3RD EDITION
Updated and Revised August 2021

Female Genital Mutilation

Information for Healthcare Professionals Working in Ireland

RCSI
ROYAL COLLEGE OF SURGEONS IN IRELAND
COLÁISTE RÍOGA NA MÁINLEÁ IN ÉIRINN

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

AkiDwA
AKINA DADA WA AFRICA

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.

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PRINCIPAL AUTHORS

Revised and Updated Third Edition 2021 Authors

Dr. Caroline Munyi – AkiDwA
Dr. Salome Mbugua – AkiDwA
Dr. Sarah Fitzgibbon – GP Partner and Founder of WiMIN Network
Dr. Maeve Eogan – Consultant Obstetrician and Gynaecologist
Pádraig Ó Luasa, MA – University College Dublin
Róisín Burbridge, MA – Utrecht University

Revised and Updated Second Edition 2013 Authors

Seema Bansal – Global Experiences
Megan Breckwoldt – Global Experiences
Siobán O'Brien Green – MSocSc (Social Policy)
Dr. Salome Mbugua – Head of Operations and Strategy, AkiDwA
Edited by Catherine Reilly

First Edition 2008 Authors

Siobán O'Brien Green – MSocSc (Social Policy), Coordinator, Migrant Women's Health Services Project, AkiDwA
Sudha Patel – Duke University, USA

Royal College of Surgeons in Ireland, MSc Women's Health

Dr. Andrea Scharfe Nugent – MB, BCh, BAO, FACOG, Course Director, Department of Obstetrics and Gynaecology
Kate Aboud – RGN, RM
Samjhana Basnet – MB, BS
Jane Cuthill – RGN, RM
Frances Finn – RGN, RM
Fiona Fox – MB, BCh, BAO, MICGP
Fanta Kaloma – MB, BCh, BAO, LRCP
Ghada Karakoshi – MB, BCh
Chandra Mishra – MB, BS, DCh
Egbal Moheildin – MB, BS
Michelle O'Connor – RGN, BNS, PG, HDip
Carol O'Rourke – RGN, RM
Anita Pappas – MB, BS
Hotham Whayeb – MB, CHR
Nisa Zaib – MB, BS

Copy Editors

Lizzie Downes and Joe Nankivell

FGM
INTRODUCTION

The first edition of this handbook was produced in 2008, as a result of successful collaboration between the director and students of the MSc in Women's Health Course in the Royal College of Surgeons (RCSI) in Ireland 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 Female Genital Mutilation (FGM) Health Forum members, 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 to a range of healthcare 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 (CSO) 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 it was estimated that there were 3,780 women living in Ireland who had undergone FGM. The most recent data has shown that despite a decline in inward migration to Ireland the number of FGM cases continues to increase. In 2016, it was estimated that nearly 6,000 women living in Ireland have undergone the practice of FGM.

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 makes it an offence to remove a girl/woman from the State for the purpose of FGM. The punishment for FGM-related crimes as per this Act is up to 14 years imprisonment and/or a fine of up to €10,000. For a summary conviction, the penalty is imprisonment for up to 12 months and/or a fine of up to €5,000.

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. In 2019, the Institute of Obstetricians and Gynaecologists at the Royal College of Physicians of Ireland, along with the Clinical Strategy and Programmes Division of the Health Service Executive (HSE) published a National Clinical Guide on the Management of FGM. Some of the guidelines from this document are included later in this 3rd edition of the Handbook.

To date, AkiDwA, with funding and support from the HSE, has delivered awareness-raising training to over 7,000 service providers and healthcare professionals. AkiDwA continues to raise awareness on FGM at local, regional, and national levels through media, seminars, workshops, conferences, and publications. In 2012, AkiDwA published an information leaflet for the public titled 'Female Genital Mutilation and the Law in Ireland[1]'. The same publication was updated and reprinted in November 2019. In February 2013, AkiDwA launched findings from a survey of General Practitioners on their understanding of FGM. 80% of these practitioners did not have knowledge about FGM.

In 2013, AkiDwA and the Mediterranean Institute of Gender Studies [MIGS], based in Cyprus, in partnership with the Italian Association for Women in Development (AIDOS), and the Family Planning Association of Portugal (APF) developed the E-Learning toolkit United to End FGM (UEFGM). This online learning tool has benefitted students of nursing and midwifery and other health and social care practitioners who are currently working in the area of FGM. It has also been of great benefit to those who want to know more about FGM as a harmful cultural practice so as to be able to understand and support women and girls who are affected by the practice – physically, psychologically and emotionally. In Ireland, the EU learning tool has benefitted over 5,500 people.

1 European Institute for Gender Equality. "United to End FGM Online Learning Tool". https://eige.europa.eu/gender-based-violence/methods-and-tools/cyprus/united-end-fgm-online-learning-tool

FGM
AN OVERVIEW

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 Organisation (WHO) estimates that more than 200 million girls and women have undergone female genital mutilation.[2]

2 World Health Organisation. "Female Genital Mutilation". February 3, 2020. https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation

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 (primagravida).

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 such as tetanus and HIV.

WHY IS FGM PERFORMED?

- Cultural 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. First and foremost, in FGM-practicing communities, it is widely believed that a girl is not marriageable if she has not undergone FGM. This inability to marry can lead the girl and her family to be stigmatised by the rest of the practicing community. In many circumstances, parents want their daughter(s) to undergo FGM in order to be accepted by the community. Marriage is also important to families as it provides social and economic security, such as through the bride price which is given to the bride's family when she is married.

The negative health complications associated with FGM are often poorly understood within practicing communities. This is due to the procedure being widely practiced and the fact that the health difficulties experienced by women as a result of FGM are seen as a normal part of their lives (suffering is considered a normal happening for women in these communities even by women themselves). 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.

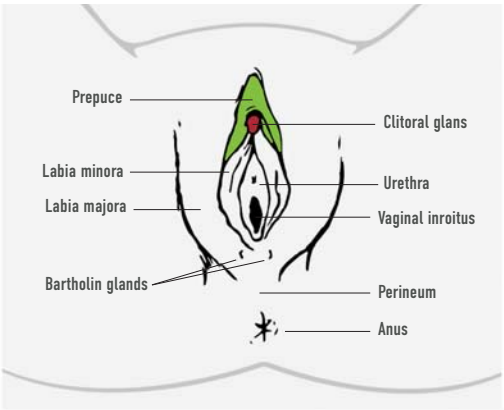
FGM
CLASSIFICATIONS OF FGM

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 potentially harmful non-medical procedures including pricking, piercing, incising or stretching the clitoris and/or labia, as well as scraping and cauterization (burning) of the clitoris and surrounding tissue, and using herbs or chemicals to cause bleeding or narrowing of the vagina.

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

Type I

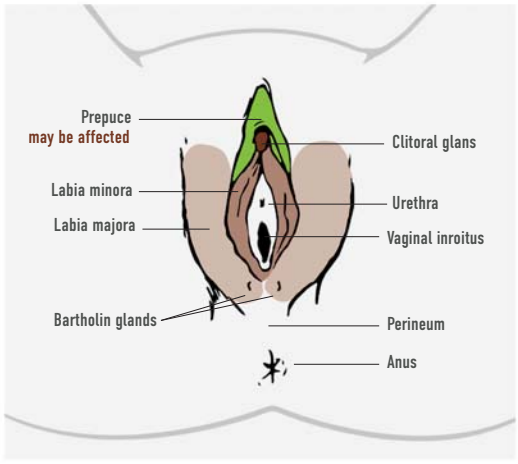
Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).



Type Ia: removal of the prepuce/clitoral hood (circumcision)
\+
Type Ib: removal of the clitoral glans with the prepuce (clitoridectomy)

Type II

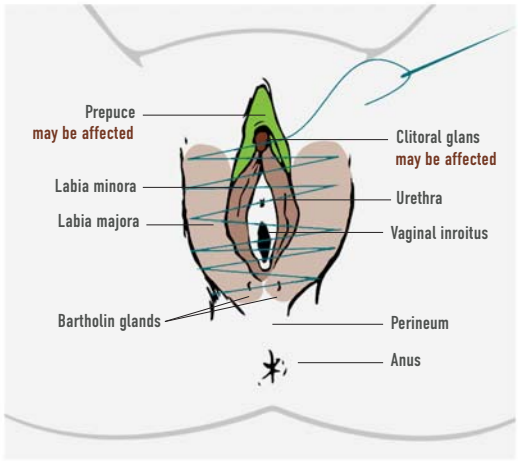
Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).



Type IIa: removal of the labia minora only
Type IIb: partial or total removal of the clitoral glans and the labia minora (prepuce may be affected)
Type IIc: partial or total removal of the clitoral glans, the labia minora and labia majora (prepuce may be affected)

Type III

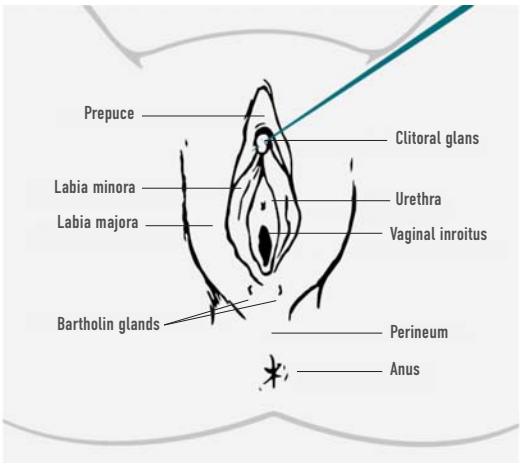
Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).



Type IIIa: appositioning of the labia minora
Type IIIb: appositioning of the labia majora

Type IV

All other potentially harmful non-medical procedures including pricking, piercing, incising or stretching the clitoris and/or labia, as well as scraping and cauterization (burning) of the clitoris and surrounding tissue, and using herbs or chemicals to cause bleeding or narrowing of the vagina.



FGM
HEALTH CONSEQUENCES OF FGM

SHORT-TERM COMPLICATIONS OF FGM CAN INCLUDE	INTERMEDIATE COMPLICATIONS OF FGM CAN INCLUDE	LONG-TERM COMPLICATIONS OF FGM CAN INCLUDE
Death	Delayed healing	Decrease or loss of sexual sensation
Haemorrhage	Abscesses	Difficult and complicated childbirth
Infection and failure of the wound to heal	Scarring/keloid formation, dysmenorrhea and haematocolpos – obstruction to period flow	Dysmenorrhea, difficulties in menstruation including passing menses
Injury or trauma to adjoining areas such as the urethra and anus	Pelvic infections	Dyspareunia (painful intercourse)
Surgical mishap	Obstruction to urinary flow	Incontinence and difficulty urinating
Tetanus (PID) and infertility	Urinary tract infections (UTIs)	Pelvic inflammatory disease
Transmission of HIV and other viruses	Absence from school due to painful menstruation and lack of menstrual hygiene support	Psychological trauma
	Increased risk of childbirth complications and newborn deaths	Scarring (with or without keloid formation) and hardening of the vaginal tissue, causing constant pain around the genital area
	The need for later surgeries because some procedures seal or narrow the vaginal opening e.g. infibulation. The vagina must be cut later to allow for sexual intercourse or/and childbirth. Sometimes it is stitched again several times including after childbirth, hence a woman goes through repeated opening and closing procedures, further increasing repeated both short-term and long-term complications.	Sebaceous cyst development

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

HEALTH CONSEQUENCES OF FGM

A major WHO study found a significant increase in adverse obstetric outcomes for women who had undergone FGM.[3] 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, postpartum 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 26 African countries.[4] The vast majority of European countries have legislation in place banning the practice of FGM, including, to name but a few, Austria, Belgium, Spain, Ireland 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.

In Ireland, the Criminal Justice (Female Genital Mutilation) Act 2012 was signed into law on 2 April 2012. It has been effective since 20 September 2012. This law makes it 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 legal requirements, section 3 does make it an offence to remove a girl from the State for the purpose of FGM. The first FGM conviction took place in January 2020, when a father and mother of a young girl were sentenced to 5.5 years and 4 years and 9 months respectively in prison.[5] This conviction can be attributed to AkiDwA awareness-raising campaign regarding FGM, as well as to its work with the Gardai and healthcare professionals.

3 World Health Organization. "Female Genital Mutilation and Obstetric Outcome: WHO Collaborative Prospective Study in Six African Countries". Geneva, 2006.

4 Equality Now. "FGM And The Law Around The World". June 19, 2019. https://www.equalitynow.org/the_law_and_fgm

5 "Parents jailed over female genital mutilation of daughter." The Irish Times. January 27, 2020. https://www.irishtimes.com/news/crime-and-law/courts/circuit-court/parents-jailed-over-female-genital-mutilation-of-daughter-1.4152765 "Ireland's first FGM conviction: Father sentenced to 5.5 years, mother sentenced to 4 years and 9 months". The Journal.ie. January 27, 2020. https://www.thejournal.ie/fgm-trial-sentencing-ireland-4975318-Jan2020/ Sharon Gaffney. "Couple sentenced over female genital mutilation of baby daughter in 2016". RTE News. January 27, 2020. https://www.rte.ie/news/courts/2020/0127/1111201-fgm-court/

FGM

PREVALENCE: GLOBAL, EUROPEAN, AND IRISH STATISTICS

UNICEF estimates that over 4 million girls are at risk of FGM annually.[6] This means that thousands of women and girls worldwide undergo FGM each day. FGM is most prevalent in Africa, the Middle East and Middle Asia, while prevalence often varies widely within countries, depending on regional and cultural traditions.

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PREVALENCE OF FGM IN PRACTISING COUNTRIES – UNICEF Global Databases[7]

Country	FGM prevalence among girls and women (%)	FGM prevalence among girls and women aged 15 to 49 years, by residence and wealth quintile (%)							Reference year	Data source
		Residence		Weath quintile						
		Urban	Rural	Poorest	Second	Middle	Fourth	Richest		
Benin	9	5	13	16	14	10	7	2	2014	MICS
Burkino Faso	76	69	78	77	78	78	80	68	2010	DHS/MICS
Cameroon	1	1	2	1	4	1	1	1	2004	DHS
Central African Republic	24	18	29	34	31	26	17	15	2010	MICS
Chad	38	40	38	46	42	37	30	37	2014-15	DHS
Côte d'Ivoire	37	31	44	50	44	43	34	20	2016	MICS
Djibouti	94	94	98	97	96	94	95	93	2012	EDSF/PAPFAM
Egypt	87	77	93	94	93	92	87	70	2015	Health Issues Survey (DHS)
Eritrea	83	80	85	89	86	84	83	75	2010	Population and Health Survey
Ethiopia	65	54	68	65	69	69	69	57	2016	DHS
Gambia	76	77	72	68	78	85	81	67	2018	MICS
Ghana	4	3	5	13	4	3	1	1	2011	MICS
Guinea	95	95	94	95	94	93	96	95	2018	DHS
Guinea-Bissau	45	40	50	18	59	65	47	36	2014	MICS
Iraq	7	7	8	1	3	3	6	22	2018	MICS
Kenya	21	14	26	40	26	18	17	12	2014	DHS
Liberia	44	37	56	58	56	51	38	26	2013	DHS
Mali	89	89	88	86	86	90	90	90	2018	DHS
Maldives	13	14	12	14	12	12	15	12	2016-17	DHS
Mauritania	67	55	79	92	86	70	60	37	2015	MICS
Niger	2	1	2	2	2	2	3	1	2012	DHS
Nigeria	19	24	16	16	18	20	23	20	2018	DHS
Senegal	24	20	28	41	30	25	17	14	2017	DHS
Sierra Leone	86	80	82	93	93	90	85	74	2017	MICS
Somalia	98	97	98	98	99	98	97	96	2006	MICS
Sudan	87	85	87	88	82	81	90	92	2014	MICS
Togo	3	3	4	4	4	3	4	2	2017	MICS
Uganda	0	0	0	1	0	0	0	0	2016	DHS
United Republic of Tanzania	10	5	13	19	10	12	9	4	2015-16	DHS
Yemen	19	17	19	27	21	13	20	14	2013	DHS

Indicator definition: Percentage of girls and women aged 15 to 49 years who have undergone FGM.
Notes: In Liberia, only girls and women who have heard of the Sande society were asked whether they were members; this provides indirect information on FGM, since it is performed during initiation into the society.
Source: UNICEF global databases 2020, based on Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and other nationally representative surveys. [2]

7 UNICEF. "Girls and women who have undergone FGM (by place of residence and household wealth quintile)". February 2020. https://data.unicef.org/topic/child-protection/female-genital-mutilation/

AkiDwA table on estimated prevalence of FGM in Ireland (Enumerated by 2016 Census)[8]

The Prevalence of FGM in Ireland was estimated using census statistics (CSO) on the number of women residents in Ireland from FGM practising countries. The statistics were synthesised with global prevalence data to ascertain an estimate for the number of women living in Ireland who have undergone FGM.

The data reveals that there is an increase in migrants coming to Ireland from countries where FGM is practiced. The table below shows an estimation of the number of women living with FGM in Ireland as estimated from the 2016 Census.

FGM-practising country	Global prevalence %	Total number of women from FGM-practising countries, aged 15–44 and resident in Ireland	Estimated number of women in Ireland who have undergone FGM
Benin	•	•	•
Burkina Faso	•	•	•
Cameroon	1	519	5
Central African Republic	•	•	•
Chad	•	•	•
Cote d'Ivoire	38	147	56
Democratic Republic of Congo	•	•	•
Djibouti	•	•	•
Egypt	91	675	614
Ethiopia	74	400	296
Eritrea	•	•	•
Gambia	•	•	•
Ghana	4	558	7
Guinea	•	•	•
Guinea-Bissau	•	•	•
Indonesia	•	•	•
Iraq	8	818	65
Kenya	27	630	170
Liberia	66	90	59
Mali	•	•	•
Mauritania	69	976	673
Niger	•	•	•
Nigeria	27	8,606	2378
Senegal	•	•	•
Sierra Leone	88	138	121
Somalia	98	747	732
Sudan	88	666	586
Tanzania	15	157	24
Togo	4	147	6
Uganda	1	276	3
Zambia	•	•	•
TOTAL TOTAL PERCENTAGE		15,550	5795 32.27%

Note: It is important to point out that while several of the countries in the above table have been left blank, this does not mean that FGM is not prevalent there. Rather, the data from these countries has not been made available by the CSO. For example, in 2019 UNICEF estimated that almost 80% of women in Djibouti have undergone FGM.[9]

With this in mind, it is likely that the total number of women living in Ireland who have undergone FGM in Ireland could be three times higher than the above figures.

8 Central Statistics Office. "Ireland's UN SDGs 2019 - Report on Indicators for Goal 5 Gender Equality. End discrimination and violence". https://www.cso.ie/en/releasesandpublications/ep/p-sdg5/irelandsunsdgs2019-reportonindicatorsforgoal5genderequality/enddiscriminationandviolence/

9 Gilliam, Eva. "Ending female genital mutilation in Djibouti". UNICEF. February 6, 2019. https://www.unicef.org/stories/ending-female-genital-mutilation-djibouti

FGM
DEFINITION, TERMS AND GLOSSARY

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 healthcare professional. The following 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	Tigrinya	Circumcision or cutting
Ethiopia	Absum Megrez	Harrari Amharic	Ritual Circumcision or cutting
Kenya	Kutairi	Swahili	Circumcision (male and female)
Nigeria	Ibi Ugwu	Igbo	Circumcision (male and female)
Sierra Leone	Bondo	Various	Circumcision (male and female)
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 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 healthcare professionals performing FGM in public or private healthcare 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 of FGM is almost 100 percent within certain communities. Healthcare 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 or 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, vulvar cysts, fistula formations, problems in childbirth, psychological trauma, mood disorders, eating and behavioural disturbances, and sexual dysfunction.[10]

To correctly identify and care for these women, healthcare professionals need to be familiar with global areas of high FGM prevalence.

ASSESS INDIVIDUAL NEEDS

Do not assume that all women will be aware that they have been circumcised.

They may have vivid, vague or no memories of the procedure.[11] 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 delivery

BE SENSITIVE AND NON-JUDGEMENTAL

It is important to be non-judgmental 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 practiced, it may be viewed as a compulsory procedure. The term 'FGM' may make a circumcised woman feel degraded and even insulted. All healthcare professionals need to be conscious of the political and cultural sensitivities surrounding this subject, and in particular, the term 'FGM'.[12]

10 World Health Organization. "Female Genital Mutilation: Teachers' Guide for Midwives". Department of Gender and Women' s Health, 2006.
11 Lockhat, H. Female Genital Mutilation: Treating the Tears. London: Middlesex University Press, 2004.
12 Royal College of Midwives. "Female Genital Mutilation", Position Paper, 21. London, 1998.

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. Healthcare 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.[13]

If appropriate to the encounter/consultation, a healthcare 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 vulvar examination may also be required and should be performed by an appropriate healthcare professional.

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.[14] They may have vivid traumatic memories surrounding the event. Privacy and discretion should be strictly adhered to, and properly informed consent obtained before examination. Keep the number of healthcare professionals to a minimum during examinations. Female healthcare 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

Healthcare professionals have a responsibility to protect children from FGM.

Some 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, healthcare 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.

It is important to reassure a woman who has undergone FGM that she herself is not guilty of an offence. It is however vital to discuss her beliefs surrounding FGM with her to ensure that her children are not at risk.[15]

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 and the child is considered to be potentially at risk.[16] If medical staff have concerns regarding female infants born to a woman who has undergone FGM, a referral to Tusla should be made (Children First Act 2015). If this concern does not exist then this too should be documented in the maternal healthcare record.

13 Ibid.
14 Vincent, M. "The Mutilated Orchid". Midwives Magazine, March 2005.
15 Institute of Obstetricians and Gynaecologists, Royal College of Physicians of Ireland (RCPI) and the Clinical Strategy and Provisions Office, Health Service Executive (HSE). "National Clinical Guideline, Management of Female Genital Mutilation (FGM)". February, 2019.
16 Ibid.

FGM
GYNAECOLOGICAL AND HEALTH ISSUES

The exact incidence of morbidity and mortality associated with FGM is difficult to measure. Only a small percentage of complications ever come to the attention of healthcare professionals. This may be due to the unavailability and inaccessibility of healthcare, ignorance, or the fear of legal retribution. Since many women have undergone 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.[17]

17 Elchahal, U. et al. "Ritualistic Female Genital Mutilation: Current Status and Future Outlook". Obstetric and Gynaecological Survey, 52 (USA, 1997), 643-51.

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)	• Death • HIV and other blood-borne viruses (BBV) • Septicaemia • Tetanus (also due to lack of tetanus toxoid injection) • UTI • 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	• Haemorrhagic (bleeding) • Neurogenic (pain) • Septic (infection)

URINARY TRACT PROBLEMS	• 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 UTI due to use of unsterilised equipment

INTERMEDIATE COMPLICATIONS OF FGM

DELAYED HEALING	Absence from school due to painful menstruation and lack of menstrual hygiene support.
ABSCESSES	Increased risk of childbirth complications and new born deaths.
SCARRING (keloid formation) DYSMENORRHEA and HAEMATOCOLPOS – obstruction to period flow	The need for later surgeries because some procedures seal or narrow the vaginal opening e.g. infibulation. The vagina must be cut later to allow for sexual intercourse or/and childbirth. Sometimes it is stitched again several times including after childbirth, hence a woman goes through repeated opening and closing procedures, further increasing repeated both short and long-term complications.

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 vulvar 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 WHO's Medical Eligibility Criteria for Contraceptive Use should be used as a reference guide.[18] 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	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 UTIs.
PAIN	• Chronic pelvic inflammatory disease (PID) • Dysmenorrhea due to genital tract obstruction • During procedures requiring speculum examination, e.g. smear-taking, insertion of intrauterine contraceptive devices (IUCD)
RETENTION CYSTS AND ABSCESSES	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	• 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	• Bladder, urethral or kidney stones due to urinary stasis or obstruction • Incontinence due to urethral damage or fistula formation and overdistended bladder • Recurrent upper or lower UTIs • Urinary retention and overdistension 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. Could be perceived as normal by the woman
VESICOVAGINAL OR RECTOVAGINAL FISTULA	Deinfibulation, reinfibulation or obstructed labour, leading to both faecal and urinary incontinence.

18 World Health Organization." Medical Eligibility Criteria for Contraceptive Use 3rd Edition". 2004.

COMPLICATIONS

- Risks can be higher with more extensive FGM.[19]
- FGM may cause vulva and vaginal scarring and adhesion, narrowing and obliteration of the vaginal opening. It can even cause a direct mechanical barrier to delivery.
- Inadequate assessment may physically compromise mother and fetus.
- 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 vulva scarring.
- Delayed/obstructed labour, mainly in the 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 (MNCMS) under Risk Factors and outline her Management Plan/Care Type.
- Counsel the woman and her partner about the consequences of FGM, discuss 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.
- Recurrent 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 UTIs, as they may be 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. However, often this does not happen in practice. The woman's birth plan should address analgesia.

19 Elchalal, U. et al. "Ritualistic Female Genital Mutilation: Current Status and Future Outlook". Obstetric and Gynaecological Survey, 52 (USA, 1997), 643-51.

WOMEN PRESENTING LATE IN DELIVERY

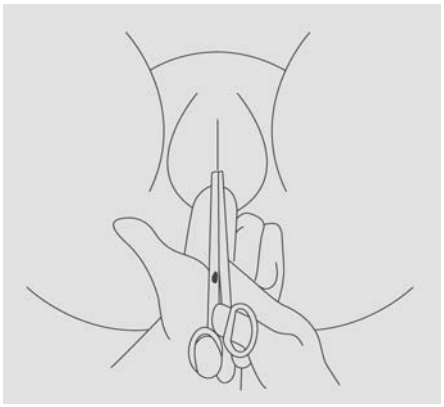
Women may delay presenting to the maternity hospital for several reasons. An uncontrolled delivery may lead to extensive laceration and haemorrhage. Tears may involve the urethra and bladder anteriorly and the rectum posteriorly. If not managed correctly, there is a high risk of fistula formation in 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. Obstetricians attending the labour ward should be familiar with intrapartum deinfibulation and training should be offered and updated regularly.

INTRAPARTUM CARE/WOMEN PRESENTING IN EARLY LABOUR

- Use a sensitive, sympathetic, and non-judgemental approach with the woman.
- Develop a rapport.
- If language is a barrier, obtain an 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, which can also be discussed antenatally.

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 the anterior incision should be sutured after labour (leaving the introitus open), unless suturing beforehand will control excessive bleeding. Do not reinfibulate.



POST-NATAL CARE

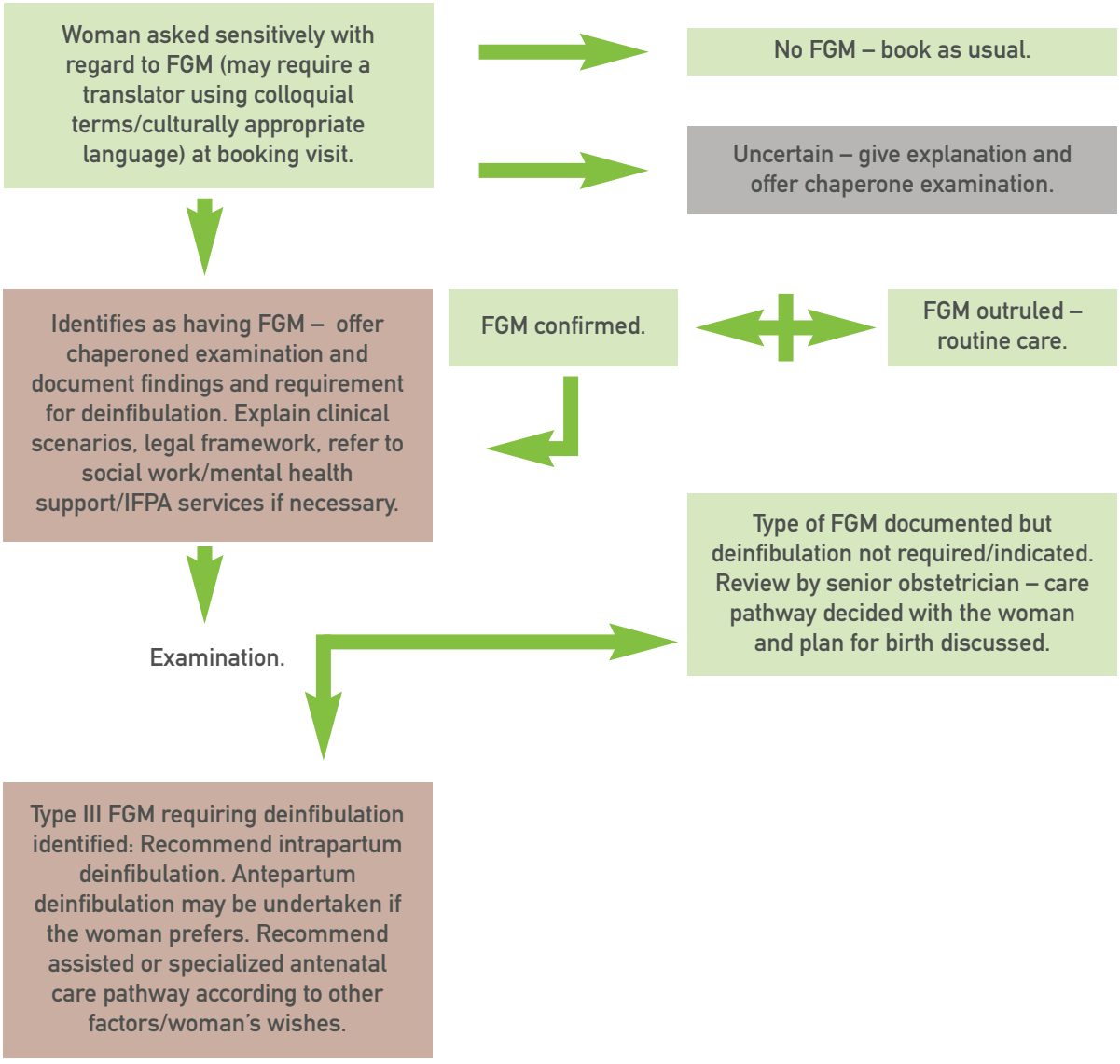
- The mother/woman with FGM does not fit into the category of a routine visit; she will require extra time for post-natal follow-up.
- Healthcare professionals should address the specific needs of women with FGM in a sensitive and compassionate manner, with an emphasis on good post-natal hygiene.

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

- Keep clear documentation in the maternity record for future pregnancies, including accurate completion of paper or electronic (MNCMS) Healthcare Record.
- Make onward referral(s), if necessary, to urogynaecology physiotherapy, especially in cases of FGM Type III.

FGM
NATIONAL CLINICAL GUIDE: MANAGEMENT OF FGM

BOOKING VISIT PATHWAY FOR THE CARE OF A PREGNANT WOMAN WHO MAY HAVE UNDERGONE FGM – FROM THE NATIONAL CLINICAL GUIDELINE[20]



20 RCPI and HSE, "National Clinical Guideline, Management of Female Genital Mutilation (FGM)".

FGM
PSYCHOLOGICAL ISSUES

Research suggests that women who have undergone FGM are at an increased risk of developing psychological and emotional health problems.[21]

While research in this area is limited, one UK study has explored the psychological effects of FGM on 53 women.[22] 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).

21 Behrendt and M Oritz, S. "Post-traumatic Stress Disorder and Memory Problems After Female Genital Mutilation". American Journal of Psychiatry, 162:5 (May 2005), 1001-2.

22 Dorkenoo E, Morison L, Macfarlane A. A statistical study to estimate the prevalence of female genital mutilation in England and Wales. Summary report. London: Foundation for Women's Health, Research and Development (FORWARD), 2007. http://openaccess.city.ac.uk/13117

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. It is also important to be conscious of the fact that other issues going on in a woman's life may contribute to the above psychological complaints.

KEY EVENTS THAT CAUSE FGM-RELATED ANXIETY

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	• Fear of pain and anxiety surrounding gynaecological and obstetric procedures and delivery. • Fear of 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. These problems may affect both the woman and man in a relationship.

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.'[23]

23 American Psychiatric Association. "Diagnostic and Statistical Manual of Mental Disorders". Washington, 1994.

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.[24]

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.[25]

24 Momoh, C. (ed.) Female Genital Mutilation. Abingdon: Radcliffe, 2005.
25 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[26]

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 (Minera) 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.

26 World Health Organization. "Medical Eligibility Criteria for Contraceptive Use, 3rd Edition".

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
Equality Now	www.equalitynow.org/the_law_and_fgm
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

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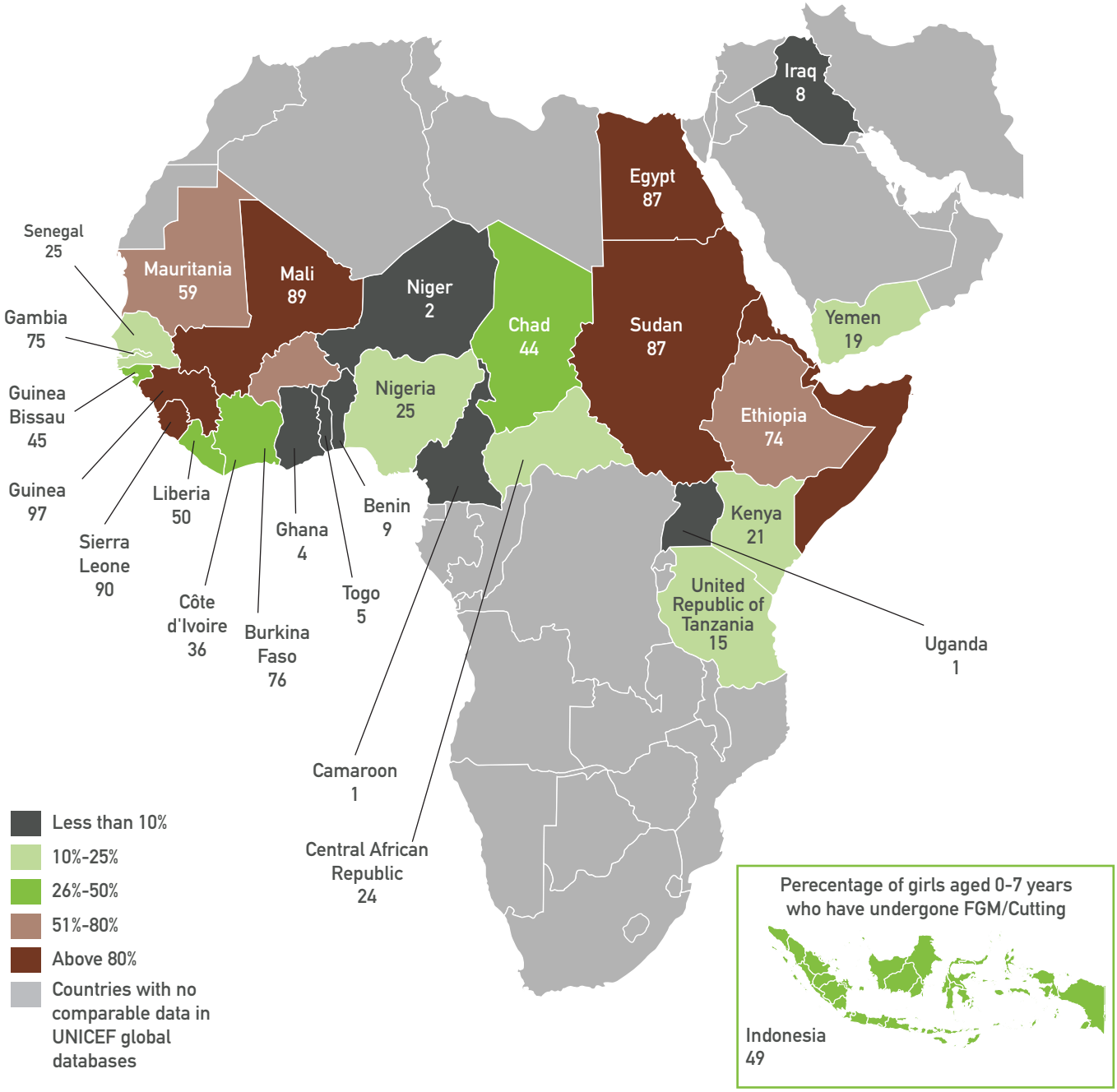
FGM

FGM MAP OF AFRICA

FEMALE GENITAL MUTILIATION AND CUTTING, UNICEF DATA, FEBRUARY 2020
https://data.unicef.org/topic/child-protection/female-genital-mutiliation/



UNICEF global databases, 2016, based on DHS, MICS and other nationally representative surveys, 2004-2005

AkiDwA
Unit 2,
Killarney Court,
Upper Buckingham Street,
Dublin 1,
Republic of Ireland.

T: (+1 353) 01 834 9851
E: info@akidwa.ie
W: www.akidwa.ie

Rialtas na hÉireann
Government of Ireland

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Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive