

# Module 4: Management of women with FGM during pregnancy, labour, delivery and the postpartum period

Module 4 is also an intervention module. This module is intended to prepare midwives and those caring for women during pregnancy, labour, delivery and the postpartum period to be able to manage women with FGM and identify problems. The module gives guidance on counselling, opening up a type III FGM, and management of other complications associated with FGM.

## Application of the module

The material in this module may be added to existing courses, such as midwifery or obstetrics. The module may also be used as a complete course in itself during in-service training of midwives and obstetricians.

## General objectives

On completion of the module, students should be able to:

- Recognize obstetric complications due to FGM.
- Manage women with FGM complications during pregnancy, labour, delivery, and after delivery.
- Demonstrate skills in opening up tight introitus and type III FGM during pregnancy and in labour.
- Demonstrate skills in counselling.
- Refer clients for further management when complications are beyond their competence.

## Background qualifications

Students working on this module should already have the following:

- basic midwifery skills (antenatal care, labour, delivery and postnatal care).

- basic life-saving skills.
- the essential competencies acquired from modules 1, 2, and 3.

## Essential competencies

Students are expected to acquire the following skills from this module:

- ability to identify special complications that may occur as a consequence FGM, during:
  - pregnancy
  - labour
  - delivery, and
  - the postpartum period.

## Suggested teaching activities

- Large group discussion.
- Small group discussion.
- Demonstrations.
- Simulation exercises.

## Teaching aids

- Slides, charts, posters and pictures.
- Trays, scissors, swabs, catgut, dummies, and antiseptics.
- Clients with FGM.

## Reference materials

- *A systematic review of the health complications of Female Genital Mutilation including sequelae in childbirth.* WHO/FCH/ WMH/00.2.Geneva (2000)
- *Female Genital Mutilation. A Handbook for Frontline Workers.* WHO/FCH/WMH/00.5 Rev.1. WHO, Geneva (2000).

- *Female Genital Mutilation: The Prevention and the Management of the Health Complications: Policy Guidelines for nurses and midwives.* WHO/FCH/GWH/01.5. WHO, Geneva (2001)
- *Management of pregnancy, childbirth and the postpartum period in the presence of Female Genital Mutilation. Report of a WHO Technical Consultation. Geneva, 15 - 17 October 1997.* WHO/FCH/WMH/00.7 Geneva.
- *Female Genital Mutilation. A joint WHO/UNICEF/UNFPA statement.* WHO. Geneva (1997).
- *A practical manual for health care providers caring for women with circumcision,* by Toubia, N. A RAINBO Publication. New York, 1999.

## The Sessions

Time in hours

Session 1:	
Assessment and management of woman with complications due to FGM during pregnancy ...	3
Session 2:	
Obstetric complications due to FGM during labour and delivery .....	2
Session 3:	
Assessment and management of women with FGM complications during labour and delivery .....	4
Session 4:	
Management of women with FGM during the postpartum period .....	3



## Session 1: Assessment and management of woman with complication due to FGM during pregnancy

### Session objectives

By the end of this session students should be able to:

1. Identify the type of FGM and assess how it may affect the woman during pregnancy.
2. Identify complications due to FGM during pregnancy.
3. Manage women with type I, II and IV FGM during pregnancy
4. Manage women with type III FGM during pregnancy.

### Key references

- *A systematic review of the health complications of Female Genital Mutilation including sequelae in childbirth.* WHO/FCH/ WMH/00.2. Geneva (2000)
- *Management of pregnancy, childbirth and the postpartum period in the presence of Female Genital Mutilation. Report of a WHO Technical Consultation. Geneva, 15 - 17 October 1997.* WHO/FCH/WMH/00.7 Geneva (2000).
- *Female Genital Mutilation: The Prevention and the Management of the Health Complications: Policy Guidelines for nurses and midwives.* WHO/FCH/ GWH/01.5. WHO, Geneva (2001)

### Suggested teaching methods

- Small group discussion.
- Plenary discussion.
- Lecture.
- Question and answer.

### Teaching aids

- Teacher's notes.
- Student manual.

### Setting the scene

- Ask students to share their experience regarding the care of women with FGM during pregnancy.

### THE SESSION

Introduce the session and its objectives

- Review the different types of FGM, and the obstetric complications which may occur during pregnancy.
  - A tight introitus may make vaginal examinations difficult, e.g. during assessment for antepartum haemorrhage, management of incomplete abortion, etc.
  - Urinary infections, which are common in women with FGM, may interfere with the normal progress of the pregnancy.
  - Chronic pelvic infections which are common in women with FGM, may interfere with normal progress of the pregnancy and may cause abortion.
  - Vulval abscesses may cause pain and discomfort to the woman.
  - Dermoid cysts, and keloids may cause discomfort and perhaps obstruction during delivery.
  - Psychosocial and sexual problems may arise as a result of FGM.

### Assessing problems associated with FGM

Remind students that in communities where FGM is a tradition, women coming to clinic may present with many types of FGM. FGM-associated complications during pregnancy can be identified through history taking and during pelvic examinations.

- Women with FGM often suffer great anxiety at

visiting a clinic when they are pregnant because of their genital mutilation. They may be fearful of being seen by a health care worker who is unfamiliar with FGM and who may advise unnecessary interventions, like Caesarean section. Women with FGM should be made to feel welcome and respected in these clinics. You should reassure them that you are comfortable with their condition and that they will get the services they need without being subjected to unnecessary interventions.

- Service providers working with immigrant communities may be unfamiliar with their cultural background. They should be aware of the need to be sensitive and respectful towards the cultural beliefs, values and attitudes of the women. They must ensure that their own values and attitudes do not interfere with the care they give to the client.
- If an interpreter is being used, she should be acceptable to the client and should be impartial, otherwise there is the risk that her own beliefs and values will bias her interpretation of what is being said.
- During assessment, it is very important to create a trusting relationship with the client by:
  - using interpersonal communication skills
  - ensuring privacy and confidentiality
  - showing respect and patience.
- During assessment, check for the presence of conditions that are likely to interfere with vaginal examinations or treatment, or cause problems during labour and delivery. These may include:
  - tight introitus
  - infections
  - abscess
  - cysts and keloids.
- Record the type of FGM and the complications identified.

**It is important for health care workers to be knowledgeable about types of FGM so that they do not ask the clients embarrassing questions**

### **Management of women with type I, II and IV FGM during pregnancy**

- Women with FGM require sensitive antenatal care. Type I, II and IV FGM can produce severe vulval and vaginal scarring which may cause obstruction during assessment and delivery. Infection and inflammation at the time FGM was performed may result in vulval adhesions which narrow or completely occlude the vaginal orifice. Insertion of herbs or other substances may also cause severe scarring and stenosis.
- Where type I, II, and IV FGM did not result in any particular complications, the woman will require no special management or treatment during pregnancy. Reassure the woman that she is not at risk because of her condition and invite her to ask any questions about her excision or any other issues relating to her pregnancy. Find time to counsel her about sexual relationship and to give her support. Provide more information by giving leaflets on FGM. During follow-up visits, ask the woman if she needs any special help. Do not ask about her excision unless she wants to discuss it.
- Pregnancy provides a good opportunity to give women education and information on:
  - basic health
  - normal and excised genitals
  - childbirth and postnatal care.
- Be aware that many women approach pregnancy and delivery with great fear of the outcome of pregnancy and delivery including fear of death. Special support and counselling is therefore required during this periods.

### Women with vaginal infections

- Where infections are serious, send a vaginal swab for diagnosis, if laboratory facilities are available.
- Give antibiotics according to policy.
- Contact partner and give same treatment.
- Counsel woman and partner about the problem, and monitor the situation closely.

### Women with abscess

- Give antibiotics and advice on vulval hygiene.
- Give client a follow-up appointment in order to monitor progress.
- If the abscess is very big and needs surgical intervention, refer for further management and advise client to have a hospital delivery.
- Monitor her progress closely.

### Women with cysts and keloids

- Make a referral of client to deliver in a hospital where there are facilities for Caesarean section if required.

## Management of women with type III FGM during pregnancy

- Perform assessment to confirm type III FGM. Remember that there is great need for sensitivity during history taking and pelvic examination. It is not necessary to perform a vaginal examination to confirm infibulation, as this condition can be identified by visual inspection.
- In some communities type III FGM may not be the prevalent form of FGM and only a minority of women may be affected. Where type III FGM is common, the vulval area should be inspected at first antenatal visit as a matter of routine.
- Women with tight introitus (i.e. opening of 1 cm. or less) are at special risk of major perineal damage during labour. As a general rule, if the urinary meatus is visible, (i.e. if there is no barrier from the urinary meatus downwards), or if two

fingers can be introduced into the vagina without discomfort, the mutilation is unlikely to cause major physical problems at delivery. If the woman has been pregnant before, her previous experiences during delivery will help to indicate whether she is likely to have problems this time.

- Because of the need to seek sensitive information, it is important to create a rapport with the client and to gain her confidence and trust. You should obtain her consent before conducting a genital examination.
- Making a record of the appearance of the vulva may help to avoid unnecessary examinations in future.
- Give client factual information about the effects of type III FGM on pregnancy and delivery. Give her information on the anatomy and physiology of the female reproductive system.
- Counsel the client and her husband (and/or other family members where appropriate) on the importance of opening up her infibulation before delivery. Discuss with them the importance of not re-suturing after delivery. Give the client and her husband detailed information about the changes that will occur in such functions as urination and sexual intercourse.

Once the woman has been opened up, it may be possible for the woman to deliver with the perineum intact, episiotomy should only be carried out if necessary and not as routine.

- Ideally, opening up of the infibulation should be performed during the second trimester. Opening up between the 20th and 28th weeks of pregnancy will allow time for healing before labour starts. It is not a good idea to perform the opening up in the first trimester. The reason is that during this trimester there is a higher risk of spontaneous abortion. If the woman happens to have a spontaneous abortion

after the opening up surgery the woman may blame the surgery for her abortion and word may spread in the community that the opening up procedure is a dangerous one.

- Follow the procedure for opening up as described earlier in this guide.
- Instruct the client on the importance of vulval hygiene, and the need to keep her vulva clean and dry.
- Advise client and her husband/partner on when it would be safe to resume sexual activity. They should be advised to wait for proper healing to take place – generally 4-6 weeks after the procedure.
- Make an appointment for a follow-up visit after one week in order to monitor the healing process.
- Information about the opening up procedure must be clearly recorded on the antenatal records.
- Once the woman has been opened up, it may be possible for her to deliver with the perineum intact. Episiotomy should only be performed if it is necessary, and not as a matter of routine.
- Opening up the infibulation during pregnancy has advantages besides preparing for delivery. It means that:
  - clean samples of urine can be obtained
  - vaginal infections, premature rupture of membranes and antepartum bleeding can be easily investigated if they occur.
- Women who refuse to be opened up during pregnancy should be informed about the dangers associated with infibulation during delivery and advised to deliver in hospital.

**The antenatal period provides an opportunity for health workers to educate women (and other family members where possible) about the health consequences of FGM. The objectives should be to discourage women from subjecting their own daughters or granddaughters to FGM, as well as to discourage the women themselves from demanding re-suturing after delivery. Counselling of the women and their husbands will help to dispel some of the myths and misunderstandings about the need for "tightness" to enhance the man's sexual pleasure. And it will provide an opportunity to explain the dangers of repeated surgery to open up the vulva at every birth and to re-stitch it again after every delivery .**

#### Summarise:

- Summarise using the checklist of complications described at the beginning of the session.
- Summarise main points in management of complications.
- Highlight the importance of documenting the FGM type and the complications presented.

#### Closing the session:

- Allow students to ask questions, and clarify points as necessary.
- Close the session.

## Session 2: Obstetric complications due to FGM during labour and delivery

### Session objectives

By the end of this session students should be able to:

1. Understand the complications which may occur during labour and delivery as a result of FGM.

### Key references

- *A systematic review of the health complications of Female Genital Mutilation including sequelae in childbirth.* WHO/FCH/ WMH/00.2. Geneva (2000)
- *Management of pregnancy, childbirth and the postpartum period in the presence of Female Genital Mutilation. Report of a WHO Technical Consultation. Geneva, 15 - 17 October 1997.* WHO/FCH/WMH/00.7 WHO, Geneva (2000).
- *Female Genital Mutilation: The Prevention and the Management of the Health Complications: Policy Guidelines for nurses and midwives.* WHO/FCH/ GWH/01.5. WHO, Geneva (2001)
- *A practical manual for health care providers caring for women with circumcision,* by Toubia, N. A RAINBO Publication. New York, 1999.

### Suggested teaching methods

- Question and answer.
- Small group discussion.
- Large group discussion.
- Case study.

### Teaching aids

- Case study.

### Setting the scene

- Ask students if any of them have seen a woman with FGM in labour.
- Ask those that have to share their experiences.

### THE SESSION

Introduce the session and its objectives

- Ask students what complications may arise during labour for a women with FGM.
- Allow students to respond.

#### Small group discussion:

- Divide students into small groups.
- Give them the following case study to discuss.

#### Case Study

**Mrs. Piego is a 20-year-old primigravid who comes to the labour ward with a family member complaining of contractions for the last five hours. From her antenatal records you note that she is full-term and also that she has undergone type III FGM. It is your responsibility to admit her and conduct a complete assessment of her condition and to monitor her labour. You need to develop a care plan for Mrs. Piego that takes account of the importance of reducing the risk of complications during labour and delivery associated with type III FGM.**

- Ask students to analyze the case study and determine what complications they might expect

for Mrs. Piego and her newborn under the circumstances.

- Ask the students to analyze the causes of these complications.
- Allow 30 minutes for discussion.

### Large group discussion:

- Allow students to share their group work with the whole class.
- Allow one hour for presentation and discussion.

### Summarise:

Use the following checklists with the students to ensure that all possible conditions are considered:

#### Complications of FGM during labour and delivery

- Reduced vaginal opening, which will present a direct mechanical barrier to delivery and will interfere with other procedures required for both assessment and management during labour. A tight introitus may, for example, prevent vaginal examination, and result in mistakes being made in assessing the degree of cervical dilatation, and monitoring the stage of labour and fetal presentation.
- Labour may be obstructed as a result of scarring of the external genitalia which prevents the normal stretching of the perineum to allow the passage of the baby.
- Prolonged second stage due to scarring of the perineum and a tight vaginal opening.
- Tears during delivery due to rigidity of the perineum as a result of scarring of the tissues around the introitus.
- Development of obstetric fistulae as a result of prolonged labour, during which the foetal head presses against the bladder or rectum.
- Death as a result of rupture of the uterus due to obstructed labour.

- Need for Caesarean section because infibulation has not been opened up during pregnancy.

#### Possible effects on newborn

- Asphyxia due to prolonged labour.
- Neonatal brain damage due to obstructed labour.
- Birth injuries due to difficult delivery.
- Death as a result of delivery complications.

#### Closing the session:

- Allow students to ask questions and clarify points for them as necessary.
- Ask students questions to check that they have understood the lesson.
- Close the session.



## Session 3: Assessment and management of women with FGM during labour and delivery

### Session objectives

By the end of this session students should be able to:

1. Use assessment skills in order to identify and manage complications during labour and delivery caused by FGM.

### Suggested teaching methods

- Buzzing.
- Discussion.
- Simulation and demonstration.
- Question and answer.

### Teaching aids

- Teacher's notes.
- Models.

### Setting the scene

- Ask students if any of them has cared for a woman with FGM during labour.
- Ask students how they ascertain that a woman is progressing well in labour.
- Allow them to share their experiences.

### THE SESSION

Introduce the session and its objectives.

#### Buzzing:

- Ask students how a woman with FGM should be assessed during labour.
- Allow them to buzz in twos or threes.
- Allow them to share their thoughts with the class.

#### Teacher's notes:

Inform students that the procedure for assessment of a woman with FGM arriving on the labour ward is as follows:

- Take a history of labour and perform a physical examination as you would for any woman in labour. Use interpersonal skills.
- Examine the genitalia with special care to assess the tightness of the introitus, and whether or not it will allow for normal vaginal delivery. If there is a problem, such as extensive scarring or keloid, the woman must be informed of the action to be taken to enable delivery.

### Physical examination

Inform students that the procedure for a physical examination entails the following:

- Head to toe assessment.
- Abdominal examination, inspection, palpation and auscultation.
- Palpation of the bladder (also, ensure that bladder is emptied regularly).
- Examination of the genitalia to identify type of FGM (follow the procedure and principles of genital examination in women with FGM described earlier in this manual)
- If introitus is tight:
  - explain to the woman the problems associated with having a tight opening during labour and delivery
  - inform her that an episiotomy will need to be performed during delivery to increase the opening, and explain carefully what is involved. If she has type III FGM, explain that she will

need to have the infibulation opened up, and explain what is involved.

## Monitoring progress of labour

Inform students that the procedure for monitoring labour is as follows:

- If there is a problem with assessment, such as a tight introitus making vaginal examination impossible, the scar can be opened along the midline. The incision should be made at the height of a contraction, and usually after the administration of a local anaesthetic. Generally speaking, there is little bleeding from the relatively avascular scar tissue, and suturing of the cut can be delayed until after delivery. If situation allows it, labour can be assessed using other parameters such as contractions, descent of the presenting parts, and fetal heart rates.
- Observe the woman closely and monitor her vital signs hourly.
- Give clear and simple information to the client about what she should expect during delivery.
- Record all observations in the partograph.

### Demonstration:

- Ask students to demonstrate assessment of women with FGM during labour
- Give guidance to the students and emphasise the key principles of history taking and physical examination of a woman with FGM.

## Assessment of the introitus during labour

Inform students that it is important to inspect the introitus carefully during second stage of labour to assess whether it is going to be able to stretch sufficiently during delivery of the baby. The procedure is as follows:

- Prepare the client psychologically for this

procedure by telling her what you are going to do and why such an assessment is needed.

- Ask her permission to examine her genitalia.
- Prepare equipment: a tray with antiseptic, sterile swabs and gloves.
- Prepare the client by putting her into a lithotomy position; expose only the necessary parts of the body - do not expose unnecessarily.
- Wash hands with soap and water; put on gloves.
- Clean the external genitalia with antiseptic swab.
- Instruct the client to relax by taking a deep breath while you are introducing a finger into the introitus.
- Try slowly and carefully to introduce first one finger into the vagina to measure the tightness of the introitus. If it allows one finger, try to move the finger upward and downward, and left to right. If there is space for a second finger, try to widen the two fingers and check the resistance.
- If it is impossible to introduce a finger, or even the tip of a finger, the introitus is extremely tight – equivalent to type III FGM.
- If it is possible to introduce a finger but impossible to stretch the opening at all because of resistance due to scar tissue, it will be necessary to open up the introitus by performing an episiotomy.
- If there is need for an episiotomy, inform the client and perform the procedure following the guidelines described earlier in the guide.

### Summarise:

- In a plenary session, summarise the important points of history taking and physical examination.
- Allow students to ask questions for clarification.

**Important note**

**Emphasise to students that, when progress is slow, they should anticipate a difficult delivery and make appropriate arrangements in good time:**

- **If it is clear an episiotomy would facilitate delivery, it should be performed skillfully.**
- **If there is a need for opening up the infibulation, the woman should be prepared and the procedure should be undertaken.**
- **If a caesarean section is required, the woman should be referred in plenty of time to a health centre with appropriate facilities.**

## Management of woman with types I, II and IV FGM during labour

Management of women with FGM during labour is the same as for any other women, except where FGM has caused vaginal stenosis and inelasticity of the perineal muscle. In such cases, there may be a need for an episiotomy (In women with type III FGM, the infibulation must be opened during second stage of labour, as described in the next page).

- Generally speaking, women with type I FGM are able to deliver vaginally without episiotomy unless there is extensive scarring causing inelasticity of the perineum.
- If FGM has caused a tight introitus, there is a need to increase the vaginal opening by doing an episiotomy. This is usually performed during the second stage of labour, when the presenting part is pressing on the vulva.
- Usually a tight introitus will have been identified during the first stage of labour, and the woman

should have been prepared for the performance of episiotomy at that time.

- If, however, the woman has arrived at the ward already in second stage of labour, explain to her the need to increase the opening by performing an episiotomy, and inform her of when and how this will be done. (As already described, this should be at the height of a contraction, under local anesthesia, using special episiotomy scissors).

### Demonstration:

Using a dummy as a model, demonstrate the performance of an episiotomy to the students:

- Prepare the client.
- Prepare a tray with antiseptic swabs, an episiotomy scissors, sterile gloves, a 5ml syringe and local anaesthetic.
- Inform the client that you are going to cut open the perineal area to increase space for the baby to come out.
- Wash hands, put on gloves, clean the perineal area.
- Introduce one or two fingers (they should go in easily), positioning them where you are going to administer the anaesthetic. This protects the baby's head.
- Infiltrate 2-3 ml of local anaesthetic into the area where the cut will be made, along the fingers to avoid injuring the baby.
- With your finger or fingers inside the vagina (they should be between the scissors and the baby's head), introduce the scissors and cut along the fingers to avoid injury to the baby. Start at the centre of the perineum and angle (slant) your scissors out at a 45 degree angle. If you are right handed, cut towards the mother's right buttock. If left handed, cut towards the mother's left buttock.
- Usually after cutting, the baby is delivered slowly. Press a gauze firmly over the cut area while the woman continues to push.

- Immediately after delivery, the cutting and any tears must be sutured.
- Take care of the mother and the baby.
- Educate client on how to keep the perineum clean.
- Wash hands and clear equipment.

## Management of women with type III FGM during labour and delivery

- If the woman attended antenatal clinic, the infibulation may have been opened during the antenatal period.
- In cases where the infibulation has not been opened during pregnancy, the woman should be informed during the first stage of labour of the need for this procedure.
- The client should be told that her vulva will be opened up during delivery to allow the passage of the baby. She should also be informed that the sides of the infibulated vulva will be sutured separately and not re-sutured to a small opening, and told why. She should be informed that the procedure will result in changes in the pattern of urination and menstrual flow, and also in sexual intercourse.
- The vulva should be opened up during the second stage of labour, at the height of a contraction to minimize pains.
- The cut should be made along the midline scar towards the pubis, taking care not to cause injury to the baby or structures along the scar. As stated earlier, it is common with type III FGM to find the structures below the scar intact, e.g. clitoris and labia minor.
- Follow the opening up procedure described on page 104. In some cases, where the scar has caused extensive inelasticity of the skin around the vagina, a posterior lateral episiotomy may be needed in addition to the opening up of the infibulation.
- Usually after cutting, the baby is delivered slowly.
- After delivery of the baby and the placenta, and after the immediate needs of the baby have been taken care of, the entire cutting and any tears must be sutured.
- If there is not sufficient time to discuss the procedure in detail with the woman – if, for example, she arrives at the labour ward already in the second stage – everything should be discussed with her after delivery. At this point the woman should be counselled about the procedure, and the importance of not re-suturing to create a small opening (re-infibulation) impressed upon her. This counselling will require great patience as the woman will be used to having a closed vulva as this is all she has experienced in life. The changes brought about by opening her up will need to be explained carefully and with sensitivity. She should be reassured that she will get used to changes in time.
- Reassure the woman that you are ready to discuss the situation with her husband/partner and/or anyone else she wishes. They may need to be counselled also. They should be informed of the procedure of opening up, the importance of keeping the genitalia open, and the health consequences of closing them again.
- Post-operative care for an infibulated woman opened up during labour is the same as for any other women whose infibulation has been opened up. Inform the woman of the need for good personal hygiene, and suggest she takes sitz baths to prevent infection. Dressings of sugar and paste have proved to be effective in treating the wound.

### Demonstration:

- Ask one student to volunteer to act as a client with a tight introitus due to FGM.
- You, the teacher, will act as the service provider.
- Make the client comfortable in bed.
- Recall all the interpersonal skills.

- Introduce yourself to the client if you have not already done so.
  - Inform the client that her labour is making good progress.
  - Inform the client that during examination you identified a tight passage which may prevent the baby from being delivered.
  - Inform her that in order to increase the size of the passage to allow delivery, she will need to have her infibulation opened up, or an episiotomy performed (whichever is appropriate in the circumstances).
  - If the need is for an episiotomy to open up a tight introitus due to type I or type II FGM, give the client this information and tell her what the procedure entails.
- If the need is to open up infibulation from type III FGM, inform the client that the scar will be cut to allow passage of the baby. Also inform her that afterwards the sides of the wound will be sutured separately; the intention is not to recreate a small opening. Also inform her about the changes this will mean in terms of urination, menstrual flow a sexual intercourse.
  - Thank the client for her co-operation.

#### Closing the session:

- Ask students to share what they have learnt from the session.
- Write down what they say for future reference.
- Close the session.



## Session 4: Management of women with FGM during the postpartum period

### Session objectives

By the end of this session students should be able to:

1. Identify problems due to FGM during the postpartum period.
2. Manage women with FGM during the postpartum period.

### Key references

- *Management of pregnancy, childbirth and the postpartum period in the presence of Female Genital Mutilation. Report of a WHO Technical Consultation. Geneva, 15 - 17 October 1997.* WHO/FCH/WMH/00.7. WHO, Geneva (2000).
- *Female Genital Mutilation: The Prevention and the Management of the Health Complications: Policy Guidelines for nurses and midwives.* WHO/FCH/GWH/01.5. WHO, Geneva (2001)
- *A Systematic review of the complications of female genital mutilation including sequelae in childbirth.* WHO/FCH/ WMH/00.2 Geneva (2000).

### Suggested teaching methods

- Buzzing.
- Plenary sessions.
- Demonstrations.
- Clinical practice.

### Teaching aids

- Writing boards.
- Charts, flip-charts.
- Posters, pictures.
- Overhead projector and transparencies.
- Models.

### Setting the scene

- Ask a few students to share their personal experiences of being very tired.

- Ask them how they felt at that time.

### THE SESSION

Introduce the session and its objectives.

#### Buzzing:

- Ask students what the procedure is for assessing a woman with FGM after delivery.
- Allow them to discuss this question by buzzing in twos or threes.
- Allow 10 minutes for buzzing.

#### Summarise:

Summarise the discussion as follows:

- It is in the period immediately following delivery that major problems may occur. These include extensive lacerations and haemorrhage from tears. If an incision has been incorrectly performed, tears may involve urethra and bladder anteriorly and rectum posteriorly. Later in the puerperium, sutured lacerations may become infected and they may break down. In cases of type III FGM and if the infibulation has not been opened, both mother and baby may suffer severe injuries, e.g. VVF and RVF in the case of the mother; and asphyxiation, stillbirth or severe brain injuries in the case of the baby. Therefore it is vital that a woman with FGM and her baby be properly assessed after delivery.

## Immediate assessment of mother and baby

Inform students that immediately after delivery, the mother should be assessed as follows:

- Check if uterus has contracted. If it has not, massage the uterus to contract, check the bladder and empty if necessary; or administer oxytocic drugs.
- If you have delivered the woman, change gloves to another sterile pair.
- Check for tears on the vulva and inside the birth canal.
- Clean the vulval area to enable you to look into the external genitalia.
- Use speculum and good light to check for tears in the vaginal wall and on the cervix.
- Introduce the speculum very slowly as this may cause pain to the woman.
- Look along the inside of the vaginal wall and at the cervix.
- If there is bleeding or tears, take appropriate action immediately.

Inform students that immediately after delivery, the baby should be assessed as follows:

- Apply the Apgar test.
- If the baby is asphyxiated, resuscitate it. But if the condition is severe, send for medical attention appropriately.

## Subsequent assessment of mother and baby

Inform students that they should:

- Assess the mother's genitalia for bleeding and any sign of infection, and check that any tears, episiotomies or the edges of an opened up type III FGM are healing properly.
- Assess contraction of the uterus and bleeding; check for the normal involution of the uterus.
- Assess the mother's mental state (psychological and emotional).

- Assess the baby according to normal routine – e.g. check site of umbilicus for healing or bleeding; check its progress with breastfeeding.

### Buzzing:

- Ask students what complications women with FGM may experience after delivery.
- Allow students to buzz in twos or threes for 10 minutes.
- Allow students to share their thoughts in discussion with the whole class.
- Allow half an hour for discussion.

## Complications after delivery

- Excessive primary bleeding due to injury of the arteries and veins as a result of tears.
- Secondary bleeding as a result of wound infection.
- Infection which may lead to septicaemia.
- Urine retention if repair was not done correctly.
- Injury to adjacent tissues due to tears, if the delivery was not managed correctly. This may result in:
  - Incontinence of urine and/or faeces .
  - Vesico-vaginal fistula (VVF).
  - sexual problems if repair was not done properly.
- Asphyxia neonatorum due to obstructed labour; this may result in brain damage to the baby.

### Large group discussion:

- Ask students what care should be given to a woman with complications of FGM during the postpartum period?
- Allow students to discuss.

## Management of a woman with FGM after delivery

Inform students that the management of women with FGM during the postpartum period is the same as for any other women. However, these women will

need more psychological care in cases where the vulva has been opened up and not closed to restore the genitalia to the condition they were in before pregnancy and delivery. Such women will have to learn to accept dramatic changes to the vulva from what they have known all their lives. The opened vulva will be different in both appearance and function from the infibulated vulva.

Women may request that they be re-sutured after delivery. In countries where there are laws against closing up an opened infibulation, it is relatively simple to deal with the situation, since the nurse/midwife can say the law does not allow the re-suturing. But in countries where there are no such laws, a request for re-suturing can cause real dilemmas for the nurse/midwife. In such a situation the nurse/midwife should follow the guideline of the health facility or her institution. Whatever the legal status of FGM, re-suturing, counselling and education over this issue are extremely important, and every effort should be made to discourage the practice of reinfibulation.

### Immediate care

#### In cases of haemorrhage:

- Suture any tears and episiotomies immediately. Also suture the sides of an opened infibulation (see procedure described earlier).
- If the uterus does not contract, expel any clots, massage the uterus to aid contraction and administer oxytocic drug if necessary.
- Keep the patient warm.
- If postpartum haemorrhage is severe, call for medical assistance.

#### In cases of neonatal asphyxia:

- Resuscitate the new-born and send for medical attention if severe.

### Postpartum follow-up

- Women with type I, II and IV with no complications after delivery should be advised like any other woman.
- Assure client that you are available to answer any queries she might have about her own care or that of the baby, or concerns about sexual matters.
- Perform the usual postpartum care for the mother and the baby.
- Women with type III FGM need the same kind of postnatal care as other women, but they will need additional information, counselling and support to help them adapt to the changes following de-infibulation, and to discourage them from seeking re-closure after discharge from the health unit. Discuss with her the feeling of wetness and increased sensitivity in her opened vulva, which she might not have experienced before. Advise her to wear loose underwear to reduce discomfort caused by friction.
- Provide psychosexual counselling to the husband separately to make him aware of the importance of not closing the opened up infibulation, and to help him deal with sexual changes.
- A women with any type of FGM who delivers a baby girl should be counselled about the consequences of allowing her daughter to be excised. The husband and other family members who are influential in decisions about FGM, e.g. mothers and mothers-in-law, should also be counselled about the same issues.
- Like any other woman in the postpartum period, those with FGM should be advised about the importance of personal hygiene, good nutrition, adequate rest, and about care of the new-born including breast feeding. They should also be given family planning advice and counselling like any other newly delivered mother.

- Information on FGM type and complications should be recorded.

### Closing the session:

- Review major points.
- Ask the students questions to check their understanding.
- Close the session.
  - Prepare students for skill practice in practicum.
  - Provide opportunity to practice in clinical areas.



