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Review Article

Health Education Program: "Sexuality in Women Female Genital Mutilation Victims (FGM)"

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Abstract

A program of Sexual Education aimed at mutilated women is presented, which is included in pre-constituted groups that address issues related to care and health. This program will be run by midwives and cultural mediators and requires interdisciplinary collaboration.

The objective of the program is to promote the positive experience of sexuality in mutilated women.

A six-session Health Program is proposed with educational objectives and outcome criteria. It is suggested to carry out the evaluation through a questionnaire, which will indicate the changes in knowledge, skills and attitudes produced, together with indicators of coverage, process and results and a satisfaction questionnaire.

Keywords: *Sexual Education; Sexuality; Female Genital Mutilation*

Introduction

Female Genital Mutilation (FGM), according to WHO, comprises all procedures involving the partial or total removal of external genitalia or any damage to female genitalia other than for medical reasons [1].

In most cases, FGM is performed by traditional circumcisers who often have other important functions in their communities, such as assisting in childbirth. The practice is carried out under poor hygienic conditions and with various utensils, ranging from a knife to a can or broken glass.

In many places, health care providers practice mutilation in the mistaken belief that the procedure is safer if performed under medicalized conditions. WHO, however, strongly urges health professionals to refrain from such interventions.

It is now known that in urban areas and in high-income families, FGM is performed by qualified health personnel under good hygienic conditions and with the use of analgesia. More than 18 per cent of FGM is performed by health care providers in the countries of origin, and this trend is increasing.

Although ablation cannot be justified on medical grounds, in many countries it is carried out by medical professionals, which constitutes a threat to the abandonment of this practice. Ablation is a highly valued and paid service, so it is easy to infer that the prestige in the community and the income of these people are linked to the practice of the intervention [1].

Although it is mainly concentrated in countries in Africa and the Middle East, it is a universal problem and is practiced in some countries in Asia and Latin America. In addition, it persists in the migrant populations of Western Europe, North America, Australia and New Zealand.

It is estimated that more than 140 million women and girls have undergone genital mutilation, which in most cases is carried out at some point between the ages of breastfeeding and 15 years. It is a common practice in the cultural context of rites of passage to adulthood and as an element of socialization of girls [2].

In Spain, FGM is a reality that is not very visible, but globalization, the media and the increase in immigration have made more and more people aware of its existence. In recent years, Spain has become a destination for people coming from countries where it is practiced, which can lead to professionals encountering this problem [2].

Although the practice has continued for more than a thousand years, there is reason to believe that it can be ended in a single generation. UNFPA, together with UNICEF, is leading the global programme to accelerate the abandonment of the practice, focusing on 17 African countries [4].

FGM is often motivated by beliefs about “proper sexual behaviour”, linked to premarital virginity and fidelity. It is considered to reduce female libido by helping women resist “illicit” sexual acts; but they do not believe it has a negative effect on women’s sexual pleasure or marital happiness, because they use male sexual satisfaction as a measure. Men see FGM as a way of ensuring chastity and fidelity and are concerned about the negative effects it may have on their own sex lives, but are not concerned if it reduces sexual pleasure in women [1].

FGM is a manifestation of gender-based violence, and constitutes a form of discrimination against women, based on a number of deeply held beliefs and perceptions in some communities. The practice violates their rights to health, safety and physical integrity, the right not to be subjected to torture and cruel, inhuman or degrading treatment, and the right to life in cases where it results in death [1,2].

It is a health problem that transcends the assistance framework, where the violation of human rights, the need for a transcultural approach and the moral commitment to avoid traditional practices that imply discriminatory, degrading and painful treatment towards women converge [5].

Collaboration between health professionals and other disciplines is essential for communication, advice, support and monitoring of affected communities, as well as for the detection and prevention of this practice. Early childhood sex education, political support, training of health providers and religious leaders, along with community programmes, are key to the approach. People exposed to anti-FGM messages are more likely to identify the sexual problems involved and not want to impose it on their daughters [1].

One of the most effective instruments for dealing with the social dynamics of FGM is the protocols for action in some autonomous communities. At a state level, it is in 2015 when a common protocol of health action against FGM is created [2].

Sex education is a necessary, privileged and useful tool for tackling the prevention of FGM. Sexual and reproductive health is understood within the integral right to health [6,7].

When sexual and reproductive health is worked on, gender equality is promoted, which is decisive in order to go further in favour of “no female genital mutilation” [2].

In Spain, some 17,000 girls could be at risk of being mutilated. In 2012, Médecins du Monde treated almost 800 women of 23 different nationalities and 360 required health, social and psychological care [4].

Catalonia is the autonomous community with the highest number of women from countries where this practice exists. The Community of Madrid is the second region of Spain [6].

For all these reasons, the choice of the topic for the elaboration of a sexual education programme for women victims of FGM is justified. It is of vital importance to carry out this programme, so that midwives, nurses and other health, education and social service professionals can deal with this practice with sufficient information and cultural sensitivity.

FGM typology

According to WHO, four types of FGM are identified [1-6] (Figure 1):

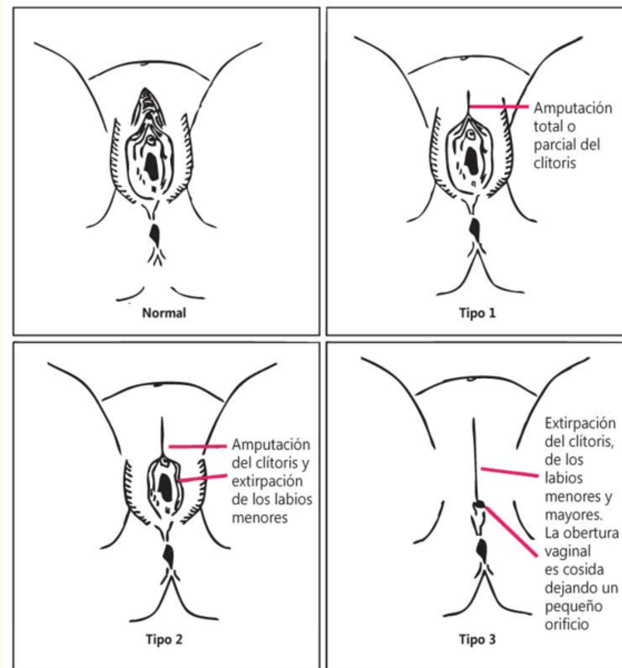

Figure 1

- Type I Clitoridectomy: Removal of the foreskin of the clitoris, with or without partial or total excision of the clitoris. In the Islamic world it is known as sunna.
- Type II Excision: Ablation of the clitoris and total or partial removal of the labia minora, leaving the labia majora intact.
- Type III Infibulation: Removal of the clitoris, labia minora, labia majora and suture of both sides of the vulva. A small hole is left for the evacuation of urine and menstrual flow.
- Type IV: Procedures that are harmful to the external genitals for non-medical purposes, such as perforation, incision, scraping, cauterization of the genital area, introduction of substances into the vagina to cause bleeding from the vagina, in order to reduce or narrow it, etc.

The type of FGM that is performed varies according to the geographical area. Types I and II constitute 80 - 85% of mutilations, predominantly in western and central sub-Saharan Africa; while type III is more common in eastern Africa. Although it is estimated that

infibulation is performed on 15 - 20% of all women who undergo FGM, it is predominant in some countries in the Horn of Africa such as Somalia, Sudan and Djibouti, where it affects 80 - 90% of women. On a smaller scale, it is carried out in Egypt, Eritrea, Ethiopia, Gambia, Kenya and Mali [6].

Consequences of FGM

FGM is considered a public health problem because of the complications it has, both physical and psychological, with a strong impact on women's health and well-being [3].

Although there are people in Spain who perform FGM, generally immigrant families perform it while travelling to their country of origin, where it is often performed by unskilled personnel and in septic conditions, and many girls die due to bleeding or infection. The degree of mutilation conditions the type of complication, we can find late obstetric, urinary, sexual, gynecological complications, etc [3].

In a systematic review that included 17 comparative observational studies with 12,755 participants from communities where FGM is performed, we concluded that there is little quality evidence on the consequences of the practice in order to establish causal relationships, but the results show that mutilated women experience dryness and pain during intercourse, reduced sexual desire and satisfaction, and no or few orgasms [8].

Some studies suggest that women with FGM are more likely to suffer from psychological disorders such as anxiety, somatization, phobias or depression [8].

Acute complications	Subacute complications	Long-term complications
Bleeding Intense pain Infection, Sepsis or gangrene Damage to adjacent tissues: urethra, vagina, rectum Urinary retention Tetanus	Anemia Transmission of HIV, HCV, etc. Repeat UTIs Delayed healing Fear, anguish, stress, anxiety.	Genitourinary: Repeat UTI kidney failure, pelvic inflammatory disease, incontinence, dysmenorrhea, hematocolpos, salpingitis, development of neovagina, abdominal pain, fistulas. Sexual: Stenosis of the vaginal introitus, dyspareunia, decreased desire, anorgasmia, negative experience of sexuality, vaginismus. Reproductive: Infertility. Obstetrics: Problems in pregnancy and childbirth, tears, fistulas, fetal distress. Mental health: Feelings of humiliation, guilt, night terrors, insomnia, anxiety, depression, eating disorders, difficulty concentrating, low self-esteem, post-traumatic stress syndrome. Abnormal healing: Keloids, dermoid cysts, neuromas or synechiae.

Table 1: *Summarizes the main complications.*

Legal framework concerning FGM

In Spain, FGM is covered by law and constitutes a crime of injury as defined in the Criminal Code (Act 10/1995 as amended by Organic Law 11/2003).

The Spanish jurisdiction is competent to prosecute FGM performed both on national territory and outside it, provided that it has been performed on a person habitually resident in Spain (even if it takes place abroad), that it is performed by a person with Spanish nationality or residence, or that it is performed in Spain.

Healthcare personnel are obliged to inform the judicial authority of the possible existence of a criminal act [12-14].

Approach to sexuality

Sexuality is a fundamental area in people’s development, as it is related to well-being, health and quality of life, and is considered a universal right. However, it is frequently forgotten in the intercultural dialogue and incorporated with difficulty in the programs related to basic needs, because it is a subject loaded with taboos [15].

Working with immigrant populations requires knowledge of their cultural characteristics. In populations where FGM is performed, sexuality is often linked to sin, shame and guilt. In addition, women often do not even know their genitals and are in a relationship of rejection towards them [15].

For this reason, the approach to sexuality cannot be carried out in these groups directly, without previous work in other fields that encourage a gradual approach to sexuality and FGM. In order to promote this approach, this type of program should be included in groups already established with other objectives.

It is necessary to explore the referential schemes of the culture, and to respect its diversity, because each culture and each person has the right to build their own vision of sexuality, always respecting human rights.

For all these reasons, a health education programme is proposed and described for women victims of FGM, focusing on the approach to sexuality in all its spheres, taking into account the particularities of the population, and providing a starting point for the prevention of FGM in future generations.

Target population

Immigrant women, over 18 years old, who have undergone FGM.

Recruitment

Through posters in support groups or NGO partners. The incorporation of intercultural mediators to the team is required to allow the monitoring of the project and to facilitate communication. Due to the characteristics of the population and the topic to be dealt with, the project will be framed within activities carried out with an already established group, as a complement to their training.

Coverage

30% of the target population.

Overall objective

Women will acquire knowledge, attitudes and skills to have a positive experience of their sexuality.

The specific objectives and their operational targets are set out in table 2.

Specific Objectives	Operational goals
Cognitive	
They will describe basic aspects of FGM: consequences, sequels, legal aspects and impact on sexuality.	70% of the participants will express the impact of FGM.
They will describe fundamental aspects of their sexuality and different ways of living it out satisfactorily.	70% of the participants will say that they have discovered positive aspects about sexuality.
Affective	
They will analyze fears, doubts, barriers and repercussions of FGM.	80% of the women will say that they have tools that facilitate the expression of their feelings.
They will develop positive experiences in relation to themselves and their sexuality.	50% of women will say they feel better about themselves.
They will analyze emotions regarding their sexuality.	80% of women will express their emotions about their sexuality.
They will analyse society’s attitudes towards FGM.	80% of women will become aware of the social influence on FGM.
Skills	
They will develop effective communication skills with their partner.	50% of women will report an improvement in communication with their partner.
They will acquire the tools to live their individual or couple sexuality in a satisfactory way.	50% of the women will be satisfied with the changes experienced.

Table 2

Development of interventions

- Number of sessions: 6
- Duration of each session: 120 minutes
- Periodicity: Weekly
- Timing: Annual
- Place: Space provided by collaborating NGO
- Participants: 10.

The content of the sessions is presented in table 3.

Session 1: Introduction to sexuality						
Educational objectives	**Content**	**Technical**	**Grouping**	**Time**	**Resources**	**Evaluation**
Women will express expectations of attending the program.	Introduction-Presentation	Group caded: Introduce your partner	GP	20 min	Slate	Initial oral evaluation
They will identify their knowledge and attitudes to sexuality.	What is sexuality to you?	Classroom Research: Rain of Ideas	GG	30 min	Slate	Final questionnaire
They will explore their emotions about their sexuality.	“Sex excites me”	Paper reflection	Individual	30 min	Tab and slate	Final questionnaire
They will recognize the dimensions of sexuality.	Definition related terms.	Colloquium Talk	GG	20 min	PowerPoint	Final questionnaire

<table>
<tr><td>They'll verbalize what they've learned.</td><td>Summary and closure. Homework: Explore your body. Look and observe how it looks.</td><td>Wheel-colloquium</td><td>GG</td><td>20 min</td><td></td><td>Oral evaluation</td></tr>
<tr><td>Educational goals</td><td>Content</td><td>Technical</td><td>Time Grouping</td><td>Time</td><td colspan="2">Resources</td></tr>
<tr><td>The woman will express herself to be in an appropriate climate to express her feelings</td><td>Introduction-Presentation</td><td>Group broth: Saying a word that defines how you are now</td><td>GG</td><td>15 min</td><td colspan="2">Slate</td></tr>
<tr><td>Women will analyze their perceptions, feelings and emotions about their body</td><td>How do I look? What difficulties have I had during the task?</td><td>Wheel-colloquium</td><td>GG</td><td>30 min</td><td colspan="2"></td></tr>
<tr><td>The woman will identify positive aspects of herself.</td><td>Acceptance of body image.

What do I like about me?</td><td>Photo booth</td><td>GP</td><td>30 min</td><td colspan="2">PC+projector

Post-it</td></tr>
<tr><td>Women will become aware of the changing nature of self-esteem</td><td>Identify ingasing situations to raise or decrease self-esteem.</td><td>Brainstorming</td><td>GP</td><td>30 min</td><td colspan="2">Sheets of paper and pencils</td></tr>
<tr><td>They will verbalize what they learned in the session</td><td>Summary and closure. Homework: Preguntar 3 people who think of FGM.</td><td>Wheel-colloquium</td><td>GG</td><td>15 min</td><td colspan="2"></td></tr>
<tr><td colspan="7">Session 3: FGM prevention</td></tr>
<tr><td>Educational goals</td><td>Content</td><td>Technical</td><td>Time Grouping</td><td>Time</td><td colspan="2">Resources</td></tr>
<tr><td>The woman will express positive feelings about herself and towards others.</td><td>Introduction-presentation</td><td>Group heating: hug dynamics</td><td>GG</td><td>10 min</td><td colspan="2"></td></tr>
<tr><td>Reflect on the group's influence on FGM.</td><td>Women's empowerment.</td><td>Video "Moolaadé"

Philips 4/4</td><td>GG

GP/GG</td><td>30 min</td><td colspan="2">PC+proyector

Pizarra</td></tr>
<tr><td>They will identify forms of FGM, their involvement in daily life and legal impact.</td><td>Reality of FGM</td><td>Talk</td><td>GG

Couples</td><td>30 min</td><td colspan="2">Power Point

Fotos</td></tr>
<tr><td>The woman will be able to identify FGM prevention strategies.</td><td>What can you do to avoid FGM?</td><td>Brainstorming</td><td>GG</td><td>30 min</td><td colspan="2">Slate</td></tr>
<tr><td>They will verbalize what they learned in the session.</td><td>Summary and closure. Homework: Give yourself 10 minutes each day to do something that makes you feel good.</td><td>Wheel-colloquium</td><td>GG</td><td>20 min</td><td colspan="2"></td></tr>
</table>

Session 4: Feel workshop					
Educational goals	**Content**	**Technical**	**Time Grouping**	**Time**	**Resources**
Women will participate in verbal expression activities through rhythms andmusic.	Welcome: pass each other's woolball into a net	Caldeamiento grupal: dinámica del ovillo con música.	GG	20 min	Music player Wool ball
They will participate in relaxation activities.	Internalize our body, take out tensions, enjoy the feeling of relaxation, and liberation.	Relaxation	Individual	20 min	Music, PC, incense, candles...
They will express feelings that show satisfaction about their sexuality.	Discover everything that can be transmitted, communicate and receive through our body and body language.	Practical workshop-demonstration. “Placereado”	GP-Couples	30 min	Feathers, balls, fabrics
They will verbalize what they learned in the session.	Summary and closure. Homework: Write 3 good things to you every day.	Wheel-Colloquium	GG	20 min	
Session 5: Communication skills					
Educational goals	**Content**	**Technical**	**Time Grouping**	**Time**	**Resources**
Women will participate in disinhibition activities.	Welcome	Group heating: sensual music and movement	GG	20 min	PC o reproductor musical
The woman will express her ability to communicate personal attitudes to aspects of her sexuality	Work communication on sexuality.	Role-playing: Assertiveness	GP-GG	30 min	
Women will demonstrate assertively in the face of their own beliefs.	Verbalize desires and ways of thinking without pressure for the environment.	Striped disc: Knowing how to say NO	GP: Couples	25 min	Tabs with examples. Situations to work assertiveness.
Verbal will hoist what they have learned and show greater personal self-knowledge.	Summary and closure. Tasks for home: reserve some time for yourself, to enjoy (give yourself abath, walk...)	Colloquium Wheel	GG	30 min	
Session 6: Farewell					
Educational goals	**Content**	**Technical**	**Time Grouping**	**Time**	**Resources**
Women will reflect on what they have learned.	What the workshop has given me. In that it has changed me.	Photo-word Discussion	GP GG	15 15	Photographs Slate
Women will reflect on female identity in different cultures.	What clothing the figure wears, what you choose, and why.	Exercise: Painting a woman with colors.	GP	15 min	Drawings, paintings
Women will express their feelings through dancing.	What makes me feel about music.	Dance	GG	15 min	Music and music player.
Women will strengthen ties through dishes typical of each ethnicity.	Each ethnic group will bring a typical dish and present it to the group.	Food party	GG	40 min	Tables, tablecloths, napkins.
Women will share moments and create bonds of support.	Farewell	Closing	GG	10 min	

Evaluation

The aim is to assess the achievement of the objectives set at the beginning of the program, considering the result criteria, for which it will be carried out:

- Continuous evaluation during the sessions. The observer will have a registration sheet in which he will note down attendance and participation data for each session.
- Final questionnaire, including a satisfaction questionnaire.

To evaluate the degree of achievement of the objectives, coverage, process and results indicators have been developed. If these objectives are not met, improvement measures will be proposed.

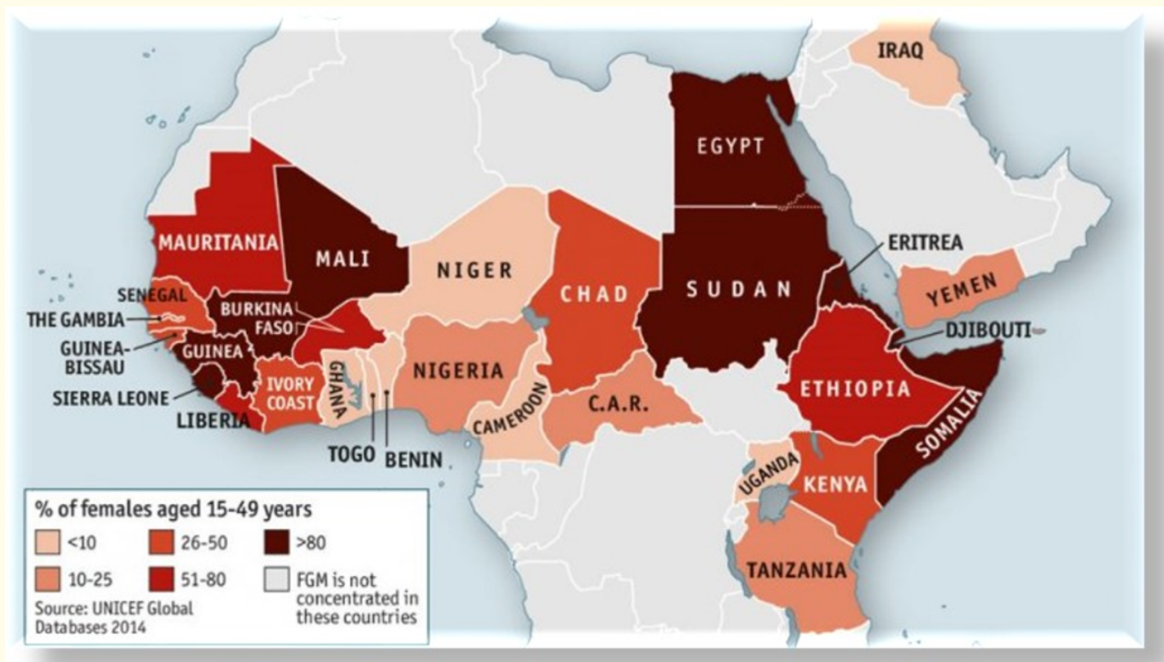

Figure 2

Indicators for the evaluation of coverage:

Three indicators will be taken into account (their calculation is explained in annex 2):

- Overall coverage rate: 70% of women will attend all sessions.
- Adherence rate: 70% of women will attend regularly (4 out of 6 sessions).
- Dropout rate: It is expected that 30% of women will drop out of the programme.

Indicators for structure evaluation: The level of satisfaction with the material and human resources, the schedule and the organization of the programme is evaluated. A questionnaire will be given to evaluate these aspects by means of a Likert Scale.

90% of the women will express their satisfaction in the evaluation, which will be evaluated in questions 10-12 of the evaluation questionnaire.

Indicators for the evaluation of the process:

Three indicators will be taken into account:

- Percentage of sessions carried out.
- Percentage of completion of methodological techniques.

Indicators for the evaluation of results: The results of the programme will be evaluated through a questionnaire to determine the acquisition of knowledge and skills (Annex 1). The calculation will be made independently for each of the sessions.

Conclusion

A Sex Education programme for women victims of FGM has been developed in order to raise awareness among all health professionals of the magnitude of this public health problem. In addition, this programme is intended to teach these women how to live a satisfactory sexuality in all their spheres.

Currently, this is a pioneer program, as far as we know, there is no specific program that addresses sexuality in these women. Despite the fact that the Community of Madrid is the second Autonomous Community in our country that receives women from countries where FGM is practiced, currently no Health Education program is being carried out with these women.

With the implementation of this programme, the aim is for these women to have a positive experience of their sexuality, in all its spheres.

Furthermore, we intend to raise awareness not only among health professionals of the devastating consequences of this practice, but also among women who have been victims of FGM, since only with their collaboration can we contribute to the eradication of this practice, which is a benefit for global public health.

We believe that it is not going to be easy to carry out this practice since we need the support of NGOs and cultural mediators to tell us how best to reach this population.

After the implementation of the program, an analysis of the structure, process and results should be made in order to find points for improvement in future editions and to carry out comparative studies to evaluate how our objectives can be better achieved.

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None.

Conflict of Interest

None.

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