

APPENDIX 1: CASE STUDIES

CASE 1

Adela is a 27 years old woman from Nigeria. She sells yams in a village market. She has been married for four years but has had no child. She goes to a Pentecostal church where she has made friends with one of the prayer sisters, Dua, who is a midwife working in one of the private clinics. One day Adela asked her friend if she would fast and pray for her because life was becoming miserable with her failure to become pregnant. Her friend agreed, but also took the time and opportunity to talk to her about the problem.

Adela told her friend that she was a virgin when she married, and she thinks that is why her husband loves her even though she is still childless. However, she wants to have children because her mother in law has been asking her husband about it. She also thinks that although her husband does not seem bothered at present, that may change since no African man could be happy for long with a wife who does not produce children.

When asked about her childhood, Adela revealed that she was excised when she was eight years old. Following the procedure she was very sick for over a month. She had fever and the wound was sore and smelly. She remembers the room where she was being nursed smelling so bad that she was embarrassed when people came to see her. She said that her mother had given her traditional medicine to drink and to apply to her genitalia, but she did not improve. She was taken to hospital when her condition was very serious and everybody thought she was going to die.

Dua advised her friend to visit a doctor for investigations, and made an appointment for Adela to

see one of the gynaecologists in the clinic where she was working. The investigations at the clinic revealed that Adela's fallopian tubes were completely blocked, and the doctor told her it was due to infection. Her problem was therefore primary infertility. The doctor said they could try to clear the obstruction in fallopian tubes with surgery. But Adela and her husband have so far not been able to raise the money necessary for the operation.

CASE 2

Yemeni is a 32 year old male midwifery tutor in a medical school in Ethiopia. His wife works as a clerk in the hospital where he teaches. They have one daughter who is 3 years old. They both come from an area where traditionally every baby girl has her clitoris excised during her first month of life. Before he got married, Yemeni had the chance to attend a workshop on female genital mutilation, which sensitised him and made him realise that the tradition is harmful.

He decided not to allow his daughter to be excised. He had educated his wife and she supported the idea of not excising their daughter. But the family lives with Yemeni's mother who wants her grand daughter to be excised. She complains constantly that the girl is becoming more and more naughty because she is not excised. "It is time you decide to excise this girl, look at how she behaves. Who is going to marry her?" Or she says to Yemeni's wife " I cannot sit here and look at you violate our tradition. This girl belongs to our clan; she must be excised; it is our culture". Yemeni keeps on talking to his mother about the harmful effects of female genital mutilation, and he has made it clear to her that under no circumstances will he excise the little

girl. He says it is hard to keep challenging his mother but he will persist.

CASE 3

Asma is a 30 year old housewife. At the age of 6 she was infibulated. She still remembers the pain and brutality of the procedure. She was married at the age of 16, and says the pain she experienced when her husband penetrated her made her terrified of him for a long time because she thought he was so brutal. Intercourse continued to be painful for the first 6 months of her marriage, and she has never enjoyed sex but accepts it as an obligation in marriage.

Asma has four children, one of whom is a 2 months old girl. At each delivery she is opened to allow the passage of the baby, and then re-stitched after the birth. Her husband insists that she should have a tight vagina. Asma is currently debating with herself whether or not to have her daughter infibulated. She feels that if it is done, then it should be less extensive than her own type of FGM, because she does not like to think of her daughter experiencing the agony she has been through.

CASE 4

Meda is a 35 years old university lecturer who decided that her two daughters would not be excised as she and her sisters had been. Meda's daughters were born while she and her husband were studying abroad. When the family returned home Meda's mother and mother-in-law asked her if the girls had been excised. Meda said they had not, and explained to the older women that she and her husband had agreed the girls would not be mutilated.

Meda went back to work, but she was unable to find a maid to look after the children while she was out of the house. Since her mother-in-law lives in the same town, she decided to leave the girls with her during the week and to fetch them on Friday evenings

to take them home for the weekends. One Friday evening when she went to fetch the girls, she was surprised not to find them playing outside as usual. Her mother-in-law explained that they could not come out because they were not well. Meda thought perhaps they just had a fever. But as she entered the room, the girls cried out: "Mum it hurts!" It did not occur to her immediately that the girls had been genitally mutilated, but then her mother-in-law announced proudly: "I have excised my grand-daughters; I have done what is right for them".

CASE 5

Agnes is a village woman who was excised when she was a child. She does not remember how old she was at the time, only that she grew up with this scar. She was married at age 17 and realized four months after her marriage that she was pregnant.

Agnes decided to deliver at home, and her husband called a well-known and experienced traditional birth attendant when labour started. She was in labour for two days, and finally gave birth to a stillborn baby. Agnes was badly torn during the delivery and had to be taken to hospital to have the tears stitched. She also bled profusely and was transfused with one unit of blood.

However, the tear was so extensive that Agnes developed a vesico-vaginal fistula (VVF), which she had repaired eight months after delivery. However, the operation was unsuccessful, and she is to have another operation to try to repair the fistula, which she hopes very much will be successful. While she is undergoing treatment, she is living with her parents again. But she says her husband, who is a farmer, is very supportive and visits her regularly.

CASE 6

Ella is a 19 year old woman married to a soldier. She has a 2 year old daughter who was infibulated 7

days after birth. The child has been admitted to hospital several times because of urinary tract infections. During discussions with Ella she reveals that she also was mutilated when she was a child, and that she has lived with the pain all her life. She explains that she was opened during delivery and stitched up again afterwards to create a small opening. She did not want her daughter to undergo the procedure, but says there was no way she could persuade her mother-in-law to accept the idea that the little girl should not be excised.

Ella's country is now at war and her husband is at the frontline. A week after he left for the front, his mother inspected Ella's genitalia and then called a traditional birth attendant who stitched her up to create an even smaller opening to ensure that she remains chaste (she does not have intercourse) until her husband returns from the war front.



APPENDIX 2: TAKING HISTORY OF A WOMAN OR GIRL WITH FGM

CHECKLIST

ITEM	OBSERVED	NOT OBSERVED	NOT APPLICABLE
1. Welcomes and greets the client in a culturally acceptable manner.			
2. Makes the client comfortable by providing a chair			
3. Sits at the same level with the client			
4. Introduces herself and ask for the name of the client			
5. Addresses the client by name			
6. Starts by asking general questions like: "How are you?", "How is your family?"			
7. Ensures that the client is relaxed and ready to open up before asking about FGM			
8. When the client is ready to open up, tactfully asks about FGM using the culturally acceptable terms for the surgery			
9. Observes client's non verbal cues			
10. Reassures the client that she is comfortable dealing with the client's condition			
11. Empathises and use facilitation skills to enable the client express herself			
12. Maintains eye contact			
13. Lets the client express herself freely			
14. Is patient and does not force client to talk if she is hesitant			
15. If the client starts crying is patient and gives support			
16. Does not give false promises			
17. Once established that the client is mutilated, informs her about physical examination which will include examination of her genitalia.			
18. Reassures the client			
19. Records findings			
20. If the client is not yet ready to share, arranges for another visit			

APPENDIX 3: PHYSICAL EXAMINATION OF A WOMAN OR GIRL WITH FGM

CHECKLIST

ITEM	OBSERVED	NOT OBSERVED	NOT APPLICABLE
1. Prepares the required equipment			
2. Explains the procedure to the client			
3. Asks client's permission to examine her			
4. Reassures client about confidentiality			
5. Ensures privacy			
6. If there is another person, asks permission of that person to be present and respects client's wishes			
7. Asks the client to empty bladder			
8. Asks the client to take off her underwear and assists her to lie comfortable on the examination bed or couch			
9. Exposes the genitalia			
10. Washes hands thoroughly and puts on gloves			
11. Inspects the external genitalia to identify type of FGM			
12. Tactfully asks the client about urination patterns, menstrual flow, and coitus if relevant			
13. If there is need to introduce finger cleans the genitalia with antiseptic lotion			
14. Where applicable lubricates the finger and tries to introduce the tip of index finger slowly observing client's reaction then introduces whole finger and second finger if necessary			
15. Respects client's reactions			
16. Before taking off the gloves checks for abnormal discharge			
17. After the procedure thanks the client for co-operation			
18. Takes off gloves and washes hands			
19. After the procedure helps the client off the bed and ensures comfort			
20. Records findings and shares with the client			
21. Soaks used instruments in disinfectant ready for sterilisation.			

APPENDIX 4: COUNSELLING A WOMAN OR GIRL WITH FGM

CHECKLIST

ITEM	OBSERVED	NOT OBSERVED	NOT APPLICABLE
Preparation for counselling			
1. Prepares a setting which is private, preferably a room: - with a locking door - where they will not be disturbed - which is well ventilated and light			
2. Confirms the time available with the client			
The counselling session:			
1. Greets and welcomes the client in a culturally acceptable manner			
2. Invites her to sit			
3. Makes the client comfortable			
4. Introduces self to the client.			
5. Asks for the client's name			
6. Sits facing the client and on the same level			
7. Thanks the client for coming and briefly explains the services provided at the facility			
8. Starts with easy and general questions			
9. Helps the client to explain why she came			
10. Listens carefully and observes non verbal cues			
11. Demonstrates patience, allowing the client to express her feelings and concerns freely			
12. Empathises with the client when she is describing a distressing situation			
13. Paraphrases the client's information to avoid misunderstanding			
14. Explains to the client how he/she can help			
15. With sensitive issues such as sexual problem, probes tactfully to discover the actual problem			
16. Provides accurate information related to the problem			
17. Refrains from giving instructions			
18. Assists the client and partner/guardian to reach informed decision			
19. Assists clients to implement the decision			
20. Plans for follow up with the client			
21. Thanks the client for coming			

APPENDIX 5:

THE PROCEDURE FOR OPENING UP TYPE III FGM (INFIBULATION)

CHECKLIST

ITEM	OBSERVED	NOT OBSERVED	NOT APPLICABLE
Preparation of the client (and partner/guardian):			
1. Educates about the normal and infibulated genitalia			
2. Educates about legal status of FGM in the specific country			
3. Gives full information about the procedure for opening up the infibulation			
4. Informs the client that after the opening up, the vulva will not be re-sutured to recreate a small opening, but the two sides will be sutured separately			
5. Informs the client of the physical changes following opening up:			
- changes in the appearance			
- changes in urination			
- changes in sexual intercourse			
- increased sensitivity of opened area			
- increased wetness			
6. Reassures the client about confidentiality			
7. Explains that local anaesthetic will be used			
8. Discusses clearly about the degree of opening up and reaches a consensus with client			
Preparation of equipment			
- Tray with antiseptic swabs			
- Gauze swabs			
- Straight scissors			
- Sterile gloves			
- 2 artery forceps			
- Haemostat forceps			
- Tissue forceps			
- Syringe and needle			
- Stitching needle and needle holder			
- Antiseptic lotion			
- Lidocaine			

CHECKLIST *continued*

ITEM	OBSERVED	NOT OBSERVED	NOT APPLICABLE
Preparation of equipment cont			
- Lubricant			
- Sterile towel, mackintosh			
- Soap - Receptacle for disposal			
The procedure:			
1. Makes the client comfortable			
2. Assembles all the required equipment at the bedside			
3. Introduces self to the client and asks or confirms client's name			
4. Ensures privacy and reassures the client about confidentiality			
5. Reflects on the initial discussion and reminds the client of the results of the physical examination and the indication for opening up			
6. Exposes genitalia and washes hands			
7. Puts on gloves			
8. Cleans the genitalia with antiseptic			
9. Introduce finger, forceps or dilator slowly and gently in the opening to lift the scar			
10. Infiltrates 2- 3 mls of local anaesthetic, as appropriate, along the scar and both sides of the scar where cuts will be made			
11. With fingers inside the scar, introduces scissors and cuts along the scar to avoid injury to the adjacent structures, or to the baby if opening up is done during labour			
12. Cuts along the midline towards the pubis to expose the urethral opening. Does not cut beyond the urethral opening			
13. Provides information about post operative care of the perineum:			
- advises on sitz bath three times a day or oat oil			
- gentle drying after sitz baths			
- advises on application of soothing cream			
14. Gives antibiotics depending on the situation			
15. Provides follow up after a week			

APPENDIX 6:

TEACHING AND LEARNING RESOURCES

Films and videos

- *A compilation of videos on Female Genital Mutilation.* UNHCR Programme and Technical Support Section. P. O. Box 2500, CH-1211 Geneva. The video is approximately 70 minutes and comprises the following films:
 - *Scarred for Life.* (25 minutes), produced by ABC, a special programme called Day One. This film compliments the topics in the introduction to FGM.
 - *A Dangerous Practice.* (12 minutes), produced by UK news programme. This film particularly addresses issues of human rights.
 - *Welcome to Womanhood.* (15 minutes) produced by Charlotte Metcalf. This is a report of the 'Reach' Project in Kapchorwa Uganda. 'Reach 'is a project which was started by the United Nations Population Fund to work with Sabinu people to stop the life threatening practice of female circumcision. The film looks at traditional beliefs, values and attitudes, and is especially relevant in discussions about involving men in the prevention of FGM.
 - *Infibulation: The Worst type of Female Genital Mutilation* (12 minutes). This film produced by the IAC shows the act of infibulation. It can be very disturbing and some students may break down in tears. They should be given support by their teachers and encouraged to support each other. This film is specially useful in teaching about the different types of FGM, or in efforts to change people's beliefs and attitudes towards FGM.

- *From Awareness to Action: Eradication of Female Genital Mutilation in Somalia. Eradicating Female Genital Mutilation in Somali Refugee Camps in Eastern Ethiopia.* UNHCR Liaison Office. P.O. Box 1076 Addis Ababa, Ethiopia.

The film is especially relevant to the lessons in Module Two, on community involvement in the prevention of FGM.

- WHO Film: *Female Genital Mutilation - "The Road to Change"*. WHO, Geneva (2000).

This film discusses the origins of the practice. It describes the different types of female genital mutilation, and the efforts made to eliminate the practice in various countries. It is especially relevant to the lessons in Modules One and Two.

Printed materials from WHO

- *Female Genital Mutilation. A joint WHO/UNICEF/UNFPA Statement.* WHO. Geneva (1997).
- *Female Genital Mutilation. Information Kit.* WHO. Geneva (1996). WHO/FRH/WHD/99.11.
- *Female Genital Mutilation. Report of a WHO Technical Working Group,* Geneva, 17-19 July 1995. Geneva, World Health Organization, 1996. (WHO/FRH/WHD/96.10)
- *Female Genital Mutilation. An overview.* WHO, Geneva (1998).
- *Management of pregnancy, childbirth and the postpartum period in the presence of Female Genital Mutilation. Report of a WHO Technical Consultation.* Geneva, 15 - 17 October 1997. WHO/FCH/GWH 01.2. WHO, Geneva (2000).

- *A systematic review of the health complications of Female Genital Mutilation including sequelae in childbirth.* WHO/FCH/WMH/00.2. Geneva (2000).
- *Female Genital Mutilation. A Handbook for frontline workers.* WHO/FCH/WMH/00.5 Rev.1. WHO, Geneva (2000).
- *Female Genital Mutilation. Programmes to date: what works and what doesn't. A review.* WHO/CHS/WMH/99.5. Geneva (1999).
- *Summary of international and regional human rights texts relevant to the prevention of violence against women.* WHO/GCWH/WMH/99.3. Geneva (1999).
- *Counselling skills training in adolescent sexuality and reproductive health: A facilitator's guide.* WHO/ADH/93.3. Geneva (1993).
- R. J. Cook (1994) *Women Health and Human Rights.* (WHO, Geneva 1994)
- *The right path to health: Health education through religion. Islamic ruling and female circumcision.* WHO, regional office for Eastern Mediterranean (1996)
- *Alia's story.* Published by The National committee on Traditional Practices in Ethiopia, 1995.
- *Fatoumata's story.* Published by Turin centre regional programme. AIC/AIDOS/ILO (1995).
- *Female Genital Mutilation: The Unspoken Issue.* Published by The Royal College of Nursing, London, 1994.
- Dorkenoo, E. (1994). *Cutting the Rose. Female Genital Mutilation: The practice and its prevention.* Minority Rights Publications, London.
- Toubia, N. (1999). *A practical manual for health care providers caring for women with circumcision.* A RAINBO Publication. New York.
- Smith, J. (1995). *Visions and discussions on genital mutilation of girls: An international survey.* Published by Defense for Children International, Netherlands,
- Johns Hopkins Population Information Program (1997). *The Essentials of contraceptives Technology: A Handbook for Clinic Staff.* Publisher of Population Reports. WHO, Geneva

Books and booklets

- *Tradition! Tradition! A story of Mother Earth,* by Dorkenoo, E. published by FORWARD Ltd. London, 1992.
- *Yimmer's story.* Published by The National committee on Traditional Practices in Ethiopia, 1995.
- The Universal Declaration of Human Rights (1948)
- The Convention on the Rights of the Child (1989)
- The Convention on the Elimination of All Forms of Discrimination Against Women (1979)
- The African Charter on Human and Peoples' Rights (1981)

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