ADDRESSING THE NEEDS OF WOMEN AND GIRLS AFFECTED BY FEMALE GENITAL MUTILATION IN SERVICE DELIVERY FACILITIES

A HANDBOOK FOR SEXUAL AND REPRODUCTIVE HEALTH ORGANIZATIONS
ACKNOWLEDGMENTS

We would like to express great appreciation to the following experts and providers in Somaliland and Egypt, who gave advice based on their field experience:

- Edna Adan Ismail (Edna Adan Hospital, Somaliland)
- Amal Ahmed Mohammed (Somaliland Family Health Association)
- Wael Ibrahim (Consultant, IPPF/Arab World Region)
- Marwa Mohamed Ismail (BSN (Bachelor of Science in Nursing) at Edna Adan University, MA candidate in PPM Hargeisa University)
- Fadumo Saed Hassan (BSN (Bachelor of Science in Nursing) at Edna Adan University)
- WHO staff members in Somaliland
- Staff members from the Somaliland Family Health Association Clinic

We are grateful to Marcela Rueda Gómez and Fernando Ruiz from the IWORDS Global Ltd team, who led the content development process and to Seri Wendoh, who provided technical oversight and guidance for the development of this handbook.

We are also grateful to colleagues from the World Health Organization who provided feedback for completion of this handbook:

- Dr Ian Askew (Director, Department of Reproductive Health and Research including UNDP-UNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction)
- Dr Christina Pallitto (Department of Reproductive Health and Research)

Finally, we gratefully acknowledge the support of Dr Yilma Melkau and colleagues from secretariat offices who reviewed the document and provided invaluable guidance, including Oussama Azri and Dr YuHsin Huang. From IPPF’s International Medical Advisory Panel (IMAP): Dr Ian Askew, Dr France Anne Donnay, Dr Kristina Gemzell-Danielsson, Dr Nahid Khodakarami, Professor Oladapo Alabi Ladipo, Dr Laura Laski, Dr Michael Mbizvo, Professor Hextan Yuen Sheung Ngar and Dr John W Townsend for their valuable and timely guidance and reviews offered during the development process, and Dr Sarah Onyango for coordinating the process.

These guidelines were made possible with funding support from the Norwegian Agency for Development Corporation (NORAD) – our valued partners in delivering services and advocating for sexual and reproductive health and rights.

Photos:
IPPF/Seri Wendoh/Somaliland
IPPF/Tommy Trenchard/Uganda
IPPF/Tom Pilston/Nepal
## CONTENTS

<table>
<thead>
<tr>
<th>Acknowledgments</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>3</td>
</tr>
<tr>
<td>Brief explanation of key terms</td>
<td>4</td>
</tr>
<tr>
<td>Introduction</td>
<td>5</td>
</tr>
<tr>
<td>Acronyms and abbreviations</td>
<td>6</td>
</tr>
<tr>
<td>About this handbook</td>
<td>7</td>
</tr>
<tr>
<td> Purpose</td>
<td>7</td>
</tr>
<tr>
<td> Target audiences</td>
<td>7</td>
</tr>
<tr>
<td> Structure</td>
<td>7</td>
</tr>
</tbody>
</table>

### SECTION A: BACKGROUND INFORMATION ON FEMALE GENITAL MUTILATION

<table>
<thead>
<tr>
<th>Prevalence</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female genital mutilation – a human rights violation</td>
<td>11</td>
</tr>
<tr>
<td>Why is female genital mutilation performed?</td>
<td>14</td>
</tr>
<tr>
<td>Types of female genital mutilation</td>
<td>14</td>
</tr>
<tr>
<td>Health consequences of female genital mutilation</td>
<td>17</td>
</tr>
<tr>
<td>In-country legal considerations when working on FGM</td>
<td>20</td>
</tr>
<tr>
<td> Professional secrecy provisions</td>
<td>21</td>
</tr>
<tr>
<td>Local regulations and plans to eliminate FGM and address its consequences</td>
<td>21</td>
</tr>
</tbody>
</table>

### SECTION B: FEMALE GENITAL MUTILATION PROGRAMMING

<table>
<thead>
<tr>
<th>Advocacy</th>
<th>23</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information, education and communication</td>
<td>23</td>
</tr>
<tr>
<td>Evaluation and research</td>
<td>23</td>
</tr>
<tr>
<td>Service provision</td>
<td>23</td>
</tr>
</tbody>
</table>
SECTION C: FEMALE GENITAL MUTILATION – ESSENTIAL HEALTH SERVICES

Entry points to access FGM-related care

Disaggregating the recommended package of services

1. Information and counselling on FGM
   - General guidelines
   - Provider competences
   - Supplies/equipment and infrastructure requirements
   - Client records

2. Screening, classification and recording of FGM and its consequences
   - General guidelines
   - Physical assessment – type of FGM and consequences
   - Assessment of mental and sexual health consequences/complications
   - Provider competences
   - Supplies/equipment and infrastructure requirements
   - Client records

3. Deinfibulation for type III FGM
   - Pre-counselling
   - Procedure
   - Post-counselling, follow-up and referrals
   - Provider competences
   - Supplies/equipment and infrastructure requirements
   - Client records

4. Management of physical and mental health consequences of FGM in sexual and reproductive health facilities
   a. Gynaecological, reproductive tract infections and sexually transmitted infections services
   b. Prenatal/post-natal care
   c. Contraceptive services
   d. Safe abortion services
   e. HIV/AIDS services
   f. Counselling on sexuality and relationships
   g. Sexual and gender-based violence
   h. Referral services

ANNEXES AND NOTES

Annex 1: Language considerations

Bibliography

References
FOREWORD

Although female genital mutilation rates are decreasing, and there is increasing recognition among global, regional, local and grassroots stakeholders of the need to encourage its abandonment, women and girls around the world continue to undergo this practice, experiencing grave consequences to their mental and physical health, including their sexual and reproductive health. In many settings, health facilities and providers are not prepared to offer timely, high-quality, rights-based, gender-responsive and non-stigmatizing care and referrals that respond to the needs of women and girls living with the consequences of female genital mutilation.

Aware of the critical role that service providers play in the fight against female genital mutilation and the promotion of gender equality, and acknowledging that efforts to eradicate this harmful practice must also address its consequences, IPPF presents the publication *Addressing the needs of women and girls affected by female genital mutilation in service delivery facilities – A handbook for sexual and reproductive health organizations*. We hope that this handbook will encourage sexual and reproductive health programmers and health providers to implement the systems necessary to offer a comprehensive package of services to women and girls living with female genital mutilation.

The recommendations in this handbook are fully aligned with those of authoritative sources such as the World Health Organization. Implementing these recommendations is a critical step in IPPF’s journey to fulfil our mandate, established in the *IPPF Strategic Plan 2016-2022* and the *IPPF Gender Equality Strategy and Implementation Plan (2016-2019)*: supporting the achievement of the highest attainable standard of sexual and reproductive health and ensuring that individuals are free to make choices about their sexuality and well-being without discrimination.

In partnership with other stakeholders, we remain committed to advocating for the eradication of female genital mutilation, upholding women’s rights and promoting gender equality. Our hope is that female genital mutilation will be abandoned completely, and the recommendations offered in this handbook will soon become unnecessary. In the meantime, we hope this publication inspires action and positively impacts the lives and health of women and girls around the world.
BRIEF EXPLANATION OF KEY TERMS

- **Female genital mutilation (FGM):** Comprises all procedures involving the deliberate partial or total removal of external genitalia or other injury to the female genital organs for non-medical reasons (see explanatory diagrams in section Types of FGM). FGM is a human rights violation.

- **Infibulation:** The narrowing of the vaginal orifice by creating a covering seal through the cutting, apposition and suturing of the labia minora and/or the labia majora, with or without excision of the clitoris.

- **Deinfibulation:** The practice of cutting open the narrowed vaginal opening in a woman who has been infibulated, which is often necessary for improving her health and well-being, as well as to allow intercourse or to facilitate childbirth, abortion and other sexual and reproductive health services. This procedure is known as ‘reversal’ in some settings, but the name is not accurate as the procedure does not reverse the damage caused to the external genitalia or the female genital organs.

- **Re-infibulation:** Actions to narrow the vaginal opening in a woman after she has been deinfibulated (i.e. after childbirth); also known as re-suturing. Re-infibulation is a human rights violation, as the practice is not justified by medical reasons.

- **Medicalization of FGM:** Situations in which the practice (including re-infibulation) is performed by any category of healthcare provider, whether in a public or private clinic, at home or elsewhere, at any point in time during a woman’s life. Medicalization of FGM is strongly condemned, is illegal in many countries, and healthcare providers must be dissuaded from performing this practice.

- **Mental health:** Mental health is defined by the World Health Organization (WHO) as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. The positive dimension of mental health is stressed in WHO’s definition of health as contained in its constitution: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” FGM has mental and physical health consequences for survivors, therefore it affects the realization of their right to health, to life, to freedom from torture or cruel, inhuman or degrading treatment, among many other human rights principles, norms and standards.

- **Integrated package of essential services (IPES):** The broad range of sexual and reproductive health services necessary to meet the most pressing needs of the populations served by IPPF Member Associations. IPES places the client at the very centre of everything we do, and ensures the delivery of quality integrated services to every individual. This approach focuses on both expanding supply and increasing demand for eight categories of services: counselling, contraception, safe abortion care, sexually transmitted infections/reproductive tract infections, HIV, gynaecology, prenatal care and gender-based violence. Specific services are recommended under each category.
INTRODUCTION

Female genital mutilation (FGM) – a human rights violation – includes actions that intentionally alter or cause injury to the female genital organs for non-medical reasons. The practice has no health benefits for girls and women, and can result in physical and mental health problems. More than 200 million girls and women alive today have undergone FGM in 30 countries in Africa, the Middle East and Asia, where FGM is concentrated. FGM cases are also found in Europe and in Latin America (among the Emberas, an indigenous group from Colombia). Furthermore, there are an estimated three million girls at risk of undergoing FGM every year. While FGM is most commonly carried out on girls under 15 years old, it is also performed on adult women who are about to be married, who are pregnant with their first child or who have just given birth.

FGM is a harmful practice that is in direct opposition to IPPF’s values, which promote a world in which all women, men and young people have access to the sexual and reproductive health and rights information and services they need. FGM is also contrary to a world in which sexuality is recognized both as a natural and precious aspect of life and as a fundamental human right. IPPF Member Associations play a pivotal role in tackling social norms that hinder meaningful and equal participation in society including, but not limited to, FGM. These Member Associations promote enabling legal environments that prohibit this human rights violation and facilitate access to services and reparation, provide comprehensive care to women affected by FGM, and generate evidence on best practices.

To date, IPPF has put in place various efforts to advance this work, including: a) the launch and dissemination of a statement by the International Medical Advisory Panel (IMAP), offering programmatic recommendations to Member Associations on how to address this issue; b) the provision of technical and financial support to implement FGM-related initiatives in key countries; c) partnership building with global, regional and local stakeholders. This publication – aligned to the WHO clinical guidelines on FGM and other authoritative sources – complements IPPF’s current work by offering recommendations on the provision of FGM-related care in sexual and reproductive health services.

“Female genital mutilation/cutting (FGM/C) is a human rights issue that affects girls and women worldwide. As such, its elimination is a global concern.”

UNICEF (2016) FEMALE GENITAL MUTILATION/CUTTING: A GLOBAL CONCERN
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBT</td>
<td>Cognitive behavioural therapy</td>
</tr>
<tr>
<td>FGM</td>
<td>Female genital mutilation</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Human immunodeficiency virus/Acquired immune deficiency syndrome</td>
</tr>
<tr>
<td>IPES</td>
<td>Integrated package of essential services</td>
</tr>
<tr>
<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
</tr>
<tr>
<td>SOFHA</td>
<td>Somaliland Family Health Association</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and reproductive health</td>
</tr>
<tr>
<td>SRHR</td>
<td>Sexual and reproductive health and rights</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
ABOUT THIS HANDBOOK

Purpose
To support the provision of high quality and integrated care for women affected by FGM by offering recommendations to prevent, screen and treat its physical and mental consequences within the existing services delivered by IPPF Member Associations and through high quality referral systems.

Target audiences
This handbook is primarily developed for programme managers, medical directors, clinic managers and other service provision staff/volunteers at IPPF Member Associations where FGM is prevalent, either because the practice is prevalent in their countries or because of the presence of communities from countries where there is high prevalence. It is also aimed at all sexual and reproductive health (SRH) organizations and the broader development community – including United Nations agencies – that are working to improve access to health services for women affected by FGM.

Structure
This handbook includes three main sections:

- **Section A:** Provides general background information on prevalence, FGM and human rights, and relevant global, regional and country-level legal provisions.

- **Section B:** Provides a brief section on programmatic recommendations for Member Associations based on the IMAP statement launched in 2015, WHO guidelines and other authoritative sources.

- **Section C:** Provides evidence and practice-based guidance to prevent, screen and treat the physical and mental health consequences of FGM. This section includes information on deinfibulation and on integration of FGM-related services in the IPPF integrated package of essential services (IPES).
SECTION A

BACKGROUND INFORMATION ON FEMALE GENITAL MUTILATION
SECTION A: BACKGROUND INFORMATION ON FEMALE GENITAL MUTILATION

Prevalence

While the exact number of girls and women worldwide who have undergone FGM remains unknown, available data gathered by UNICEF shows that at least 200 million girls and women in 30 countries have been subjected to the practice. Available data from large-scale representative surveys show that the practice is highly concentrated in a swathe of countries from the Atlantic coast to the Horn of Africa, in areas of the Middle East such as Iraq and Yemen and in some countries in Asia like Indonesia. However, FGM is a human rights issue that affects girls and women worldwide. Evidence suggests that FGM exists in some places in South America, such as Colombia, and elsewhere in the world, including India, Malaysia, Oman, Saudi Arabia and the United Arab Emirates, with large variations in terms of the FGM type performed, circumstances surrounding the practice, and size of the affected population groups. Women who have had the practice are increasingly seen in Europe, Australia, Canada and the United States, primarily among immigrants from countries where FGM is practised. Diagram I shows the prevalence across countries among women aged 15–49 (2004–2015) years and girls aged 0–14 (2010–2015).
### THE PREVALENCE OF FGM/C VARIES GREATLY ACROSS COUNTRIES

#### Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, 2004–2015

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somalia</td>
<td>98</td>
</tr>
<tr>
<td>Guinea</td>
<td>97</td>
</tr>
<tr>
<td>Djibouti</td>
<td>93</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>90</td>
</tr>
<tr>
<td>Mali</td>
<td>89</td>
</tr>
<tr>
<td>Egypt</td>
<td>87</td>
</tr>
<tr>
<td>Sudan</td>
<td>87</td>
</tr>
<tr>
<td>Eritrea</td>
<td>83</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>76</td>
</tr>
<tr>
<td>Gambia</td>
<td>75</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>74</td>
</tr>
<tr>
<td>Mauritania</td>
<td>69</td>
</tr>
<tr>
<td>Liberia</td>
<td>50</td>
</tr>
<tr>
<td>Guinea-Bissau</td>
<td>45</td>
</tr>
<tr>
<td>Chad</td>
<td>44</td>
</tr>
<tr>
<td>Cote d’Ivoire</td>
<td>38</td>
</tr>
<tr>
<td>Nigeria</td>
<td>25</td>
</tr>
<tr>
<td>Senegal</td>
<td>25</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>24</td>
</tr>
<tr>
<td>Kenya</td>
<td>21</td>
</tr>
<tr>
<td>Yemen</td>
<td>19</td>
</tr>
<tr>
<td>United Republic of Tanzania</td>
<td>15</td>
</tr>
<tr>
<td>Benin</td>
<td>9</td>
</tr>
<tr>
<td>Iraq</td>
<td>8</td>
</tr>
<tr>
<td>Togo</td>
<td>6</td>
</tr>
<tr>
<td>Ghana</td>
<td>4</td>
</tr>
<tr>
<td>Niger</td>
<td>2</td>
</tr>
<tr>
<td>Uganda</td>
<td>1</td>
</tr>
<tr>
<td>Cameroon</td>
<td>1</td>
</tr>
</tbody>
</table>

#### Percentage of girls aged 0 to 14 years who have undergone FGM/C, 2010–2015

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gambia</td>
<td>59</td>
</tr>
<tr>
<td>Mauritania</td>
<td>54</td>
</tr>
<tr>
<td>Indonesia</td>
<td>49</td>
</tr>
<tr>
<td>Guinea</td>
<td>46</td>
</tr>
<tr>
<td>Eritrea</td>
<td>33</td>
</tr>
<tr>
<td>Sudan</td>
<td>32</td>
</tr>
<tr>
<td>Guinea-Bissau</td>
<td>30</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>24</td>
</tr>
<tr>
<td>Nigeria</td>
<td>17</td>
</tr>
<tr>
<td>Yemen</td>
<td>15</td>
</tr>
<tr>
<td>Egypt</td>
<td>14</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>13</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>13</td>
</tr>
<tr>
<td>Senegal</td>
<td>13</td>
</tr>
<tr>
<td>Cote d’Ivoire</td>
<td>10</td>
</tr>
<tr>
<td>Kenya</td>
<td>3</td>
</tr>
<tr>
<td>Uganda</td>
<td>1</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>1</td>
</tr>
<tr>
<td>Ghana</td>
<td>1</td>
</tr>
<tr>
<td>Togo</td>
<td>0.3</td>
</tr>
<tr>
<td>Benin</td>
<td>0.2</td>
</tr>
</tbody>
</table>

Prevalence data for girls aged 0 to 14 reflect their current, but not final, FGM/C status since some girls who have not been cut may still be at risk of experiencing the practice once they reach the customary age for cutting.

Notes: The latest available data for each country are presented in the charts above. An older source had to be used to report on the prevalence of FGM/C among girls and women aged 15 to 49 years for Somalia (MICS 2006) since the 2011 MIS was conducted separately in the two parts of the country: the Northeast Zone (also referred to as Puntland) and Somaliland. Prevalence data on FGM/C for girls and women aged 15 to 49 are not available for Indonesia. Data on girls for Egypt refer to ages 1 to 14 years and for Indonesia to ages 0 to 11 years. Older sources had to be used to report on the prevalence of FGM/C among girls aged 0 to 14 for Gambia (MICS 2010), Sierra Leone (MICS 2010) and Yemen (National Social Protection Monitoring Survey 2012) since the latest source for each of these countries did not collect these data. Prevalence data on FGM/C among girls under age 15 are not available for the remaining nine countries. Prevalence data on FGM/C for girls and women aged 15 to 49 years for Ethiopia are from a different source than the data on FGM/C for girls aged 0 to 14 years.

While in nearly all countries FGM/C is usually performed by traditional practitioners, more than half of girls in Indonesia underwent the procedure by a trained medical professional.

In most of the countries, the majority of girls were cut before age five. In Yemen, 85 per cent of girls experienced the practice within their first week of life.

Data from authoritative sources indicate that Somaliland has an overall prevalence rate of around 99% of girls and women undergoing FGC.

Female genital mutilation – a human rights violation

FGM is a human rights violation, a form of torture and an extreme form of violence and discrimination against girls and women rooted in harmful gender norms. FGM violates a number of human rights, including women and girls’ rights to equality, life, health, security of the person and dignity, as well as freedom from discrimination and torture, cruel, inhuman or degrading treatment. The continuation of FGM sustains massive gender inequalities in practising societies, as it limits opportunity for women and girls to realize their full rights and potential.

Several treaties, general comments/recommendations of treaty monitoring bodies and consensus documents explicitly condemn FGM. Other core human rights treaties of the United Nations and African Union provide general protections for the human rights of women and girls, which have been interpreted to prohibit FGM.

“In 2012, the United Nations General Assembly adopted a milestone resolution calling on the international community to intensify efforts to end the practice. More recently, in September 2015, the global community agreed to a new set of development goals – the Sustainable Development Goals (SDGs) – which includes a target under Goal 5 to eliminate all harmful practices, such as child, early and forced marriage and FGM/C, by the year 2030. Both the resolution and the SDG framework signify the political will of the international community and national partners to work together to accelerate action towards a total, and final, end to the practice in all continents of the world.”

UNICEF (2016) FEMALE GENITAL MUTILATION/CUTTING: A GLOBAL CONCERN.

---

For a full list of International Law on female genital mutilation, access https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-017-0322-5 and http://www.equalitynow.org/international-law-fgm
A non-exhaustive list of international law and global consensus documents that explicitly mention FGM is included below:

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>WHAT DOES IT SAY?</th>
</tr>
</thead>
</table>
- Numeral b: prohibition, through legislative measures backed by sanctions, of all forms of FGM, scarification, medicalisation and para-medicalisation of FGM and all other practices in order to eradicate them.  
- Numeral c: provision of necessary support to victims of harmful practices through basic services such as health services, legal and judicial support, emotional and psychological counselling as well as vocational training to make them self-supporting. |
| Council of Europe Convention on preventing and combating violence against women and domestic violence. Adopted 11 May 2011; Entered into force 1 August 2014. | Article 38: Parties shall take the necessary legislative or other measures to ensure that the following intentional conducts are criminalised:  
- a) Excising, infibulating or performing any other mutilation to the whole or any part of a woman’s labia majora, labia minora or clitoris;  
- b) Coercing or procuring a woman to undergo any of the acts listed in point a;  
- c) Inciting, coercing or procuring a girl to undergo any of the acts listed in point a.  
There is not a specific section about FGM and health, but Article 20 “General support services”, second part states: “Parties shall take the necessary legislative or other measures to ensure that victims have access to health care and social services and that services are adequately resourced and professionals are trained to assist victims and refer them to the appropriate services.” |
| Transforming our World: The 2030 Agenda for Sustainable Development. General Assembly Resolution A/RES/70/1. 25 September 2015. | Goal 5. Achieve gender equality and empower all women and girls  
- 5.3. Eliminate all harmful practices, such as child, early and forced marriage and FGM. |
| General Assembly Resolution 67/146, Intensifying global efforts for the elimination of FGMs. 20 December 2012. | In section: “Having considered”, include the following regarding the participation of health sector and care provision for women who have undergone FGM: “5. …and further urges States to protect and support women and girls who have been subjected to FGMs and those at risk, including by developing social and psychological support services and care, and to take measures to improve their health, including sexual and reproductive health, in order to assist women and girls who are subjected to the practices.” |
Several other core international and regional human rights treaties generally protect women's and girls' human rights, including protection from FGM.

- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Adopted 10 December 1984; Entered into force 26 June 1987.

Several United Nations human rights treaty monitoring bodies have explicitly condemned FGM as a human rights violation.

Why is female genital mutilation performed?

Reasons for performing FGM are complex, and vary by country, region and ethnicity, and even within communities. Multiple sources report that FGM can be seen as:

- a rite of passage to womanhood
- a way to improve the marriage prospects of a young girl
- a means to preserve virginity before marriage and ensure fidelity during marriage, as it is believed in some settings that women’s sexuality is insatiable if parts of the female genitalia are not removed
- a hygienic practice – however, the practice can increase the risk of secretions and odours associated with reproductive tract infections. The practice does not have any positive impact on hygiene, as believed in some cultures.
- a cultural practice rooted in religious beliefs, despite the fact that none of the religions explicitly prescribes FGM. Although FGM is often perceived as being connected to Islam, perhaps because it is practised among many Muslim groups, not all Islamic groups practise FGM, and many non-Islamic groups do, including some Christians, Ethiopian Jews, and followers of certain traditional African religions.

Understanding how to respond to these cultural and societal beliefs is a critical element of all work that aims to eliminate this harmful practice and/or address its consequences (for more information, see Section B: Female genital mutilation programming). Alternative rites of passage, which do not have immediate and long-term health consequences, have been successfully implemented in some communities – these include social events, presents, and other symbolic activities.

Types of female genital mutilation

WHO identifies four types of FGM. To understand these types, it is important to observe what normal genitals look like.

“FGM is often practised even when it is known to inflict harm upon girls because the perceived social benefits of the practice are deemed higher than its disadvantages.”

UNFPA (2017) FEMALE GENITAL MUTILATION ONLINE RESOURCE
FGM TYPE I: PARTIAL OR TOTAL REMOVAL OF THE CLITORIS (CLITORIDECTOMY) AND/OR THE PREPUCE

FGM TYPE II: PARTIAL OR TOTAL REMOVAL OF THE CLITORIS AND THE LABIA MINORA, WITH OR WITHOUT EXCISION OF THE LABIA MAJORA (EXCISION)

FGM TYPE IV: ALL OTHER HARMFUL PRACTICES TO THE FEMALE GENITALS FOR NON-MEDICAL PURPOSES, FOR EXAMPLE: PRICKING, PULLING, PIERCING, INCISING, SCRAPING AND CAUTERIZING.

Health consequences of female genital mutilation

FGM implies a lifelong physical change as, once removed, genital tissues cannot be replaced or regrown and scar tissue can form. Other adverse physical and mental health consequences for the woman can present immediately (within eight weeks of performing the practice), in the long term (through the life cycle) or during a specific event in a woman’s reproductive life (e.g. pregnancy, delivery or post-partum period) as summarized below. (Note: management of these complications is further discussed in the section Management of physical and mental health consequences of FGM in sexual and reproductive health facilities.)

<table>
<thead>
<tr>
<th>TYPE OF COMPLICATION</th>
<th>COMPLICATION</th>
<th>REMARKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate or during the recovery period (within the following eight weeks): these consequences may be the result of the use of non-surgical, unsterilized instruments such as razor blades, knives or broken glass and of unhygienic conditions</td>
<td>Haemorrhage</td>
<td>Bleeding commonly occurs during or immediately following FGM. The management of bleeding associated with excision is the same as the management of bleeding in any other circumstances.</td>
</tr>
<tr>
<td></td>
<td>Pain</td>
<td>Cutting the nerve ends and sensitive genital tissue causes extreme pain. Proper anaesthesia is rarely used and, when used, is not always effective. The healing period is also painful. Type III FGM is a more extensive procedure of longer duration, hence the intensity and duration of pain may be more severe. The healing period is also prolonged and intensified accordingly.</td>
</tr>
<tr>
<td></td>
<td>Shock</td>
<td>Haemorrhagic, neurogenic, septic or psychological shock</td>
</tr>
<tr>
<td></td>
<td>Genital tissue swelling</td>
<td>Due to inflammatory response or local infection</td>
</tr>
<tr>
<td></td>
<td>Infections</td>
<td>Acute local infections; abscess formation; septicaemia; genital and reproductive tract infections; urinary tract infections. The direct association between FGM and HIV remains unclear, although the disruption of genital tissues and the use of unsterilized instruments for the practice may increase the risk of HIV transmission and other blood-borne infections such as hepatitis B and C.</td>
</tr>
<tr>
<td></td>
<td>Urinary tract infections</td>
<td>Acute urine retention; pain passing urine; injury to the urethra</td>
</tr>
<tr>
<td></td>
<td>Wound healing problems</td>
<td>Which can lead to pain, infections and abnormal scarring</td>
</tr>
<tr>
<td></td>
<td>Death</td>
<td>Due to severe bleeding or septicaemia</td>
</tr>
</tbody>
</table>

Note: this table was developed after consultation of multiple sources. Its content is primarily adapted from World Health Organization publications, including:


• When the information provided in the remarks is not explicitly mentioned in WHO’s documents, a reference has been added to the source of information.
### Type of Complication

| Long-term or delayed complications can occur at any time during the lifespan of a woman who has undergone FGM
<table>
<thead>
<tr>
<th>Type of complication</th>
<th>Complication</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-term physical complications</td>
<td>Genital tissue damage</td>
<td>With consequent chronic vulvar and clitoral pain</td>
</tr>
<tr>
<td></td>
<td>Vaginal discharge</td>
<td>Due to chronic genital tract infections</td>
</tr>
<tr>
<td></td>
<td>Vaginal itching</td>
<td>Caused by the chronic genital infections</td>
</tr>
<tr>
<td></td>
<td>Menstrual problems</td>
<td>Dysmenorrhea, irregular menses and difficulty in passing menstrual blood</td>
</tr>
<tr>
<td></td>
<td>Reproductive tract infections</td>
<td>Chronic pelvic pain can appear due to general infections</td>
</tr>
<tr>
<td></td>
<td>Chronic genital infections</td>
<td>Including increased risk of bacterial vaginosis</td>
</tr>
<tr>
<td></td>
<td>Urinary tract infections</td>
<td>Often, these are recurrent</td>
</tr>
<tr>
<td></td>
<td>Painful urination</td>
<td>Due to obstruction and recurrent urinary tract infections</td>
</tr>
<tr>
<td>Long-term sexual functioning complications</td>
<td>Dyspareunia (pain during sexual intercourse)</td>
<td>There is a higher risk of dyspareunia with type III FGM relative to types I and II.</td>
</tr>
<tr>
<td></td>
<td>Decreased pleasure/sexual satisfaction</td>
<td>• Caused by the removal of, or damage to highly sensitive genital tissue, especially the clitoris, which may affect sexual sensitivity and lead to sexual problems.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Vaginal penetration for women with a tight introitus may be difficult or even impossible without tearing or re-cutting the scar. This may lead to loss of self-esteem and sexual dysfunction.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Vaginismus — recurrent or persistent involuntary tightening of muscles around the vagina whenever penetration is attempted — may appear as a result of injury to the vulval area. Inhibition of coitus because of fear of pain may damage the marital relationship and even lead to divorce.</td>
</tr>
<tr>
<td></td>
<td>Reduced sexual desire and arousal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Decreased lubrication during sexual intercourse</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reduced frequency of orgasm or anorgasmia</td>
<td></td>
</tr>
<tr>
<td>Long-term psychological complications</td>
<td>Post-traumatic stress disorder (PTSD)</td>
<td>Mental and psychosomatic disorders may include:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Disturbances in 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.</td>
</tr>
<tr>
<td></td>
<td>Anxiety disorders</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Depression</td>
<td>• As they grow older, women may develop feelings of incompleteness, loss of self-esteem, depression, chronic anxiety, phobias, panic or even psychotic disorders.</td>
</tr>
</tbody>
</table>

---

ii A systematic review by Berg (Berg RC, Underland V, Odgaard-Jensen J, Fretheim A, Vist GE (2014) Effects of female genital cutting on physical health outcomes: a systematic review and meta-analysis. BMJ Open. 4:e006316) demonstrated, in the long term, an association of FGM with urinary tract infection, dyspareunia and bacterial vaginosis. Cohort studies and case reports have also found associations with other sequelae. Most studies are of poor methodological quality (as reported by RCOG, 2015 – see bibliography).
## ADDRESSING THE NEEDS OF WOMEN AND GIRLS AFFECTED BY FEMALE GENITAL MUTILATION

### BACKGROUND INFORMATION

<table>
<thead>
<tr>
<th>Type of Complication</th>
<th>Complication</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetric consequences</td>
<td>Caesarean section</td>
<td>A caesarean section may be indicated when keloids have formed and are too large; or when the vagina is seen to be too rigid and scarred, and thought to be a possible cause of severe vaginal lacerations or third-degree tears. In some diaspora communities, providers who are not trained in deinfibulation may recommend a caesarean section, despite not being clinically indicated.</td>
</tr>
<tr>
<td></td>
<td>Post-partum haemorrhage</td>
<td>Post-partum blood loss of 500 ml or more within 24 hours after birth</td>
</tr>
<tr>
<td></td>
<td>Episiotomy</td>
<td>If FGM has caused a tight introitus, there is a need to increase the vaginal opening by doing an episiotomy. This is usually performed during the second stage of labour, when the presenting part is pressing on the vulva.</td>
</tr>
<tr>
<td></td>
<td>Prolonged labour and Difficult labour/dystocia</td>
<td>Because the vagina, perineum and the labia have all undergone mutilation that has left extensive scar formation, the vaginal canal becomes inelastic and the pelvic floor muscles rigid. This prevents the normal and gradual dilation of the vagina as well as the descent of the presenting part of the child during the second stage of labour.</td>
</tr>
<tr>
<td></td>
<td>Obstetric tears/lacerations</td>
<td>Due to rigidity of the perineum as a result of scarring of the tissues around the introitus</td>
</tr>
<tr>
<td></td>
<td>Instrumental delivery</td>
<td>Caused by FGM obstetric complications</td>
</tr>
<tr>
<td></td>
<td>Extended maternal hospital stay</td>
<td>Caused by FGM obstetric complications during delivery</td>
</tr>
<tr>
<td></td>
<td>Obstetric fistulae</td>
<td>A direct association between FGM and obstetric fistula has not been established. However, given the causal relationship between prolonged and obstructed labour and fistula, and the fact that FGM is also associated with prolonged and obstructed labour it is reasonable to presume that both conditions could be linked in women living with FGM.</td>
</tr>
<tr>
<td></td>
<td>Stillbirth and early neonatal death</td>
<td>Obstetric complications can result in a higher incidence of infant resuscitation at delivery and intrapartum stillbirth and neonatal death.</td>
</tr>
</tbody>
</table>
As shown on the following diagram, the social and physical and mental health consequences of FGM can appear through a woman’s life cycle. See the following diagram for some examples:

<table>
<thead>
<tr>
<th>Childhood</th>
<th>Puberty</th>
<th>Reproductive age</th>
<th>Older years</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Infection, bleeding and all immediate consequences, as FGM is often performed during the early years</td>
<td>• Menstrual problems</td>
<td>• Menstrual problems</td>
<td>• Epidermal clitoral inclusion cysts</td>
</tr>
<tr>
<td>• Trauma (e.g. changes in eating and sleeping habits)</td>
<td>• Trauma (e.g. changes in eating and sleeping habits)</td>
<td>• Infertility</td>
<td>• Pain in area of suture</td>
</tr>
<tr>
<td>• Missing education due to health problems caused by the FGM procedure</td>
<td>• Missing education due to pain related to menstruation</td>
<td>• Labour/obstetric problems</td>
<td>• Pain/discomfort during sex</td>
</tr>
<tr>
<td></td>
<td>• Self-stigmatization</td>
<td>• Anxiety, depression, other psychological consequences</td>
<td>• Anxiety, depression, other psychological consequences</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Self-stigmatization</td>
</tr>
</tbody>
</table>

In-country legal considerations when working on FGM

In addition to international and regional law sources and consensus documents, countries where FGM is prevalent have national instruments to prohibit or regulate FGM:

• European laws often include the principle of extraterritoriality, with country-level legislation focused on preventing children from being taken to other countries (primarily in Africa) where the FGM will be performed.  

• Most African countries where the practice is concentrated have passed national legislation outlawing FGM. Eighteen countries have enacted national laws banning FGM. While Sudan lacks national legislation outlawing FGM, several states in the country have enacted legislation outlawing FGM.

• In Somaliland, FGM is not banned in the local regulations. Advocacy efforts are currently underway to support criminalization in the context of a holistic programme.
PROFESSIONAL SECRECY PROVISIONS

Some countries also have professional secrecy provisions related to FGM in place, most frequently targeted at health professionals, social workers and teachers. However, there are significant differences between countries in terms of whether these professionals have a ‘duty to report’ or merely are offered the ‘right to report’:

• In Europe, the right to report for professionals is applicable in Belgium, Ireland, Germany and the Netherlands.\(^{16}\)

• The duty to report for at least one category of professionals (doctors, teachers and social workers) is applicable in the following European countries: Austria, Bulgaria, Cyprus, Denmark, Estonia, Finland, France, Greece, Hungary, Italy, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden and Switzerland (United Nations 2009).\(^{17}\)

• In Africa, Benin, Burkina Faso, Cote D’Ivoire, Eritrea and Togo also have provisions regarding failing to report FGM to the relevant authorities.\(^{18}\)

Local regulations and plans to eliminate FGM and address its consequences

• Several countries, including Burkina Faso, Djibouti, Egypt, Ethiopia, Gambia, Guinea, Guinea-Bissau, Kenya, Mauritania, Nigeria, Senegal and Sudan have developed national plans aimed at preventing FGM or accelerating its abandonment.\(^{19}\)

• FGM prevention and care has been integrated into the health policies and programmes of several countries. Burkina Faso, Eritrea, Ethiopia, Gambia, Guinea, Kenya, Mali (in its Action Plan for the prevention and care of FGM), Mauritania, Senegal and Sudan have integrated FGM into their sexual and reproductive health strategies and other health frameworks, while Kenya has integrated FGM into its reproductive health policy.\(^{20}\)

• Other countries include FGM in their healthcare training programmes. In Burkina Faso, Egypt, Gambia, Guinea, Kenya, Mauritania, Mali and Sudan, FGM is included as part of health professionals’ training, while Djibouti offers a module on FGM to all health professionals.\(^{21}\) Information on the quality and comprehensiveness of these programmes is not available.

• Elsewhere, frameworks have been established within health policies to tackle specific issues related to FGM (e.g. anti-medicalization strategy in Somalia\(^{22}\)).
SECTION B

FEMALE GENITAL MUTILATION PROGRAMMING
SECTION B: FEMALE GENITAL MUTILATION PROGRAMMING

IPPF Member Associations working to eliminate and prevent, screen and treat the consequences of FGM must implement a wide range of efforts, including advocacy, information, education and communication, evaluation/research and provision of services. Advancing this work requires an enabling internal environment fostered through the development and dissemination of policies on the organization’s position on FGM, general sensitization efforts for all staff members and volunteers and adequate training for relevant personnel.

<table>
<thead>
<tr>
<th>ADVOCACY</th>
<th>INFORMATION, EDUCATION AND COMMUNICATION</th>
<th>EVALUATION AND RESEARCH</th>
<th>SERVICE PROVISION</th>
</tr>
</thead>
</table>
| Member Associations should:  
  • use Sexual Rights: An IPPF Declaration and IPPF Charter on Reproductive Rights as advocacy tools  
  • use United Nations reporting mechanisms as well as shadow reports to hold their governments accountable  
  • build partnerships with a broad range of actors to advocate for creating and/or enforcing legislation that criminalizes the practice | Member Associations should:  
  • sensitize communities and families to change their attitudes and practices on FGM; this work must be evidence-informed and scientifically accurate, non-prejudicial, non-judgemental, sensitive and respectful, non-stereotypical and based on adolescents’ evolving capacities (when provided to this group)  
  • create awareness about the physical and mental health consequences of FGM among parents, women living with any type of FGM, service providers and the broader community  
  • provide information on deinfibulation to survivors of type III FGM | Member Associations can play a critical role in documenting best practices and generating evidence for the wider movement. WHO highlights multiple areas where additional evidence is required:  
  • How to ameliorate the practice around deinfibulation among different cadres of providers in a range of clinical settings and cultural contexts.  
  • The factors that promote uptake of or act as barriers to deinfibulation.  
  • The type of psychological intervention and/or rehabilitation that would be most helpful to girls and women living with FGM. | See Section C. |
### ADVOCACY

- adopt an evidence-based advocacy strategy. Best practices from areas where a decline has been identified are showcased in UNICEF’s 2013 report *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*.
- conduct research into trends related to the medicalization of FGM and be actively involved in advocacy campaigns to eliminate the practice within health settings.

### INFORMATION, EDUCATION AND COMMUNICATION

- link women to prevention, screening and treatment services related to FGM.
- find ways to make hidden attitudes favouring the abandonment of the practice more visible and encourage alternative initiation rituals that preserve positive social norms.
- engage with men and boys as well as religious and secular leaders to grow the support base to eliminate FGM.
- increase the exposure of groups that do not practise FGM to create awareness of the benefits of abandoning the practice.

### EVALUATION AND RESEARCH

- Efficacy of sexual counselling interventions in treating sexual dysfunction among women living with FGM.
- Effectiveness, acceptability and sustainability of community-based information, education and communication interventions on FGM.
- How to improve providers’ knowledge and attitudes related to FGM.
- Impact of health education interventions on women’s knowledge about anatomy, health effects of FGM and health benefits of deinfibulation.
- How male partner involvement in the health education process can influence women’s satisfaction with services and their rate of requests for re-infibulation.

### SERVICE PROVISION

See Section C.
SECTION C

FEMALE GENITAL MUTILATION – ESSENTIAL HEALTH SERVICES
SECTION C: FEMALE GENITAL MUTILATION – ESSENTIAL HEALTH SERVICES

Member Associations play a pivotal role in the provision of services for women living with FGM. Women (and/or their partners, parents or relatives) may consult services to address a concern directly linked to the FGM practice, or may attend services to receive care offered as part of the integrated package of essential services (IPES). Regardless of the reason behind the consultation or the entry point, the following key principles should guide the provision of services at Member Associations:

- Medicalization of FGM (i.e. performance of FGM by healthcare providers) is never acceptable because it violates medical ethics, as (i) FGM is a harmful practice; (ii) medicalization perpetuates FGM; and (iii) the risks of the procedure outweigh any perceived benefit.24
- Zero tolerance to FGM means that Member Associations should not recommend the implementation of less harmful types of FGM (e.g. FGM I or II instead of FGM III – or Sunna instead of Pharaonic, for example, in Somaliland).
- Girls and women living with FGM have experienced a harmful practice and have the right to access quality health care.
- FGM-related care must be rights based, gender sensitive, women centred, evidence based, stigma free, universally accessible and offered through the continuum of care (home/community-based services, mobile health units, fixed facilities, primary care and in other levels of complexity as deemed medically appropriate).
- Member Associations should understand that FGM may be constructed as an important part of the cultural identity of girls and women, and services must be sensitive to the specifics of each woman or girl’s context (e.g. providers should consider words that are familiar to their clients when choosing language to refer to FGM – for more information see Annex 1).
As with all services, successful implementation of FGM-related care is achieved by addressing elements of supply and demand and by creating an enabling environment:

<table>
<thead>
<tr>
<th>FGM-RELATED CARE</th>
<th>Demand</th>
<th>Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Enabling environment</strong></td>
<td>• Develop a statement opposing FGM. Disseminate this institutional statement to staff members, partners and other stakeholders. • Work with community and religious leaders and other stakeholders to create awareness of the type of care needed by a woman living with FGM and the type of care offered by the Member Association. • Establish partnerships with women and youth organisations, professional associations, schools and authorities to advocate for the criminalization of FGM and the provision of rights-based services to women living with FGM. Partnerships can also help develop a strong referral network and serve as a way to promote services. • Sensitize all personnel so they understand that FGM is a human rights violation, as well as the potential consequences of FGM and how the Member Association responds to these needs.</td>
<td>• Identify key populations that may require your services and assess barriers. While in some countries the majority of women live with FGM, in others the practice is concentrated within some diaspora groups. • Do not implement a ‘one-size-fits-all’ approach: women living with FGM are very diverse and have had very different experiences with the procedure (e.g. do not assume that all women living with FGM will face mental consequences). Based on this understanding, define a comprehensive package of services that suits the needs of different women (and/or their partners, parents and relatives). • Implement efforts to create demand for FGM-related services (e.g. targeting engaged couples and offering professional deinfibulation services before the wedding to avoid unsafe procedures or forced penetration through the infibulation scar tissue). • Involve individual clients and communities in planning, monitoring and improvement of services.</td>
</tr>
</tbody>
</table>
As mentioned above, FGM is most commonly carried out on girls between 0–15 years old. As Member Associations’ service delivery points generally serve clients above 15 years old, they are more likely to deal with the long-term consequences of FGM or the subsequent consequences linked to a specific event in a woman’s reproductive life (pregnancy, abortion, delivery, post-partum).

This, of course, does not exclude the possibility of cases where the Member Association is in contact with women who may be experiencing immediate consequences, e.g. FGM is sometimes performed later in life, or women are re-infibulated after giving birth. Some Member Associations are also able to reach girls aged 9–13 through services such as HPV vaccination.

It should not exclude the ability of Member Associations to play a role in preventing the practice through its services, e.g. by offering a space to discuss parents’ thoughts on FGM during prenatal or post-natal counselling.

**Entry points to access FGM-related care**

A woman may have different entry points to access FGM-related care at a Member Association based on the reason for consultation. These entry points help us to establish the recommended package of services offered:

<table>
<thead>
<tr>
<th>ENTRY POINTS</th>
<th>RECOMMENDED PACKAGE OF SERVICES</th>
</tr>
</thead>
</table>
| A. A woman living with FGM (and/or her partner, parents or relatives) consults a service provider to discuss physical, mental or sexual health issues linked specifically to the procedure | • Information and counselling on FGM, including but not limited to: fertility/infertility, sexuality and relationships.  
• Screening, classification and recording of FGM.  
• Prevention of immediate and long-term physical and mental health consequences including but not limited to: deinfibulation at the time of marriage or during the prenatal period (including pre-/post-counselling, antepartum/intrapartum procedure and follow-up).  
• Management of immediate and long-term physical and mental health consequences, including but not limited to: deinfibulation (including for the management of existing sexually transmitted infections and reproductive tract infections), anaemia, eating disorders, urination complications or discomforts, etc.  
• Internal referral to other IPES services.  
• Referral services, including but not limited to psychiatric and infertility services (as needed). |
| B. A woman accesses a service included in the IPES and during the medical history process the provider identifies she has experienced FGM | • The provider delivers, in an integrated way, the service requested, adapting it to the needs of a woman who has been affected by FGM. This can mean discouraging/discard the use of specific contraceptive methods, performing deinfibulation (including pre-/post-counselling, procedure and follow-up) before an abortion procedure, using the least invasive method available for cervical cancer screening, among other adaptations. Note: once a provider confirms that a woman is living with FGM, screening/classification/recording should be implemented before providing other sexual and reproductive health services.  
• Referral services, including but not limited to psychiatric and infertility services (as needed). |
**ENTRY POINTS** | **RECOMMENDED PACKAGE OF SERVICES**  
---|---  
C. A young girl accesses HPV vaccination services and during the medical history process the provider identifies she has been subject to FGM/is at risk of being subject to the practice  
• Information and counselling on FGM for the family/tutors and the young girl.  
• Screening and classification of FGM type (if FGM has taken place).  
• Management of immediate and long-term physical and mental health consequences, including but not limited to: deinfibulation (including pre-/post-counselling, procedure and follow-up), monitoring services during puberty to detect psychological disorders, menstrual problems, etc., among others. Parental consent is an important consideration for services provided to minors.  
• Referral services, including but not limited to psychiatric services and protection/welfare agencies involved in the prevention/enforcement of legislation against FGM (as needed).  
D. A woman/family member/tutor brings a baby girl to access immunization services* and the provider identifies she has been subject/is at risk of being subject to the practice  
• Information and counselling on FGM prevention and potential mental and physical health consequences offered to the woman/family member/tutor.  
• Referral to specialized infant/child services, including for management of immediate physical health consequences.  

*As part of their diversified services, some Member Associations offer vaccination and other pediatric services

**Disaggregating the recommended package of services**

Recommendations to offer the following services are covered throughout the rest of the document. Women living with FGM may require other services that are beyond the capacities and infrastructure existing in a Member Association (e.g. sexual dysfunction, infertility, others). Strong referral systems are recommended to respond to such cases:

1. General information and counselling on FGM
2. Screening, classification and recording of FGM and its consequences
3. Deinfibulation for Type III FGM (including pre- and post-deinfibulation counselling)  
   - Note: Deinfibulation is often provided in the context of other services (e.g. gynaecological)  
4. Management of FGM-related physical and mental health consequences as part of the IPES:
   - a. Gynaecological, reproductive tract infections and sexually transmitted infections services  
   - b. Prenatal and post-natal care  
   - c. Contraceptive services  
   - d. Safe abortion services  
   - e. HIV/AIDS services  
   - f. Sexuality and relationship counselling  
   - g. Sexual and gender-based violence services  
   - h. Referrals
1. INFORMATION AND COUNSELLING ON FGM

General guidelines

- Any staff member can provide information on FGM during the check-in process (e.g. a receptionist) or through interactive waiting room activities and information materials available at the service delivery point. All service provision staff and volunteers, including peer educators, should be sensitized and have basic knowledge of FGM so that they can answer general questions on this practice and its potential consequences.

- A competent, adequately trained service provider should offer counselling. The main objective of a counselling session on FGM is to support the client in making a decision related to this practice by offering her information on her rights and the tools necessary to facilitate the decision-making process. There are a wide range of reasons for someone to access a FGM counselling session, e.g. a woman with type III FGM who is considering the possibility of a deinfibulation; a parent who wants to decide about when/how/if to cut his/her daughter; a young woman who needs tools to face her parents or husband regarding the practice; or a couple who fear/have been diagnosed with infertility as a result of FGM.

- As with any sexual and reproductive health counselling session, a counselling intervention on FGM should:
  - Ensure privacy and confidentiality.
  - Be provided by a counsellor who is patient, makes eye contact, listens attentively, shows empathy and respect to the client, avoids stigmatization and who has an adequate management of verbal and body language. (See recommendations on use of culturally sensitive language on FGM in Annex 1.)
  - An FGM counselling intervention does not aim to indoctrinate, share a counsellor’s personal experience as example, judge or provide therapy.
  - Address two levels: the client’s level (her circumstances, religious beliefs and needs), as well as the social context in which the request is made (e.g. how the context in which she lives supports, contributes to or perpetuates the continuation of the practice).
  - Be implemented in two parts: a) the counselling itself and b) provision of information about medical, referral or support processes. The counselling component should have a consistent framework: what the assistance consists of, what a client can expect from the intervention, what is not possible to address during the session, client rights, and opportunities to ask questions. The information component should be based on evidence and be available in a client-centred format.
The counselling intervention requires carefully choosing the way a counsellor enquires and interacts with the client. Below are some examples of expressions/language to use and avoid, in order to ensure the provision of rights-based care and prevent stigmatization:

- **Avoid saying:** “You should ask your husband if he agrees about the deinfibulation procedure.”
- **Use instead:** “Have you discussed this procedure with your partner? What does he think? Do you fear any negative repercussions in your life if you go ahead with the procedure?”
- **Avoid saying:** “Why do you want to ‘cut’ your daughter?”
- **Use instead:** “How do you feel about doing this procedure to your daughter?”
- **Avoid saying:** “Have you already thought about this decision?”
- **Use instead:** “What do you think could happen in your life (the life of your daughter/partner) if you go ahead with this decision?”

If a woman prefers to include her partner during the FGM-related intervention, the counsellor can take the opportunity to share information on the long-term consequences of FGM and the benefits of available interventions that can help both the woman and her partner (e.g. deinfibulation before marriage to avoid infections, painful sexual relationships and other complications resulting from deinfibulation at the time of marriage).

Involving family members during the FGM counselling intervention can help close relatives to understand the consequences of the practice on a woman's/girl's mental and physical health, ensure parental consent is given for deinfibulation (when required by law) or avert the implementation of the practice by other members of the family.

**TIP**

Note:
- For specific guidance on pre-counselling/post-counselling for deinfibulation see section: Deinfibulation
- For specific guidance on counselling on sexuality and relationships linked to FGM see section: Sexuality counselling
Provider competences

Counselling on FGM can be provided by all types of providers, ranging from a more professionalized healthcare worker to an existing lower-level cadre (e.g. competently trained community health worker/youth peer provider). The knowledge and skills required are listed below:

<table>
<thead>
<tr>
<th>TASK</th>
<th>KNOWLEDGE AND SKILLS</th>
</tr>
</thead>
</table>
| Plan a counselling session, including the creation of a conducive counselling environment | Knowledge of:  
- physical, social, cognitive and emotional development at different life stages, including adolescence  
- factors that facilitate and impede counselling, such as privacy, environment, time, etc.  
- client’s rights  
- decision-making processes  
- behavioural change theories  
- health-seeking behaviour  
Skills – ability to:  
- plan an effective counselling session  
- create a secure, safe and effective counselling space  
- assemble appropriate counselling materials or aids related to sexual and reproductive health |
| Counsel effectively on FGM | Knowledge of:  
- areas listed in the task above ‘Plan a counselling session’  
- FGM prevalence within the context, physical and mental health consequences (immediate, long-term, during a specific event of a woman’s reproductive life), available alternatives to prevent and manage consequences  
- support mechanisms available to clients  
Skills – ability to:  
- communicate with individuals effectively and provide appropriate information, demonstrating awareness of gender and cultural differences  
- provide information to empower individuals to make informed decisions  
- discuss the impact of gender-based societal and cultural roles and context on health care and on women’s and men’s sexual and reproductive health  
- tailor counselling to the needs of the individual  
- use basic counselling techniques, including establishing rapport, active listening, demonstrating empathy, questioning and probing, summarizing and reflecting  
- screen SGBV  
- screen risk of HIV/AIDS  
- identify possible victims of FGM |
| Assess the effectiveness of counselling | Knowledge of:  
- basic techniques of assessing client satisfaction  
Skills – ability to:  
- use rapid assessment techniques  
- follow up with clients after counselling |
Supplies/equipment and infrastructure requirements

- Supplies/equipment: vaginal demonstration models, posters/other materials showing the different types of FGM
- Infrastructure: a private and confidential space (preferably with a door and a high wall to avoid noise travelling) and a seating arrangement that enables communication and avoids unnecessary obstacles or hierarchies

Client records

- The reason for consultation, symptoms, FGM type (self-reported by the woman during the counselling intervention), decision reached (if any) and referrals made (internal and external) must be adequately documented in the client’s medical records.

2. SCREENING, CLASSIFICATION AND RECORDING OF FGM AND ITS CONSEQUENCES

General guidelines

- Given the potential physical and mental health consequences of FGM and the impact of these consequences on a woman’s sexual and reproductive health, the partial or total removal of external genitalia or other injury to the female genital organs for non-medical reasons must be documented in a client’s medical record before providing any service. In countries where FGM is prevalent or where diaspora populations seek services, Member Association service delivery points must adapt their client records to include FGM screening, classification and recording as part of the general sexual and reproductive health history of a client.
- Screening, classification and recording of FGM and its consequences requires a trusting relationship with clients, including showing empathy, ensuring the client’s privacy and the confidential nature of the client-provider interaction, showing respect and being patient. Because women who have undergone FGM will most likely come to a Member Association facility for reasons not linked to the FGM procedure, providers must be careful when raising the issue of FGM. It is recommended that providers adhere to the following steps:  
  - Greet the client in a culturally accepted manner. Ask her to sit comfortably near you and facing you. Introduce yourself, and address the client by her preferred name.
  - Begin by asking general questions, such as: How are you? How is the family? Do you have any information you would like to share with me?
  - When the client is relaxed and seems ready to talk about personal matters, start filling out the general sections of the medical record (name, age, operations, etc.). Ask her tactfully about any medical procedures she has had, including FGM. Use terminology that is familiar to the client’s literacy level. Ask her if she would like to share any information about the operation and any complications she may fear due to FGM. Reassure her that you are comfortable dealing with the condition and that it is not a barrier to her accessing services.
  - Let the client express her feelings and give you the information she wants to share. If she starts crying, be patient and provide support. Listen carefully and empathize with her. Let the client know that you are concerned and that you can help her.
• Encourage the client to talk by nodding or making eye contact when you look at her. Clients may be very slow in sharing information about FGM; be patient and do not force her to speak. If the client is not ready to share information yet, invite her to come for another visit.

• Once it has been confirmed that the woman has undergone FGM (self-reported), reassure the client she is in the right place to receive support.

• Record the information in the relevant sections of the client’s medical history.

• Explain how a physical assessment can help identify or confirm the type of FGM, and how a physical, laboratory and/or psychosocial assessment can help to discard potential complications associated with her general sexual and reproductive health and well-being. Use a vaginal demonstration model to explain what a physical assessment consists of.

• Request verbal consent (and written, as needed) to conduct the physical assessment.

Physical assessment – type of FGM and consequences

• Before conducting an assessment, the provider should confirm that all required supplies/equipment are available.

• Reassure the client that she is in good hands.

• Instruct the client to take off her underwear and help her to lie down on the examination couch with her legs apart and flexed.

• Expose the necessary area for inspection and examination. Cover the client until you are ready to begin the examination.

• Wash your hands thoroughly and put on gloves.

• Expose the genitalia. Inspect the external genitalia to identify the type of FGM and to check for ulcers, infection, abscesses or any abnormal swelling.

• If relevant, tactfully ask the client about her experiences during urination, menstruation and sexual intercourse.

• Most of the time, there is no need to introduce fingers into the vagina, as most complications can be detected by inspection of the external genitalia. If necessary, (e.g. when there is reporting/suspicion of discharge or infections) follow the steps below:
  » Try to introduce the tip of the index finger slowly, and then introduce the whole finger very slowly if the introitus allows. If there is room for more than one finger, introduce the second finger very slowly and observe the client’s reaction, as this may cause pain. Applying an oily substance can minimize pain when introducing the finger.
  » Respect the client’s reactions.
  » In cases of type III FGM (infibulation) the introitus may be very tight and may not allow the introduction of even the tip of a finger. In such cases, you should not attempt to introduce any fingers.
  » Look for abnormal vaginal discharge before taking off the gloves.
- After completing the procedure, thank the client for her cooperation.
- Take off the gloves and wash your hands.
- Help the client into a sitting position; if appropriate, assist her with dressing and seat her comfortably for the next step of the procedure.
- Record your findings.
- Explain the findings to the client (e.g. confirm FGM type), as well as the importance of assessing other consequences/complications through additional exams and laboratory tests (as needed). This moment is also an opportunity to discuss alternatives, such as deinfibulation. For more information, see section: Deinfibulation for type III FGM.

Assessment of mental and sexual health consequences/complications

Interviewing clients in a tactful way helps identify mental and sexual consequences/complications. Providers must work on their interpersonal communication, observation and listening skills. The following recommendations should be implemented when conducting this type of assessment with a client who has undergone FGM:

- Reassure the client about the privacy and confidentiality of the service.
- Explain that sexuality and mental health are sensitive and taboo issues in many societies, and many clients feel uncomfortable sharing their concerns.
- Explain that some women who have undergone FGM experience fear, feelings of helplessness, intrusive re-experiences of their circumcision and dissatisfaction with sexual intercourse, among other problems. It is important to acknowledge that not all women will experience these problems and to understand the client’s specific needs.
- Ask her about her eating and sleeping patterns; presence of intrusive thoughts, flashbacks, irritability, self-destructive behaviours and emotional state; thoughts about herself and her perceived self-value; interest in activities and social interaction; capacity to give and receive affection; use of medication or other substances.
- Ask about menstrual patterns and sexual relationships extremely tactfully, as these questions may embarrass the client and result in a communication breakdown. When discussing sexual relationships, ask about pleasure, lubrication and overall sexual satisfaction.
- Assess the client’s ability to understand information and comprehend a situation by asking her to share what she identifies as the possible cause(s) of her current circumstances, and/or by asking her to repeat some of the information you have provided in her own words.
- Record your findings and share these with the client when appropriate.
Provider competences
The following groups of providers can provide screening for FGM (classification, physical and mental/sexual health assessment): physician clinicians, non-physician clinicians (different job titles include medical assistant, nurse practitioner, etc.), nurses, auxiliary nurses, midwives, auxiliary nurse midwives and trained traditional midwives.

<table>
<thead>
<tr>
<th>TASK</th>
<th>KNOWLEDGE AND SKILLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collecting self-reported information about FGM</td>
<td>Knowledge of:</td>
</tr>
<tr>
<td></td>
<td>• FGM prevalence and types</td>
</tr>
<tr>
<td></td>
<td>• basic anatomy</td>
</tr>
<tr>
<td></td>
<td>• signs and symptoms of mental/sexual health problems</td>
</tr>
<tr>
<td>Skills – ability to:</td>
<td>• create a trust relationship with the client</td>
</tr>
<tr>
<td>Physical assessment – classification of FGM and screening of health consequences and complications</td>
<td>Knowledge of:</td>
</tr>
<tr>
<td></td>
<td>• types of immediate, long-term and obstetric consequences of FGM</td>
</tr>
<tr>
<td></td>
<td>• basic anatomy</td>
</tr>
<tr>
<td></td>
<td>• conditions that can be detected by physical observation (e.g. bleeding, keloids,</td>
</tr>
<tr>
<td></td>
<td>genital tissue swelling, vaginal discharge)</td>
</tr>
<tr>
<td></td>
<td>• conditions that can be detected by touching (e.g. pain)</td>
</tr>
<tr>
<td></td>
<td>• conditions that can be detected by smelling (e.g. specific infections)</td>
</tr>
<tr>
<td></td>
<td>• indications for bimanual examination (pelvic pain, bloating, menorrhagia,</td>
</tr>
<tr>
<td></td>
<td>amenorrhea, abnormal uterine bleeding)</td>
</tr>
<tr>
<td></td>
<td>• indications for requesting further laboratory assessments</td>
</tr>
<tr>
<td>Skills – ability to:</td>
<td>• perform a general physical assessment and bimanual pelvic examination,</td>
</tr>
<tr>
<td></td>
<td>minimizing client discomfort and respecting her dignity/privacy</td>
</tr>
<tr>
<td>Mental health/sexual health assessment</td>
<td>Knowledge of:</td>
</tr>
<tr>
<td></td>
<td>• conditions that can be detected by a psychological assessment (chronic anxiety,</td>
</tr>
<tr>
<td></td>
<td>feelings of fear, humiliation, betrayal, stress, loss of self-esteem, depression,</td>
</tr>
<tr>
<td></td>
<td>phobias and panic attacks. These may manifest as psychosomatic symptoms such as</td>
</tr>
<tr>
<td></td>
<td>nightmares, sleeping and eating disorders, mood and cognition disturbances,</td>
</tr>
<tr>
<td></td>
<td>loss of appetite, excessive weight loss or gain and negative body image)</td>
</tr>
<tr>
<td>Skills – ability to:</td>
<td>• use observation skills continuously to pick up non-verbal cues</td>
</tr>
<tr>
<td></td>
<td>• listen carefully and empathetically (showing concern)</td>
</tr>
<tr>
<td></td>
<td>• use all senses to try to understand the client’s circumstances</td>
</tr>
<tr>
<td></td>
<td>• support the client throughout the interview to give her psychological strength</td>
</tr>
</tbody>
</table>

Supplies/equipment and infrastructure requirements
- Supplies/equipment: vaginal demonstration models, gloves, examination couch
- Infrastructure: a private and confidential space (preferably with a door and a high wall to avoid noise travelling); a seating arrangement that enables communication and avoids unnecessary obstacles or hierarchies; enough space for an examination couch
Client records

In some countries, findings recorded from FGM screenings must be reported to relevant authorities. It is important to ensure that the client’s confidentiality is not undermined when sharing this data, and that clients are aware of the duties that the service delivery point and the provider have regarding recording and reporting. The following data should be recorded:

<table>
<thead>
<tr>
<th>DATA</th>
<th>SECTION OF MEDICAL HISTORY WHERE DATA MIGHT BE DOCUMENTED</th>
<th>REMARKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial or total removal of external genitalia</td>
<td>General sexual history</td>
<td>Self-reported by the client</td>
</tr>
<tr>
<td>If partial or total removal of external genitalia is confirmed: age when occurred</td>
<td>General sexual history</td>
<td>Self-reported by the client</td>
</tr>
<tr>
<td>Any other injury to the female genital organs</td>
<td>General sexual history</td>
<td>Self-reported by the client</td>
</tr>
<tr>
<td>If other injury to the female genital organs is confirmed: age when occurred</td>
<td>General sexual history</td>
<td>Self-reported by the client</td>
</tr>
<tr>
<td>Conditions/utensils used for removing/modifying the external genitalia</td>
<td>General sexual history</td>
<td>Self-reported by the client</td>
</tr>
<tr>
<td>Type of FGM – I, II, III, IV</td>
<td>General sexual history</td>
<td>Reported by provider after physical assessment</td>
</tr>
<tr>
<td>Vaginal discharge, swelling, pain, pelvic pain, bloating, abnormal uterine bleeding, etc.</td>
<td>General sexual history</td>
<td>Reported by provider after physical assessment</td>
</tr>
<tr>
<td>Sleeping and eating disorders, mood and cognition disturbances, loss of appetite, excessive weight loss or gain, negative body image</td>
<td>General sexual history and/or Sexual and Gender-Based Violence record (based on the context)</td>
<td>Self-reported by the client; recorded by the provider after mental health assessment</td>
</tr>
<tr>
<td>Level of satisfaction with sexual relationships, lubrication, pleasure, other</td>
<td>General sexual history</td>
<td>Self-reported by the client; recorded by the provider after mental health assessment</td>
</tr>
</tbody>
</table>

REMEMBER!
Recording refers to the collection of essential information about the client’s health and needs. Reporting implies sharing key information collected in the clinical setting with relevant authorities/stakeholders for legal, epidemiological or administrative purposes.
3. DEINFIBULATION FOR TYPE III FGM

For women who have been diagnosed with type III FGM, deinfibulation may be required to manage some of the identified immediate and long-term health consequences. Deinfibulation is recommended if the client presents:

- recurrent urinary tract infections
- severe genital tract infections
- severe menstrual problems
- difficulty with penetration during sexual intercourse (e.g. after having a small deinfibulation at the time of marriage, or after being opened up by force)
- incomplete abortion
- termination of pregnancy
- childbirth – though tissue oedema (intrapartum) may result in difficulties during the procedure. If health providers are not well experienced, it is recommended to have deinfibulation during the prenatal period
- gynaecological problems of the genital tract
- desire to use certain contraceptive methods for family planning purposes.

Deinfibulation should also be offered when a woman:

- is getting married – the closure of the introitus must be reopened at the time of marriage so that the woman is able to have sexual intercourse
- voluntarily decides she wants to go through with this procedure to improve aspects of her mental or sexual health and general well-being.

A comprehensive deinfibulation service includes pre- and post-counselling, the procedure, and follow-up and referral services.
Pre-counselling

Pre-counselling services should be offered to support a woman’s (and/or couple’s, family’s) decision-making process regarding deinfibulation. This counselling may consist of an intervention only for the woman, or, if she desires, the intervention may be complemented with:

a) couples counselling and individual counselling for the husband/husband-to-be to assist them in dealing with the changes in sexual intercourse, social stigma, and to address potential gender-based violence situations that might arise; or

b) parent counselling (when the procedure is for a young woman or girl) to address their fears, concerns and issues regarding parental consent.

The content of the pre-counselling session should include:

- reassuring a woman or girl that she has the right to make autonomous decisions about her body and to access high quality care
- teaching a woman or girl about her genitalia and making her aware of the difference between normal and infibulated genitalia
- providing information about complications associated with infibulated genitalia
- informing a woman or girl about the legal status of FGM in the country
- giving full and clear information about the procedure, including informing the woman or girl that the procedure will be done under local anaesthesia
- informing the woman about the physical changes that might result from the procedure, including the possibility of faster micturition, increased vaginal discharge and changes in sexual intercourse; this information can also be useful for a woman’s partner
- addressing a woman’s/girl’s fears about the social, physical and mental outcomes of deinfibulation (including potential stigma)
- addressing a woman’s/girl’s fears about pain management
- obtaining informed consent. In the case of adolescents, family members may refuse to give consent, in which case a separate counselling session for the parents may be useful
- recording the outcomes of the pre-counselling intervention.
Procedure

Note: Deinfibulation should **always** be carried out under local anaesthesia. If a woman is frightened about going through the procedure with the use of local anaesthetic, she should receive additional support – relaxation, dispelling myths, etc. General anaesthesia should be offered only in cases of women who feel extremely nervous or anxious about the procedure, always explaining the risks associated and performing a thorough assessment to identify contraindications.

- Confirm that informed consent has been obtained.
- Make the client comfortable in bed or on a couch.
- Introduce yourself to the client if you have not already done so and remind her about the main steps of the procedure.
- Confirm that recommended practices for infection prevention have been followed, e.g. using disinfectant to sterilize the area.
- Wash hands, put on sterile gloves, expose the genitalia and clean the perineal area with antiseptic swabs.
- Introduce index finger, forceps or dilator slowly and gently into the opening to lift the scar tissue (see Diagrams I and II).
- Infiltrate 2–3 mls of local anaesthetic into the area where the cut will be made, along the scar and in both sides of the scar (see Diagram III).
- With your finger or dilator inside the scar, introduce the scissors and cut the scar alongside the finger or dilator to avoid injury to the adjacent tissues (or to the baby, if the procedure is performed during labour).
- The cut should be made along the mid-line of the scar towards the pubis (see Diagram IV).
- Take care that you do not cause injury to the structures along the scar. It is common with type III FGM to find the structures below the scar intact, e.g. clitoris and labia minora.

• Incise the midline to expose the urethral opening (see Diagram IV). Do not incise beyond the urethra. Extending the incision forward may cause haemorrhage, which is difficult to control. A cut of about 5–7 cm towards the urethra is usually appropriate – although women (and/or couples or parents) may request a shorter cut for deinfibulation just before marriage. Generally speaking, there is little bleeding for the relatively avascular scar tissue.

• Suture the raw edges separately using fine 3/0 plain chromic catgut to secure haemostasis and prevent adhesion formation (see Diagram V). Closure of the newly opened edges should be brought together with fine absorbable material (Vicryl Rapide) to reduce the likelihood of infection and bleeding and to keep the opposed edges separated.

• Prescribe analgesia and anti-inflammatory following the opening-up procedure.

• Antibiotics may also be prescribed depending on the situation (triple antibiotics are recommended).

• Bleeding, abnormal discharges and urine output should be monitored.

• Women should drink plenty of water after the procedure to help dilute the urine and reduce stinging sensation to the area.

• The client can be discharged one hour after the procedure. Recommendations for homecare include avoiding soap or detergent (only plain water) to keep the area clean for the first 3–4 days following the procedure.

ATTENTION
When performing clinical procedures, including deinfibulation, providers must follow all guidelines for infection prevention and control. For more information, visit: http://www.who.int/csr/biosafetyreduction/infection_control/publications/en/
Post-counselling, follow-up and referrals

- Many women report increased sensitivity in the vulvar area previously covered by scar tissue for 2–4 weeks following the procedure. They may also report discomfort about having wet genitals. Prepare each woman for these experiences by explaining to her that there will be changes in appearance, and that she is likely to experience increased sensitivity for a while. Reassure her that the increased sensitivity will diminish or disappear after a while and she will get used to the feeling of wet genitals.

- Suggest that she take warm water salt baths three times a day, followed by gently drying the area and applying a soothing cream that she will be prescribed for the first 1–2 weeks.

- Advise her and her partner when they can resume/start sexual intercourse: typically the wound will be healed in 4–6 weeks, but the most important thing is to wait until she feels ready. This may require sexuality counselling. Male partners in particular often need psychosexual counselling to help them understand and accept the changes in sexual intercourse (i.e. to ensure they do not try to persuade the woman to be re-infibulated) and to address potential social stigma.

- In the event that the service was provided to a young woman or girl, address concerns the parents may have, including how to address potential social stigma.

- Provide each woman with advice on the importance of personal hygiene.

- Make a follow-up appointment to monitor healing progress, deal with any other issues that may have arisen concerning the genitals or sexual relationship and refer to other essential services as necessary. Home visits are ideal to provide the client and her family with the further support and counselling necessary in order to successfully cope with the many changes following the opening-up procedure. In cases where the client is referred to community services for follow-up, the doctor/nurse/midwife who performed the procedure must provide clear information to the healthcare provider who will be responsible for follow-up to ensure there is no lapse in support.
Provider competences

The relatively simple nature of deinfibulation allows for mid-level health workers to receive training to perform this surgical procedure.

<table>
<thead>
<tr>
<th>TASK</th>
<th>KNOWLEDGE AND SKILLS</th>
</tr>
</thead>
</table>
| Provide pre- and post-counselling services for deinfibulation | Knowledge of:  
- client’s rights  
- infibulation and deinfibulation procedures  
- physical and mental health consequences of FGM  
- factors that facilitate and impede counselling, such as privacy, environment, time, etc.  
- decision-making processes  
- principles and processes for obtaining informed consent  
- mental and sexual health  
**Skills – ability to:**  
- plan an effective counselling session  
- create a secure, safe and effective counselling space  
- assemble appropriate counselling materials or aids related to the deinfibulation procedure  
- cognitive behavioural therapy |
| Perform a deinfibulation procedure | Knowledge of:  
- infibulation and deinfibulation procedures  
- physical and mental health consequences of FGM  
**Skills – ability to:**  
- perform all steps required to provide a high quality deinfibulation procedure |

Supplies/equipment and infrastructure requirements

| Pre-counselling services for deinfibulation | Supplies: vaginal demonstration models, including models that show how the different types of FGM look  
Infrastructure: a private and confidential space (preferably with a door and a high wall to avoid noise travelling); a seating arrangement that enables communication and avoids unnecessary obstacles or hierarchies |
| Deinfibulation procedure | Supplies/equipment: prepared tray with antiseptic swabs, a pair of straight scissors, a dilator, two artery forceps, a gailipot with sterile swabs, sterile gloves, a 5ml syringe and needles, local anaesthetic, catgut, lubricant, sterile towel/cloth or mackintosh, antiseptic solution, a receptacle for used instruments and soap/water for hand washing  
Infrastructure: minor gynaecological procedure set-up with proper bed and fittings suitable to put the client in dorsal lithotomy position |
| Post-counselling services for deinfibulation | Supplies/equipment/materials: flyers/written information on homecare indications and sexuality  
Infrastructure: a private and confidential space (preferably with a door and a high wall to avoid noise travelling); a seating arrangement that enables communication and avoids unnecessary obstacles or hierarchies |

Client records

Medical records should clearly document the findings and outcomes of the pre- and post-counselling, the procedure and the follow-up visits. Any referrals and completion of referrals should also be noted. The informed consent form must be included in the client record.
4. MANAGEMENT OF PHYSICAL AND MENTAL HEALTH CONSEQUENCES OF FGM IN SEXUAL AND REPRODUCTIVE HEALTH FACILITIES

IPPF Member Associations provide an IPES, which includes the following services: gynaecology, reproductive tract infections/sexually transmitted infections (STIs), prenatal and post-natal care, contraception, safe abortion care, HIV/AIDS, counselling on sexuality and relationships and sexual and gender-based violence. All these services must be prepared to address the diverse needs of women living with FGM.

a. Gynaecological, reproductive tract infections and sexually transmitted infections services

Through these services, Member Associations have the capacity to address the majority of immediate and long-term physical health consequences of FGM, as per recommendations from the World Health Organization:

<table>
<thead>
<tr>
<th>BLEEDING</th>
<th>Bleeing commonly occurs during or immediately following the FGM procedure. The management of bleeding associated with excision is the same as the management of bleeding in any other circumstances. The procedure is as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Inspect the site of the bleeding.</td>
<td></td>
</tr>
<tr>
<td>2. Clean the area.</td>
<td></td>
</tr>
<tr>
<td>3. Apply pressure at the site to stop the bleeding by packing with sterile gauze or pad.</td>
<td></td>
</tr>
<tr>
<td>4. Assess the seriousness of the bleeding and the condition of the girl or woman.</td>
<td></td>
</tr>
<tr>
<td>5. If client is in shock, see instructions under shock.</td>
<td></td>
</tr>
<tr>
<td>6. If necessary, refer her to access a blood transfusion in a secondary-level facility to replace lost fluid.</td>
<td></td>
</tr>
<tr>
<td>7. Prescribe vitamin K, especially in the case of babies.</td>
<td></td>
</tr>
<tr>
<td>8. Provide the tetanus vaccine (if available in the facility) and prescribe antibiotics in accordance with national guidelines. This is particularly important, as in some cases a traditional compound (e.g. containing ash, herbs, soil and cow dung) may have been applied to the wound after the FGM procedure, possibly leading to tetanus or other infection.</td>
<td></td>
</tr>
<tr>
<td>9. If the problem is not serious, clean the site with antiseptic and advise client or her attendants to keep it dry.</td>
<td></td>
</tr>
<tr>
<td>10. Record the treatment provided.</td>
<td></td>
</tr>
<tr>
<td>11. Follow up with client to monitor progress by making a follow-up appointment for her to return at a later date.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SEVERE PAIN AND INJURY TO TISSUES</th>
<th>Pain is usually immediate and can be so severe that it causes shock. The management of pain associated with FGM is the same as pain management under any other circumstances. The procedure is as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assess the severity of pain and injury.</td>
<td></td>
</tr>
<tr>
<td>2. Give strong analgesic and treat injury.</td>
<td></td>
</tr>
<tr>
<td>3. Clean site with antiseptic and advise the client or her attendants to keep it dry.</td>
<td></td>
</tr>
<tr>
<td>4. If the client is in shock, see instructions under shock.</td>
<td></td>
</tr>
<tr>
<td>5. If there is no relief from pain, refer client to a secondary-level facility.</td>
<td></td>
</tr>
</tbody>
</table>
### Urine retention

Urine retention may be the result of injury, pain, fear of passing urine or occlusion of the urethra during infibulation. This condition should be managed as follows:

- Carry out an assessment to determine cause.
- Use appropriate nursing skills and techniques to encourage the client to pass urine, such as turning on a water tap.
- If she is unable to pass urine because of pain and/or fear, give her strong analgesics.
- Give the client personal encouragement and support.
- If inability to pass urine is due to infibulation, assess the possibility of inserting a catheter or opening up the infibulation (see: Deinfibulation).
- If there is suspicion that the retention is due to injury of the urethra, refer to a secondary-level facility.

### Infection and septicaemia

Infection may occur as a result of unhygienic surroundings and unclean/unsterilized instruments used during the FGM procedure. This condition should be managed as follows:

- Inspect the vulva carefully for signs of an infected wound and check for anything that might be contributing to the infection, such as obstruction of urine or associated vaginal/vulval infections.
- Take a vaginal swab and a urine sample to test for the presence of infection and to identify the organisms involved. Any obstruction found should be removed.
- If the wound is infected it should be cleaned and left to dry. The client should be treated with antibiotics and analgesics.
- Follow up client after seven days to assess the progress. Recommend cleaning of the wound twice a day during this period.
- If infection persists, refer the client internally or to a secondary-level facility.

### Shock

Shock can occur because of severe bleeding and/or pain. The management of shock associated with FGM is the same as the management of shock under any other circumstances. The procedure is as follows:

- Assess the severity of shock by checking vital signs.
- Treat for shock by raising the client’s extremities above the level of her head to allow blood to drain to the vital centres in the brain.
- Cover the client to keep her warm.
- If she is having difficulty breathing, administer oxygen (if available) or refer immediately to a secondary-level facility.
- Check vital signs and record every quarter of an hour (15 minutes).
- If client’s condition does not improve, refer her to a secondary-level facility.

### Anaemia

Anaemia can be due to bleeding or infection, or it can be due to malaria (more common in children). This condition should be managed as follows:

- Assess the severity of anaemia and send blood for Hb and grouping.
- If anaemia is mild, prescribe folic acid and iron tablets and advise on a nutritious diet.
- In cases of malaria, refer to an external provider.
- If anaemia is severe, refer to a secondary-level facility.
### Managing Long-Term Physical Complications

<table>
<thead>
<tr>
<th>Issue</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Keloid formation</strong></td>
<td>A keloid may form in the scar tissue and may cause obstruction to the introitus. This condition should be managed as follows:</td>
</tr>
<tr>
<td></td>
<td>- Inspect client’s genitalia to assess size of keloid.</td>
</tr>
<tr>
<td></td>
<td>- If the keloid is small, advise the woman to leave it undisturbed and reassure her that it will not cause harm.</td>
</tr>
<tr>
<td></td>
<td>- If the keloid is large, causing difficulties during intercourse or possible obstruction during childbirth, the woman should be referred to a specialist experienced in removing keloid scars. Alternatively, providers can pilot the use of intralesional injection to decrease the size and discomfort of the keloid.</td>
</tr>
<tr>
<td></td>
<td>- The presence or appearance of a keloid may cause excessive distress to a woman, in which case a provider should consider referring her to a secondary-level facility for surgery because of mental health effects.</td>
</tr>
<tr>
<td><strong>Clitoral neuroma</strong></td>
<td>The clitoral nerve may be trapped in the fibrous scar tissue following clitoridectomy. This may result in an extremely sharp pain. With such a condition, intercourse, or even the friction caused by underpants, will result in pain. This condition should be managed as follows:</td>
</tr>
<tr>
<td></td>
<td>- Check for the presence of a neuroma. A neuroma cannot usually be seen, but can be detected by carefully touching the area around the clitoral scar with a delicate object and asking the client if she feels any pain.</td>
</tr>
<tr>
<td></td>
<td>- Advise the woman to wear loose underwear and give her a local anaesthetic to apply to the area, for example lidocaine cream.</td>
</tr>
<tr>
<td></td>
<td>- If the symptoms are severe, refer the client to a secondary-level facility, although this is rarely necessary. Each woman should be carefully counselled before the referral is made, as the symptoms may be psychosomatic (the result of the traumatic experience of excision or the fear of sexual intercourse).</td>
</tr>
<tr>
<td><strong>Ulcers</strong></td>
<td>Vulvar ulcers may develop because of the formation of urea crystals in urine trapped under the scar tissue. This condition should be managed as follows:</td>
</tr>
<tr>
<td></td>
<td>- Counsel the client on the need to open up her infibulation and advise her that her vulva should be kept open thereafter.</td>
</tr>
<tr>
<td></td>
<td>- Perform the deinfibulation (see: Deinfibulation).</td>
</tr>
<tr>
<td></td>
<td>- Apply local antibiotics, with or without 1% hydrocortisone cream.</td>
</tr>
<tr>
<td></td>
<td>- If the ulcer is chronic, refer to a secondary-level facility.</td>
</tr>
<tr>
<td><strong>Urinary tract infections</strong></td>
<td>Urinary tract infections are a common symptom in women who have undergone type III FGM. This can be due to obstruction of the urine in infibulated women, the presence of urinary stones or previous injury to the urethra. This condition should be managed as follows:</td>
</tr>
<tr>
<td></td>
<td>- Inspect the vulva carefully to establish the cause of infection.</td>
</tr>
<tr>
<td></td>
<td>- If infibulation is the cause, counsel the woman or her attendants on the need to open up the infibulation.</td>
</tr>
<tr>
<td></td>
<td>- Carry out urine analysis to identify specific infection and prescribe appropriate antibiotics.</td>
</tr>
<tr>
<td></td>
<td>- Give antibiotics and urinary antiseptics.</td>
</tr>
<tr>
<td></td>
<td>- Advise the client to drink plenty of water.</td>
</tr>
<tr>
<td></td>
<td>- If urinary tract infection is recurrent, refer the client for medical attention.</td>
</tr>
</tbody>
</table>
### Chronic pelvic infection

Chronic pelvic infection may be the result of obstruction of the vaginal secretions due to occlusion of the vaginal orifice in infibulated women, or due to the presence of vaginal stones or vaginal stenosis. This condition should be managed as follows:

- Identify type of FGM and likely cause of problem.
- If the client has type III FGM, counsel her and/or her attendants on the need to open up the infibulation, and seek their informed consent (See: Deinfibulation).
- Take vaginal swab for culture and sensitivity.
- Give antibiotics that are appropriate and available locally, e.g. tetracycline 500mg six hourly for 10 days, or doxycycline 100mg twice daily for 10 days.
- If the infection is fungal, prescribe Flagyl.
- If the client has a husband or partner, treat him for the same infection and recommend screening for sexually transmitted infections.
- If symptoms persist, refer client for medical intervention at a secondary-level facility.
- If the cause of the infection is obstruction due to stones or injury, refer the client for surgical intervention.

### Vaginal obstruction

Partial or total obstruction of the vagina may occur because of infibulation, vaginal stenosis or the presence of a vaginal haematoma. The condition may be accompanied by an accumulation of trapped menstrual blood. Unmarried girls may be suspected of being pregnant because the amenorrhoea and swelling of the abdomen. This condition should be managed as follows:

- Assess the client to identify the problem and type of FGM.
- If the client has been infibulated, counsel on the need to open up.
- If the client has trapped menstrual blood, stones or stenosis, refer to a gynaecologist or secondary-level facility for further management.

### Dysmenorrhoea

Many women who have been subject to FGM report severe dysmenorrhoea with or without menstrual regularity. Possible causes of this problem are increased pelvic congestion due to infection or unknown causes, or anxiety over the state of the genitals, sexuality or fertility. This condition should be managed as follows:

- Try to establish the cause of dysmenorrhoea by taking a history and performing a clinical examination of the client’s genitalia.
- Counsel the client to find out how she feels and support her in dealing with the situation.
- Give antispasmodic drugs to relieve pain.
- If dysmenorrhoea is due to the accumulation of menstrual flow resulting from infibulation, counsel the client on the need for opening up.
- If the condition is severe, refer to a gynaecologist for further management.

### Hepatitis B and C

The risk of hepatitis B and C is high in women affected by FGM, as the same unsterilized instrument is often used on several girls at a time. Symptoms of hepatitis B can include tiredness, general aches and pains, fever, a general sense of feeling unwell, abdominal pain, etc. However, many of these symptoms can be mistaken for other illnesses such as the flu, so testing is essential. This condition should be managed as follows:

- Provide information on the risk of hepatitis B and C.
- Refer the client to laboratory testing.
- If positive, follow treatment assessment and monitoring guidelines on hepatitis B and C.
| Cervical cancer screening and preventive therapy<sup>ii</sup> | Women living with type I or II FGM can access any available screening method – pap smear, VIA, HPV DNA testing (depending on local availability) and preventative treatment. However, as some women may face mental health consequences as a result of the FGM (fear or trauma related to the FGM procedure) or discomfort with the idea of having a speculum inserted, Member Associations should explore the least invasive/most acceptable methods. Self-collected or provider-collected sampling for HPV DNA testing may offer advantages for women living with FGM. Women living with type III FGM should delay screening until deinfibulation is performed, e.g., during child delivery. If a woman has not been deinfibulated by the age of 30, e.g. because she decided not to have children and/or suffers from infertility or if she has been re-infibulated, then deinfibulation should be discussed as an option to facilitate cervical cancer screening.

- A broad package of services, information and counselling on FGM is available for the family/tutors of young girls (9–13) who are targeted for HPV vaccination and have been subject to or are at risk of FGM, as well as for the girl herself, including; screening and classification of FGM type (if FGM has taken place); management of immediate and long-term physical and mental health consequences, including but not limited to: deinfibulation (including pre-/post-counselling, procedure and follow-up), follow-up services during puberty to detect psychological disorders, menstrual problems, etc., among others. Parental consent is an important consideration for services provided to minors.

b. Prenatal/post-natal care<sup>iii</sup>

In countries where FGM is prevalent, or where there is a presence of migrant communities from countries with high prevalence of FGM, information on deinfibulation and management of other frequent physical health consequences of FGM should be an essential component of prenatal and post-natal care visits. Women with type III FGM must be made aware of:

- The need to deinfibulate during the pregnancy to facilitate diagnosis and exploration of potential complications; if deinfibulation is not performed during the gestational period, women may need to be deinfibulated during labour.

- The risks due to type III FGM, including a possible required C-section or prolonged second stage of labour due to the lack of elasticity and rigidity in the pelvic floor muscles. There is also a risk of foetal complications such as: large caput formation, excessive moulding of the head, intracranial haemorrhage, hypoxia, foetal distress and intrauterine death; and of maternal health complications such as obstructed labour, extensive vaginal and perineal lacerations, third-degree tears, uterine inertia, uterine rupture, maternal distress, maternal death, post-natal infection of the lacerations, delayed healing of the repaired perineum and vaginal tissues, sloughing of the vaginal wall, anaemia, puerperal infection and prolapse of either the bladder or rectum into the vagina.<sup>44</sup>

- The importance of follow-up visits to assess post-natal complications.

Prenatal and post-natal care visits present an opportunity to discuss the intentions of the woman and her partner regarding FGM for their future child (when the couple is expecting a girl).

---

c. Contraceptive services
Contraception for women who have been subject to FGM must be provided following WHO eligibility criteria. Certain considerations include:

- An IUD is not recommended for cases where visualization of the cervix is difficult or impossible, or when the woman has recurrent vaginal infections. Internal referral to deinfibulation services should be offered.
- Female condoms, diaphragms and cervical caps are not recommended, since they can be challenging to place for a woman who has had her genitalia partially or completely removed.
- Natural methods should not be recommended, given that women who have had FGM may experience modification of the vaginal mucus and have frequent discharges that may be confused with the mucus produced during ovulation days.

d. Safe abortion services
Deinfibulation may be required prior to procedures such as medical or surgical abortion or treatment of incomplete abortion, as the vaginal opening needs to be of sufficient size to allow the passing of a speculum and, in the case of a medical termination, to allow the passing of the products of conception.

e. HIV/AIDS services
The connection between FGM and HIV remains unconfirmed, although cutting genital tissues with the same unsterilized surgical instrument might increase the risk for transmission of HIV between girls who undergo FGM at the same time. In light of this, all women living with FGM, regardless of their HIV status, should be offered HIV testing, including pre-/post-counselling.

f. Counselling on sexuality and relationships
The need for counselling on sexuality and relationships is determined by the findings of the mental and sexual health assessment implemented with women living with FGM. However, it is possible that some women come to the Member Association looking specifically for this type of support. In these cases, women may initially be shy in revealing they have had the excision. Being aware of the prevalence of FGM in a specific context/population and of its consequences, having access to the client’s sexual and reproductive health history and using facilitation skills to build a rapport with the client can help counsellors address each woman’s needs, even if there is no explicit confirmation of FGM.

Sexuality and relationship counselling is particularly important for women living with FGM. However, this service may not be enough to address all the psychological and/or psychiatric care needs of a client. A strong referral system is needed to ensure women receive comprehensive care.

A sexuality and relationship counselling intervention might provide information about various ways of conducting sexual relationships; appropriate techniques through which both the woman and her partner may be aroused; explanation about sexual issues that may be due to fear of pain, rather than to any physical malfunction; and deinfibulation as an alternative to overcome some sexual problems, e.g. when sexual
intercourse is not possible as a result of infibulation or extensive scarring. The following recommendations should be followed:

- Encourage clients to share their needs and fears. It can sometimes be difficult for women who have been through FGM to think about having sex. Women may be worried that it will be painful because of the scar tissue, or that they may not have an orgasm if the external part of their clitoris has been removed. It may help to explain that complete removal of the clitoris is not possible, as part of the organ continues up into the body and under the labia. Regardless of the FGM procedure they experienced, some women find it satisfying to stimulate the area around the clitoris, the outer labia or inside the vagina.

- Assist the client – and her partner, when relevant – to make an informed decision on the steps to be taken to solve the issue. Clients may find it useful to discuss ways of touching/being intimate that they enjoy, and explore whether they would feel comfortable seeing what feels good by touching themselves, or involving a partner. In order to understand a range of sexual experiences, clients who have experienced FGM may find it useful to speak to or read the stories of other women who have been cut.

- Assist the woman – and her partner, where appropriate – to act on their decision(s) by providing advice on how to proceed.

- Give the client an appointment for another counseling session or follow-up session to prepare for the next steps.

- If the problem persists, refer the client to a specialist.

### POINTS TO CONSIDER ON SEXUALITY AND FGM:

- Research with women who have experienced FGM suggests that many women believe that being ‘circumcised’ increases their own and their (male) partner’s enjoyment of sex. In small studies of migrant women from Somalia and the Horn of Africa, most women report that they find penetrative sex pleasurable and are able to experience orgasm. Other research with Somali and Sudanese migrant women living in the UK suggests that women do not enjoy penetrative sex but experience pleasure from kissing, cuddling and having erogenous zones such as thighs, breasts and lips stimulated.

- Studies showing that women who have experienced FGM can and do experience pleasure during sex can be puzzling for cultures that do not endorse such practices and suggest that there are radically different views of pain and pleasure across cultures. For counsellors working with women who have experienced FGM, this means that it is important to start by trying to understand how a woman feels about her body and her sexual relationships and how she reflects on and makes sense of her experience of being cut.
g. Sexual and gender-based violence

Sexual and gender-based violence (SGBV) services should be provided based on the findings of the mental and sexual health assessment given to women who have experienced FGM. In some contexts, FGM may be classified as a type of SGBV. However, some women may not feel comfortable being considered/categorized as survivors of SGBV, as the experiences and consequences of FGM are diverse, and FGM often plays a role in both individual and cultural identity.

Regardless of how FGM is recorded in the medical records, SGBV screening services offer an excellent opportunity to assess and safeguard the needs of women living with or at risk of FGM, and to refer her accordingly. Potential cases where additional support and referrals are needed include:

- cases when a young girl/adolescent refuses to go through with the FGM procedure
- cases when a woman refuses to be re-infibulated
- cases when a woman accesses a deinfibulation service but she does not have the support of her parents, husband or relatives.

h. Referral services

Internal and external referrals should be made available for women living with or at risk of FGM. FGM-related health needs that may require external referral from Member Associations include, but are not limited to:

- safety/shelter
- specialized child psychologists
- psychiatric care
- paediatricians for management of FGM consequences in infants and children
- specialized urology care
- diagnosis and management of vesico-vaginal (VVF) or recto-vaginal (RVF) fistulae and incontinence
- detection and management of infected/big cysts
- diagnosis of infertility and treatment
- blood banks.

Strong internal and external referral systems must be in place. General recommendations to develop these systems include:

- Develop a directory of services and organisations within the defined catchment area. (Note: ideally, referrals with external organisations/services should be backed by a memorandum of understanding).
- Develop a referral path (internal and external) for each service and train providers to follow it.
- Develop and implement a standardized referral form.
- Develop and implement a referral tracking system.
- Implement follow-up mechanisms with clients (e.g. home visits, phone calls or SMS text messages); prior conversation with clients is important to determine the best follow-up mechanism.
Provider competences – sexual and reproductive health services

- The following groups of providers can provide management of immediate and long-term consequences: physician clinicians, non-physician clinicians (different job titles include medical assistant, nurse practitioner), nurses, auxiliary nurses, midwives, auxiliary nurse midwives and trained traditional midwives.

- For guidance on cadres of providers that can deliver services included in the IPES, access the IPPF Medical Bulletin on task sharing in sexual and reproductive health.

- For guidance on the knowledge and skills required to implement services included in the IPES, access the Exchange platform – IPES Module.

Supplies/equipment and infrastructure requirements – sexual and reproductive health services

- Supplies/equipment: swaps for vaginal use, urine recipient, antibiotics with or without 1% hydrocortisone cream, strong analgesics, sterile gauze or pads, tetanus vaccine (if available in the facility), oxygen, and other supplies/equipment relevant to the provision of services included in the IPES.

- Infrastructure: private and confidential spaces (preferably with a door and a high wall to avoid noise travelling); a seating arrangement that enables communication and avoids unnecessary obstacles or hierarchies; and other infrastructure requirements relevant to the services included in the IPES.

Client records – sexual and reproductive health services

- Medical records should clearly document how FGM was taken into consideration when providing services included in the IPES.
ANNEXES AND NOTES
## ANNEX 1: LANGUAGE CONSIDERATIONS

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>TERM USED FOR FGM</th>
<th>LANGUAGE</th>
<th>MEANING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Egypt</td>
<td>Thara</td>
<td>Arabic</td>
<td>Deriving from the Arabic word ‘tahar’ meaning to clean/purify</td>
</tr>
<tr>
<td></td>
<td>Khitan</td>
<td>Arabic</td>
<td>Circumcision – used for both FGM and male circumcision</td>
</tr>
<tr>
<td></td>
<td>Khifad</td>
<td>Arabic</td>
<td>Deriving from the Arabic word ‘khafad’ meaning to lower (rarely used in everyday language)</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>Megrez</td>
<td>Amharic</td>
<td>Circumcision/cutting</td>
</tr>
<tr>
<td></td>
<td>Absum</td>
<td>Harrari</td>
<td>Name giving ritual</td>
</tr>
<tr>
<td>Eritrea</td>
<td>Mekhnishab</td>
<td>Tigregna</td>
<td>Circumcision/cutting</td>
</tr>
<tr>
<td>Kenya</td>
<td>Kutairi</td>
<td>Swahili</td>
<td>Circumcision – used for both FGM and male circumcision</td>
</tr>
<tr>
<td></td>
<td>Kutairi ichana</td>
<td>Swahili</td>
<td>Circumcision of girls</td>
</tr>
<tr>
<td>Nigeria</td>
<td>Ibi/Ugwu</td>
<td>Igbo</td>
<td>The act of cutting – used for both FGM and male circumcision</td>
</tr>
<tr>
<td></td>
<td>Sunna</td>
<td>Mandingo</td>
<td>Religious tradition/obligation – for Muslims</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>Sunna</td>
<td>Soussou</td>
<td>Religious tradition/obligation – for Muslims</td>
</tr>
<tr>
<td></td>
<td>Bondo</td>
<td>Temenee/ Mandingo/Limba</td>
<td>Integral part of an initiation rite into adulthood – for non-Muslims</td>
</tr>
<tr>
<td></td>
<td>Bondo/Sonde</td>
<td>Mendee</td>
<td>Integral part of an initiation rite into adulthood – for non-Muslims</td>
</tr>
<tr>
<td>Somalia</td>
<td>Gudniin</td>
<td>Somali</td>
<td>Circumcision – used for both FGM and male circumcision</td>
</tr>
<tr>
<td></td>
<td>Halalays</td>
<td>Somali</td>
<td>Deriving from the Arabic word ‘halal’, i.e. ‘sanctioned’ – implies purity. Used by Northern and Arabic-speaking Somalis</td>
</tr>
<tr>
<td></td>
<td>Qodiin</td>
<td>Somali</td>
<td>Stitching/tightening/sewing – refers to infibulation</td>
</tr>
<tr>
<td>Sudan</td>
<td>Khifad</td>
<td>Arabic</td>
<td>Deriving from the Arabic word ‘khafad’ meaning to lower (rarely used in everyday language)</td>
</tr>
<tr>
<td></td>
<td>Tahoor</td>
<td>Arabic</td>
<td>Deriving from the Arabic word ‘tahar’ meaning to purify</td>
</tr>
<tr>
<td>Chad – The Ngama</td>
<td>Bagne</td>
<td></td>
<td>Used by the Sara Madjingaye</td>
</tr>
<tr>
<td>Sara subgroup</td>
<td>Gadja</td>
<td></td>
<td>Adapted from ‘ganza’ used in the Central African Republic</td>
</tr>
<tr>
<td>Guinea-Bissau</td>
<td>Fanadu di Mindjer</td>
<td>Kriolu</td>
<td>Circumcision of girls</td>
</tr>
<tr>
<td>Gambia</td>
<td>Niaka</td>
<td>Mandinka</td>
<td>Literally to ‘cut/weed clean’</td>
</tr>
<tr>
<td></td>
<td>Kuyango</td>
<td>Mandinka</td>
<td>Meaning ‘the affair’ but also the name for the shed built for initiates</td>
</tr>
<tr>
<td></td>
<td>Musolula Karoola</td>
<td>Mandinka</td>
<td>Meaning ‘the women’s side’/‘that which concerns women’</td>
</tr>
</tbody>
</table>

Source: Department of Health. United Kingdom, 2015:25–26
BIBLIOGRAPHY


• Edna Adan University Hospital (2016) Female Genital Mutilation Survey in Somaliland. Somaliland.
• Homeyard, C, and Hill, V (2012) Maternity Guideline for the Care of Women who have been affected by Female Genital Mutilation. London: Barking, Havering and Redbridge University Hospitals NHS Trust.
• IPPF (2015a) Vision 2020. Sexual and reproductive health and rights – the key to gender equality and women’s empowerment. London: IPPF.
• IPPF (2015b) IMAP Statement on the elimination of female genital mutilation. London: IPPF.

• Matsuuke, E (2011) *Female genital mutilation (FGM) and its future among Somali women in Finland*. Master. University of Tampere.


• Njue, C and Askew, I (2004) *Medicalization of Female Genital Cutting Among the Abagusii in Nyanza Province, Kenya*. USAID.


• Royal College of Obstetricians and Gynaecologists (2015) *Female Genital Mutilation and its Management (Green-top Guideline No. 53)*. London: RCOG.


• The Women’s Health Council (nd_b) *Female Genital Mutilation/Cutting: A Literature Review*. Dublin: The Women’s Health Council.


• United Nations Population Fund (nd_b) *Demographic Perspectives on Female Genital Mutilation*. New York: UNFPA. Available at: http://www.unfpa.org/es/node/13047

• World Health Organization (nd_b) *Health risks of female genital mutilation (FGM)*. Available at: http://www.who.int/reproductivehealth/topics/fgm/health_consequences_fgm/en/


• World Health Organization (2010b) *Dynamics of decision-making and change in the practice of female genital mutilation in the Gambia and Senegal*. WHO.


REFERENCES


11 Edna Adan University Hospital (2016) Female Genital Mutilation Survey in Somaliland. Somaliland.

12 Ibid.


15 Testimonials from IPPF Member Association in Somaliland.


17 Ibid.


19 Ibid.

20 Ibid.

21 Ibid.

22 Ibid.


24 Ibid.


27 Ibid.


31 Ibid.

32 Ibid.

33 Ibid.
34 Ibid.
35 Ibid.
36 Ibid.
37 Ibid.
38 Ibid.
39 Ibid.
40 Ibid.
41 Ibid.
42 Ibid.
43 Ibid.
44 Edna Adan University Hospital (2016) Female Genital Mutilation Survey in Somaliland. Somaliland.
46 Royal College of Obstetricians and Gynaecologists (2015) Female Genital Mutilation and its Management (Green-top Guideline No. 53). London: RCOG.