital mutilation. Geneva, World Health Organization. 2007 (forthcoming).

Statement developed by the International Medical Advisory Panel (IMAP) in November 1991, amended by the Panel in October 2001 and in October 2007. IMAP reserves the right to amend this statement in the light of further developments in this field.

Women Deliver conference – London

The world gathered on 18-20 October to mark the twentieth anniversary of the Safe Motherhood initiative, and to assess the progress made in the prevention of maternal deaths and the promotion of mother and child survival.

The event was attended by more than 1,500 delegates from 109 countries, including politicians, human rights activists, health professionals, economists, the media and civil society organizations. The International Planned Parenthood Federation (IPPF) was one of 12 partners involved in the Core Planning Group, and various IPPF staff and volunteers moderated conference sessions and/or delivered presentations.

Conference participants identified health interventions, crucial to the improvement of maternal and child health, which will require more focus in the future. These include:

- Emergency obstetric care
- Skilled care during pregnancy and after childbirth
- Comprehensive reproductive health services, including family planning for all (affordable and accessible)
- Partnership with civil society and other non-Governmental organizations (NGOs)

The participants also proposed initiatives to highlight maternal health issues:

- Increase health budgets and prioritize health agendas at national, regional and international levels
- Build synergies between health and other sectors
- Convene a United Nations General Assembly special session on maternal health that would result in a global plan of action
- Create a global fund for women's health
- Improve the collection of data concerning maternal health, such as health audits or confidential inquiries

A special Ministers' Forum was held during the conference, in which 70 parliamentarians were involved. They released a final statement, which pledged their commitment to achieve Millennium Development Goal 5 (improve maternal health) by making it "a high priority on the national, regional and international health agenda."

The Lancet issued a special Women Deliver issue on October 12 to mark the conference; it includes various articles related specifically to maternal health issues. (See www.thelancet.com)

In recognition of Women Deliver, and to highlight the importance of maternal and child health issues, *IPPF Medical Bulletin* will report over the coming year on topics related to maternal health. An article on obstetric fistula by Dr Joseph Ruminjo is included in the current edition.

Obstetric fistula and the challenge to maternal health care systems

Joseph K. Ruminjo

Background and context

Women in the developing world pay heavily for becoming pregnant and giving birth. Over 300 million suffer complications of pregnancy, childbirth or abortion. These complications are the leading causes of death and disability—an estimated 529,000 deaths annually—most of which are preventable.¹ The lifetime risk disparity of maternal death, 1 in 16 in the poorest countries, but 1 in over 2,800 in developed countries, is the most dramatic indicator between resource-replete and resource-depleted countries.

For every death, at least another 50 women (a Family Health International study estimates many times more) suffer a serious maternal health problem.² One of the most devastating long-term disabilities is obstetric fistula: a preventable, treatable condition that can leave the woman with incontinence, nerve damage and severe social stigma.

Definition and causation

Obstetric fistula is an abnormal communication between the reproductive tract (usually the vagina) and the urinary tract (frequently the bladder) or alimentary tract (usually the rectum) or both. Typically, it develops after several days of prolonged, obstructed labour, during which the baby's head continuously compresses maternal soft tissues against the pelvis, causing ischaemic necrosis and subsequent sloughing of maternal perineal tissues.

Some cases are caused by surgical interventions during difficult labour, including instrumental vaginal delivery, destructive vaginal operations, and injuries such as the *gichiri yankan* cut into the anterior vaginal wall, a traditional treatment mainly in northern Nigeria, which is implicated in 5-10% of the region's fistulas.

Gynaecological causes, including cancer and irradiation, are less common in the developing world. One exception is traumatic gynaecological fistula from sexual violence in conflict settings, but such causes are outside the ambit of this article.

Associated factors

EngenderHealth with the United Nations Population Fund (UNFPA) and the Averting Maternal Mortality and Disability (AMDD) project of Columbia University conducted the first multinational fistula needs assessments concerning obstetric and traumatic fistula in twelve countries across sub-Saharan Africa and South Asia.^{3,4} In collaboration with other key institutions, and national and international

stakeholders, these organizations have since advocated for a critical debate on international policy and programmes in reproductive health and safe motherhood. They have also striven to carve out national fistula programmes and services, to undertake social sciences and clinical research, and to conduct clinical and communications training to increase levels of awareness.

The assessment findings showed that governments and health ministries are burdened by poor health systems, shortage of human resources and political instability. They are overwhelmed by other priorities, medical (malaria, HIV, malnutrition) and non-medical (poverty, conflict, insecurity, poor governance, inequity). They have poor health management information systems, policy guidelines and standards.

In the community, problems were identified as poverty, illiteracy, poor infrastructure, ignorance of danger signs in pregnancy and labour, and lack of birth plans. Cultural and gender norms, and health misconceptions, disempower women, especially in financial and reproductive health decision-making.

Health referral systems are inefficient, transportation is unreliable and costly. Health facilities may have poor quality, and are perceived as places where 'people go to die'; they have inadequate infrastructure, utilities, equipment, supplies and medication. National and facility level policies, guidelines and health management information systems do not support fistula prevention, curative and rehabilitative services, and the fees for care can be prohibitive. Skilled expatriate surgeons, and a few dedicated, self-motivated indigenous doctors, nurses and other paramedical staff struggle with inadequate equipment and supplies for emergency obstetric care and timely Caesarean-section, but many women may sustain hospital-acquired fistula.⁵

Many of these barriers to fistula treatment are very similar to those described by Maine et al⁶ in the 3-Delay model for safe motherhood and access to emergency obstetric care, including delays in seeking health care, in reaching the health facility, and in receiving care once at the health facility. It is not known how much other morbidities and vulnerabilities—HIV, malnutrition and cultural practices such as female genital mutilation—contribute to fistula occurrence and treatment.

Aftermath of fistula

Physical effects include dermatitis of the vulva and thighs, urinary tract infections, renal failure, sexual dysfunction, stillbirths in up to 90% of cases, and infertility. The social effects are devastating. The constant wetness and unpleasant, overpowering odour, with the history of stillbirth, can cause a woman's loss of dignity, leading to stigma and discrimination, even in the family, and abandonment by her spouse. There are also negative implications for schooling, employment, transportation, and myriad other social interactions.

Fistula has a long history, and has been reported in a female Egyptian mummy. Globally, it is common where timely emergency obstetric care is unavailable and indicates a failed maternal health care system: wherever there is fistula, women are dying from pregnancy and childbirth.

More than two million women are living with obstetric fistula, predominantly in sub-Saharan Africa, parts of south Asia and the Arab world, with 50,000 to 100,000 new cases annually. These figures, based on health facility cases because community data are sparse, are probably underestimates,⁷ and it will take many years to clear the backlog of new and old cases of fistula given current resources and repair levels.

Almost any woman can have a fistula. Most are young first-time mothers, and their babies are usually stillborn, despite belated medical intervention.³ Extreme poverty, compromised health status, little or no education, limited access to health, gender inequity, poor governance, and lack of government and provider accountability all contribute. In emergencies, the risk is increased by a cultural preference for home delivery for the first child, and non-acceptance of Caesarean section.

Programmatic interventions

Health systems need improvement, a supportive policy at national and facility level, guidelines and standards. There is a crucial lack of standardization for training, service delivery guidelines and materials, fistula classification, and clinical and operational research to inform prevention, treatment and social re-integration.

A co-ordinated effort is needed for this public health problem.

Key players include governments, international and national non-Governmental organizations (NGOs), professional associations and regional bureaux, health providers and public-private partnerships.

Prevention

The costs of skilled surgeons, health providers and other resources are prohibitive for fistula repair in low-resource settings—where it is most needed—so prevention is the key. That involves multiple sectors and stakeholders to be committed to safe pregnancy and delivery. Policymakers should allocate resources equitably and enforce laws against child marriage. There need to be widespread information and access to family planning; high quality health care services in facilities with well-trained staff and adequate equipment; and community health workers, such as traditional birth attendants, have to be brought on board.

A safe motherhood initiative should define the standard minimum interventions and the methodology for ensuring national and institutional policies to raise awareness, improve information and achieve quality health care. It should include a spectrum of early and late prevention strategies for maternal mortality and morbidity, including fistula.

It should safeguard the health and nutrition of all pregnant women, to improve the environment of the fetus; ensure female children's nutrition, education and immunizations; provide family planning services or referrals; and ensure that well-informed women can reach and receive care at a holistic, client-centred facility.

These interventions must be integrated into a horizontal safe motherhood programme by:

- Encouraging stronger links between communities and clinical facilities through education about safe pregnancy practices and skilled delivery care, dialogue, emergency preparedness and transport (supported by micro-credit and insurance)
- Upgrading the capacity of facilities to include comprehensive emergency obstetric and neonatal care, including routine labour monitoring (using the partograph) and Caesarean section
- Assessing regularly the quality of care; the level of quality is crucial to the survival chances of mother and baby
- The use of an indwelling catheter may prevent a fistula that results from late obstructed labour, or promote the healing of an existing fistula⁸

Treatment

Some women save money for years, for medical and transport expenses. Delay increases the likelihood of medical and psychosocial complications. However, the community can actively demand fistula treatment through awareness-raising and engaging men at all levels. Policymakers can leverage resources; men can be educated about the resources needed by, and available to, women, through radio, theatre, music, and other interactive information sharing.

Treatment facilities need to upgrade infrastructure, utilities, general and fistula-specific equipment, supplies and medication. They also need supportive national and site-specific policies, facilitative supervision, monitoring and evaluation of provider performance, training, quality of care and institutional accountability. Medical and programmatic oversight is important, and logistical and health information management systems need improvement.

It is difficult to motivate, train and retain fistula surgeons. They will need career advancement, professional recognition, a conducive work environment and supervisory support. Further capacity building is needed for nurses, anaesthetists, social workers, physiotherapists and occupational therapists.

Re-integration

Women who have lived with fistula for a relatively short time before a successful repair are more easily re-integrated into their community.

Unsuccessful repairs or the need for urinary or faecal diversions and stoma, can pose medical, logistical, ethical and social challenges.

Physical, psychological and vocational rehabilitation are necessary. EngenderHealth has a fistula counselling curriculum. These clients have special need of counselling because of previous or continuous physical and emotional trauma, ambivalence about family planning, threatened rights to informed choice, and vulnerability to HIV. Some NGOs and community-based organizations (CBOs) assist with numeracy, financial literacy, income generation skills and start-up micro-credit in cash or kind.

Re-integration interventions must engage the woman, her family and the community to overcome the stigma, discrimination and misconceptions about fistula. The community can contribute through money or the workforce to fistula prevention, liaise with health providers to identify women with fistula, and demand treatment.

Impact

Women will benefit from lifesaving interventions, safer pregnancies and deliveries, healthier newborns, and fistula prevention and treatment. They will be assured of respect, dignity, and privacy in making informed choices. With increased trust in the quality of care, they will be more willing to return.

Health care providers will be empowered to use evidence-based best practices, state-of-the-art equipment and management systems to prevent infection and treat pregnancy-related complications, reduce stigma related to fistula, counsel clients and make appropriate referrals for family planning, maternal and child health, and other services.

Communities and health systems will be transformed by increased and sustained capacity and support for safe motherhood and reproductive health services.

Conclusion

By working closely with local and international partners to create supportive environments, the prevention and treatment of fistula is feasible. The many women who become pregnant around the world every minute deserve nothing less.

Dr Joseph Ruminjo
Senior Clinical Manager
Safe Motherhood Programme, EngenderHealth/ACQUIRE

1. World Health Organization. World Health Day highlights scandal of 600 maternal deaths each year. Press release, WHO/33, April 6, 1998. www.who.int/inf-pr-1998/en/pr98-33.html
2. Family Health International. The base of the iceberg: Prevalence and perceptions of maternal morbidity in four developing countries. Research Triangle Park, NC: Family Health International, 1997.
3. United Nation's Population Fund (UNFPA), EngenderHealth. Obstetric fistula needs assessment report: Findings from nine African countries. New York, NY: UNFPA & EngenderHealth, 2003
4. EngenderHealth, Mailman School of Public Health of Columbia University. Obstetric fistula: a needs assessment in Ghana and Rwanda; expanding knowledge. New York, NY: EngenderHealth & Columbia University, 2004.
5. Association of East, Central and Southern African Obstetrics and Gynecology Societies (2005). Women's Dignity Project Symposium on Obstetric Fistula, ECSAOGS 7th Scientific Conference, Dar-es-Salaam, Tanzania Nov 13-16, 2005.
6. Maine D et al. Prevention of maternal deaths in developing countries: Programme options and practical considerations. Paper presented at the International Safe Motherhood Conference, Nairobi, 10-13 February, 1987.
7. Murray C, Lopez A, eds. Health dimensions of sex and reproduction: The global burden of sexually transmitted diseases, HIV, maternal conditions, perinatal disorders, and congenital anomalies. Cambridge, MA: Harvard University Press on behalf of the World Health Organization and World Bank, 1998; p390.
8. Waaldijk K. Immediate management of fresh obstetric fistulas. *Am J Obstet Gynecol* 2004; **191**: 795-99
9. Ghachatou AK. Taking care of fistula patient's social reintegration. Presentation at International Fistula Ethics Meeting, Duke University, Durham, NC, Feb 2007. mc.duke.edu/pdf/Ghachatou.pdf