FEDERAL MINISTRY OF
HEALTH

NATIONAL PROTOCOL ON THE MANAGEMENT OF COMPLICATIONS FROM FEMALE GENITAL MUTILATION (FGM) IN NIGERIA

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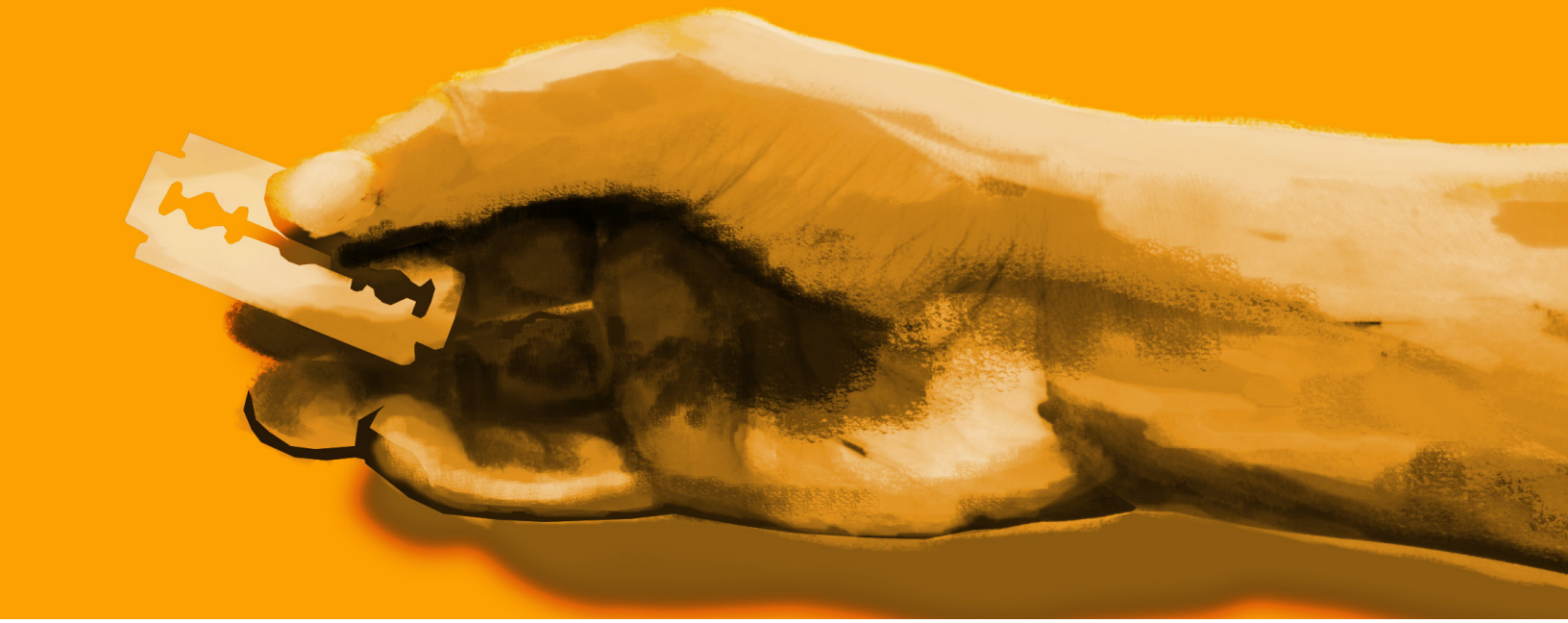

National Protocol on the Management of Complications from Female Genital Mutilation (FGM) in Nigeria

UNFPA

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Three Grant winners of the Against My Will Competition proffering Girl-led solutions to Ending Female Genital Mutilation in Nigeria

Foreword

The World Health Organization (WHO) whose core mandate is to provide assistance to member states in achieving the goal of the highest attainable standard of health for citizens, issued an inter-agency statement in 2018 on eliminating FGM

Female Genital Mutilation (FGM) remains a serious health burden and violation of the dignity of girls and women in many countries of Africa, Middle East and parts of Asia. The practice is prevalent in all the six geo-political zones of Nigeria with 25% of Nigerian females "circumcised". Over 82% of affected females suffered before their fifth birthday. It is mostly conducted by traditional "circumcisers" and intertwined with culture, religion, aesthetics and group identity.

The World Health Organization (WHO) whose core mandate is to provide assistance to member states in achieving the goal of the highest attainable standard of health for citizens, issued an inter-agency statement in 2018 on eliminating FGM, highlighting the negative implications of the practice on health and the infringement on the human rights of girls and women, and declaring strong support for its abolishment. Member countries with a high burden of FGM have been provided with guidelines and templates to develop protocols for managing the problem and supporting its elimination.

This protocol was developed to serve as a working tool for the management of FGM in Nigeria and safeguarding the rights of girls and women. It is designed for the use of all categories of health workers, psychologists, counselors, social workers and police, among others. It reflects current Nigerian legislation and professional requirements in relation to FGM, as well as being in line with existing guidelines of 2018 WHO 'CARE OF GIRLS & WOMEN LIVING WITH FEMALE GENITAL MUTILATION - A CLINICAL HANDBOOK'.

The protocol outlines the legal frameworks underpinning interventions in FGM guiding principles and management of complications. It also makes provisions for providing care on psycho-social and sexual problems emanating from FGM.

It is envisaged that the production of the protocol will accelerate interventions in FGM in the country and encourage many states, LGAs and communities to take active action on FGM, thereby engendering conducive environment for abandonment of FGM and facilitating attainment of FGM-free status.

We therefore implore all stakeholders to embrace this initiative of a working document to guide FGM programming in the country and promote its utilization by all professionals in the field.

Dr. Osagie E. Ehanire MD, FWACS
Honourable Minister of Health

Acknowledgements

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This protocol would not have been completed without the valuable contributions of all the stakeholders that participated in the drafting of this document. These include the Federal Ministry of Women Affairs, State Ministries of Health and State Primary Health Care Development Boards. We appreciate the efforts of Centre for Population and Reproductive Health (CPRH) and the contributions of the relevant health regulatory and professional bodies, namely, Nigeria Medical Association (NMA), Medical and Dental Council of Nigeria (MDCN), National Association of Nigerian Nurses and Midwives (NANNM), Society of Gynaecology and Obstetrics of Nigeria (SOGON), Nurses and Midwifery Council of Nigeria (NMCN) and Paediatric Association of Nigeria (PAN).

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Executive Summary

Female Genital Mutilation (FGM) involves the partial or total removal of external genitalia or other injury to the female genital organs for non-medical reasons. It is internationally recognized as violation of human rights. The procedure is practised in 30 countries in Africa and in a few others in Asia and the Middle East. An estimated 200 million girls and women are subjected to the practice globally and every year about 3 million are at risk of FGM.

The practice is prevalent in all the six geo-political zones of Nigeria with 25% of girls and women aged 15 to 49 being circumcised. The prevalence is higher in the southern zones, among rural dwellers, women with no educational training and the lowest wealth quintiles. Six percent (6%) of circumcised women had cutting with no flesh removed, 63% had cutting with some flesh removed and 5% had infibulation. Most female circumcision in Nigeria (82%) occurred in childhood and was conducted by traditional circumcisers.

Purpose of the protocol

The Nigerian Government in conjunction with the World Health Organization (WHO) have the goal of ensuring that citizens attain the highest standard of health and preserving the human rights of all people including girls and women.

The WHO in 2008 issued an inter-agency statement on eliminating FGM and declared vigorous support for its abandonment. Guidelines have been developed to serve as a template for member nations with high burden FGM to develop country protocols for managing the condition. The aim is to alleviate the associated adverse health conditions and to restore violated human rights.

This protocol is aimed at adopting the 2016 WHO guidelines on the management of FGM in Nigeria.

Thus, the objectives of this protocol are:

Provide evidence-informed recommendations on the management of complications associated with or caused by FGM.

Guide clinical decision-making and ensure the delivery of standardized, quality health services to girls and women currently suffering complications of FGM.

Serve as resource material for both pre and in-service medical training programmes.

Following the recognition that FGM violates human rights, the Member States of the United Nations (UN) in 2012 agreed in UN General Assembly Resolution 67/146 to intensify efforts to eliminate FGM, as a practice that is "an irreparable, irreversible abuse that impacts negatively on the human rights of women and girls". Also, the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the UN Convention on the Rights of the Child (CRC) called for an end to the practice. Similarly, the Protocol on the Rights of Women in Africa ("the Maputo Protocol") mandates legal prohibition of harmful practices such as FGM.

The Violence Against Persons Prohibition Act (VAPP) enacted by the Nigerian government provides legal backing against FGM. It aims to eliminate violence in private and public life, prohibit all forms of violence against persons, and to provide maximum protection and effective remedies for victims and punishment of offenders. About 25 states have passed legislations against FGM with different degrees of penalties against it. The states include Edo, Delta, Ebonyi, Rivers, Cross River, Bayelsa, Ogun, Osun, Ondo, Ekiti, Kwara and Kaduna.

Guiding Principles

The guiding principles for intervention in FGM are:

Girls and women living with FGM have experienced a harmful practice and should be provided quality health care.

All stakeholders – at the community, national, regional, and international level should initiate or con-tinue actions directed towards primary prevention of FGM.

Medicalization of FGM (i.e., performance of FGM by health-care providers) is never acceptable be-cause this violates medical ethics because:

FGM is a harmful practice, Medicalization perpetuates FGM and The risks of the procedure outweigh any perceived benefit.

This protocol provides healthcare providers and all other professionals working in the area of FGM, a working guide in dealing with the onerous task of restoring health and hope to violated girls and wom-en and pursing the overall goal of eliminating FGM. It outlines instructions in the following areas:
Management of FGM complications - assessment of clients, management of clients' complications (immediate, short term and long term).

Management of psycho-social and sexual complications of FGM including identifying psycho-social and sexual complications.

The procedure for opening up type III FGM (infibulation).
Management of women with FGM during pregnancy, labour, delivery and postpartum.
Use of family planning in the presence of FGM.
Procedure for referral of clients.

Acronyms & Abbreviations

CBOs	Community Based Organisations
CBT	Cognitive Behavioural Therapy
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CRC	Convention of the Rights of the Child
FBC	Full Blood Count
FGM	Female Genital Mutilation/Cutting
FIDA	International Federation of Women Lawyers
Hb	Haemoglobin
HBC	Hepatitis B
HBsAg	Hepatitis B Surface Antigen
OHCHR	Office of the United Nations Commission for Human Rights
PID	Pelvic Inflammatory Disease
PTSD	Post Traumatic Stress Disorders
PVC	Packed Cell Volume
RBS	Random Blood Sugar
RVF	Recto-Vaginal Fistula
RVS	Retro-Viral Screening
TBAs	Traditional Birth Attendants
UN	United Nations
UNDP	United Nations Development Programme
UNDS	United Nations Development System
UNECA	United Nations Economic Commission for Africa
UNESCO	United Nations Educational Scientific and Cultural Organisation
UNIAIDS	United Nations Programme on AIDs
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Funds for Women
UTI	Urinary Tract Infection
VAPP	Violence Against Persons Prohibition (Act)
VVF	Vesico-Vaginal Fistula
WHO	World Health Organisation

Introduction

Background

Female Genital Mutilation (FGM) comprises all procedures that involve the partial or total removal of external genitalia or other injury to the female genital organs for non-medical reasons.

Although, it is internationally recognized as a violation of human rights and legislation to prohibit the procedure has been in many countries; till date the practice is still prevalent in 30 countries in Africa and a few countries in Asia and the Middle East. Some forms of FGM have also been reported in other countries, including among certain ethnic groups in Central and South America. The rise in international migration has also increased the number of girls and women living in the various diaspora populations, including in Europe and North America, who have undergone or may undergo the practice. Globally it is estimated that at least 200 million girls and women worldwide have been subjected to the practice of FGM, and despite efforts to eradicate the practice, every year some 3 million girls and women are at risk of FGM and are therefore exposed to the potential negative health consequences of this harmful practice.

Twenty five percent (25%) of Nigerian girls and women aged 15 to 49 years are circumcised. The practice is widespread across the 6 geo-political zones but with higher prevalence in the southern zones among rural dwellers, women with no educational training and the lowest wealth quintiles. Six percent (6%) of circumcised women had cutting with no flesh removed, 63% had cutting with flesh removed and 5% had infibulation (Narrowing of the vaginal orifice with the creation of a covering seal by cutting and re- positioning the labia minora and/ or the labia majora, with or without excision of the clitoris). Infibulation is more prevalent in Nasarawa, Kaduna and Bayelsa States. Eighty two percent (82%) of circumcised females in Nigeria had it before their fifth birthday. The FGM is conducted mostly by traditional circumcisers (84% of circumcised girls 0-14 years and 72% of circumcised women aged 15-49years), 3% of the girls by traditional birth attendants and 12% by health professionals (nurses, midwives and doctors) ,

Purpose and objectives of the protocol

The World Health Organization (WHO), as part of its core mandate to provide support to Member States in achieving the goal of the highest attainable standard of health for all, issued in 2008 an inter-agency statement on eliminating FGM. The statement highlighted the negative implication of the practice on health and, very importantly, for the human rights of girls and women, and declared vigorous support for its abolishment. The 2016 WHO guidelines on the management of health complications from FGM serves as a template for member nations with high burden FGM to develop country protocols for managing the condition .

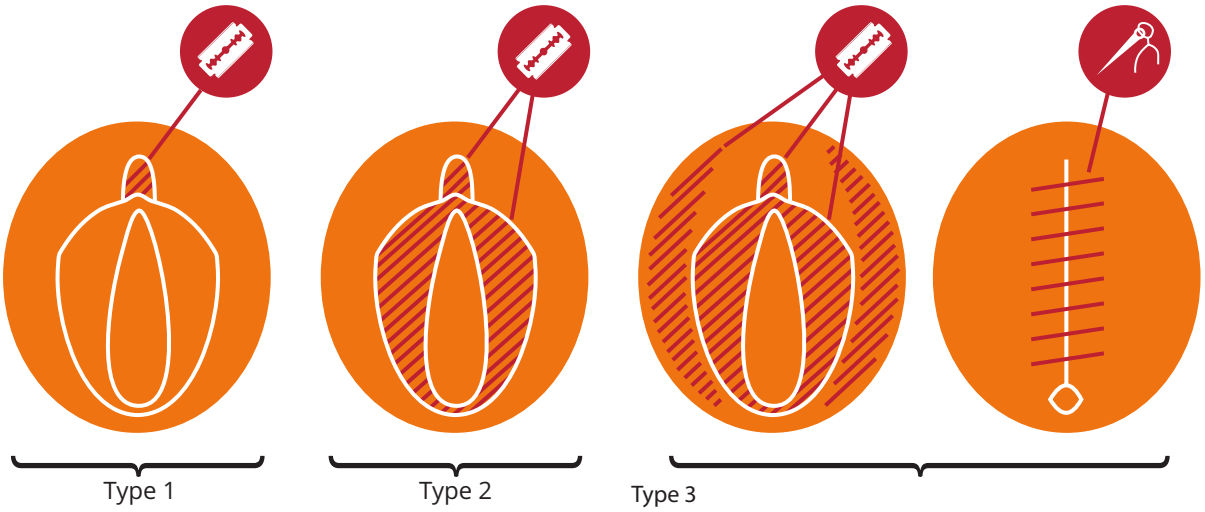
This FGM protocol and Case Management Form is aimed at adopting the 2016 WHO guidelines on the management of FGM in Nigeria. This protocol serves as a guideline for all health care workers at different levels of care to provide quality clinical management of complications arising from FGM.

This document is in line with the National Policy on FGM and relevant existing legal documents including but not limited to the following VAAP Act and Child Rights Act. However, this document will, where appropriate, reference existing guidance protocols.

Thus, the objectives of this protocol are as follows:

- Enhance effective and sensitive communications between health providers, husbands, partners, family members of those affected.

Figure 1.1: Different types of female genital mutilation



- Provide evidence-informed recommendations on the management of complications associated with or caused by FGM.
- Guide clinical decision-making and ensure the delivery of standardized and comprehensive quality health services to girls and women currently suffering complications of FGM.
- Serve as resource material for both pre- and in-service medical training programmes.

Definition of Terms and Scope of FGM

Female Genital Mutilation (FGM)

Female Genital Mutilation (FGM) comprises all procedures that involve the partial or total removal of the external genitalia or other injury to the female genital organs for non-medical reasons .

Medicalization of FGM

Medicalization of FGM refers to situations in which the procedure (including re- infibulation) is practised by any category of health-care provider, whether in a public or a private clinic, at home or elsewhere, at any point in time in a woman's life.

FGM performed by a health-care provider is contrary to fundamental medical ethical principles. Health-care providers who agree to perform FGM are violating the fundamental medical ethical principle or duty of non-maleficence ("do no harm") and the fundamental principle of providing the highest quality health care possible.

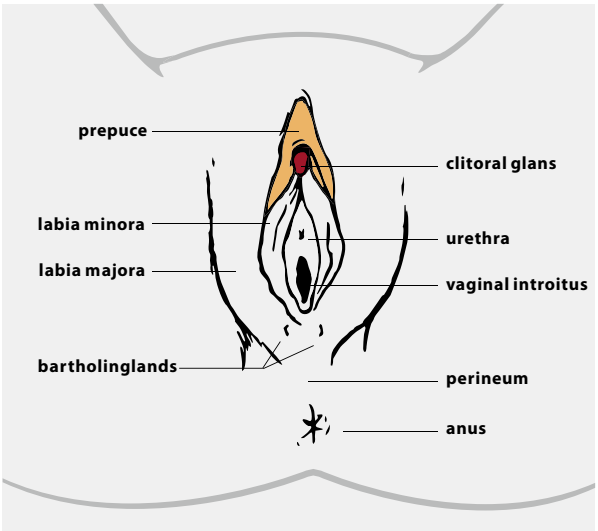
Beneficence: This word means the act of doing good or the quality of being good, kind or charitable to others. In the medical context, this refers to actions that serve the best interests and promote the well-being of patients.

Non-maleficence: This means the avoidance of doing harm or hurting others. In the medical field, this concept is embodied in the phrase "do no harm".

WHO classifies FGM into four types:

- Type I: Partial or total removal of the clitoris (clitoridectomy) and/or the prepuce.
- Type II: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).
- Type III: Narrowing of the vaginal orifice with the creation of a covering seal by cutting and re- positioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
- Type IV: All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, pulling, piercing, incising, scraping, cauterization.

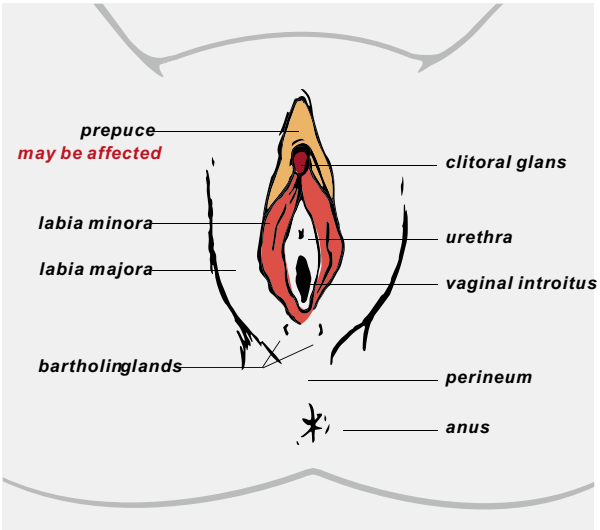
Figure 1.2: TYPE I: Partial or total removal of the clitoral glans (clitoridectomy) and/or the prepuce



Type Ia: removal of the prepuce/clitoral hood (circumcision)

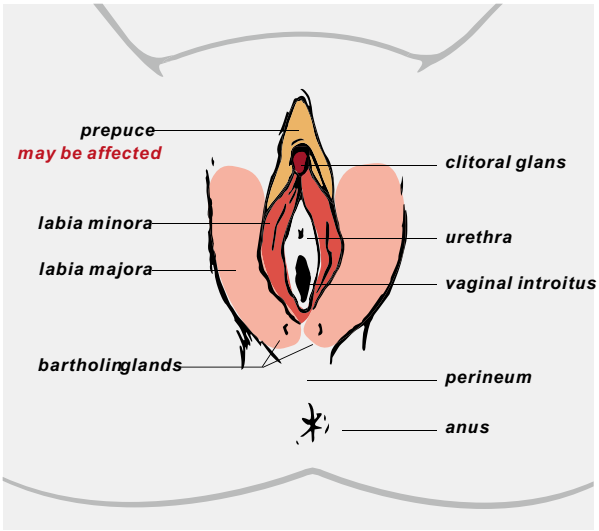
Type Ib: removal of the clitoral glans with the prepuce (clitoridectomy)

Figure 1.3: TYPE II: Partial or total removal of the clitoral glans and the labia minora, with or without excision of the labia majora (excision)



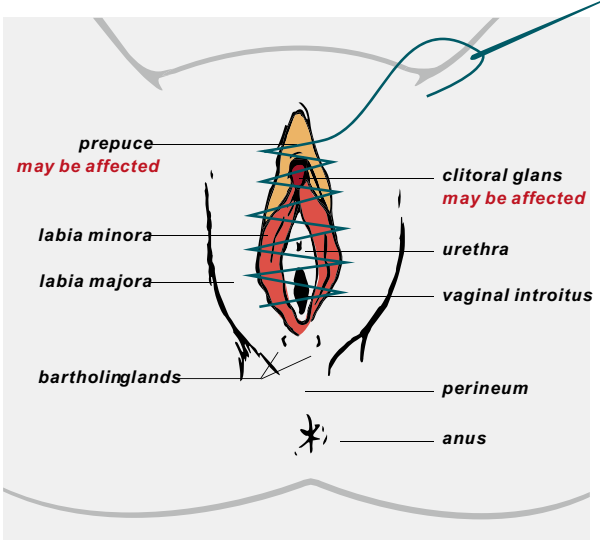
Type IIa: removal of the labia minora only

Type IIb: partial or total removal of the clitoral glans and the labia minora *(prepuce may be affected)*



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

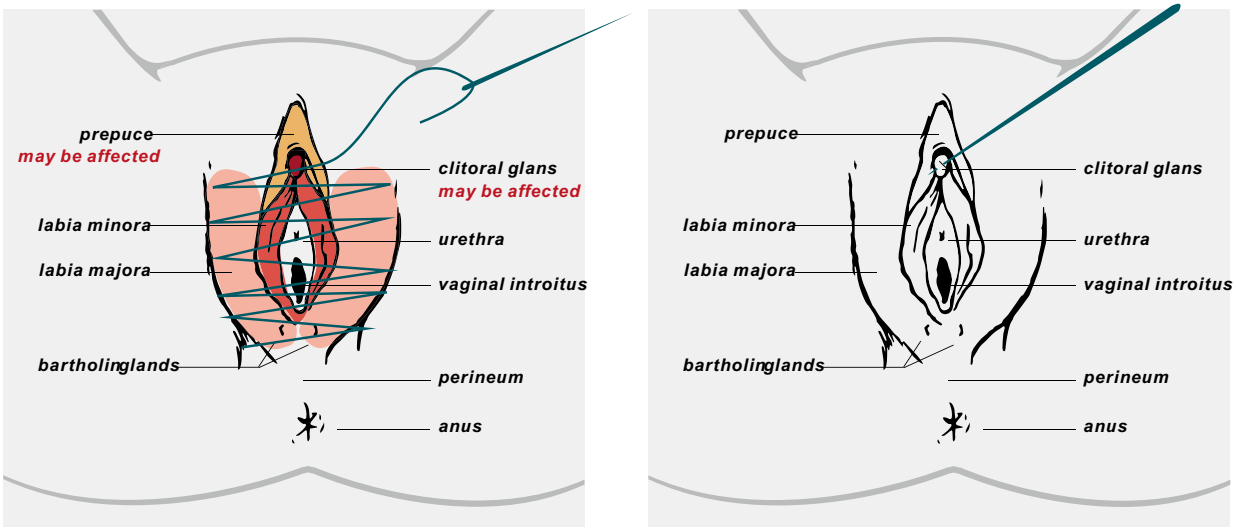
Figure 1.4: TYPE III: Narrowing of the vaginal opening with the creation of a covering seal by cutting and appositioning the labia minora or labia majora with or without excision of the clitoral prepuce and glans (infibulation)



Type IIIa:

+ + appositioning of the labia minora

Figure 1.5: TYPE IV: All other harmful procedures to the female genitalia for non-medical purposes, for example pricking, piercing, incising, scraping and cauterization



Type IIIb:

+ + + + appositioning of the labia majora

FGM is known as "gishiri" and "angruya" cuts in Hausa, 'ikola' in Yoruba and "ibi-ugwunwanyi" in Igbo.

Reasons for FGM

FGM is practised for a variety of socio-cultural reasons, varying from one region and ethnic group to another. The primary reason is that it is part of the history and cultural tradition of the community. In many cultures, it constitutes a rite of passage to adulthood and is also performed, to confer a sense of ethnic and gender identity within the community. In many contexts, social acceptance is a primary reason for continuing the practice.

Other reasons include safeguarding virginity before marriage, promoting eligibility for marriage (i.e., increasing a girl's chances of finding a husband), ensuring fidelity after marriage, preventing rape, providing a source of income for circumcisers, as well as aesthetic reasons (cleanliness and beauty).

Some communities believe that FGM increases sexual pleasure for a man and reduces sexual desires and pleasure in women. Some claim it is a religious requirement, although it is not mentioned in major religious texts such as the Quran or the Bible. In fact, FGM predates Islam and is not practised in many Muslim countries, while it is performed in some Christian communities.

Consequences of Female Genital Mutilation

FGM has no known health benefits, and those girls and women who have undergone the procedure are at great risk of suffering from its complications and consequences throughout their lives. The procedure is painful and traumatic, and it is often performed under unhygienic unsterile conditions by a traditional practitioner who has little knowledge of the female anatomy or how to manage possible adverse effects. Moreover, the removal of, or damage to healthy genital tissue interferes with the natural functioning of the body and may cause several immediate and long-term Genito-urinary health consequences. The evidence indicates that there might be a greater risk of immediate harms with type III FGM, relative to types I and II; and that these events tend to be considerably under-reported.

Immediate Consequences

The immediate consequences of FGM include haemorrhage, pain, shock, sepsis, genital tissue

A member of the State Monitoring Team with a trained health worker in BHC Basiri, Ekiti South-West LGA

swelling, inflammatory response or local infection, abscess formation; septicaemia; genital and reproductive tract infections; urinary tract infections and psychological distress etc.

The direct association between FGM and HIV remains unclear, although the disruption of genital tissues may increase the risk of HIV transmission. Urination problems; acute urine retention; painful urination; injury to the urethra; wound healing problems; and sometimes death due to severe bleeding or septicaemia.

Long Term Consequences

The risks here are genital tissue damage with consequent chronic vulvar and clitoral pain, vaginal discharge due to chronic genital tract infections, vaginal itching, chronic vulvae pain, clitoral neuroma, menstrual problems, dysmenorrhoea, irregular menses and difficulty in passing menstrual blood. Others include reproductive tract infections which can cause chronic pelvic pain; cyst in the genital area; chronic genital infections including increased risk of; urinary tract infections; keloids in the genital area recurrent painful urination due to obstruction and recurrent urinary tract infections.

Obstetric Risks

Caesarean Section may be necessary in type III FGM; postpartum haemorrhage (postpartum blood loss of 500 ml or more); generous episiotomy may be required; prolonged labour; obstetric tears/ lacerations; instrumental delivery; difficult labour/ dystocia; extended maternal hospital stay; stillbirth and early neonatal death; Infant resuscitation at delivery due to low Apgar score.

Sexual Functioning Risks

Some of the sexuality risks are highlighted here:
Dyspareunia (pain during sexual intercourse): There is a higher risk of dyspareunia with type III FGM relative to types I and II. Other associated problems include decreased sexual satisfaction, reduced sexual desire and arousal, decreased lubrication during sexual intercourse, reduced frequency of orgasm or anorgasmia.

Psychological Risks

The psychological risks associated with FGM include post-traumatic stress disorder (PTSD), anxiety disorders and depression.

FGM and Legal Frameworks

Community Entry and Distribution of Girls' Survival Kit (Girls' Survival Project Phase 1) organized by Value Female Network in Osun State

FGM violates a series of well-established human rights principles, norms and standards, including the principles of equality and non-discrimination on the basis of sex, the right to life when the procedure results in death, and the right to freedom from torture or cruelty, inhuman or degrading treatment or punishment and violation of the bodily integrity of girls and women. Therefore, the Member States of the United Nations (UN) in 2012 agreed in UN General Assembly Resolution 67/146 to intensify efforts to eliminate FGM, as a practice that is "an irreparable, irreversible abuse that impacts negatively on the human rights of women and girls". Nigeria is a member state of the UN and issues of human rights are also captured in professional regulatory documents (Code of Conducts of various professional bodies) governing the practice of the health professions in Nigeria.

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- The principles of respect for Autonomy.
- The principles of non- Maleficence.
- The principles of beneficence
- The principles of Justice

Also, the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the UN Convention on the Rights of the Child

(CRC) called for an end to the practice. Similarly, the Protocol on the Rights of Women in Africa ("the Maputo Protocol") mandates legal prohibition of harmful practices such as FGM.

Violence Against Persons Prohibition Act (VAPP ACT) May 25, 2015

The Violence Against Persons Prohibition Act (VAPP) enacted by the Nigerian government provides legal backing against FGM. It aims to eliminate violence in private and public life, prohibit all forms of violence against persons, and to provide maximum protection and effective remedies for victims and punishment of offenders. It addresses the gaps in current laws on violence in private and public spaces, addressing old as well as new forms of violence, establishing institutional mechanisms to prohibit violence and a regulatory body for administering the Act's provisions. The Act recognizes FGM as violence against girls and women.

Legislation in States

Several States (25) have passed legislations against FGM with different degrees of penalties against it. The states include Anambra, Edo, Delta, Ebonyi, Imo, Rivers, Cross River, Bayelsa, Ogun, Osun, Ondo, Oyo, Ekiti, Kwara and Kaduna. Some other States are in various stages of enacting legislation on criminalization of FGM.

These legislations prohibit the practice of all forms of FGM (including medicalization of FGM) and prescribe punishment for offenders.

Legal Advice

All health providers should endeavour to report/refer cases of FGM to the appropriate security agents for legal actions. There is the need to consider the use of specific legal orders to protect all potential victims (girl child and women):

- Establishment of FGM Task Force to prosecute the offenders.
- The following laws should be enforced to protect the child and survivors:
  - FGM (Prohibition Law)
  - State Child Rights Law
  - Gender Based Violence Prohibition Law

Guidance and Recommendations

Action Health Incorporated conducted consenus building meeting with community/traditional leaders and law enforcement agents in Boripe & Olorunda LGAs in collaboration with Osun State ministry of Health and Women Affairs.

General Guiding Principles

- Girls and women living with FGM have experienced a harmful practice and should be provided quality health care.
- All stakeholders – from family level, to community, State, national, regional and international levels – should initiate or continue actions directed towards primary prevention of FGM.
- Medicalization of FGM (i.e. performance of FGM by health-care providers) is never acceptable because this violates medical ethics thus: Medical Ethics disallow the performance of FGM in any form because:
  - FGM is a harmful practice.
  - Medicalization perpetuates FGM; and
  - The risks of the procedure outweigh any perceived benefit.

Specific Guiding Principles Best Practice Statements.

Guiding Principle on patients care 1

- Girls and women who are candidates for de-infibulation should receive adequate pre-operative briefing
- Girls and women undergoing de-infibulation should be offered local anaesthesia
- Psychological support should be available for girls and women who will receive or have received any surgical intervention to correct health complications of FGM

Guiding Principle on Information and Education 2

- Information, Education and Communication (IEC) interventions regarding FGM and women's health should be provided to girls and women living with any type of FGM.
- Health education and information on de-infibulation should be provided to girls and women living with type III FGM.
- Health-care providers have the responsibility to convey accurate and clear information, using language and methods that can be readily understood by clients
- Information regarding different types of FGM and the associated respective, immediate and long-term health risks should be provided to health-care providers who care for girls and women living with FGM

Guiding Principle for Health Workers 3

- Information about FGM delivered to health workers should clearly convey the message that medicalization is unacceptable.

Recommendations

- De-infibulation is recommended for preventing and treating obstetric complications in women living with type III FGM.
- Either ante-partum or intrapartum de-infibulation is recommended to facilitate childbirth in women living with type III FGM, depending on the context.
- De-infibulation is recommended for preventing and treating urologic complications – specifically recurrent urinary tract infections and urinary retention – in girls and women living with type III FGM.
- Cognitive behavioural therapy (CBT) should be considered for girls and women living with FGM who are experiencing symptoms consistent with anxiety disorders, depression or post-traumatic stress disorder (PTSD).
- Sexual counselling is recommended for preventing or treating female sexual dysfunction among women living with FGM.

Management of FGM complications

Important considerations in the management of FGM

Counseling on Female Genital Mutilation

Women who have undergone FGM often delay or do not seek help when they experience health problems that may be linked to the procedure because they may be ashamed, they may not be able to access the health-care facility or they may not have money to pay for treatment. Another reason they may not seek care for these health problems is that many female community members have experienced similar health complications such that certain FGM related symptoms have become "normalized" and women do not think they are relevant enough to consult a health-care provider about. On the other hand, women who do seek care for particular medical problems may not be aware that FGM has caused these problems as such may not spontaneously mention their experience of FGM to the health care providers.

Discussing FGM, and the health complications linked with the practice, can be challenging both for the health-care providers and for girls and women seeking care. Providing care and treatment requires not only understanding the woman's physical, mental and sexual health needs but also supporting

Centre for Reproductive Health presentation on feedback on data collected by healthworkers at Ikere LGA in Ekiti State

her and providing adequate information so that she can make informed decisions. To achieve this, it is essential that you communicate effectively with your female patients and that you openly discuss their health and FGM status with them in a sensitive manner.

Establishing Effective Communication

Effective communication is a process by which information is exchanged between individuals through a common system of symbols, signs or rapport . In the health care setting, it requires a two-way dialogue between the health-care provider and the patient5. This means that during the conversation both participants will listen and provide information to each other. In an ideal situation, the patient will initiate this dialogue by explaining the reason for seeking health care or counselling. However, in reality, especially with a sensitive topic such as FGM, you may need to initiate the conversation yourself by asking a few open-ended questions and creating a safe space in which the girl or woman can freely express her views and needs regarding her own health and well-being.

The following are some suggestions to help a care provider have an effective dialogue about FGM with a female patient.

- Create a welcoming environment.
- Ensure privacy and confidentiality.
- Listen attentively and allow the woman to speak.
- Use appropriate language and terminology.
- Pay attention to your body language.
- Pay attention to the patient's or parent's non-verbal cues and attitudes.
- Use a professional yet friendly tone.
- Do not judge the woman, her culture, ethnicity, or state of origin.
- Show cultural awareness and respect.
- Stay open to other health issues and remember that FGM is only one aspect of the girl's or woman's life.

Ethical Considerations

Patient confidentiality, consent and choice are all aspects of ethics that must be adhered to in the provision of health care for girls and women living with FGM. They are compulsory and must be communicated verbally to the patient.

- **Patient Confidentiality**

It is compulsory for the health care provider to always adhere to this ethical principle. It is also important that verbal reassurance is given to the girl or woman stating that absolute confidentiality is assured and nothing she says will be communicated to anyone else without her agreement, including her family members. She should be told that her medical record will only be shared with other health care professionals if it is absolutely necessary, and they will also be obliged to respect her confidentiality. Knowing this may help relieve the patient's fear and anxiety when talking about what she has experienced.

- **Informed Consent**

General legal and ethical principles require that a valid consent must be obtained before providing a person with personal care or conducting any physical examination or starting any medical treatment. This principle reflects the right of patients to determine what happens to their own bodies and is a fundamental part of good practice. Therefore, before carrying out any clinical actions or procedures it is compulsory that you explain what you are about to do to the girl or woman in detail and obtain her consent. It is her right to refuse.

Non-adherence to this principle by a health-care provider may lead to legal action by the woman and their professional body.

- **Choice**

As a health-care provider, it is required that you provide a range of treatment options for how your patient's medical condition can be handled. These must be explained explicitly stating the pros and cons of each option.

This will give the woman or the girl's parents/ guardians a chance to make an informed decision.

Patient-Centred Care and the Role of Family Members

In the African context, Nigeria inclusive, women are closely linked to their social and family environments. In some cultures, a woman's decision-making is hampered and involves members of the family, especially her husband/partner or female relatives. These family members may consider it their duty to be present during the consultation about FGM and to participate during the development of a care plan. This is often seen as an important way of supporting or protecting the woman. It should not, however, interfere with her care as the care and support provided to a woman should always be determined by her wishes. This means that her autonomy and privacy should be respected.

Evaluation of clients to identify physical complications of FGM

In line with clinical procedures, follow a systematic approach to assess the client and seek to obtain the following information:

History taking:

Use the following steps to guide history taking.

- Introduce yourself and build a relationship.
- Reassure client to build trust and confidence in services being provided.
- Ask questions for information gathering using simple terminology.
- Listen carefully, show empathy and concern.
- Obtain relevant bio-data of the client such as contact address, age, educational background, marital status, occupation; client's family and social life (family and social history). Remember to include number of female siblings, number of female children by index person, practice of FGM by family and extended families.
- Enquire on possible features (symptoms and signs) of complications of FGM. Ask the following questions: Did you undergo any procedure/ surgery (including traditional surgery) on your private part? Do you have urinary problems, reduced menstrual flow or no menstrual flow, pain during sexual act, foul smelling or offensive vaginal discharges, and lower abdominal pain.
- Record information in line with National FGM policy.

Clinical Examination.

- Conduct clinical examination following the most appropriate procedures.
  - Explain –If the patient is alert, explain to the girl or woman that you will examine her and that this will include a genital tract examination. If she is unconscious or a minor and a family member is present, explain to the family member what you are about to do. Ensure a chaperone during patient's examination.
  - Examine – by exposing the necessary area for inspection and examination. Cover the patient until you are ready for the examination.
  - Visual inspection of the external genitalia– clitoris, prepuce, labia minora, labia majora, and perineum. Observe and note for abnormalities, scars, distortions, narrowing of vaginal orifice through suturing/scar tissue formation etc.
  - Palpation – using gloved fingers, explore the area as may be necessary ascertaining patency of vaginal orifice, adhesions, sutured tissue, masses, etc. Discuss with the girl or woman and parent/guardian after completing the procedure.
  - Record findings of the procedure.

Assessment/Treatment plan:

- Ascertain the presence of FGM.
- Determine the type of FGM and associated complications.
- Decide if the client's needs and concerns can be addressed in the health facility, or would require referral to a higher level of care.

Management of clients' complications of FGM (Immediate and Short Term)

Bleeding

- Inspect the site of the bleeding.
- Clean the area.

- Stop the bleeding e.g., apply digital pressure, pack with sterile gauze or pad, suture bleeding site etc.
- Re-assess the client and determine the clinical state, outline necessary actions to address the condition and manage accordingly e.g.
- If wound is contaminated, clean with antiseptic and use antibiotics and tetanus toxoid vaccine.
- If large volume of blood has been lost – fluid replacement or blood transfusion may be required.
- Prescribe vitamin K if this is the policy of the health-care institution, especially in the case of babies.
- If the condition cannot be managed at the facility, refer to the next level of health care
- Follow up the patient.

Pain and injury to tissues

- Assess the severity of pain and/or injury.
- Give psychological support and reassurance.
- Give analgesics, antibiotics, and tetanus toxoid.
- Clean site with antiseptic and advise the client or her guardian to keep it clean.
- If the client is in shock, (see instructions under shock).
- If the condition cannot be managed at the facility, refer to the next level of health care.

Shock

Haemorrhagic shock can occur when there is a reduced volume of blood circulating in the body due to severe bleeding. In the case of FGM, severe damage caused to the genital tissues can lead to excessive blood loss. Death can occur within a relatively short time if the patient fails to receive adequate treatment.

In the management of shock:

- Assess the severity of shock by checking vital signs.
- Ensure patent airway. Put client in head down position to allow blood flow to vital organs (if available, apply anti-shock garment).
- If there is difficulty in breathing, administer oxygen.
- Give intravenous fluids to replace lost fluid.
- Transfuse with blood if necessary.
- Monitor vital signs every 15 minutes.
- If the condition cannot be managed at the facility, refer to the next level of health care.

Infection and Septicaemia

- Infection may occur when FGM is conducted in unhygienic surroundings with unsterile instruments, and if there is a lack of proper wound care following the procedure. Assess the client and examine the external genitalia – vulva, perineum and clitoris for symptoms and signs of infected wound. Identify other sources of infection and take actions to treat the infection e.g., clean the infected wound.
- If obstruction to urine flow, catheterize the patient.
- To manage this condition:
- Take blood and urinary samples for laboratory investigations.
- Treat patient with antibiotics (broad spectrum) while awaiting results of the laboratory investigation.
- Provide supportive management to the patient depending on need.
- Follow up patient closely to re-assess progress.
- If the condition cannot be managed at the facility, refer to the next level of health care.

Urine retention

Urine retention may be the result of injury, pain and fear of passing urine, or occlusion of the urethra during infibulation. Acute retention of urine usually occurs due to genital tissue swelling and inflammation around the wound.

To manage this condition:

- Assess the patient to determine cause (s) of the retention e.g., swelling and inflammation around the wound, pains, and fear of passing urine or occlusion of the urethra during infibulation.
- Apply necessary techniques to encourage the client to pass urine, e.g., turning on a water tap. You may relieve pain associated with micturition by administering analgesics.
- If not relieved, catheterize the patient.

- If retention is due to infibulation, make arrangements for opening up the infibulation.
- If retention is due to injury of the urethra opening, refer for surgical intervention.

Anaemia

- Assess the patient to ascertain the degree of haemoglobin concentration or PCV.
- If anaemia is mild or moderate, treat with haematinics (folic acid, iron tablets and multivitamins) and advice on adequate diet.
- If anaemia is severe, make arrangements for blood transfusion or transfer to higher level of health facility.

Genital Tissue Swelling

Cutting and damaging the genital tissues causes a local inflammatory response. Genital swelling may also be caused by an acute local infection.

To manage this condition:

- Assess the patient to ascertain the degree and the cause of tissue swelling.
- Inspect the vulva for signs of wound infection and possible causes of the infection.
- If there is a definitive diagnosis of the infection, administer anti –inflammatory drug orally or intravenously (if possible), antibiotics and treat wound site.
- If the condition cannot be managed at the facility, refer to the next level of health care.

Management of Patients with Long-term Complications of FGM.

The removal of, or injury to healthy genital tissue can cause immediate and short-term health complications to the girl child and women who undergo FGM, which often require immediate medical care. However, FGM can also result in health complications and conditions that appear months or even years after the genital cutting took place. These negative long-term health consequences usually, although not exclusively, affect the female Genito-urinary system, i.e., affecting the urinary system and/or the reproductive system.

Girl child and woman who experience long-term gynecological and/or urogynecology health complications often live with the symptoms of these conditions without seeking care. This happens for a number or reasons; lack of access to health care; reluctance to acknowledge – that FGM has caused the medical problems they are experiencing; the knowledge that other women and girls have similar health conditions therefore they may not consider it relevant to consult a health-care provider about their symptoms.

a. Keloid Formation in the genital Area

Keloids are raised scars that grow excessively and can become larger than the original area of the skin damage. Once it appears, a keloid can enlarge slowly for months or years and it may be painful or itchy. Keloids can be difficult to treat and may re-occur after surgical removal. A keloid may form in the scar tissue and may cause obstruction during sexual intercourse or delivery.

To manage this condition:

- Assess the client and determine the location and size of keloid.
- If small and does not cause any symptom, leave it undisturbed and reassure the client.
- If large and likely to cause obstruction during intercourse or delivery, refer to higher level of health facility.

Cysts

The cutting of the genital area leads to a wound which heals and leaves a scar. Sometimes, external layers of the skin (epidermis) become "trapped" in the deeper layers (dermis). This can lead to epidermal inclusion cysts that can gradually increase in size, become inflamed or infected, resulting in pain and tenderness.

To manage this condition:

- Assess the patient and determine the size, location and type of cyst.
- If small and non-infected, may be left alone after counselling patients or arrangements may be made for its removal by experienced health-

care provider.
- If large or infected, refer for excision or marsupialization (a procedure for cyst removal).

Clitoral neuroma

A neuroma is a benign tumour that arises after the cutting or injury of a nerve.

This may result from trapping of the clitoral nerve in the fibrous tissue of the scar during clitoridectomy leading to sharp pain over the fibrous scar.

To manage this condition:

- Assess the client and establish the diagnosis.
- Advise patient to wear loose underwear.
- Patient may benefit from local anaesthetic cream like lidocaine cream.
- If symptoms are severe, refer the patient for surgical excision of the neuroma.

d. Vulva Abscess

An abscess is formed when a wound heals and leaves a scar with trapped layers of the epidermis in the dermis which becomes inflamed or infected.
To manage this condition:

- Assess the client and ascertain the presence and size of the abscess.
- Drain the abscess (incision and drainage).
- Administer broad spectrum antibiotics.
- If incision and drainage is not possible, refer to a higher level of health care.

Urinary Tract Infection (UTI)

UTIs in women and girls living with FGM usually occur due to obstruction and stasis of the urine. This may happen among infibulated patients due to injury to the urethral opening. The obstruction affects the normal flow of urine, which is only able to slowly drip out when the patient urinates. This causes urinary retention, making it susceptible to bacterial growth that can lead to UTI, which can become recurrent.

To manage this condition:

- Determine existence of symptoms and signs of UTI.
- Carry out necessary laboratory investigations e.g., urinalysis, urine microscopy, culture, and sensitivity where available.
- Treat with appropriate antibiotics.
- If condition cannot be managed at the facility, refer to the next level of health care.

Reproductive Tract Infection (RTI)

Reproductive tract infection, including chronic pelvic Inflammatory Disease (PID) occurs in FGM patients especially type III. Reproductive Tract Infections can occur due to partial occlusion of the vaginal opening – as a result of the presence of scar tissue or infibulation.

Chronic Pelvic Inflammatory Diseases (PID)
To manage this condition:

- Establish the symptoms and signs of Pelvic Inflammatory Diseases (PID).
- If the client has type III FGM, counsel on the need for de-infibulation (opening up).
- Carry out necessary laboratory investigations e.g., high vaginal swab/endo-cervical swab for microscopy culture and sensitivity (m/c/s).
- Treat with appropriate antibiotics.
- The partner of the client needs to be counselled and treated as appropriate.
- If condition cannot be managed at the facility, refer to the next level of health care.

Fistulae and incontinence

This may be Vesico-vaginal fistula (VVF) or Recto-Vaginal Fistula (RVF) or a combination of both resulting in incontinence and usually arising from prolonged obstructed labour. There is an increased risk in women with FGM.

To manage this condition:

- Ascertain the presence of fistula and type.
- For VVF or RVF patients, refer to next level of healthcare.
- If stress incontinence, counsel the patient and commence her on exercise to strengthen the pelvic floor muscles or refer to next level of care.

Vaginal obstruction

Partial or total obstruction of the vagina may occur due to infibulation, vaginal stenosis, or the presence of a vaginal haematoma. It may be accompanied by haematocolpos (accumulation of trapped menstrual blood).

Unmarried girls may be suspected of being pregnant because of the amenorrhoea and swelling of the abdomen).

To manage this condition:

- Identify the problem and type of FGM.
- If client is infibulated, counsel on the need for de-infibulation (opening up).
- If the condition is as a result of stenosis or cannot be managed at the health facility, refer to the next level of care for surgical intervention.

Menstrual Difficulties

Menstrual difficulties include dysmenorrhoea (painful menstruation), difficulty in passing menstrual blood, and haematocolpos and haematometria (accumulation of blood within the vagina and uterus, respectively). Patients with FGM often report dysmenorrhoea with or without menstrual irregularity. Possible causes include tight infibulation or severe scarring leading to narrowing of the vaginal opening. A very narrow vaginal opening may not allow normal menstrual flow, which can result in dysmenorrhoea and haematocolpos/ haematometria.

To manage this condition:

- Determine the possible cause of dysmenorrhoea.
- Counsel the client on the condition and how to cope with it.
- Give analgesics/ antispasmodic drugs to relieve pain.
- If dysmenorrhoea is due to the accumulation of menstrual flow/ infibulation, counsel the client on the need for de-infibulation (opening up).
- If the condition cannot be managed at the facility, refer to the next level of health care.

Ulcers

Vulva ulcers may develop as a result of the formation of urea crystals in urine trapped under the scar tissue.

- Determine the status of the ulcer and associated conditions.
- If there is infibulation, counsel the client on the need for de-infibulation (opening up).
- Administer antibiotics, analgesics, and wound care.
- If condition cannot be managed at the facility, refer to the next level of health care.

Chronic Vulva Pain

This is mainly caused by the formation of inelastic scar tissue, keloids, cysts and neuromas. It may also be associated with mental health disorders such as anxiety, depression, and traumatic stress.

To manage this condition:

- Determine the cause of the pain via history taking and genital examination.
- If there is no diagnosed cause on physical examination, consider psychosocial factors of infibulation,
- Refer to the next level of health care.

Management of psychosocial and sexual complications of FGM

Identifying psychosocial and sexual complications of FGM

Psychosocial condition refers to the psychological and social aspects of human experience – i.e., how a person feels about her or his relationships with others in society. Psychosocial problems include chronic anxiety, and feelings of fear, humiliation, betrayal, stress, loss of self-esteem, depression, phobias, and panic attacks. These may manifest as psychosomatic symptoms such as nightmares, sleeping and eating disorders, disturbances of mood and cognition, loss of appetite, excessive weight loss or gain, and negative body image.

Sexual complications refer to a problem during any

phase of the sexual response cycle that prevents the individual or couple from experiencing satisfaction from the sexual activity e.g., rigidity, dyspareunia, phobia for sex.

Psychosocial and sexual problems are identified by interviewing clients employing interpersonal communication skills; observation and listening skills. The health provider should pick up non-verbal cues of psychosocial problems, by observing body language, listening carefully to the tone of voice, enquire about her eating and sleeping patterns, menstrual patterns, sexual relationships, her concerns/worries, etc. Listen carefully and empathetically (showing concern). Provide support to the client during interview to give her psychological strength.

Managing psychosocial and sexual complications of FGM

The key elements in managing psychosocial and sexual complications are outlined below:

- Identify the problem by interviewing the client (history taking).
- Counsel to help identify the problem and recognize it
- Refer clients who are severely disturbed for more specialized care
- Counsel partner where appropriate
- If type III FGM, counsel on the need for de-infibulation (opening up).
- If other types of FGM manage as appropriate.

Procedure for Referral of FGM Client

Care providers particularly those at the Primary Health Care facilities are likely to encounter clients whose conditions would necessitate management at higher levels of care. Such clients would benefit from referrals to experienced practitioners.

FGM complications which may require referral if there is:

- Severe bleeding, difficulty in breathing, calculus, VVF or RVF, epidermal or dermal cyst, clitoral neuroma, depression, infertility, obstructed labour etc.
- Information to be captured in the referral notes include client's demographic data, summary of health history, clinical findings, care given thus far and reason for referral.
- Refer as appropriate to the next level of care to any of the following:
  - Obstetricians & Gynaecologists
  - Psychologists
  - Mental health physicians
  - Social workers
  - Paediatricians
  - Counsellors

Note: Referral for legal intervention may be required. Refer to the law enforcement agency.

- Follow-up as appropriate.

De-infibulation of Type III FGM

This procedure is to be carried out by doctors or nurse midwives who have been trained in managing type III FGM and de-infibulation.

- Counsel the client on the procedure and assure her of confidentiality
- Make the client comfortable in bed or on a couch.
- Perform assessment to confirm type III FGM.
- In communities where type III FGM is common, the vulval area should be inspected at the first antenatal visit as a component of routine care.

Indications for de-infibulation

- Opening up an infibulation is indicated in many cases. These include the following:
- Urinary retention (common in children).
- Recurrent urinary tract infection and or kidney infections.
- Severe genital tract infection.
- Haematocolpos (especially in adolescents).
- Severe menstrual problems.
- Difficulty in penetration during sexual intercourse.
- Incomplete abortion.
- Termination of pregnancy.
- Childbirth.
- Gynaecological problems of the genital tract.
- Gynaecological diseases in elderly requiring manual or speculum examination or treatment vaginally.
- For the use of certain contraceptive methods for family planning.
- For certain religious/purification purposes.
- For cosmetic reasons.

Contraindication of de-infibulation

- Refusal of the woman to have the procedure done
- Scar tissue that cannot be lifted and cut e.g., in the presence of extensive tissue loss

The procedure for de-infibulation

  - Make the client comfortable in bed or on a couch.
  - Counsel the client on the procedure and assure her of confidentiality.
- Position the patient lithotomy.
  - Wash hands, put on sterile gloves, expose the genitalia, and clean the perineal area with antiseptic swabs.
- Infiltrate 2–3 mls of local anaesthetic into the area where the cut will be made, along the scar and in both sides of the scar.
- Introduce index finger or forceps or dilator slowly and gently into the opening to lift the scar skin
- The cut should be made along the mid-line of the scar towards the pubis.
- With your finger or dilator inside the scar, introduce the scissors and cut the scar alongside the finger or fingers to avoid injury to the adjacent tissues (or to the baby, if the procedure is done during labour). Take care not to cause injury to the structures underneath the scar (urethra, labia minora and clitoris). It is common with type III FGM to find the structures below the scar intact. Incise to expose the urethral opening. Do not incise beyond the urethra. Extending the incision forward may cause haemorrhage, which is difficult to control.
- A cut of about 5cm towards the urethra is usually appropriate depending on the extent, there is little bleeding for the relatively avascular scar tissue.
- Women should not be allowed to suffer pain as this may reinforce negative ideas about being opened up. Therefore, analgesia should be prescribed following opening up.
- Antibiotics should also be prescribed.

Director of Public Health, Dr. Gbenga Adegoke addressing the health providers at the 3-days capacity building training organized by Action Health Incorporated in Osun State

Reproductive health services for women with FGM

Cervical Screening for Women living with FGM

Women who have undergone FGM may have been exposed to the human papillomavirus (HPV) and therefore are also at risk of developing genital warts and cervical cancer. As such, women with FGM should also undergo cervical screening at regular intervals. The human papillomavirus (HPV) is the most common viral infection of the reproductive tract – most people get it at some time in their life. Cervical cancer is caused by certain types of HPV that are passed through sexual contact.

- Explain the purpose and importance of the cervical screening
- Create space for dialogue between client and care provider
- It may sometimes be difficult or impossible to insert the speculum in women who have undergone FGM.

Use of family planning in the presence of FGM

Girls and women who have had FGM are in need of and have a right to family planning services just like any other female.

The main challenge is that women who have been infibulated may have difficulties in using a method which has to be inserted vaginally (e.g. female condom, spermicides) or an intrauterine device (IUD). FGM predisposes females to infections of the genital tract, therefore IUDs or other methods that will require insertion vaginally should be only used after careful consideration.

Caring for Women with FGM During Pregnancy, Labour, Childbirth & Postpartum

Distribution of IEC materials during EndFGM campaign in Ekiti State by The New Generation Girls and Women Development Initiative

Management of Women with FGM during Pregnancy

Objectives

- Develop an adequate birth plan in the context of FGM.
- Manage common complications which may occur during pregnancy as a result of FGM.
- Use proper history-taking and physical examination skills to:
  - assess FGM status (FGM versus no FGM).
  - assess the type of FGM (I, II, III or IV).
  - identify and prevent complications that may occur during labour, childbirth, and the postpartum period, which may be related to FGM.
- Understand how to manage labour and childbirth in women with FGM.
- Understand the particular considerations of managing women with type III FGM during pregnancy, labour, childbirth and the postpartum period.

Obstetric Risk Associated with FGM

Many women who have undergone FGM experience a healthy pregnancy and childbirth. However, evidence shows that FGM is associated with a number of obstetric complications, and that greater risk is associated with the most severe forms of FGM (i.e., those classed as type III FGM, also referred to as "infibulation")

Women who have undergone FGM have increased risk of

the following:

- Caesarean section
- Postpartum haemorrhage (PPH)
- Episiotomy
- Prolonged or difficult labour
- Obstetric tears and lacerations
- Instrumental delivery
- Extended maternal hospital stay

Babies born to women who have undergone FGM have an increased risk of:

- Stillbirth and early neonatal death
- Asphyxia and resuscitation of the baby at birth

Antenatal Care:

Antenatal care visits provides an ideal opportunity for assessment, support and institute appropriate care to women who have experienced FGM. This includes identifying whether she has undergone FGM and what type; treating common health complications; discussing the potential for complications to arise during labour and childbirth and creating an appropriate birth plan.

Assessment for Antenatal Care

When assessing, do not immediately ask the woman about her FGM status. It is best to start by taking a full history that includes asking general questions about her physical and mental health. Make the woman feel welcomed, always respect her privacy and confidentiality.

A good time to ask about FGM is when you ask about her surgical or reproductive history.

Pregnant women from communities where FGM is traditionally performed should receive routine antenatal care that incorporates additional assessment of the following questions:

- Has the woman undergone FGM (or what is her FGM status?)
- What type of FGM has she undergone?
- What health conditions does the woman have and are they potentially related to FGM?
- If the woman discloses that she has undergone FGM,

Ask her about:

- Vaginal discharge. Rule out the possibility of an on-going reproductive tract infection (RTI).
- Urinary symptoms, such as how long it takes the woman to empty her bladder and whether this causes pain, to rule out the possibility of partial urinary tract obstruction or infection.
- Previous complications during pregnancy and childbirth, such as prolonged or obstructed labour, postpartum haemorrhage (PPH) or resuscitation of her new-born at birth.
- Worries or fears associated with the pregnancy or childbirth, including nightmares or flashbacks regarding her genital cutting.
- Past experience of de-infibulation and/or re-infibulation.
- Whether she has any specific questions she would like to ask.
- The woman should be provided with routine antenatal care information in addition to any special care due to her FGM status. This should include but not limited to the following.
- The importance of healthy eating and keeping physically active during pregnancy.
- Daily oral iron and folic acid supplementation and other context specific dietary supplements;
- The health risks of tobacco use (past and present) and exposure to second-hand smoke;
- Sexual health during pregnancy, and postpartum care (including breastfeeding).
- Contraceptive alternatives after childbirth.
- Where to access further psychological or social support.

Visual Recording of FGM

If after performing a genital examination you cannot determine the exact type of FGM the patient has, you should at least record that she has undergone FGM (i.e. her genitalia are altered). Describe which anatomical structures have been removed or damaged. Keep in mind that some girls or women may have different forms of FGM and therefore you should always develop your own drawings to put in the patient's medical record based on the findings

Figure 8.1: Diagram of unaltered genitalia

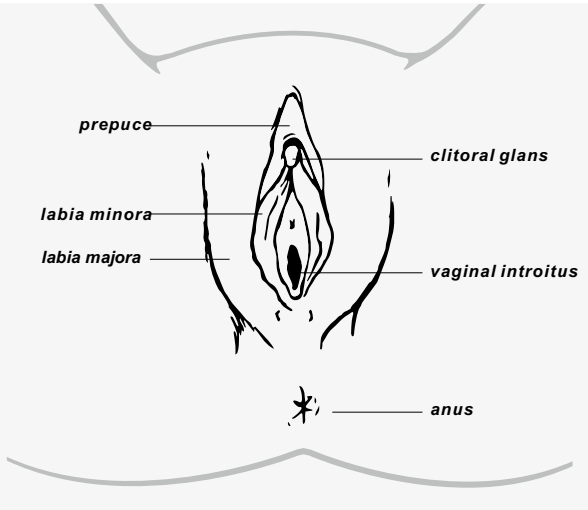


Figure 8.2: Drawing of unaltered genitalia

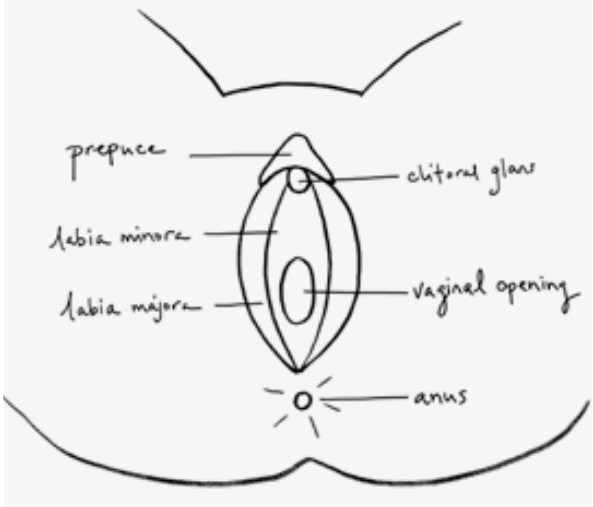


Figure 8.3: Type I: prepuce and clitoral glans removed

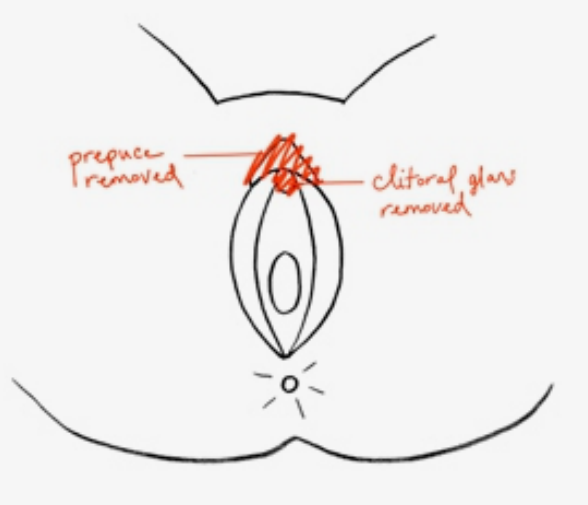


Figure 8.4: Type II: prepuce, clitoral glans and labia majora removed

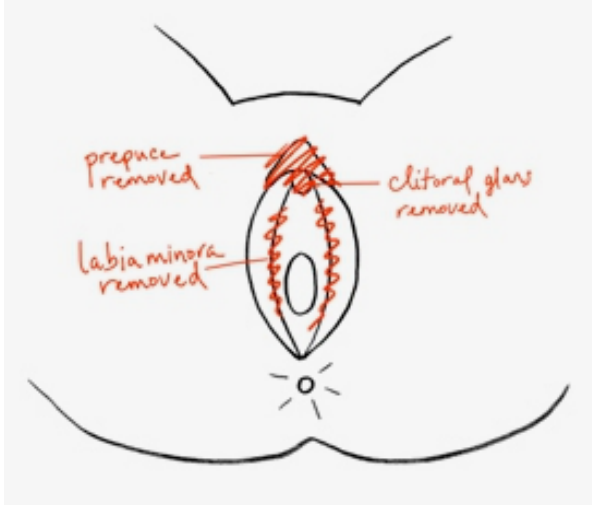


Figure 8.5: Type IIIa: labia minora closed

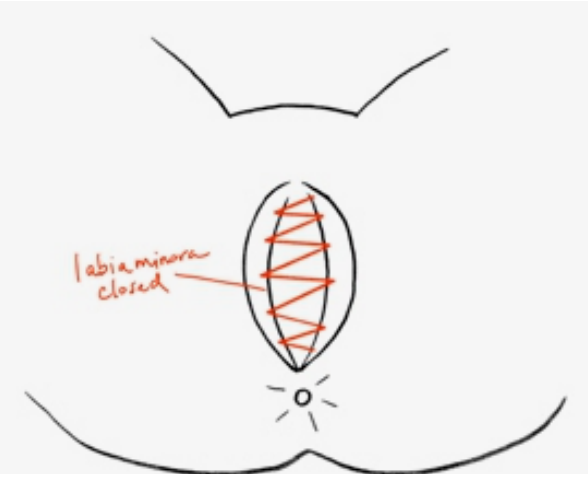
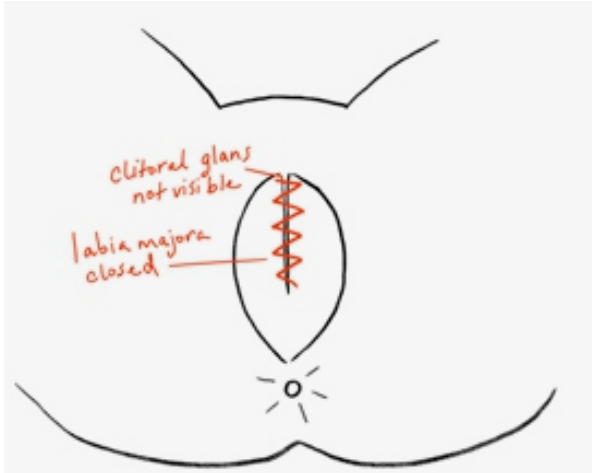


Figure 8.6: Type IIIb: labia majora closed



of the genital examination. All structures affected should be noted.

Take the following steps:

- Start by making a simple drawing of the female genitalia in the patient's medical record
- Based on the findings of the genital examination, specify which anatomical structures were removed or altered by marking these with a pen or pencil on the drawing.
- It is also recommended that you describe highlighted anatomical structures by labelling them (e.g., "clitoral glans" or "labia minora") or adding in a few words about what the drawing shows (i.e., "prepuce and clitoral glans removed" or "labia majora closed").

FGM-Related Complications in Pregnancy

- Dyspareunia.
- Reproductive tract infections (RTIs).
- Vulvar adhesions.
- Urinary tract infections (UTIs).
- Vulvar abscesses.
- Epidermal inclusion cysts and keloids.
- Mental health problems.

Reproductive Tract Infections.

Reproductive tract infections (RTIs), including some sexually transmitted infections (STIs), can often be asymptomatic, therefore it is important that you ask about RTI/STI signs and symptoms at each antenatal visit or if you perform a vaginal examination on a patient for other reasons (whether during pregnancy or not). Symptoms suggestive of infection include abnormal vaginal discharge, vulvar itching, lower abdominal pain, pain on urination, spotting after sexual intercourse, and fever (8).

- If laboratory facilities or rapid diagnostic tests (RDTs) are available, take a vaginal and cervical swab also, if appropriate, to test for the presence of infection and then provide treatment based on aetiology.
- In the absence of laboratory testing facilities or RDTs, treat the woman based on symptoms and signs (syndromic treatment) and according to national guidelines
- If an STI is diagnosed or suspected, provide partner management– ask the women to notify her husband/ partner and provide the same treatment for him. An exception to this is bacterial vaginosis or candidiasis.
- Provide the woman with guidance about vulvar hygiene
  - Use only clean water or mild soap and clean water.
  - Avoid all perfumed products or "washes."
  - Only wash yourself "outside" there is no need to clean yourself "inside" (do not use vaginal douches).
  - If you prefer to use a cleanser, use an unscented, soap-free skin cleanser or soap once a day. Make sure you rinse thoroughly.
  - Wipe yourself from front to back.
  - Always dry your vulva thoroughly after washing your genital area

Vulval Adhesions

Vulval adhesions appear due to inflammation or infection that may have occurred at the time that FGM was performed. They appear as thin, filmy tissue that partially covers the vaginal opening. The patient should be examined as follows:

- Put on sterile gloves.
- If the adhesions are thin, under local anaesthesia, perform blunt separation of the adhesions by gently pulling the labia laterally with the fingers or cotton-tipped swabs.
- Thick or extensive adhesions may require surgical separation under local anaesthesia or general anaesthesia
- Provide guidance on vulvar hygiene

Urinary Tract Infections

Urinary tract infections (UTIs) are common in pregnant women and have been associated with adverse pregnancy outcomes, including pre-term birth and small-for-gestational-age new-born.

The symptoms include dysuria (pain and discomfort during urination), increased urinary urgency and frequency, strong-smelling urine, haematuria (urine that appears red or pink due to the presence of blood) and pelvic pain.

- If laboratory facilities are available, send a urine sample for urinalysis and urine microscopy, culture, and sensitivity before providing treatment.

- Give antibiotic treatment according to local protocol (i.e. national guidelines or hospital protocol), whether or not laboratory facilities are available

Vulval Abscess

A vulval abscess is a localized collection of pus that usually appears as a tender and reddened mass in the genital area. It is often painful and warm to touch.

- To relieve the pain and promote spontaneous drainage of the abscess, recommend soaking the affected area for 10–15 minutes in clean warm water (e.g., in the bathtub) several times a day for three or four days, if possible. You can also recommend holding a warm compress (cotton or a flannel towel soaked with hot water) against the affected area.
- If there is no spontaneous rupture within 48 hours, incision and drained should be performed by a trained healthcare provider.
- Provide guidance on vulvar hygiene.

Epidermal Inclusion Cysts and Keloids

Epidermal inclusion cysts appear as small, hard lumps that develop under the skin, including the genital area. They grow slowly and are usually not painful and can often go untreated. Treatment may be necessary if the cyst becomes infected or if, due to its size, it obstructs the vaginal opening. Keloids are raised scars that grow excessively and can become larger than the original area of skin damage.

- Assess the size and location of the cyst or keloid
- IF THERE ARE NO OBSERVED epidermal inclusion cyst or keloid:
- Reassure the woman that her FGM status is unlikely to cause complications during childbirth and invite her to ask any questions about her excision or any other issues relating to her pregnancy or reproductive and sexual health.
- Discuss the agreed birth plan with her.
- Continue antenatal care visits as per routine
- IF EPIDERMAL INCLUSION CYST OR KELOIDS ARE PRESENT, then do the following:
- An experienced skilled birth attendant should take a decision on birth plan as to whether SVD is possible or patients be referred,

Type III FGM during pregnancy:

Necessary care and support are needed to attend to girls and women who have undergone FGM during pregnancy, labour, delivery and post-partum.

Complications of FGM type III (Infibulation):

- Tight introitus may make vaginal examinations difficult, e.g., during assessment for ante-partum haemorrhage, management of incomplete abortion, etc. The scar can be opened along the midline.
- Urinary infections may interfere with the normal progress of the pregnancy. Assess the client and commence appropriate management action – treat with antibiotics and other adjunct remedies where necessary.
- Chronic pelvic infections may interfere with normal progress of the pregnancy and may cause abortion – assess client properly and commence treatment – use appropriate antibiotics covering broad spectrum and also for gram-negative organisms.
- Vulvar abscesses may cause pain and discomfort to the woman –if abscess is present, it should be drained, and client treated with appropriate antibiotics
- Epidermal inclusion cysts and keloids may cause discomfort and perhaps obstruction during delivery.
- Seek assistance from experienced hands to manage it.
- Psychosocial and sexual problems may arise as a result of FGM.

Assessment of Women with Type III FGM during Pregnancy
Women who have been infibulated (type III FGM) are at increased risk of obstetric complications during childbirth due to the obstruction that covers the vaginal opening.

- To develop an appropriate birth plan it is important that you adequately assess a woman with type III FGM from as early as possible during antenatal care – at the first visit if possible, the following should be done:
  - Perform assessment to confirm type III FGM.
  - Where type III FGM is common, the vulvar area should be inspected - as a matter of routine.
  - Depending on the type of complication identified, address it following the steps as outlined below or alternatively refer to a higher level of care.
  - Steps in the Management of FGM type III during pregnancy
  - Establish rapport and obtain consent
  - Take comprehensive history from the client
  - Conduct complete abdominal examination

A one-day Engagement to Religious leaders to delink FGM from Religion, organized by Value Female Network in Osun State

(including the foetus)

- Conduct physical examination of the vulva as a routine during the first antenatal clinic which includes inspection and digital examination where necessary. Look for:
- Depending on the size of the vaginal opening, carefully assess the elasticity of the tissue with your index and middle fingers or a cotton swab/ bud.
- As a general rule, if the urinary meatus is visible (i.e. if there is no barrier from the urinary meatus downwards), major obstructive problems at childbirth are unlikely.
- It is not necessary to perform a vaginal examination (insertion of a speculum or fingers) to confirm infibulation, as this condition can be identified by visual inspection of the external genitalia
- If the urinary meatus is not visible (i.e. if there is a barrier from the urinary meatus downwards), obstructive problems at childbirth are likely, then
- Proper record of de-infibulation (opening up) on patient's ANC card should be made.
- Provide information, education and communication on the effects of type III FGM during pregnancy and delivery including basic knowledge on female reproductive system.
- Provide counseling to the client and husband/ partner and/or family member where necessary on the importance of opening up the infibulation before delivery (ideally during the second trimester) and importance of not re-suturing after delivery (re-infibulation).
- Provide detailed information to the client and husband/partner and/or family member about the changes that may occur in such functions as urination and sexual intercourse including menstrual functions following the procedure.
- Instruct client on vulvar hygiene (the need and how to keep her vulva clean and dry)
- If she declines de-infibulation, then consider caesarean section as an elective procedure
- Treat any other complication as appropriate (PID, UTI, Vulvar abscess, epidermal Cyst, and psychosocial, sexual problems etc.)

Management of Women with FGM during labour and delivery

Management of FGM type III during labour

Labour is only allowed in a comprehensive health center at the minimum where blood transfusion services are available.

- Steps in the Management of Women with FGM during labour. Establish rapport and obtain consent.
- Take comprehensive history from the client.
- Conduct complete abdominal examination (including the fetus).
- Conduct physical examination of the vulva which includes inspection and digital examination to determine if she has been de-infibulated.
- Provide information, education and communication on the effect of type III FGM during delivery including basic knowledge on female reproductive system.
- Consider Caesarean section as an option, if presenting part is still high there is any co-existing complication.
- Monitor labour using partograph if de-infibulated; if not, de-infibulate at second stage of labour and give episiotomy only when necessary. De-infibulation should always precede the performance of an episiotomy. This will help enlarge vaginal opening, allowing the decision regarding episiotomy to occur as it would for any woman in labour.
- Provide active management of third stage of labour.
- Ensure availability of blood transfusion services.

Obstetric Complications Due to FGM During Labour and Delivery

Women with type I, II and IV FGM without complications; and women who undergo de-infibulation during pregnancy, are all likely to have a childbirth that will require routine management. However, women with an intact infibulation (type III FGM) and those who have extensive scarring of the external genitalia have a higher risk of encountering complications during childbirth, both for themselves and for their babies. Some of the complications of FGM/ during labour and delivery include tight introitus, urinary infections, chronic pelvic infections, vulva abscesses, epidermal cysts, keloids, psychosocial problems etc. The outlines for the management of these conditions are provided in chapter 8.

MONITORING PROGRESS OF LABOUR

Management of women with FGM during labour is the same as for other women, except in the case of infibulation (type III FGM), extensive scarring and/or a tight vaginal opening.

- Observe the woman closely and routinely monitor progression of labour and her vital signs.
- If necessary, labour can be assessed using other parameters such as contractions and descent of the baby. If needed, cervical dilation can be assessed through rectal evaluation.
- Record all observations in the partograph.
- Give the woman clear and simple information about what she should expect at delivery.
- In the case of women with tight vaginal opening, assess the vaginal opening carefully and as indicated during labour to evaluate whether it will be able to stretch sufficiently during delivery.
- If during the assessment, it is possible to introduce a finger but impossible to stretch the opening because of resistance due to scar tissue, inform the woman that it will be necessary to open up the vaginal opening during delivery by performing a medio-lateral episiotomy.
- If during the assessment, it is impossible to introduce a finger, or even the tip of a finger, into the vagina, this means that the vaginal opening is extremely tight – equivalent to type III FGM, inform the woman that a de-infibulation is necessary. Obtain her consent and perform the procedure as soon as possible.
- If intrapartum and de-infibulation is required, the

procedure can be performed during the first stage or second stage of labour. De-infibulating during the first stage of labour will make it easier to monitor the progress of labour.

Assessment and management of women with FGM during labour and delivery

Following careful assessment of the FGM patient during labour and delivery, the health provider proceeds with the following measures to address the patient's condition.

- In situation of tight introitus making vaginal examination impossible, the scar can be opened along the midline. The incision should be made under local anesthetic.
- For women with vaginal stenosis and inelasticity of the perineal muscle, episiotomy may be done to enhance passage of the baby.
- Post-operative care for an infibulated woman opened up during labour is the same as for other women whose infibulation has been opened up. It should include good personal hygiene, Sitz baths, antibiotics, etc.
- Take a history of the labour and perform physical examination which includes the following.
  - complete general physical examination.
  - Abdominal examination, inspection, palpation, and auscultation.
  - Palpation of the bladder ensure that bladder is emptied regularly.
  - Examination of the genitalia to identify type of FGM.
- Observe the woman closely and monitor her vital signs hourly.
- Monitor progress of labour using partograph.

Management of Women with complications of FGM during post-partum period.

The New Generation Girls and Women Development Initiative conducted review meeting with established surveillance team in Ekiti State

The postpartum period – the days and weeks following childbirth is a critical phase in the lives of women and new-born babies. Health-care providers must be aware that certain health complications related to FGM may also occur after childbirth

FGM-related health complications that may occur after childbirth

Health-care providers should remain vigilant to the following conditions:

- Postpartum haemorrhage from an atonic uterus, which is more common after prolonged labour.
- Excessive blood loss and injury to neighbouring structures such as the urethra and bladder anteriorly and the rectum posteriorly, due to extensive perineal tears.
- Urine retention if the urethra has inadvertently been sutured during repair of tears.
- Damage to neighbouring structures such as the urethra and bladder if an incision (episiotomy or de-infibulation) has been incorrectly performed.
- Infection of sutured perineal tears that may lead to wound breakdown and, in severe cases, septicaemia.
- Extensive perineal tears and/or vesico-vaginal -or rectovaginal fistulae are complications that a woman with type III FGM may suffer if de-infibulation was not performed.
- Psychological problems may occur if the delivery has

been difficult, especially if it resulted in the loss of her baby.
- Discuss with her the feeling of wetness and increased sensitivity in her opened vulva, which she might not have experienced before.

IMMEDIATE ASSESSMENT OF THE WOMAN AFTER CHILDBIRTH

The following are the steps to be taken in assessment of a woman immediately after childbirth.

- Check and ensure the bladder is emptied.
- Check if uterus is well contracted. If it's not, then massage the uterus every 15 minutes until it is well to contracted or administer oxytocic.
- Clean and Check for tears on the vulva and vagina and the cervix.
- Use speculum and good light source 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.

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 and where necessary refer.

Care of the New-born

- The baby should be assessed, and the Apgar score documented.
- If the baby is asphyxiated (does not cry well), resuscitate and where necessary hand over to experienced hands or refer the baby to a neonatal unit.

Subsequent assessment of mother and baby

At the follow-up visits of the mother and baby, the following measures should be taken.

- 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.
- Check for the normal involution of the uterus.
- Assess the mother's mental state (psychological and emotional).
- Provide 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. (Reassure her on the new shape of the vulva and that the opened vulva will be different in both appearance and function from the infibulated vulva. Counselling and education is important to discourage the practice of re-infibulation.
- 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 if any.
- A woman 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 counselled on family planning options like any other newly delivered mother.

MANAGEMENT OF A WOMAN WITH FGM AFTER CHILDBIRTH

The management of women with FGM during the postpartum period is essentially the same as for any other women. However, women who have undergone de-infibulation during pregnancy, labour or childbirth may

Health-care providers have the responsibility to convey accurate and clear information, using language and methods that can be readily understood by clients

need additional care and psychological support during this period. The following steps are suggested.

- Provide counselling and support to help her adapt to the changes following de infibulation, and to discourage her from seeking re-infibulation after leaving the health centre.
- Advise her to wear loose underwear to reduce discomfort caused by friction.
- If necessary, provide counselling to the husband/partner as well, to make him aware of the importance of not closing the opened-up infibulation, and to help him understand the changes that may arise during sexual intercourse.
- Remind him that sexual intercourse should only be re-initiated once his wife/partner feels ready and the wound has had adequate time to heal, which typically occurs 4–6 weeks after the surgical procedure.
- Finally, take time to reassure the woman by reinforcing the reasons that the de-infibulation was performed, highlighting that this will improve her health. If needed, explain this to the woman's husband/partner and family.

Appendices

Appendix 1: Family Planning Methods And Types of FGM

CONTRACEPTIVES	TYPE I	TYPE II	TYPE III	TYPE IV
Oral Pills	YES	YES	YES	YES
Injectables (DMPA)	YES	YES	YES	YES
IUCD: (Copper T, Mirena)	YES	ONLY AFTER PELVIC ASSESSMENT	CANNOT BE USED	YES
Barrier Methods: (Condom, Spermicides, Cervical Cap)	YES	YES	MAY BE VERY DIFFICULT	YES
Implants: (Norplants, Jadelle)	YES	YES	YES	YES
The Sympto-thermal Methods	YES	YES	YES	YES
The Basal Body Temp. Method	YES	YES	YES	YES
The Calendar Method	YES	YES	YES	YES
The Cervical Mucus Method (Billings Method)	YES	YES	CANNOT BE USED	YES
The Lactational Amenorrhea Method (LAM)	YES	YES	YES	YES

Notes

TYPE III FGM is the only FGM type with restriction to the use of some family planning methods, such as;

- Intrauterine device – Copper T, Levonorgestrel intrauterine system.
- Barrier Methods – Female Condoms, Cervical caps.
- Cervical Mucus Methods (Billings Methods).
- Permanent method or bilateral tubal ligation (BTL): applicable to all types of FGM.

Appendix 2: List of Contributors to the Development of the National Protocol Document

List of contributors to the development of the national protocol document:

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Appendix 3

Case Management Forms

1. History Taking and Examination for FGM

General Instructions	This form must be filled out by a health practitioner, social worker or other authorized persons providing health services to the survivor. Note that all questions are relevant to gathering information on the survivors of FGM depending on the age at time of mutilation, type and the consequences being experienced by the survivor. Unless otherwise specified, always mark only one response field for each question. Please feel free to add as many questions to this form as needed in your context and/or attach additional pages with continued narrative, if needed. Please be sure to remind your patients or clients that all information given will be kept confidential, and that they may choose to decline to answer any of the questions.

1-Administrative Information
Client File Number [ ]
Date history was taken (day/month/year) *: [ ][ ][ ][ ][ ][ ]
Reported by (Tick the appropriate) o The Patient o Informant (Specify) _____ o Accompanying person Others specify_____
Name of facility/organization _____ 3. Location of facility Town/Village _____ Ward (geopolitical) _____ Local Government Area _____ State: _____ 4.Type of Facility (Tick one box) Tertiary Health facility [ ] Secondary Health facility [ ] Primary Health facility [ ] Private Health facility [ ] Others (specify)_____

2. Socio-Demographic Details of Client

5. Age [ ] 6. Nationality: _____ 7. State of Origin: _____

8. Marital status
Married [ ] b. Single [ ] c. Divorced [ ] d. Separated [ ] e. Widowed [ ]
9. Educational level
a. None [ ] b. Primary [ ] c. Secondary [ ] d. Tertiary [ ]
10. Religion:
a. Christianity [ ] b. Islam [ ] c. Traditional [ ] d. Others (specify) _____
11. Ethnic group
a. Hausa [ ] b. Yoruba [ ] c. Igbo [ ] Others (specify)_____
12. Occupation: _____

3.Menstrual and Obstetric History

13. Age at onset of menstruation: _____ Don't know [ ]
14. Have you commenced menstruation at the time of incident? a. Yes [ ] b. No [ ] c. Don't know [ ]
15. Number of Pregnancies:
16. Number of Birth: Male _____ Female _____ None: [ ]
16. Number alive Male _____ Female _____ None: [ ]
17. Number of female children mutilated _____
18. Number of other children _____

4.History of Female Genital Mutilation

Date of incident (day/month/year)

Don't Know

19. Age at time of genital mutilation: _____ Don't Know [ ]
20. At what period of your life was this Genital Mutilation done?
a. During infancy [ ] b. During childhood [ ] c. As part of marriage rites [ ] d. During pregnancy or labour [ ] e. No response [ ]
21. Who performed the FGM? (Give name if known) _____
a. Traditional Birth Attendant (unskilled) [ ] b. CHO/CHEW [ ] b. Nurse/Midwife [ ]
c. Doctor [ ] d. Traditional Circumciser [ ] e. Don't know [ ] f. Others (specify)_____
22. Where was the FGM performed?
a. Home [ ] b. Health facility [ ] c. TBAs house [ ]d. Traditional circumcisers house [ ]
e. Don't know [ ] f. others (specify _____
23. Who influenced the performance of the FGM
a. Mother [ ] b. Father [ ] c. Grand Mother [ ]d. Grand Father [ ] e. Self [ ] f. Don't know [ ] g. Others (specify)_____
24. What part of your genital was mutilated?
a. Clitoral Hood [ ] b. Clitoris[ ] c. Labia Minora [ ] d. Labia Majora [ ] e. Don't know [ ]
25. Was your genitalia stitched after the cutting
a. Yes [ ] b. No[ ] c. Don't know [ ]
26. Which of the following health problems did you experience immediately and after FGM?
a. Bleeding Yes [ ] No [ ]
b. Painful urination Yes [ ] No [ ]
c. Painful sexual intercourse Yes [ ] No [ ]
d. Infection (Vaginal discharge/itching, lower abdominal pain and fever Yes [ ] No [ ]
e. Others (specify) _____

27. Any other useful information or Details of the Incident

5.MANAGEMENT OF SURVIVORS

28. General Examination/investigation
a. Temperature _____
b. Pulse _____
c. Respiration _____
d. Blood Pressure _____
e. Others _____
29. Abdominal Examination
a. Tenderness Yes [ ] No [ ]
b. Mass/Swelling Yes [ ] No [ ]
c. Scarification marks Yes [ ] No [ ]
d. Other Findings _____
30. Genital Examination (Tick as appropriate)
a. Type I [ ] b. Type II [ ] c. Type III [ ] d. Type IV (Unclassified- describe or specify the type) [ ]_____
_____
b. Presence of ulcers Yes [ ] No [ ]
c. Infection Yes [ ] No [ ]
d. Abscess Yes [ ] No [ ]
e. Vaginal discharge Yes [ ] No [ ]
f. Vesico Vagina Fistula Yes [ ] No [ ]
g. Recto Vaginal Fistula Yes [ ] No [ ]
h. Cysts Yes [ ] No [ ]
i. Keloid formation Yes [ ] No [ ]
Others (please specify) _____
31. Investigations:
a. Packed Cell Volume (PVC)/HB Screening _____
b. Retro Viral Screening (RVS) _____
c. Random Blood Sugar (RBS) _____
d. Hepatitis B Surface Antigen (HBsAg)/Hepatitis C (HBC) _____
e. Full Blood Count (FBC) _____
f. Urinalysis
32. Psychosocial and Sexual Status
a. Depression Yes [ ] No [ ]
b. Anxiety Yes [ ] No [ ]
c. Post-Traumatic Stress Disorder Yes [ ] No [ ]
d. Lack of sexual interest Yes [ ] No [ ]
e. Dyspareunia (Painful Intercourse) Yes [ ] No [ ]
f. Frigidity (Lack of response to sexual stimulation) Yes [ ] No [ ]
Others (please specify) _____

33. Treatment Prescribed

Treatment	Yes	No	Type/Comments
Wound treatment			
Tetanus prophylaxis			
Post-Exposure Prophylaxis for HIV*1			
De-infibulation			
Antibiotics			
Others (please specify)			

6. COUNSELING, REFERRAL AND FOLLOW-UP

34. Survivor plans to report or has already reported Yes [ ] No[ ]
35. If yes, to where
a. Police
b. International Federation of Women Lawyers (FIDA)
c. Ministry of Women Affairs and Social Development
d. Legal Aid
e. Disciplinary organ of a health regulatory body
f. Others specify _____
36. Survivor has a safe place to go? Yes [ ] No[ ]
37. Counselling provided: _____
_____
38. Referrals: _____
39. Follow-up required:
40. Date of next visit:

Name of health worker: _____
Title: _____
Phone Number_____
Email: _____
Signature: _____

Consent Form –Management of Clients Living With FGM
History and Examination

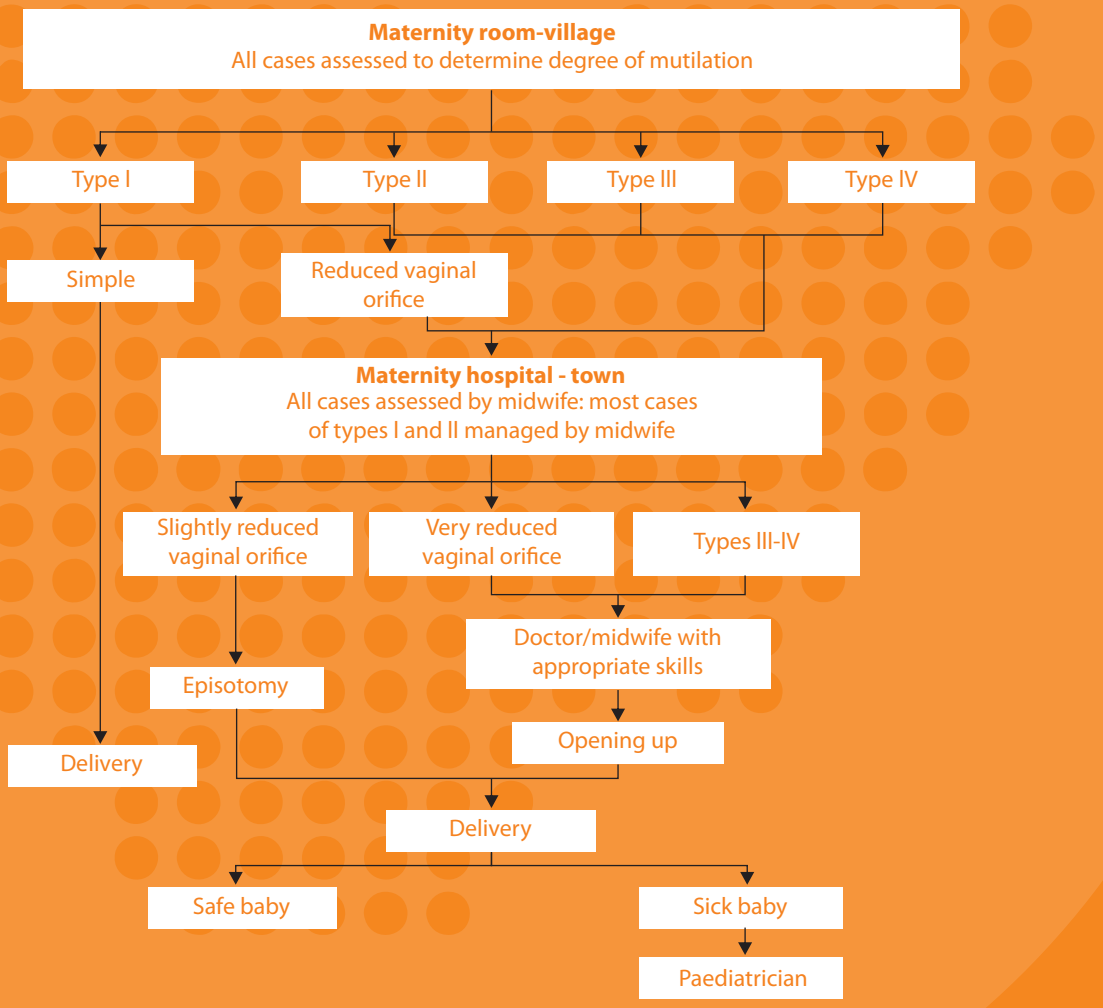
I_____ agree that history be taken and medical examination be conducted on me/ my ward_____ by _____ _ for the purpose of management of complications of Female Genital Mutilation (FGM).
Name /Signature of client (parent, guardian):
Date
Age of client (parent, guardian):
Health Facility:
Name of Health Worker:
Title:
Signature:

Consent Form – Surgical Management of Complication of FGM

I _____agree that the procedure of _____ _____ be carried out on me/my ward _____by _____ _____ for the purpose of treatment of _____ _____ complication/s from Female Genital Mutilation (FGM).
Name /Signature of client (parent, guardian): Date
Age of client (parent, guardian):
Health Facility:
Name of Health Worker:
Title:
Signature:
(Footnotes)
1 * If indicated.

Management Flow Chart for pregnancy and delivery

(b) Care of pregnant women with FGM in areas where types III and IV are uncommon



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