Guideline

Ministry of Health, NSW
73 Miller Street North Sydney NSW 2060
Locked Mail Bag 961 North Sydney NSW 2059
Telephone (02) 9391 9000 Fax (02) 9391 9101
http://www.health.nsw.gov.au/policies/

Maternity-Pregnancy and Birthing Care for Women Affected by Female Genital Mutilation / Cutting

Document Number GL2014_016

Publication date 23-Sep-2014

Functional Sub group Clinical/ Patient Services - Maternity

Summary The purpose of this document is to assist health care professionals within NSW Public Health Organisations to provide sensitive and culturally appropriate, evidence-based antenatal, intrapartum and postnatal care for women and their families affected by Female Genital Mutilation/Cutting (FGM/C). It is an expectation that clinical care provided to women with FGM/C will be provided in accordance with these guidelines.

Author Branch NSW Kids and Families

Branch contact NSW Kids and Families 02 9424 5868

Applies to Specialty Network Governed Statutory Health Corporations, Public Health Units, Public Hospitals

Audience All Clinicians in Maternity Services

Distributed to Public Health System, Divisions of General Practice, NSW Ambulance Service, Ministry of Health, Private Hospitals and Day Procedure Centres, Tertiary Education Institutes

Review date 23-Sep-2019

Policy Manual Patient Matters

File No. 13/3946

Status Active

Director-General

MATERNITY-PREGNANCY AND BIRTHING CARE FOR WOMEN AFFECTED BY FEMALE GENITAL MUTILATION / CUTTING

PURPOSE

The purpose of this document is to assist health care professionals within NSW Public Health Organisations to provide sensitive and culturally appropriate, evidence-based antenatal, intrapartum and postnatal care for women and their families affected by Female Genital Mutilation/Cutting (FGM/C). It is an expectation that clinical care provided to women with FGM/C will be provided in accordance with these guidelines.

KEY PRINCIPLES

Women with FGM/C are significantly more likely than those without FGM/C to have adverse obstetric outcomes. As more women from these countries settle in Australia, clinicians working within maternity services will increasingly need to become familiar with the skills required to optimise the health of women affected by FGM/C during pregnancy and childbirth.

USE OF THE GUIDELINE

Tiered Maternity Networks (Section 1.5.1)

Delivering best practice care will require a coordinated approach within NSW public hospitals for women affected by FGM/C, including support, counselling and related surgery.

Consultation and referral pathways should also be in place to facilitate the woman's movement between services within her tiered maternity network, to enable her to access skilled care. Local Health Districts (LHDs) should ensure that local guidelines for referral and transfer remain current and are in line with State policy.

Maternity Units in LHDs with a high population of women from countries that practice FGM/C (section 1.5.2)

These facilities should consider establishing an experienced designated team specialising in FGM/C issues, potentially comprising the following staff:

- Midwife
- Doctor
- Nurses, including women's health nurse, child and family health nurse
- Mental Health workers.

The designated team members should:

- Have a sound knowledge of FGM/C and understand the cultural and social complexities around the practice of FGM/C and its health effects through established contact with the NSW Education Program on FGM (WSLHD)[2]
- Undertake regular clinical education / training on FGM/C. More information can be obtained through the NSW Education Program on FGM (WSLHD)[2]
- Act in an advisory capacity or a referral point for maternity units that see fewer affected women.

Maternity Units in LHDs with a low population of women from countries that practice FGM/C

Although all LHDs should be familiar with guidance provided in this guideline it may not be practical for facilities to establish or maintain substantial local expertise. This may be due to factors such as low incidence of FGM/C, staff turnover and difficulty in accessing clinical education / training on FGM/C. In such instances, it will be necessary for these hospitals to establish and maintain links with hospitals that have staff with the required expertise in their tiered maternity network or source the nearest facility that offers FGM/C expertise. These arrangements will be best determined locally. Advice on appropriate contacts and clinical education/training can be sourced from the NSW Education Program on FGM.

REVISION HISTORY

Version	Approved by	Amendment notes
July 2014 (GL2014_016)	Deputy Secretary, Population and Public Health	New guideline

ATTACHMENTS

1. Maternity-Pregnancy and Birthing Care for Women Affected by Female Genital Mutilation/Cutting-Guideline

Maternity-Pregnancy and Birthing Care for Women Affected by Female Genital Mutilation / Cutting Guidelines

GUIDELINES

Issue date: September 2014

GL2014_016

CONTENTS

1. BACKGROUND 1

1.1 Purpose 1

1.2 Context 1

1.3 Classification of the different types of FGM/C 2

1.4 Key definitions 2

1.5 Service responsibilities 2

1.5.1 Tiered Maternity Networks 2

1.5.2 Local Health District Responsibilities 3

1.6 Legal implications 3

2. CLINICAL MANAGEMENT 4

2.1 Antenatal 4

2.1.1 Health implications associated with FGM/C during pregnancy 4

2.1.2 Care of the woman during pregnancy 5

2.2 Intrapartum 8

2.2.1 Implications for birth in relation to FGM/C 8

2.2.2 Care of the woman during labour and birth 8

2.3 Postnatal care 11

2.3.1 Health implications associated with FGM/C during the postpartum period 11

2.3.2 Care of the woman during the postpartum period 11

REFERENCES 13

APPENDIX A: 14

APPENDIX B 15

APPENDIX C 16

APPENDIX D 18

1. BACKGROUND

1.1 Purpose

The purpose of this document is to assist health care professionals within NSW Public Health Organisations to provide sensitive and culturally appropriate, evidence-based antenatal, intrapartum and postnatal care for women and their families affected by Female Genital Mutilation/Cutting (FGM/C). It is an expectation that clinical care provided to women with FGM/C will be provided in accordance with these guidelines.

This document refers frequently to a comprehensive national resource[1], "*Improving health care of women and girls affected by female genital mutilation/cutting: A national approach to service coordination"* which addresses the broader health care needs of women and girls affected by FGM/C. The term Female Genital Mutilation/Cutting (FGM/C) is used throughout this national resource document to reflect the importance of using non-judgemental and culturally sensitive language. For consistency, this language has also been incorporated within the NSW guideline, except when referencing or quoting other sources.

This document has been prepared with the assistance of the NSW Education Program on FGM[2] and an Expert Advisory Group comprising of representatives from the Ministry of Health, Auburn Hospital, the Refugee Health Service, the NSW FGM Bilingual Community Workers, the Sudanese Australian Women's Association and members from communities affected by FGM/C.

1.2 Context

Female genital mutilation/Cutting (FGM/C) is a complex reproductive health issue, with multiple obstetric, gynaecological, sexual and psychological consequences.

FGM/C is a traditional practice that occurs in more than 40 countries, including communities in 28 African countries, communities in countries in the southern parts of the Arab peninsula and along the Persian Gulf, and in communities in India, Indonesia and Malaysia. The prevalence of FGM/C varies considerably, both between and within countries[3].

It is estimated that in the world there are over 130–140 million women and girls who have undergone some form of FGM/C, and it is further estimated that FGM/C is performed on up to 2-3 million girls each year[1]. Most women who have experienced FGM/C live in Somalia, Egypt, Guinea, Sierra Leone, Djibouti, Mali, Sudan and Eritrea[4] See Appendix A for prevalence of FGM/C by country.

The continuation of FGM/C is motivated by a complex mix of interlinked socio-cultural factors, which vary from region to region, within single countries, between and even within practising communities. It is deeply rooted in tradition and is supported by a wide range of beliefs and sociological pressures[1], and considered a rite of passage within some communities. It should be noted that women will hold diverse views about the practice of FGM/C.

Women with FGM/C are significantly more likely than those without FGM/C to have adverse obstetric outcomes. As more women from these countries settle in Australia, clinicians working within maternity services will increasingly need to become familiar with the skills required to optimise the health of women affected by FGM/C during pregnancy and childbirth.

1.3 Classification of the different types of FGM/C

The FGM/C types are illustrated in Appendix B

Type I	Excision of the prepuce, with or without excision of part or the entire clitoris (clitoridectomy or circumcision).
Type II	Excision of the clitoris with partial to total excision of the labia minora (excision).
Type III	Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).
Type IV	Unclassified: includes pricking, piercing, or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterisation by burning of the clitoris and surrounding tissue; scraping of the tissue surrounding the vagina.

1.4 Key definitions

Clitoridectomy: Refers to excision of the clitoris

De-infibulation (sometimes referred to as de-infibulation or de-fibulation or FGM/C reversal): The surgical procedure to open up the closed vagina of FGM/C Type III

Excision: Refers to removal of the clitoral hood, with or without removal of part or all of the clitoris

Female Genital Mutilation/Cutting (FGM/C): Comprises all procedures involving partial or total removal of the external genitalia or other injury to the female genital organs for non-medical reasons

Infibulation or Pharaonic circumcision: Refers to FGM/C Type III, the most extensive form of FGM/C

Re-infibulation (sometimes referred to as re-suturing): The re-suturing of FGM/C Type III to re-close the vagina again after childbirth.

Sunna: The traditional name for a form of FGM/C that involves the removal of the prepuce of the clitoris only. 'Sunna' is often used in FGM/C practicing communities to refer to all forms of FGM/C, not just FGM/C that involves the removal of the hood of the clitoris

1.5 Service responsibilities

1.5.1 Tiered Maternity Networks

Consultation and referral pathways should be in place to facilitate the woman's movement between services within her tiered maternity network, to enable her to

access skilled care. LHDs should ensure that local guidelines for referral and transfer remain current and are in line with State policy.

1.5.2 Local Health District Responsibilities

Delivering best practice care will require a coordinated approach within NSW public hospitals for women affected by FGM/C, including support, counselling and related surgery.

Maternity Units in Local Health Districts (LHDs) with a high population of women from countries that practice FGM/C

These facilities should consider establishing an experienced designated team specialising in FGM/C issues, potentially comprising the following staff:

- Midwife
- Doctor
- Nurses, including women's health nurse, child and family health nurse
- Mental Health workers.

The designated team members should:

- Have a sound knowledge of FGM/C and understand the cultural and social complexities around the practice of FGM/C and its health effects through established contact with the NSW Education Program on FGM (WSLHD)[2]
- Undertake regular clinical education / training on FGM/C. More information can be obtained through the NSW Education Program on FGM (WSLHD)[2]
- Act in an advisory capacity or a referral point for maternity units that see fewer affected women.

Maternity Units in LHDs with a low population of women from countries that practice FGM/C.

Although all LHDs should be familiar with guidance provided in this document it may not be practical for facilities to establish or maintain substantial local expertise. This may be due to factors such as low incidence of FGM/C, staff turnover and difficulty in accessing clinical education / training on FGM/C. In such instances, it will be necessary for these hospitals to establish and maintain links with hospitals that have staff with the required expertise in their tiered maternity network or source the nearest facility that offers FGM/C expertise. These arrangements will be best determined locally. Advice on appropriate contacts and clinical education/training can be sourced from the NSW Education Program on FGM[2].

1.6 Legal implications

In NSW FGM/C is covered under specific legislation *The Crimes (Female Genital Mutilation) Amendment Act 1994* (NSW)[5], enacted May 1995.

Section 45 states that:

A person cannot:

- Excise, infibulate or mutilate the whole or any part of the labia minora or labia majora or clitoris of another person
- Aid, abet, counsel or procure a person to perform any of those acts on another person.

This means that it is against the law for non-therapeutic purposes to:

- Circumcise a woman, girl or female baby.
- Remove or cut out any part of the female genital area ('excise').
- Stitch up (close) the labia majora or labia minora of the female genitalia (infibulation). Whilst it is undesirable and should under no circumstances be supported or recommended its absolute illegality is not entirely clear as legislation varies between jurisdictions.
- Cut the clitoris or part of the clitoris.
- Damage the female genital area in other ways.

2. CLINICAL MANAGEMENT

2.1 Antenatal

2.1.1 Health implications associated with FGM/C during pregnancy

Pregnant women who have experienced Types 2 and 3 FGM/C and have not undergone de-infibulation are more at risk of the following health issues during the antenatal period[6]:

Examinations during pregnancy

Difficulty with vaginal and/or speculum examination during pregnancy

Urinary tract complications

Urinary tract infections are commonly reported by women affected by FGM/C. These can be exacerbated during pregnancy

Obstructed miscarriage

In the event of a miscarriage, the fetus may be retained in the uterus or birth canal of an infibulated woman

Reproductive tract infections and sexually transmitted infections

Women who are affected by FGM/C may experience an increased frequency of genital infections, including bacterial vaginosis

Restricted diet

There have been reports of women restricting their dietary intake in order to reduce the size of the baby, in an attempt to reduce perineal trauma

Psychological consequences

Women may develop a fear of childbirth as a result of post-traumatic stress disorder, anxiety and depression related to their experience of FGM/C

2.1.2 Care of the woman during pregnancy

- **Booking visit**

Ensure a female interpreter is present where possible. Use of a family member for the purpose of interpreting is never appropriate. Refer to PD2006_053 *Interpreters - Standard Procedures for Working with Health Care Interpreters*[7].

During routine history taking, all women should be asked if they have experienced any form of FGM/C, cutting, piercing or injury to their genitalia, using sensitive and culturally appropriate language. Early identification of FGM/C facilitates timely access to counselling and allows appropriate care to be initiated. NSW Kids and Families have developed an educational resource to support clinicians in their discussions with women who have experienced FGM/C. This resource is available at www.nswkidsfamilies.com.au.

If the woman has experienced FGM/C, or if FGM/C is suspected, the midwife should explain that it may have implications for her pregnancy and birth and refer as appropriate[8]. Maternity care professionals should have sufficient knowledge about FGM/C to discuss these implications and to assist the woman in understanding her options for care. The depth of discussion will depend on the type of grading of FGM/C and the receptiveness of the woman and her family.

In order to plan appropriate care all women with FGM/C should be examined by an experienced female (where possible) clinician following informed consent. Where a clinician is inexperienced in identification and management of FGM/C, referral to an experienced clinician should occur with the woman's consent. This may involve referral through the tiered maternity network.

Consideration for further referrals may be necessary such as social work, refugee or woman's health services.

- **Subsequent antenatal care**

Referral to a clinician skilled in FGM/C will involve a detailed consultation in relation to her history, physical and psychological health status and a physical examination in relation to FGM/C.

Provide the woman with basic information (written, visual or verbal) about FGM/C in an appropriate language if available. If appropriate, use diagrams in Appendix B to help the woman understand how she may be affected during childbirth.

It is recommended that a care plan be developed for pregnancy in conjunction with the relevant health professional. The care plan may include notifying the woman's GP and arranging relevant community referrals such as a refugee health worker.

Encourage the woman and her partner/support person to come to future visits. Subsequent antenatal care will be shared between the booking-in hospital and specialist services.

Ensure the woman and her partner understand the meaning of the NSW legislation surrounding FGM and child protection (see Section 1.6).

- **Referral for antenatal de-infibulation**

If antenatal de-infibulation is required, it will be recommended antenatally between 20 and 28 weeks gestation at a facility with access to appropriately skilled clinicians. Each LHD will need to develop appropriate referral pathways for this to occur.

Discussions with the woman should include the health benefits of de-infibulation and provide sufficient information that assists her to make an informed decision regarding de-infibulation. Information should also be provided on the physiological changes she is likely to experience post procedure.

The woman should be informed if de-infibulation is not undertaken antenatally, there may be an increased likelihood of complications during labour and birth such as difficulty with catheterisation and fetal blood sampling.

Refer to Appendix C for instructions and illustrations outlining the process and repair of antenatal de-infibulation.

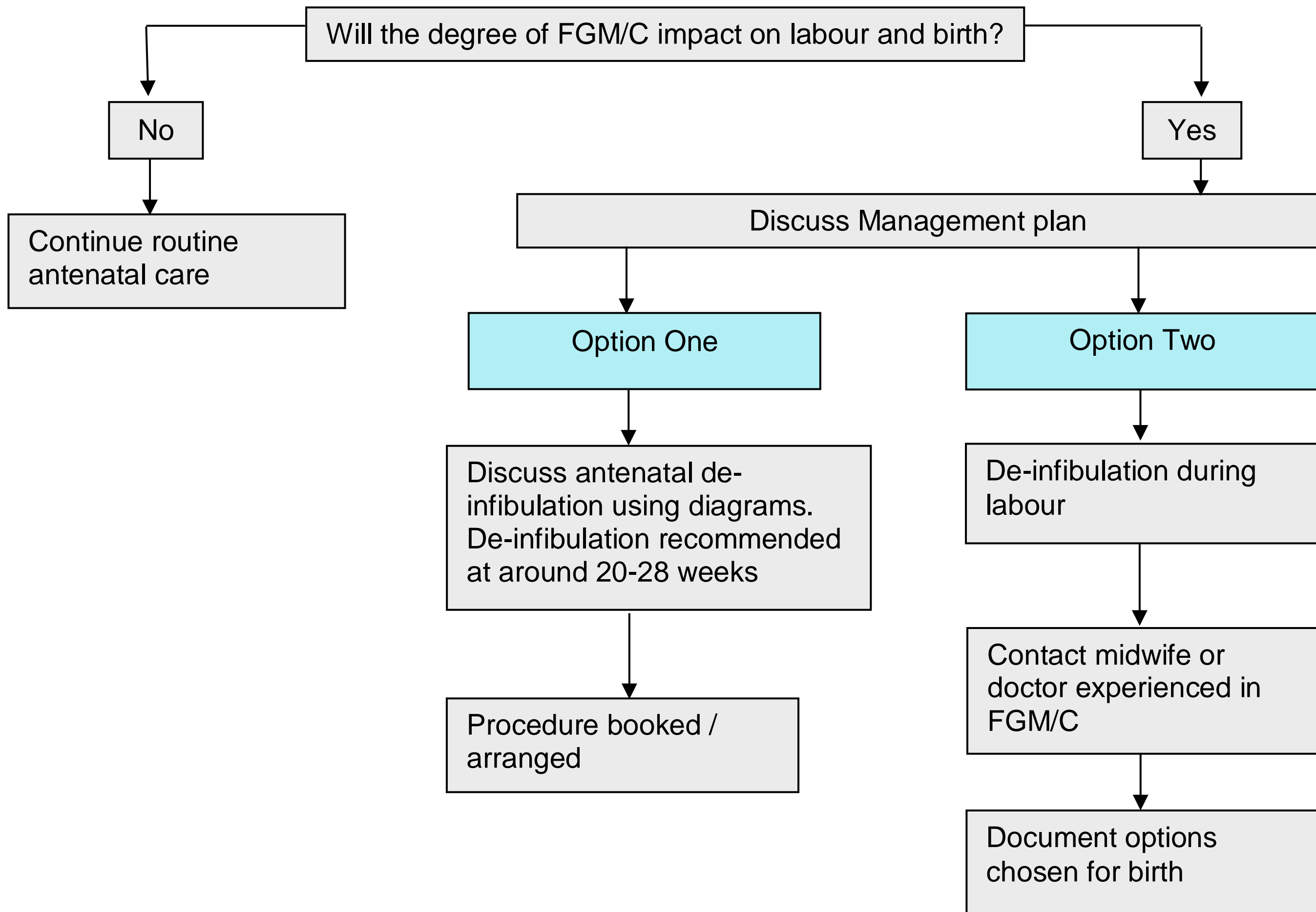
Ensure the woman and her partner understands that re-infibulation after the birth of the baby is illegal in NSW.

- **Preparation for birth**

Where a woman does not consent to antenatal de-infibulation, she should be informed that de-infibulation may be required during labour. A management plan for birth should be developed in conjunction with the woman and her support persons and should be documented in her medical record[1].

Flow chart: Antenatal Care

Adapted from the NZ FGM Education Programme (2009)[9]



2.2 Intrapartum

2.2.1 Implications for birth in relation to FGM/C

In the absence of antenatal de-infibulation, risks can include[8]:

- Vaginal examination may be difficult, painful or impossible depending on the type and extent of FGM/C
- Difficulty in applying fetal scalp electrode
- Difficulty in performing fetal blood sampling
- Difficulty in catheterisation of the bladder
- Prolonged second stage of labour
- Increased risk of perineal lacerations / tears
- Increased need for episiotomy
- Haemorrhage
- Caesarean section.

2.2.2 Care of the woman during labour and birth

Consult the woman's medical record regarding her FGM/C status and any management plan for labour.

Labour care

- The woman should be consulted regarding her preference for a female clinician and this request should be respected where possible
- For women who have previously undiagnosed FGM/C, assessment of the type of FGM/C should be undertaken by an experienced obstetric registrar or an FGM/C designated midwife as early in labour as possible
- FGM/C may not have been diagnosed during the antenatal period or the woman may have declined antenatal de-infibulation
- Depending on the type of FGM/C, at the first vaginal examination in labour the clinician may find that the examination is extremely difficult to perform and painful for the woman
- Where vaginal examination is difficult or painful, the clinician should not persevere. A one fingered examination may be necessary and in some cases other methods of measuring progress may be necessary
- Due to the narrowed vaginal opening, difficulties may also be experienced if the need for fetal blood sampling or urinary catheterisation become necessary. In some circumstances de-infibulation during the first stage of labour may be necessary in order to facilitate appropriate intrapartum care
- For women who have undergone de-infibulation during the antenatal period, continue routine labour and birth care.

De-infibulation during Birth

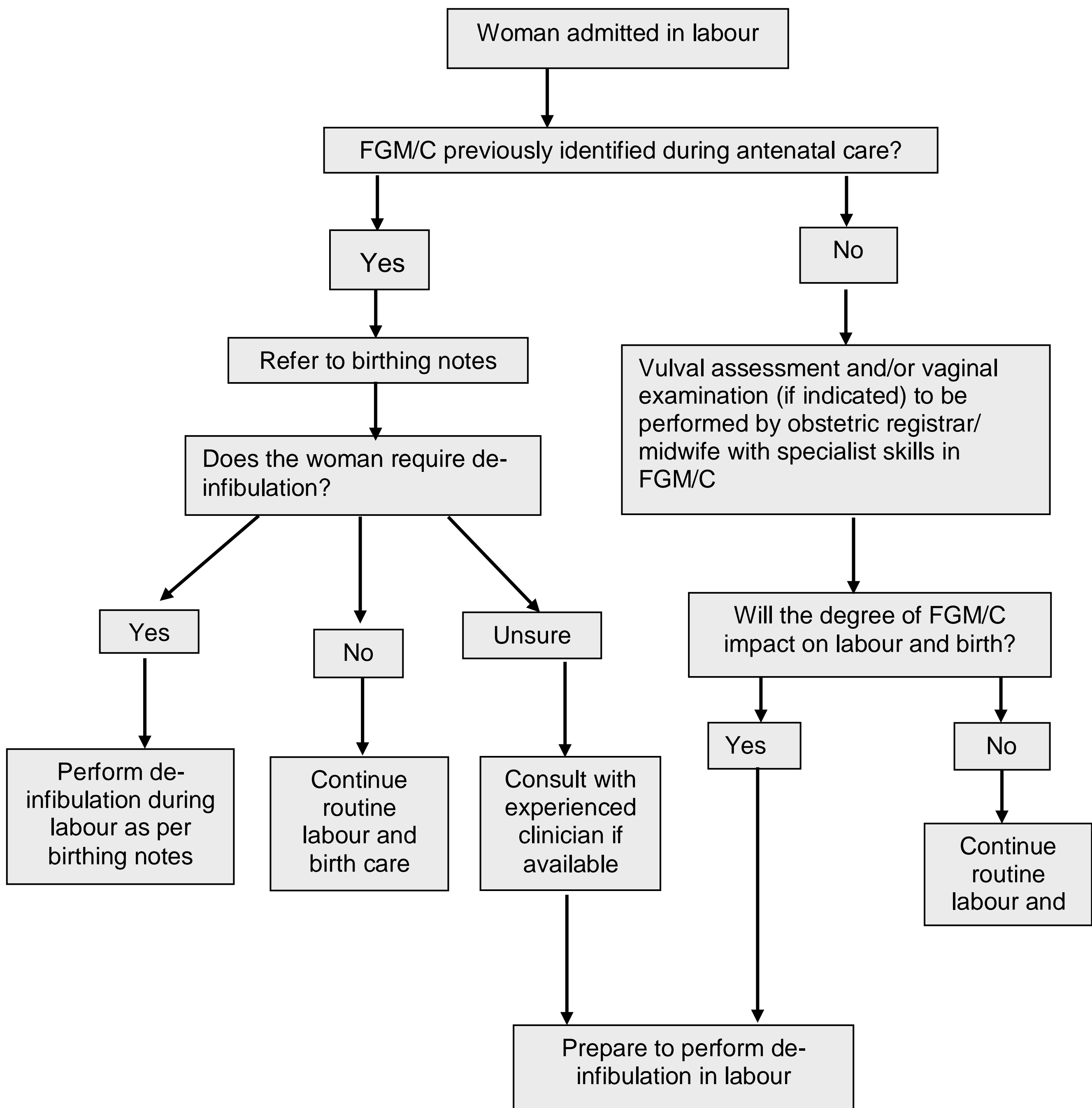
- Most infibulated women will require anterior incisions of their scar tissue to allow for the birth of the baby
- The anterior incision (de-infibulation) should be made during 2nd stage of labour. This will enlarge the introitus, without causing trauma to urethra or surrounding tissue[8]
- De-infibulation should be undertaken by an experienced obstetric registrar or midwife
- Some women may also require a mediolateral episiotomy
- Refer to Appendix D for instructions and illustrations outlining the process of de-infibulation in labour.

Repair of the perineum

- Clinicians should be aware that re-infibulation is illegal after the birth under the NSW Crimes Act[5]
- The anterior incision (de-infibulation) should be repaired by an experienced obstetric registrar or midwife. Subcuticular suturing of the retracted tissue should be undertaken to promote haemostasis and prevent re-anastamosis of the raw edges. If not sutured or repaired correctly the raw edges will heal together to form an uneven re-infibulation
- It may be helpful to catheterise the woman during repair of the perineum to prevent damage to the urethra
- Refer to Appendix D for instructions and illustrations outlining the process of repair post-de-infibulation
- Ensure adequate analgesia is provided and appropriate advice on wound management and body changes discussed with the woman
- Monitor urine output post-birth and observe for urinary retention in the first 24 hours.

Flow chart: Intrapartum care

Adapted from the NZ FGM Education Programme (2009)[9]



2.3 Postnatal care

For the purpose of this document, postpartum care refers to the immediate postnatal period i.e. the first 7 days after birth.

2.3.1 Health implications associated with FGM/C during the postpartum period

Pain

Due to de-infibulation or other genital lacerations

Infection

Potential for urinary tract, perineal, vulval, vaginal or de-infibulation site infection

Psychological issues

Vulval and perineal pain may bring back unpleasant memories of initial infibulation procedures. If de-infibulation has occurred during labour it may result in a significant change in body image. Women may also experience fear associated with acceptance of de-infibulation by partner and her culture.

2.3.2 Care of the woman during the postpartum period

- Discuss physiological changes following de-infibulation including changes in urination, menstruation and sexual intercourse in addition to advice provided antenatally. Include the woman's partner if appropriate and with her consent
- Provide sufficient pain relief, especially if de-infibulation has occurred during labour
- Provide appropriate advice on care of vulval, perineal or vaginal wounds
- Assess the site daily and provide information in relation to excessive bleeding, signs of infection and healing if de-infibulation has occurred during labour
- Advise the woman/partner to avoid sexual intercourse until healing of de-infibulation and/or perineal wounds are complete and the woman is comfortable
- Encourage the woman to talk about any feelings she may have in relation to the birth and/or the de-infibulation process
- Consideration may be given for referral to the Maternity Social Worker (if available) on the postnatal ward to provide support and to facilitate referrals to community support services upon discharge
- Follow local protocol within the tiered maternity network regarding 6 week follow up of women who have had de-infibulation during labour
- Ensure the woman and her partner are aware of the legal implications of FGM/C in Australia (See section 1.6) especially in relation to FGM/C of female infants/children.

Discharge planning

- Ensure that the woman has information about support services in the community that are relevant to her needs such as refugee health worker, family planning, women's health nursing and/or physiotherapy as required[1].
- If de-infibulation has occurred in labour, ensure that the woman's General Practitioner is informed so that the woman's progress can be monitored on discharge

REFERENCES

[1] Jordan L, Neophytou K, James C (2014) *Improving the health care of women and girls affected by female genital mutilation/cutting: a national approach to service coordination.* Family Planning Victoria, Victoria. Available at:

http://www.fpv.org.au/advocacy-projects-research/projects/a-national-approach-to-service-coordination/

[2] NSW Education Program on Female Genital Mutilation. Available at: http://www.dhi.health.nsw.gov.au/NSW-Education-Program-on-Female-Genital-Mutilation/NSW-Education-Program-on-Female-Genital-Mutilation/default.aspx

[3] World Health Organization (WHO). (Cited March 2014). Female genital mutilation and other harmful practices: Research studies on the prevalence and classification of female genital mutilation. Available at:

http://www.who.int/reproductivehealth/topics/fgm/fgm_prevalence_classification_toc/en/

[4] World Health Organization. (2008). *Eliminating FGM: an interagency statement: OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO.* World Health Organization, Geneva. Available at:

http://www.unifem.org/materials/item_detaila0f3.html?ProductID=110

[5] The Crimes (Prohibition of Female Genital Mutilation) Amendment Act 1994 (NSW). Available at:

http://www.austlii.org/au/legis/nsw/consol_act/ca190082/s45.html

[6] Costello S, Quinn M, Tatchell A, Jordan L, Neophytou K, James C. (2014). A Tradition in Transition: Female Genital Mutilation/Cutting. A literature Review, an Overview of prevention programs and demographic data for Australia. Family Planning Victoria, Victoria. Available at:

http://www.fpv.org.au/advocacy-projects-research/projects/female-genital-mutilation-cutting-in-victoria/

[7] Ministry of Health, NSW (2006). PD2006_053 *Interpreters – Standard procedures for Working with Health Care Interpreters.* NSW Health, Sydney. Available at:

http://www0.health.nsw.gov.au/policies/pd/2006/pdf/PD2006_053.pdf

[8] Australian College of Midwives (2013). National Midwifery Guidelines for Consultation and Referral.

[9] Royal Australian and New Zealand College of Obstetricians and Gynaecologists. (2013). *Female Genital Mutilation (FGM).* Available at:

www.ranzcog.edu.au/doc/female-genital-mutilation.html

[10] NZ FGM Education Programme (2009) *Female Genital Mutilation Clinical Care: Antenatal, Labour & Birth and Postnatal Guidelines.* New Zealand Ministry of Health, Auckland. Available at: http://www.fgm.co.nz/media/2602/fgm-antenatal-labour-and-birth-and-postnatal-guidelines-2009.pdf

[11] United Nations Children's Fund, Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change, UNICEF, New York, 2013.

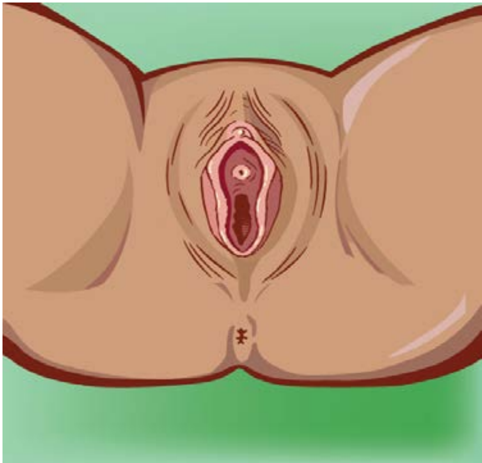
APPENDIX A: Data on FGM/C available for countries where the practice is concentrated[1,11]

FGM/C is also present in other countries across the Middle East (including Iran and Saudi Arabia), South, Southeast and Central Asia (including India, Sri Lanka, Malaysia, Indonesia, Thailand) and South America. Europe, Australia and New Zealand have also noted an increase in FGM/C where immigration from countries that practice FGM has led to the introduction of the practice in these regions.[1,11]

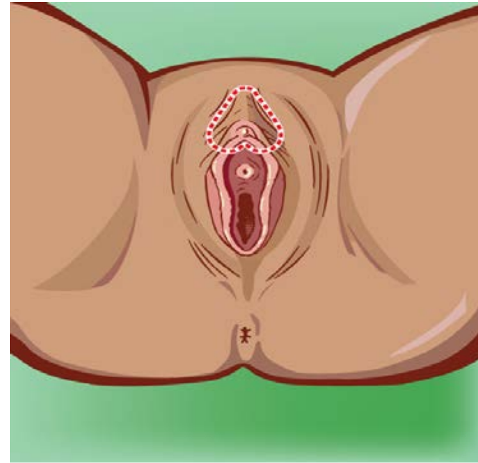
REGION	COUNTRY	PREVALENCE (estimated)
WEST AFRICA	**BENIN**	16.8%
	BURKINA FASO	72.5%
	COTE d'IVOIRE	41.7%
	GUINEA	95.6%
	THE GAMBIA	78.3%
	GHANA	3.8%
	GUINEA-BISSAU	44.5%
	LIBERIA	45%
	MALI	91.6%
	MAURITIANA	71.3%
	NIGER	2.2%
	NIGERIA	19%
	SENEGAL	28.2%
	SIERRA LEONE	94%
	TOGO	5.8%
CENTRAL AFRICA	**CAMEROON**	1.4%
	CENTRAL AFRICAN REPUBLIC	25.7%
	CHAD	44.9%
EAST AFRICA	**DJIBOUTI**	93.1%
	ETHIOPIA	74.3%
	ERITREA	88.7%
	KENYA	32.2%
	SOMALIA	97.9%
	UGANDA	0.6%
	TANZANIA	14.6%
NORTH AFRICA	**EGYPT**	95.8%
	SUDAN	90%
MIDDLE EAST	**IRAQ**	8%
	YEMEN	23%

APPENDIX B Types of FGM/C

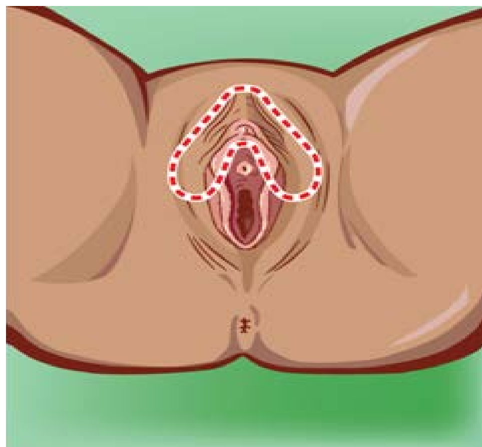
Normal Female Genitalia



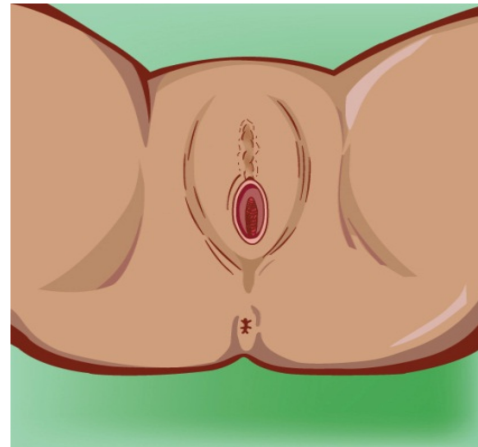
Type I FGM/C



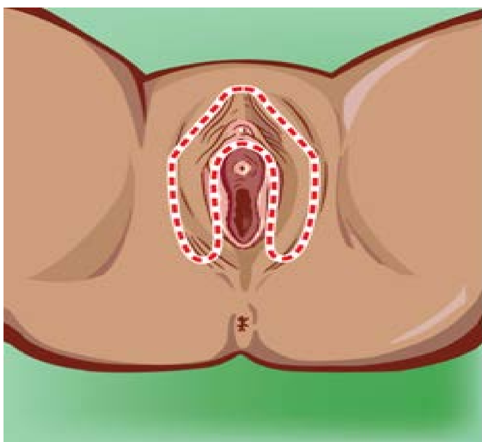
Type II FGM/C



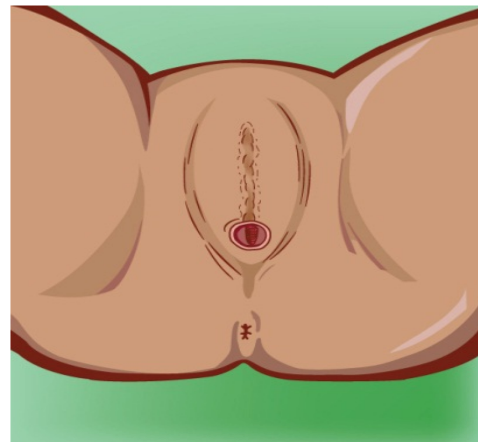
Type II FGM/C after excision



Type III FGM/C



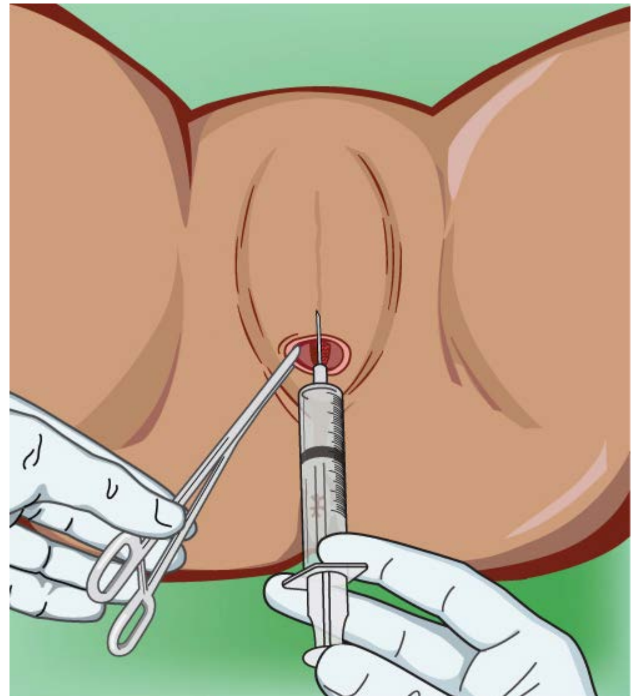
Type III FGM/C after infibulation



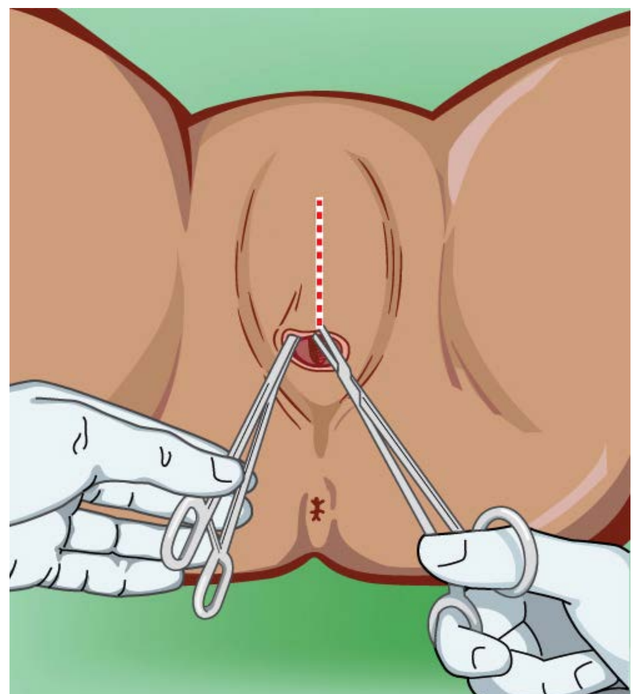
APPENDIX C

Antenatal (elective) de-infibulation and repair

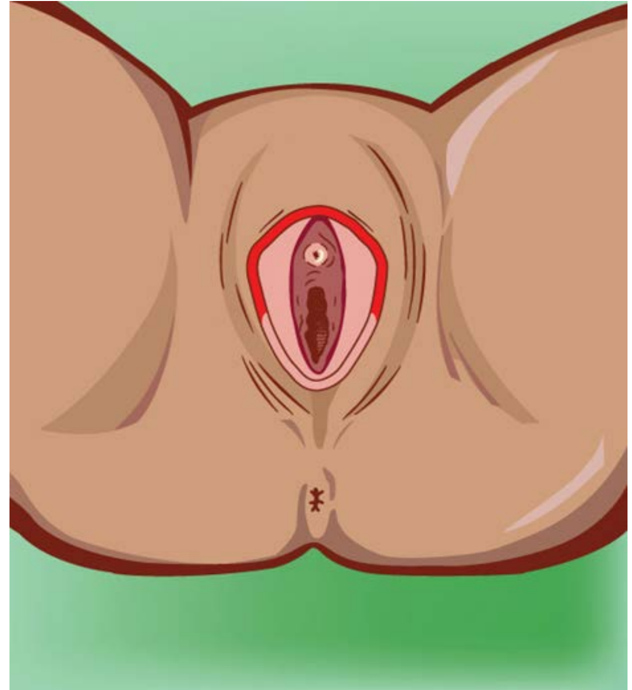
- Insert forceps under the scar and infiltrate with local anaesthesia.



- Open the scar in the midline exposing the underlying tissues which sometimes include the clitoris.
- Most women who are infibulated will require an anterior incision of their scar tissue as the first option before considering the need for a right medio-lateral episiotomy.

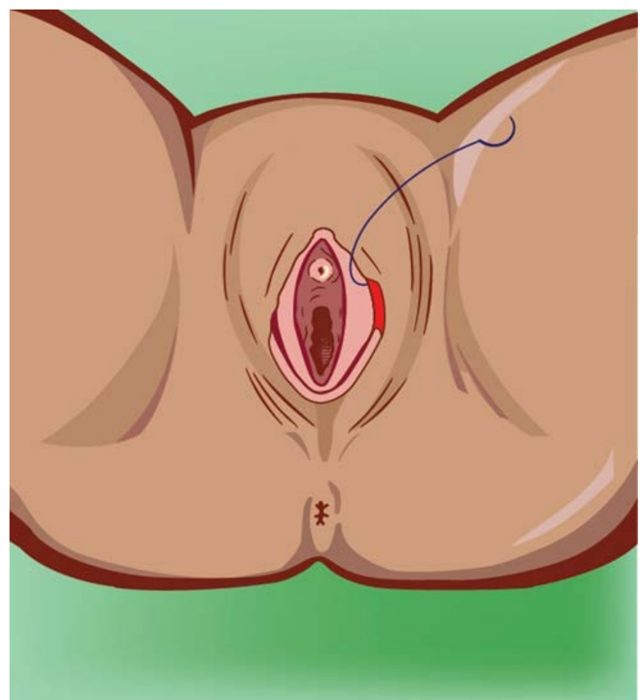


- There is usually minimal bleeding, as the incision is through scar tissue.



Post de-infibulation repair

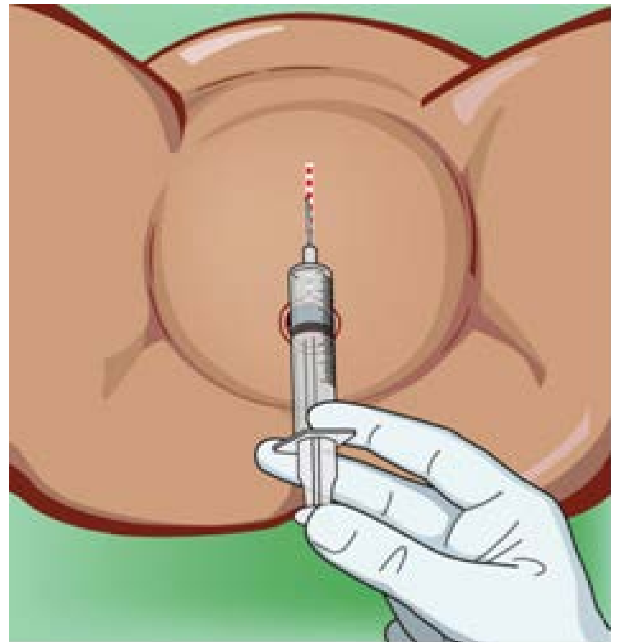
- Repaired by subcuticular suturing
- Repair the de-infibulation by suturing the retracted tissue to promote haemostasis and prevent re-anastamosis of the raw edges.
- Monitor urine output post operatively and observe for urinary retention in first 24 hours.
- Provide analgesia as required



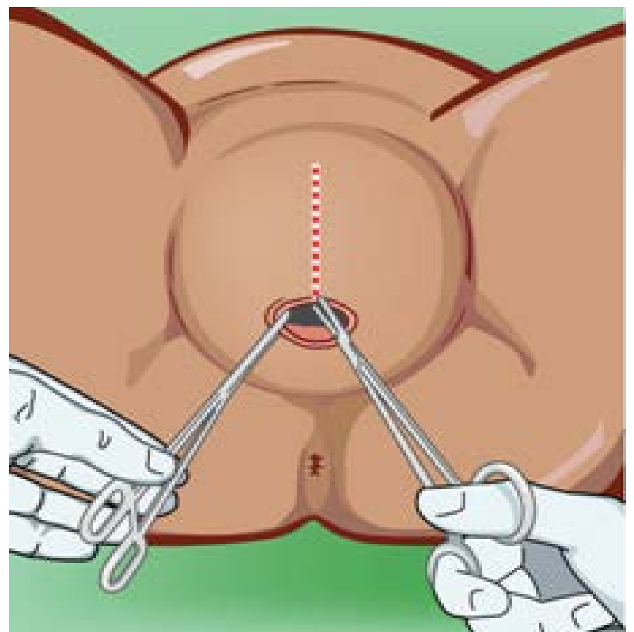
APPENDIX D

Intrapartum de-infibulation and repair

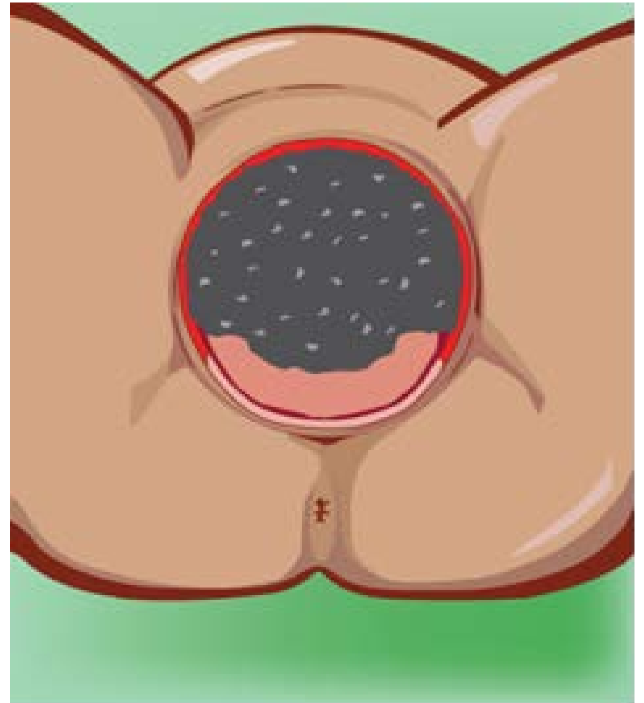
- When undertaking a de-infibulation in labour, the steps are the same as for the elective procedure
- Some adjustment is required to compensate for the distension of the perineum as the baby's head descends.
- If possible, administer local anaesthetic along the anterior scar tissue.
- Infiltrate the scar using a very superficial angle on the needle to protect the babies head.



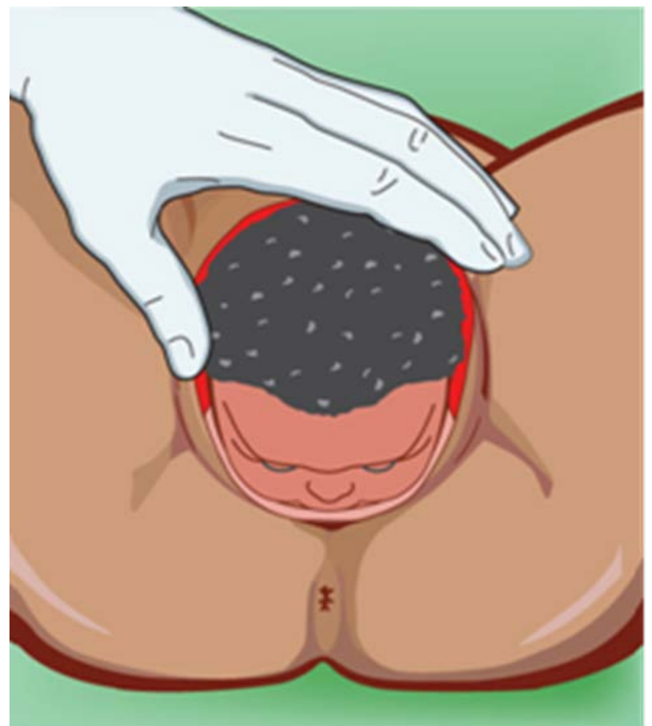
- Place forceps underneath and to the left of the anterior scar tissue.
- Make the anterior incision up to the midline scar to just above the urethral meatus.



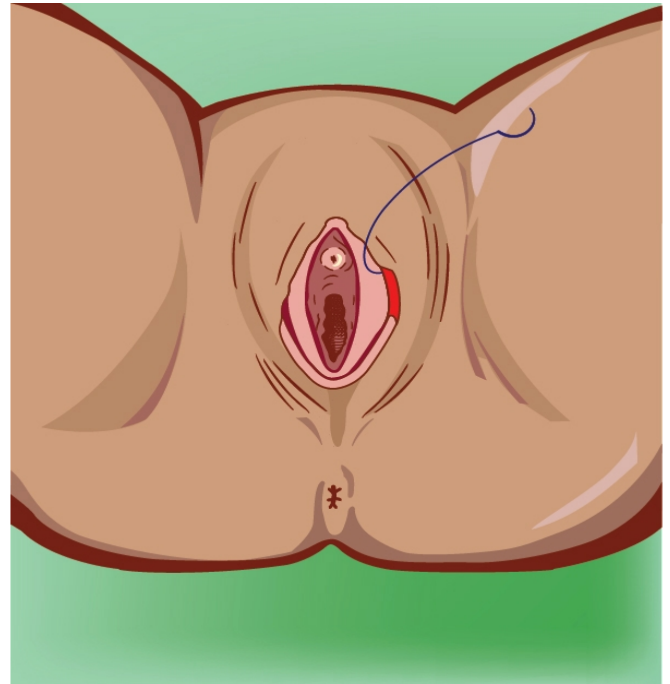
- The raw edges will retract and the head will begin crowning.
- Check that the perineal area is stretching adequately.
- Note that post infective vaginal scarring from the original infibulation, and fibrous tissue of the anterior scar may not stretch under pressure.



- Monitor perineal stretching throughout as occasionally corrosive substances may have been inserted into the vagina to induce scarring that is not evident externally
- If there is a degree of tightness, or evidence of severe scarring, perform an early medio-lateral episiotomy. (A bilateral episiotomy is rarely needed or recommended).
- Avoid downward midline incisions as these have a potential to extend to a 3rd or 4th degree tear.



Post birth



Repair the anterior incision as per antenatal management. If not sutured or repaired correctly the raw edges can form an uneven re-infibulation.

- Any excision of the anterior incision above the urethra may also be repaired at this time.
- Ensure adequate analgesia is provided and appropriate advice on wound management and body changes given to the woman.