

2ND EDITION

Updated and Revised June 2013

Female Genital Mutilation

Information for
Health-Care Professionals
Working in Ireland



This document is designed to provide relevant and pertinent information for you within your professional capacity. It is not an exhaustive source of information and should not be used as a substitute for obtaining appropriate legal or medical advice, where necessary.

FGM

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FGM

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FGM

INTRODUCTION

The first edition of this handbook was produced in 2008, as a result of successful collaboration between the Royal College of Surgeons in Ireland's MSc Women's Health Course Director and students and the Coordinator of the Migrant Women's Health Services Project in AkiDwA. This initial resource would not have been completed without the active participation and assistance of the then AkiDwA FGM Health Forum members (listed below), the board and staff of AkiDwA, the significant contribution from the RCSI, and the courageous women who have endured FGM and are seeking supports and services in Ireland. The original publication was funded by the then Office of the Minister for Integration. Since 2008 substantial work and progress on the issue of FGM has been realised in Ireland.

The Revised and Updated Second Edition of this handbook was produced by AkiDwA with support from the National Social Inclusion Office of the Health Service Executive. It is envisaged that this resource will be of help and useful to a range health care professionals.

In 2008 AkiDwA produced the first initial statistical extrapolation of the prevalence of FGM in Ireland. This was done by using Irish 2006 census data from the Central Statistics Office and synthesising it with global FGM prevalence data. A figure of 2,585 women living in Ireland who had undergone FGM was estimated. This figure was updated in 2010 and in 2013 after the 2011 census and there are currently estimated to be 3,780 women living in Ireland who have undergone FGM. The most recent data has shown that despite a decline in inward migration to Ireland the figure of the prevalence of FGM in Ireland continues to increase.

After a decade of campaigning and lobbying, the Criminal Justice (Female Genital Mutilation) Act 2012 was signed into law in April 2012, and became effective in September 2012. The Act creates an innovative offence of removal from the State of a girl for the purpose of FGM. Punishment is up to 14 years imprisonment and/or a fine; for a summary conviction, the penalty is a fine of up to €5,000 and/or imprisonment for up to 12 months or both.

Female Genital Mutilation (FGM) is now included in the new Irish National Maternity Healthcare Record under Risk Factors. This new Record will be used for all women booking for maternity care and includes for the first time at a national level, FGM as a risk factor for obstetric care. To date AkiDwA with the funding and support from the HSE has delivered awareness raising and training to over 3,000 service providers and health care professionals. AkiDwA continues to raise awareness on FGM at local, regional and national level through media, seminars, workshops, conferences and publications. In 2012, AkiDwA published an information leaflet for the public 'Female Genital Mutilation and the law in Ireland' and in February 2013 AkiDwA launched findings from a survey with General Practitioners on their understanding of FGM. The purpose of this survey was to ascertain knowledge of FGM amongst General Practitioners in Ireland.

In 2013, AkiDwA, the Mediterranean Institute of Gender Studies [M.I.G.S], based in Cyprus, in partnership with the Italian Association for Women in Development (AIDOS), AkiDwA in Ireland, and the Family Planning Association of Portugal (APF) developed the E-Learning toolkit, United to END FGM (UEFGM)

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FGM

AN OVERVIEW

Female genital mutilation (FGM) is defined as the partial or total removal of the external female genitalia, or any practice that purposely alters or injures the female genital organs for non-medical reasons. The practice is internationally recognised as a human rights violation of women and girls.

THE WORLD HEALTH ORGANIZATION'S CLASSIFICATION OF FGM (2007)

Type I	Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
Type II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).
Type III	Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
Type IV	All other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterisation.

NB Women may not be able to correctly self-identify the specific type of FGM that they have experienced.

WHEN IS FGM PERFORMED?

The age at which girls undergo FGM varies by community. The most common age at which FGM is performed is between four and ten years, although this can vary from birth until pregnancy with first child (primagravia).

WHO PERFORMS FGM?

Typically, FGM is performed by an older woman in the community who has had no medical training or by a traditional birth attendant (TBA). The use of anaesthetics and antiseptics is uncommon. Instruments used to perform FGM include razor blades, knives, pieces of glass, scissors and scalpels. In some instances, several girls will be cut using the same instrument, heightening the risk of infections including HIV.

WHY IS FGM PERFORMED?

- tradition
- rite of passage into womanhood
- religion (although no religion includes FGM as a requirement)
- preservation of virginity until marriage
- social acceptance, among peers as well as for marriage
- cultural/aesthetic reasons

The origins of FGM are largely unknown, but the practice predates contemporary world religions. Local and cultural factors are likely to be some of the reasons for the development and continuation of the practice over time.

WHY DOES FGM CONTINUE?

The practice of FGM persists today for several reasons. In many instances, parents want their daughters to undergo FGM in order to avoid stigmatisation or social exclusion by the rest of the community. In practising communities, it is strongly believed that a girl is not marriageable if she has not undergone FGM. Therefore, she may become a social outcast.

The negative health complications associated with FGM are often poorly understood within practising communities. If the correlation between FGM and certain complications was more clearly realised among community members, particularly maternal morbidity/mortality and fistula formation, it is likely that FGM's prevalence would decrease.

HEALTH CONSEQUENCES OF FGM

THE SHORT-TERM COMPLICATIONS OF FGM CAN INCLUDE:	THE LONG-TERM COMPLICATIONS OF FGM CAN INCLUDE:
Death	Decrease or loss of sexual sensation
Haemorrhage	Difficult and complicated childbirth
Infection and failure of the wound to heal	Dysmenorrhoea, difficulties in menstruation including passing menses
Injury or trauma to adjoining areas, such as the urethra and anus	Dyspareunia (painful intercourse)
Shock from severe pain and bleeding	Incontinence and difficulty urinating
Surgical mishap	Pelvic inflammatory disease (PID) and infertility
Tetanus	Psychological trauma
Transmission of HIV and other viruses	Scarring (with or without keloid formation) and hardening of the vaginal tissue, causing constant pain around the genital area
	Sebaceous cyst development

For detailed definitions, please refer to: **FGM – GYNAECOLOGICAL AND HEALTH ISSUES**

A major World Health Organization study found a significant increase in adverse obstetric outcomes for women who had undergone FGM [1]. The study involved 28,393 women at 28 obstetric centres in six African countries (Burkina Faso, Ghana, Kenya, Nigeria, Senegal and Sudan). Deliveries are more likely to be complicated by Caesarean section, post-partum haemorrhage, episiotomy, an extended stay in maternity hospital, resuscitation of the infant, and inpatient perinatal death.

WHAT LEGISLATION EXISTS AGAINST FGM?

Many nations around the world have passed specific legislation against the practice of FGM, including 24 African countries. European countries that have legislation applicable to FGM include, but are not limited to, Austria, Belgium, Spain and the UK. In some of the African countries that have passed anti-FGM legislation, there has been a trend toward the medicalisation of the practice instead of an overall decrease in prevalence. Several of the industrialised nations with anti-FGM legislation include the **principle of extraterritoriality** as a stipulation. That is, it is illegal to perform FGM on a resident of such a nation, even if it is done elsewhere.

The Criminal Justice (Female Genital Mutilation) Act 2012 was signed into law on 2 April 2012. This law has been effective since 20 September. It is now a criminal offence for someone resident in Ireland to perform FGM. The maximum penalty under all sections of this new law is a fine or imprisonment for up to 14 years or both. While the principle of extraterritoriality is not included in the Act in order to conform to Constitutional and international law requirements, section 3 provides an innovative offence of removal for the State of a girl for the purpose of FGM.

FGM

PREVALENCE: GLOBAL, EUROPEAN AND IRISH STATISTICS

The World Health Organization estimates that between 100 and 140 million women worldwide have undergone **female genital mutilation (FGM)**, and 3 million girls are at risk of FGM in Africa annually. This equates to 6,000 women and girls undergoing FGM daily in the world. Prevalence often varies widely within countries, depending on regional and tribal cultural traditions.

PREVALENCE OF FGM IN PRACTISING COUNTRIES

COUNTRY	ESTIMATED PREVALENCE OF FGM IN GIRLS AND WOMEN AGED 15 – 49 YEARS (%)	YEAR	SOURCE
Benin	17	2006	WHO/DHS
Burkina Faso	77	2006	WHO/MICS
Cameroon	1.4	2004	WHO/DHS
Cote D'Ivoire	45	2006	WHO/MICS
Central Africa Republic	36	2008	WHO/MICS
Chad	45	2006	WHO
Congo, Democratic Republic of	5	2011	HARVARD
Djibouti	93.1	2006	WHO/MICS
Egypt	97	2008	WHO/DHS
Eritrea	89	2006	WHO/DHS
Ethiopia	80	2006	WHO/DHS
Gambia	78.3	2005-6	WHO/MICS
Ghana	5	2006	WHO/MICS
Guinea	99	2006	WHO/DHS
Guinea- Bissau	44.5	2006	WHO/MICS
Ivory Coast	45	2006	WHO
Kenya	32	2008-9	WHO/DHS
Liberia	60	2007	WHO/DHS
Mali	92	2006	WHO/DHS
Mauritania	71	2007	WHO/MICS
Niger	5	2006	WHO/DHS
Nigeria	19	2008	WHO/DHS
Senegal	28	2005	WHO/DHS
Sierra Leona	94	2006	WHO/MICS
Somalia	97.9	2006	WHO/MICS
Sudan, Northern	90	2000	WHO
Tanzania, United Republic of	18	2006	WHO/DHS
Togo	5.8	2006	WHO/MICS
Uganda	0.6	2006	WHO/DHS
Yemen	23	2003	WHO

PREVALENCE OF FGM IN EUROPE

Countries with FGM prevalence of 90% or above.

* Approximately 80% of total population in survey.

As migration to Europe from FGM-practising countries becomes an increasing trend, FGM has become an issue in several European countries. In many cases, families and communities will attempt to continue to practise FGM after moving to Europe as a way of upholding traditional customs. Despite legislative efforts to stop this practice, several studies have indicated that many girls living in Europe are still at risk for undergoing the procedure.

A 2007 study by the UK organisation FORWARD estimated that nearly 66,000 women with FGM were residing in England and Wales in 2001 [2]. The study speculated that this number would likely increase in the years thereafter. The study also found that nearly 21,000 girls in England and Wales aged eight and younger were at risk of FGM, and 11,000 of this cohort were likely to have already undergone some type of FGM.

PREVALENCE OF FGM IN IRELAND

The prevalence of FGM in Ireland was estimated by obtaining census statistics (CSO) from 2011 and other relevant population data on the number of women residing in Ireland, originally from FGM-practising countries. These statistics were then synthesised with global FGM prevalence data to ascertain an estimated total of 3,780 women between the ages of 15 and 44 residing in Ireland who have undergone FGM. Data has shown that, despite a decline in inward migration to Ireland the figures of the prevalence of FGM in Ireland continue to increase.

ESTIMATED PREVALENCE OF FGM IN IRELAND (ENUMERATED BY 2011 CENSUS)

FGM-PRACTISING COUNTRY	GLOBAL PREVALENCE	TOTAL NUMBER OF WOMEN FROM FGM- PRACTISING COUNTRIES AGED 15-44 AND RESIDENT IN IRELAND	ESTIMATED NUMBER WITH FGM
Benin	17	21	5.3
Cameroon	1.4	356	4.9
Central Africa Republic	36	42	15.12
Egypt	97	247	239.59
Eritrea	89	59	52.51
Ethiopia	80	94	75.2
Gambia	78.3	22	17.36
Ghana	5	475	18.05
Guinea	99	49	46.84
Ivory Coast	45	97	43.65
Kenya	32	290	78.59
Liberia	60	66	38.42
Mali	92	8	6.8
Mauritania	71	11	7.9
Niger	5	24	0.52
Nigeria	19	7,544	2233.02
Senegal	28	12	3.4
Sierra Leona	94	84	78.96
Somalia	97.9	414	405.3
Sudan, Northern	90	432	388.8
Tanzania, United Republic of	18	57	8.32
Togo	5.8	90	5.22
Uganda	0.6	129	1.032
Yemen	23	13	4.9
TOTAL NUMBER		10,636	3,780
TOTAL PERCENTAGE			35.5%

FGM

DEFINITION, TERMS AND GLOSSARY

Female genital mutilation (FGM) comprises all procedures involving partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.

It is important to realise that the term 'female genital mutilation' is unlikely to be used by a woman to refer to her body or related health issues. She may use one of the following terms or refer to being 'closed', 'cut' or 'circumcised'. The appropriate use of terms or phrases is vital to encouraging communication between the woman and a health-care professional. Following on is a brief selection of terms commonly used to refer to FGM.

TRADITIONAL AND REGIONAL TERMS FOR FGM

COUNTRY	TERM (PHONETIC PRONUNCIATION)	LANGUAGE	SIGNIFICANCE
Egypt	Khitan	Arabic	Circumcision
Eritrea	Mkhenshab	Tigreya	Circumcision or cutting
Ethiopia	Absum	Harrari	Ritual
	Megerez	Amharic	Circumcision or cutting
Kenya	Kutairi	Swahili	Circumcision (male and female)
Nigeria	Ibi ugwu	Igbo	Circumcision (male and female)
Sierra Leone	Bondo	Various	Circumcision
Somalia	Gudniin	Somali	Circumcision
Sudan	Tahoor	Arabic	Circumcision (male and female)

For the World Health Organization's classification of FGM, please refer to: **FGM – AN OVERVIEW**

GLOSSARY

ANGURYA CUTS	A form of FGM Type IV that involves scraping the tissue around the vaginal opening.
DEINFIBULATION	The medical procedure to open up the vaginal area of a woman who has undergone FGM Type III .
DRY SEX	The use of drying agents such as herbs, powders and other substances to dry and tighten the vagina prior to sexual intercourse; may constitute FGM Type IV .
GISHIRI CUTS	A form of FGM Type IV that involves cutting the vagina.
MEDICALISATION	Refers to trained health-care professionals performing FGM in public or private health-care facilities. This practice has been strongly denounced by WHO, UNFPA and other international medical and health organisations.
PHARAONIC CIRCUMCISION	Refers to FGM Type III .
REINFIBULATION	A re-suturing of FGM Type III after childbirth.
SUNNA	Signifies 'tradition' in Arabic and refers to a range of practices that follow the teachings of Islam; used mainly to refer to FGM Type I . References to the term 'Sunna' in the Koran are often used to justify FGM as being a religious obligation (UNFPA).

FGM

THE ENCOUNTER/ CONSULTATION

BE AWARE AND INFORMED

In many countries, **female genital mutilation (FGM)** is an accepted and expected part of local custom. Incidence is almost 100 per cent within certain communities. Health-care professionals need to be aware that a significant number of women who have undergone FGM now reside in Western countries.

Women and girls may present in various settings/circumstances, e.g. GP, obstetric/gynaecological, psychological, asylum-seeking, domestic violence and rape/sexual assault. Presentations may include: recurrent urinary tract/pelvic infections, infertility, abscesses, vulval cysts, fistula formations, problems in childbirth, psychological trauma, mood disorders, eating and behavioural disturbances, and sexual dysfunction [3].

In order to correctly identify and care for these women, health-care professionals need to be familiar with global areas of high FGM prevalence.

ASSESS INDIVIDUAL NEEDS

Don't assume that all women will be aware that they have been circumcised.

They may have vivid, vague or no memories of the procedure [4]. They may have no understanding of the type of FGM that they have undergone, and may not be aware of any links to subsequent health complications. Spend time explaining how and why there may be a physical problem because of the circumcision. Explain all options available to the woman, however, bear in mind that individuals may not be in a position to make decisions there and then, as they may need to consult with family members. This may slow down the process and require further consultation(s).

FGM is most commonly performed on girls aged between four and ten, but it is also carried out at other times, including:

- shortly after birth
- adolescence
- at time of marriage
- at time of first pregnancy.

BE SENSITIVE AND NON-JUDGEMENTAL

It is important to be non-judgemental about a woman's cultural beliefs, irrespective of one's own culture.

Although FGM is a human rights violation, in the societies in which it is practised, it may be viewed as a compulsory procedure. The term 'FGM' may make a circumcised woman feel degraded and even insulted. All health-care professionals need to be conscious of the political and cultural sensitivities surrounding this subject, and in particular, the term 'FGM' [5].

LANGUAGE AND COMMUNICATION

Women may not volunteer information.

Where appropriate, ask about circumcision as a routine part of taking patient history. Use simple language and images to facilitate understanding. Health-care professionals should not rely on familiar verbal and non-verbal cues to form their medical opinions. Women may find it difficult to answer questions about thoughts and feelings, and may not openly acknowledge or complain about pain and discomfort. Alternative methods can be used for gauging thoughts and feelings, e.g. symbols, diagrams, analogue scales and other creative methods [5].

If appropriate to the encounter/consultation, a health-care professional should ask the woman about FGM in simple, familiar language, in a sensitive and caring way, such as:

- Have you been cut down below?
- Have you been closed?
- Have you been circumcised?
- I understand that female circumcision is common in some African countries. Have you been cut down there?

Do not appear surprised or shocked with the woman's response to any of these questions.

It may be necessary to establish with the woman if she has undergone FGM through visual aids – firstly, to determine if she had the procedure, and secondly, to determine the type of FGM that she has undergone. A vulval examination may also be required, and should be performed by an appropriate health-care professional.

For further assistance, please refer to: **FGM – DEFINITION, TERMS AND GLOSSARY**

CONSENT AND PRIVACY

All encounters should be confidential, respectful and mindful of the woman's dignity.

In accordance with the customs of their cultures, many women may only be comfortable discussing this issue with another woman [6]. They may have vivid traumatic memories surrounding the event. Privacy and discretion should be strictly adhered to, and proper informed consent obtained before examination. Keep the number of health-care professionals to a minimum during examinations. Female health-care professionals are essential – if one is not available, a female chaperone is appropriate. Identify how to access interpreters in your service and use them effectively. Ensure that they can translate medical terminology. Female interpreters are, again, preferable. It is **inappropriate** to use family members as interpreters or chaperones.

CHILDREN AND FGM

Health-care professionals have a responsibility to protect children from FGM.

Many women who have undergone FGM may have left their home countries to protect their own daughters from the practice. However, some women and their families may still support FGM, and if there are any girls in these families, health-care professionals need to be aware of child protection issues and the rights of these children.

Under the Criminal Justice (Female Genital Mutilation) Act 2012 FGM is illegal, and identified as a form of child abuse in Children First: National Guidance for the Protection and Welfare of Children 2011. Furthermore, the Criminal Justice (Withholding of Information on Offences Against Children and Vulnerable Persons) Act 2012 declares that the failure to report such an offence is a criminal act.

FGM

GYNAECOLOGICAL AND HEALTH ISSUES

The exact incidence of morbidity and mortality associated with **female genital mutilation (FGM)** is difficult to measure. Only a small percentage of complications ever come to the attention of health-care professionals. Reasons for this may be due to the unavailability and distance of health care, ignorance or fear of legal retribution. Since many women undergo FGM as infants, they may not remember any immediate adverse effects. Complications arising during childbirth or later in life may not be linked by women to the ‘surgery’ they underwent as children, especially if the FGM occurred prior to menarche. FGM-related complications may be considered normal and natural to women, especially among populations in which FGM is prevalent. Complications may occur with all types of FGM, but are most frequent with **FGM Type III** [7].

SHORT-TERM COMPLICATIONS OF FGM

AGONISING PAIN	Due to lack of anaesthesia or pain-relieving medication at the time of FGM procedure.
DEATH	Lack of access to first aid and immediate hospital access in acute situations.
HAEMORRHAGE	Amputation of the clitoris involves cutting across the clitoral artery vessel, which has a strong vascular flow and high pressure. Haemorrhage may also occur due to sloughing of the clot over the artery, usually because of infection. If bleeding is very severe and uncontrolled, it may lead to exsanguination.
INFECTION (due to use of unsterilised/ shared cutting instruments)	<ul style="list-style-type: none"> • death • HIV and other blood-borne viruses (BBV) • septicaemia • tetanus (also due to lack of tetanus toxoid injection) • urinary tract infection • wound infection
INJURY	Fractures, dislocations or other injuries due to restraining a struggling child. Injury to adjacent structures, such as the urethra, labia and Bartholin's gland.
SHOCK	<ul style="list-style-type: none"> • haemorrhagic (bleeding) • neurogenic (pain) • septic (infection)
URINARY TRACT PROBLEMS	<ul style="list-style-type: none"> • acute urinary retention and labial adhesion (almost complete closure of the vaginal orifice), as in infibulation, nearly always occurs because of the following: • incontinence due to urethral damage at time of procedure • painful micturition/urophobia due to pain and burning sensation of urine on raw wound • upper or lower urinary tract infection due to use of unsterilised equipment

LONG-TERM COMPLICATIONS OF FGM

ANAEMIA	Due to profuse bleeding at time of FGM procedure.
CLITORAL NEUROMA	Develops on the dorsal nerve of the clitoris; can lead to genital hypersensitivity.
CONTRACEPTION	Women who have undergone FGM will need a thorough and sensitive medical history taken. A vulval examination is necessary to determine the type of FGM that a woman has undergone, as some contraceptive methods are not indicated. Women with FGM are at increased risk of recurrent vaginal and pelvic infections, therefore, avoid insertable contraceptive devices. Women who have undergone FGM Type III will have a reduced introital opening, which may contraindicate certain contraceptive methods. Hormonal contraceptive methods can be recommended with careful explanation to the woman. The World Health Organization's Medical Eligibility Criteria for Contraceptive Use should be used as a reference guide [8]. For more information, please refer to: FGM – CONTRACEPTIVE TABLE
DYSMENORRHOEA	Difficulties in menstruation, including passing menses.

ENDOMETRIOSIS	May result from blocked menstrual flow.
HAEMATOCOLPOS	Menstrual blood accumulates over many months in the vagina and uterus due to the closure of the vaginal opening by scar tissue; appears as a bluish bulging membrane on vaginal examination.
INFECTION	<ul style="list-style-type: none"> • HIV and other blood-borne viruses (BBV) due to use of unsterilised/shared cutting instruments • infertility due to tubal damage from infection • miscarriage from recurrent infections • recurrent pelvic and urinary tract infections
LOCAL VULVAL PROBLEMS	<ul style="list-style-type: none"> • aggravated atrophic symptoms after menopause • neuronal trauma/damage leading to insensate vulva • poor wound-healing due to infection, malnutrition, anaemia • retention cysts from damage to ducts • ulceration, skin breakdown and bleeding due to recurrent trauma • vulval and dermoid abscesses
PAIN	<ul style="list-style-type: none"> • chronic pelvic inflammatory disease (PID) • dysmenorrhoea due to genital tract obstruction • during procedures requiring speculum examination, e.g. smear-taking, insertion of intrauterine contraceptive devices (IUCD)
RETENTION CYSTS AND ABSCESES	From damage to ducts, e.g. Bartholin's duct.
SCARRING (with or without keloid formation)	Formation of a keloid scar because of slow and incomplete healing of the wound and infection after procedure, leading to excessive connective tissue in scar and possible obstructed menstrual and urinary flow.
SEXUAL DIFFICULTIES	<ul style="list-style-type: none"> • anal fissure, haemorrhoids or faecal incontinence due to lack of easy access to introitus, leading to anal intercourse • dyspareunia (painful intercourse) • impaired sexual response and enjoyment • non-consummation due to obstruction, vaginismus or painful scar tissue • trauma on deinfibulation by partner or traditional birth attendant (TBA) • vaginismus with or without introital scarring
URINARY TRACT PROBLEMS	<ul style="list-style-type: none"> • bladder, urethral or kidney stones due to urinary stasis or obstruction • incontinence due to urethral damage or fistula formation and over-distended bladder • recurrent upper or lower urinary tract infections • urinary retention and over-distension of bladder, leading to neurogenic bladder • voiding difficulties due to urethral damage, scarring or obstruction, leading to prolonged bladder-emptying or altered direction of flow; can be perceived as normal by the woman
VESICOVAGINAL OR RECTOVAGINAL FISTULA	Deinfibulation, reinfibulation or obstructed labour, leading to both faecal and urinary incontinence.

FGM

OBSTETRIC ISSUES

COMPLICATIONS

- Risks can be higher with more extensive **female genital mutilation (FGM)** [7].
- **FGM Type III causes a direct mechanical barrier to delivery.**
FGM Types I, II and IV can be presented with unintentional vulval and vaginal scarring and adhesion, narrowing and obliteration of the vaginal opening.
- **Inadequate assessment may physically compromise mother and foetus.**
Prolonged or obstructed labour, difficult antenatal and intrapartum vaginal assessment, proteinuria during pregnancy due to contamination, catheterisation and retention of urine in labour.
- Fear of labour due to small-size introitus and tender vulval scarring.
- Delayed labour, mainly in second stage of labour.
- **Episiotomies and perineal tears are the most common complication.**
More perineal damage is noted with FGM. Pain may lead to arrest of labour, i.e. the woman may be reluctant to push in the second stage of labour. Adequate pain relief is essential.
- Infection, haemorrhage, fistula, maternal death, stillbirth and neonatal death.

MANAGEMENT OF ANTENATAL CARE

- **The antenatal period is the optimum time to identify a woman who has undergone FGM.**
During this time, counselling by skilled practitioners should take place with the woman and her partner regarding the best management to achieve a safe delivery and prevent future FGM.
- Document FGM, if present, on the patient's National Maternity Healthcare Record (NMHCR) under risk factors and outline her Management Plan/Care Type on the NMHCR.
- Counsel the woman and her partner about the consequences of FGM, propose a birth plan, and plan possible deinfibulation (in cases of **FGM Type III**).
- **Developing a rapport between the obstetrical team and the woman is vital.**
Scheduling frequent antenatal visits allows the woman to become more familiar and open to the team as they make decisions regarding her care.
- **Recurrent urinary tract infections (UTIs) during pregnancy are a known risk factor for preterm labour and sepsis.**
It is important to be vigilant about screening women with FGM for recurrent urinary tract infections, as they are at particular risk.
- Usually, pregnant women with **FGM Type III** should undergo deinfibulation between 20 and 28 weeks, allowing the area to completely heal well before delivery.
- The woman's birth plan should address analgesia and anaesthesia in labour.

WOMEN PRESENTING LATE IN DELIVERY

Women may delay presenting to the maternity hospital for a number of reasons. An uncontrolled delivery may lead to extensive laceration and haemorrhage. Tears may involve the urethra and bladder anteriorly and the rectum posteriorly. If not managed correctly, there is a high risk of fistula formation in these cases. Fistula repair should take place in an operating theatre with adequate anaesthesia. Appropriate surgical management should then be applied, i.e. experienced surgeons should be consulted according to the injury.

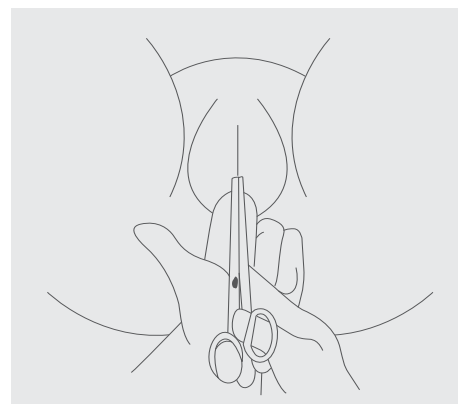
INTRAPARTUM CARE/WOMEN PRESENTING IN EARLY LABOUR

- Use a sensitive, sympathetic, non-judgemental approach with the woman.
- Develop a rapport.
- If language is a barrier, obtain a female interpreter (non-family member).
- Involve the woman's partner, if possible.
- Explain FGM (its complications and reversibility) by drawing diagrams or anatomical models.
- Make an anterior midline incision in the early stage(s) of labour.

ANTERIOR MIDLINE INCISION (FORMERLY ANTERIOR EPISIOTOMY)

When the introitus is aberrantly closed, such as in **FGM Type III**, it is difficult to assess cervical dilation. The scar can be opened anteriorly, and there is little bleeding from relatively avascular scar tissue. The incision should begin at the vaginal opening, extend anteriorly in the midline, and not extend beyond the urethra, as it may cause excessive bleeding due to the rich blood supply in the clitoral region [9]. The edges of anterior incision should be sutured after labour (leaving the introitus open), unless suturing beforehand will control excessive bleeding.

Do not reinfibulate.



POST-NATAL CARE

- The mother/woman with FGM does not fit into the category of a routine antenatal visit; she will require extra time for post-natal follow-up.
- Health-care professionals should address the specific needs of women with FGM in a sensitive and compassionate manner, with an emphasis on good post-natal hygiene.
- Under WHO guidelines, the Criminal Justice (Female Genital Mutilation) Act 2012 in cases of **FGM Type III**, no re-infibulation of the vulval area should be performed [10].

Extensive counselling may be required for women and their partners in order to understand the associated risks of reinfibulation, such as:

- retention of lochia and sepsis
- urinary tract infection and sepsis
- poor healing, haemorrhage and infection
- future obstetrical complications.

REMEMBER: PRIMUM NON NOCERUM, 'FIRST DO NO HARM'

- Keep clear documentation in maternity record for future pregnancies, including accurate completion of National Maternity Healthcare Record (NMHCR).
- Make onward referral(s), if necessary, to urogynaecologic physiotherapy, especially in cases of **FGM Type III**.
- For child protection reasons, it is imperative to make referrals and get support from the social work team and public health nurse, particularly in cases where a daughter is born [11].

FGM

PSYCHOLOGICAL ISSUES

Research suggests that women who have undergone **female genital mutilation (FGM)** are at an increased risk of developing psychological and emotional health problems [12].

While research in this area is limited, one UK study describes the psychological effects of FGM on 53 women [4]. It found that women who have had **FGM Types I and II** are less likely to experience the serious adverse psychological effects of FGM, compared with those who have had **FGM Type III**, which has been linked with **post-traumatic stress disorder (PTSD)**.

WHILE RESEARCH IN THE AREA OF THE PSYCHOLOGICAL IMPLICATIONS OF FGM IS LIMITED, INDIVIDUAL DISORDERS HAVE BEEN IDENTIFIED AS:

- anxiety
- depression
- low self-esteem
- fear of intimacy
- relationship problems
- emotional disturbance.

NB It is important to be aware that not all women will experience adverse psychological effects as a result of FGM.

KEY FGM-RELATED ANXIETY TIMES [4, 11, 13]

MENSTRUATION	Anxiety surrounding menstrual flow and pelvic pain.
PRE-MARRIAGE	Anticipation of wedding night and ensuing physical pain.
FOLLOWING MARRIAGE	Fear of intimacy and pain related to sexual intercourse.
PREGNANCY AND CHILDBIRTH	<ul style="list-style-type: none"> • Fear of pain and anxiety surrounding gynaecological and obstetric procedures and delivery. • Fear of deinfibulation and severe tearing of vagina during childbirth. • Fear of post-delivery reinfibulation.

PSYCHOSEXUAL AND RELATIONSHIP ISSUES FOLLOWING FGM

Women who have undergone FGM are more likely to experience psychosexual health problems than non-circumcised women, which can lead to long-term marriage and relationship problems [14]. These problems may affect both the woman and man in a couple.

Psychosexual health problems may include:

- lack of sexual desire
- decreased initiation of sexual activity with partner
- inability to reach orgasm.

The psychological implications of FGM may include:

- feelings of indifference
- loneliness
- depression
- body-image concerns
- low self-esteem
- emotional problems.

Post-traumatic stress disorder (PTSD) can be defined as 'the development of characteristic symptoms following exposure to an extreme form of traumatic stress' [15].

Determining factors in the development of PTSD are [4]:

- typology of FGM – greater risk with **FGM Type III**
- absence of community support
- appraisal of the event as negative
- absence of anaesthetic
- age of the woman at time of circumcision; psychological problems are exacerbated if circumcision takes place in an older girl or when the girl is old enough to be fully aware of what is being done to her [11].

MANIFESTATION

The onset of symptoms can be immediate or may be delayed by months or years, including:

- flashbacks – having repeated intrusive memories or nightmares of the event, which could be triggered by obstetric/gynaecological procedures
- guilt or shame
- anxiety disorders
- depression
- unexplained physical symptoms, e.g. back pain, headaches.

TREATMENT

Basic counselling skills include being aware of the following:

- privacy and confidentiality
- patience
- creating a trusting relationship
- remaining non-judgemental
- understanding non-verbal cues from your client
- being empathetic and appreciative of what your client is going through.

The **National Institute for Health and Clinical Excellence Guidelines (UK, 2005)** recommends offering trauma-focused cognitive behavioural therapy. Appropriate referral(s) should also be encouraged [16].

FGM

REFERENCES

1. World Health Organization. **Female Genital Mutilation and Obstetric Outcome: WHO Collaborative Prospective Study in Six African Countries**. Geneva, 2006.
2. Dorkenoo, E. et al. **A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales**. London: FORWARD, 2007.
3. World Health Organization. **Female Genital Mutilation: Teachers' Guide for Midwives**. Department of Gender and Women's Health, 2006.
4. Lockhat, H. **Female Genital Mutilation: Treating the Tears**. London: Middlesex University Press, 2004.
5. Royal College of Midwives. **'Female Genital Mutilation'**, Position Paper, 21. London, 1998.
6. Vincent, M. **'The Mutilated Orchid'**, Midwives Magazine, March 2005.
7. Elchalal, U. et al. **'Ritualistic Female Genital Mutilation: Current Status and Future Outlook'**, Obstetric and Gynaecological Survey, 52 (USA, 1997), 643-51.
8. World Health Organization. **Medical Eligibility Criteria for Contraceptive Use**, 3rd edn. 2004.
9. World Health Organization. **Female Genital Mutilation: A Student's Manual**. Geneva, 2001.
10. World Health Organization. **Eliminating Female Genital Mutilation: An Interagency Statement**. Geneva, 2008.
11. Momoh, C. (ed.) **Female Genital Mutilation**. Abingdon: Radcliffe, 2005.
12. Behrendt, A. and Moritz, S. **'Post-traumatic Stress Disorder and Memory Problems After Female Genital Mutilation'**, American Journal of Psychiatry, 162:5 (May 2005), 1001-2.
13. Pranee, C. et al. **'Experiences from Pregnancy and Childbirth Related to Female Genital Mutilation Among Eritrean Immigrant Women in Sweden'**, Midwifery, 24:2 (2006).
14. Women's Health Council. **Female Genital Mutilation/Cutting: A Literature Review**. Dublin, 2008.
15. American Psychiatric Association. **Diagnostic and Statistical Manual of Mental Disorders**. Washington, 1994.
16. National Institute for Health and Clinical Excellence. **Post-traumatic Stress Disorder (PTSD): The Treatment of PTSD in Adults and Children**. UK, 2005.

FGM

CONTRACEPTIVE TABLE

CONTRACEPTIVE METHOD SUITABILITY IN THE PRESENCE OF FGM

CONTRACEPTIVE METHOD (HORMONAL)	FGM TYPE I	FGM TYPE II	FGM TYPE III	FGM TYPE IV
Combined Oral Contraceptive Pill Effectiveness: 99%	+	+	+	+
Combined Contraceptive Patch (Evra) Effectiveness: 99%	+	+	+	+
Progesterone-Only Pill Effectiveness: 96-99%	+	+	+	+
Intravaginal Combined Contraceptive Ring (Nuvaring) Effectiveness: 99%	+	+	-	-
Progestogen-Only Implant (Implanon) Effectiveness: 99%	+	+	+	+
Progestogen-Only Injectables (Depo-Provera) Effectiveness: 99%	+	+	+	+
Levonorgestrel-Releasing Intrauterine System (Mirena) Effectiveness: 99%	+	+	-	-
CONTRACEPTIVE METHOD (NON-HORMONAL)				
Condoms (Male and Female) Effectiveness: 95-99%	+	+	-	+
Spermicides Effectiveness: 99%	+	+	-	- OR +
Barrier Methods (Diaphragm, Cervical Cap) Effectiveness: 92-98%	+	+	-	- OR +
Fertility Awareness-Based Methods (Including Lactational Amenorrhoea Method – LAM) Effectiveness: 80-98%	+	+	- OR +	+

- + Can use. Follow World Health Organization's **Medical Eligibility Criteria for Contraceptive Use**, 3rd edn. 2004.
- Not indicated or may be difficult to use.

NB Efficacy rates are based on correct and consistent use (with necessary training or instruction, where appropriate) of the chosen contraceptive method.

FGM

FURTHER INFORMATION AND RESOURCES

WEBSITES

AkiDwA: African and Migrant Women's Network in Ireland

www.akidwa.ie

APF, AkiDwA, M.I.G.S. and AIDOS, E-learning toolkit on FGM

www.uefgm.org/index.aspx

European Institute for Gender Equality

www.eige.europa.eu

FORWARD: Foundation for Women's Health, Research and Development

www.forwarduk.org.uk

HSE National Counselling Service

www.hse-ncs.ie

Irish College of General Practitioners

www.icgp.ie

Irish Family Planning Association

www.ifpa.ie

Irish Statute Book

www.irishstatutebook.ie/2012/en/act/pub/0011

National Institute for Health and Clinical Excellence

www.nice.org.uk

Royal College of Obstetricians and Gynaecologists

www.rcog.org.uk

Royal College of Surgeons in Ireland

www.rcsi.ie

United Nations Population Fund

www.unfpa.org

World Health Organization

www.who.org

BOOKS

Akinjobi, O.P. **Herstory: Migration Stories of African Women in Ireland**. Dublin: AkiDwA, 2006.

Dirie, W. and Milborn, C. **Desert Children**. London: Time Warner Press, 2007.

Lockhat, H. **Female Genital Mutilation: Treating the Tears**. London: Middlesex University Press, 2004.

Momoh, C. (ed.) **Female Genital Mutilation**. Abingdon: Radcliffe, 2005.

PUBLICATIONS

An Bord Altranais. **Practice Standards for Midwives**, 2010.

APF, AkiDwA, M.I.G.S. and AIDOS, **E-learning toolkit on FGM**, 2013 www.uefgm.org/index.aspx

British Medical Association. **Female Genital Mutilation: Caring for Patients and Safeguarding Children**, 2011.

Egide Dhala, **Knowledge of General Practitioners in Ireland on Female Genital Mutilation**, 2013.

Department of Children and Youth Affairs. **Children First National Guidance for the Protection and Welfare of Children**, 2011.

Health Service Executive. **Child Protection and Welfare Practice Handbook**, 2011.

National Sexual Assault Treatment Unit (SATU) Guidelines Development Group. **Recent Rape/Sexual Assault: National Guidelines on Referral and Clinical Examination in Ireland**, 2010.

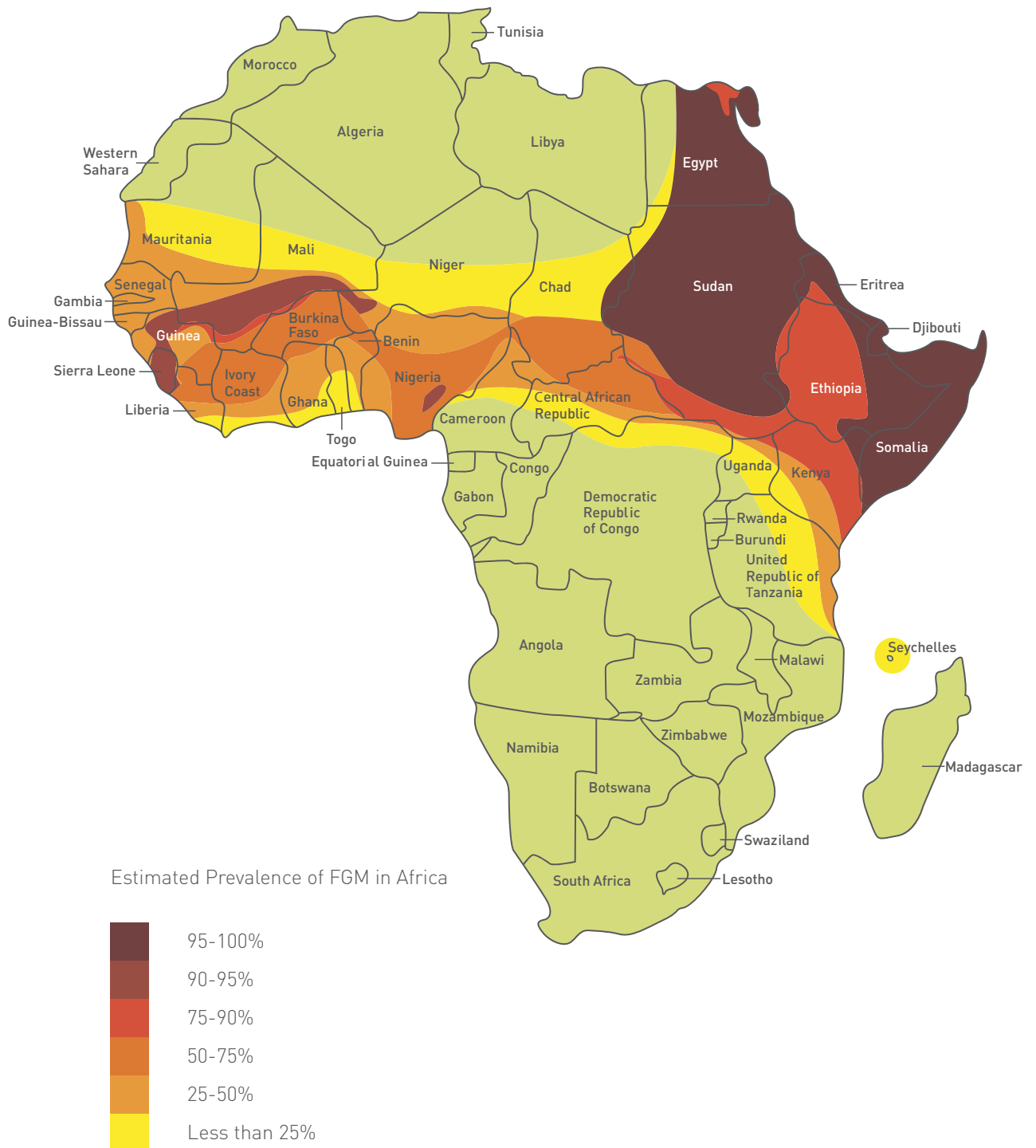
Royal College of Obstetricians and Gynaecologists. **Female Genital Mutilation and its Management (Green Top Guideline No. 53)**, 2009.

Women's Health Council. **Female Genital Mutilation/cutting: A Literature Review**, 2008

FGM

MAP OF AFRICA

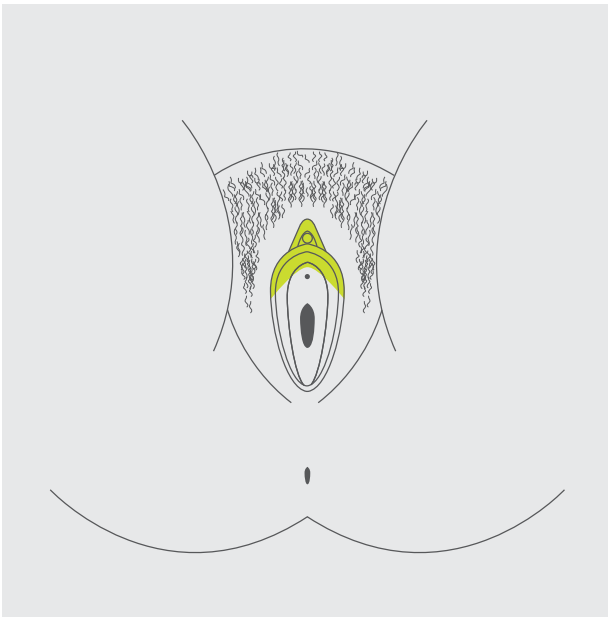
Map source: Afrol News



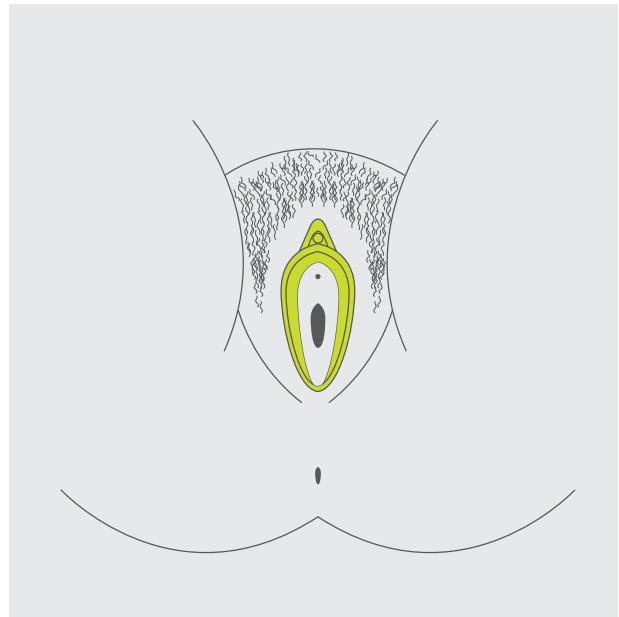
For more information, please refer to: [FGM – PREVALENCE: GLOBAL, EUROPEAN AND IRISH STATISTICS](#)

FGM

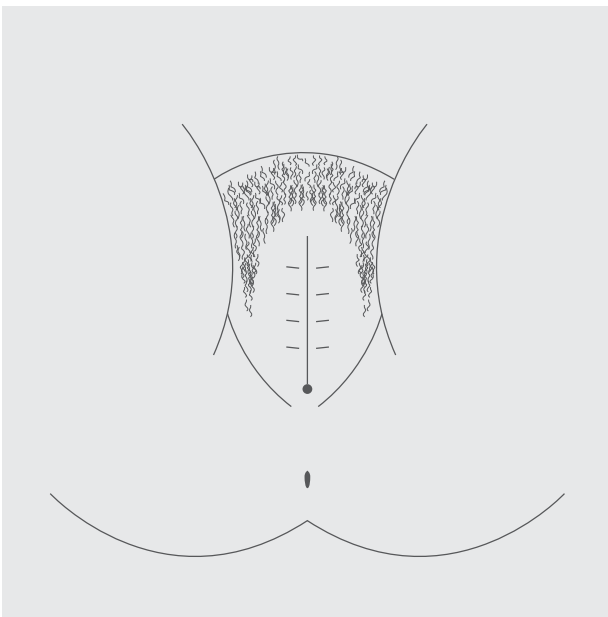
TYPES OF FGM



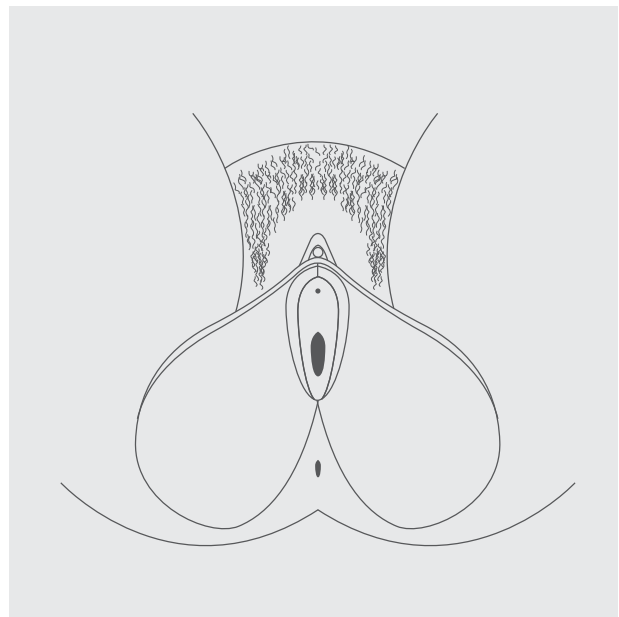
FGM Type I: Shaded areas refer to tissue removed.



FGM Type II: Shaded areas refer to tissue removed.



FGM Type III



FGM Type IV: Example.

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National Development Plan 2007 - 2013



government supporting communities