FEMALE GENITAL MUTILATION CLINICAL CARE

ANTENATAL, LABOUR & BIRTH AND POSTNATAL GUIDELINES

These Antenatal, Labour & Birth and Postnatal Clinical Care Guidelines have been produced by the FGM Education Programme for the New Zealand Ministry of Health.

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Antenatal Guidelines

These Antenatal Guidelines are intended for use in conjunction with *Female Genital Mutilation in New Zealand - A Guide for Health and Child Protection Professionals* (2004) available from www.fgm.co.nz

FIRST ANTENATAL VISIT	SECOND ANTENATAL VISIT OR BIRTH PLANNING VISIT	PRE - BIRTH VISIT
• Identify FGM when taking client history • Document which type of FGM the woman has undergone based on her description • Discuss possible implications for her antenatal, labour and birth care • LMC to contact FGM Education Programme if further advice is needed info@fgm.co.nz	• Assess genitals and/or perform vaginal assessment (if indicated and possible) to identify: - type of FGM - size of introitus - integrity of scar tissue • Assess the need for deinfibulation antenatally or during labour. Will the degree of FGM impact on labour and birth? ***(See flowchart below)*** • Arrange ante-natal deinfibulation if this is the woman's preferred option • In addition to routine antenatal care, discuss FGM related issues ***(See box below)***	• Review the birth plan • Perform vaginal examination if deinfibulation occurred at 20 - 24 weeks gestation to assess healing • Review plan for deinfibulation during labour • Reiterate physiological changes following deinfibulation • Discuss suturing scar site following deinfibulation • Provide the woman an *FGM in NZ* pamphlet containing information about FGM and the NZ law

WILL THE DEGREE OF FGM IMPACT ON LABOUR AND BIRTH?

Yes

Labour and birth planning to include FGM management

No

Continue routine birth planning

FGM MANAGEMENT

Discuss the following options with the woman:

OPTION 1 antenatal deinfibulation (recommended around 24 weeks gestation)

OPTION 2 deinfibulation during second stage of labour

OPTION 1 - Woman accepts antenatal deinfibulation

Refer to antenatal or gynaecology clinic (depending on local services). Deinfibulation can usually be performed as an out-patient procedure under local anesthesia

Document the woman's chosen option in the birth plan

OPTION 2 - Woman accepts deinfibulation during labour

Refer to antenatal clinic if LMC is not confident about performing de-infibulation during labour

Document the woman's chosen option in the birth plan

In addition to routine antenatal education, the following areas relating to FGM should be discussed:

- Anatomy and physiology of unaltered genitalia compared with FGM
- Physiological changes following deinfibulation including changes in menstruation, urination and sexual intercourse
- Potential for referral to registrar/obstetrician during labour or birth
- Gender preference of registrar/obstetrician is dependant on availability. Women may request a female registrar/obstetrician. Where possible, staff should endeavour to arrange this
- Suturing the scar site post deinfibulation (restoring the scar site to a state of infibulation is illegal in NZ)
- Culturally appropriate dietary advice
- Gender preference of interpreter
- Cultural resistance to induction of labour and relevant district health board induction of labour practices for post term pregnancies. *NB: Where there is opposition to induction of labour or other interventions this should be clearly documented in the clients notes*
- Cultural resistance to caesarean section and relevant district health board indications for performing caesarean
- Post natal support – some women may experience psychological trauma or flashbacks related to FGM and/or the refugee experience during the child birth period. If necessary refer to culturally appropriate support services. See www.refugeehealth.govt.nz for contact details

Discussing FGM

The term female genital mutilation is recommended for use at policy level but can be offensive to some woman and their families. Terms such as female circumcision or “cutting” are appropriate during consultations.

For more information see *Female Genital Mutilation in New Zealand – A Guide for Health and Child Protection Professionals* (2004) available from www.fgm.co.nz

Female Genital Mutilation Clinical Care

Labour and Birth Guidelines

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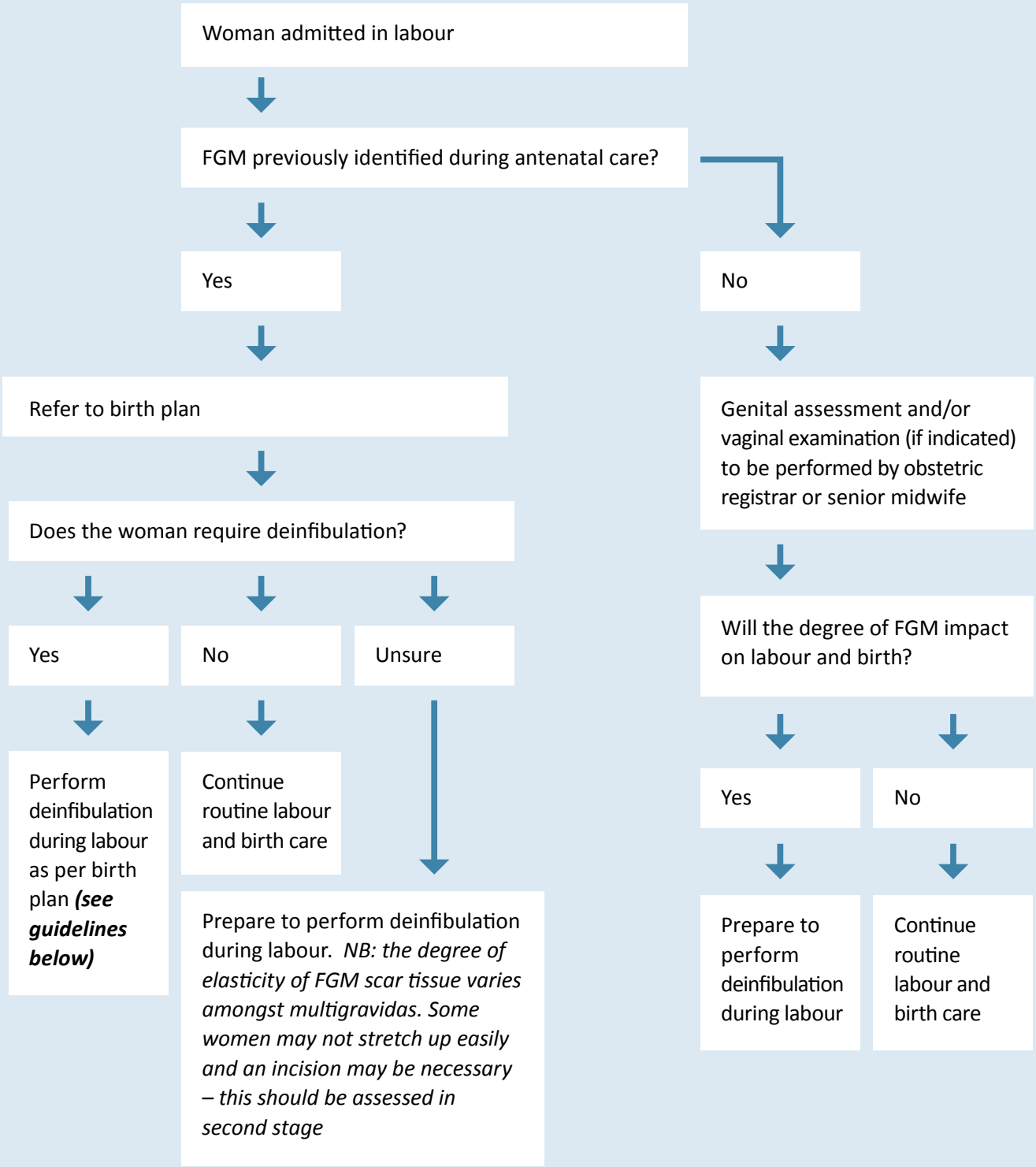


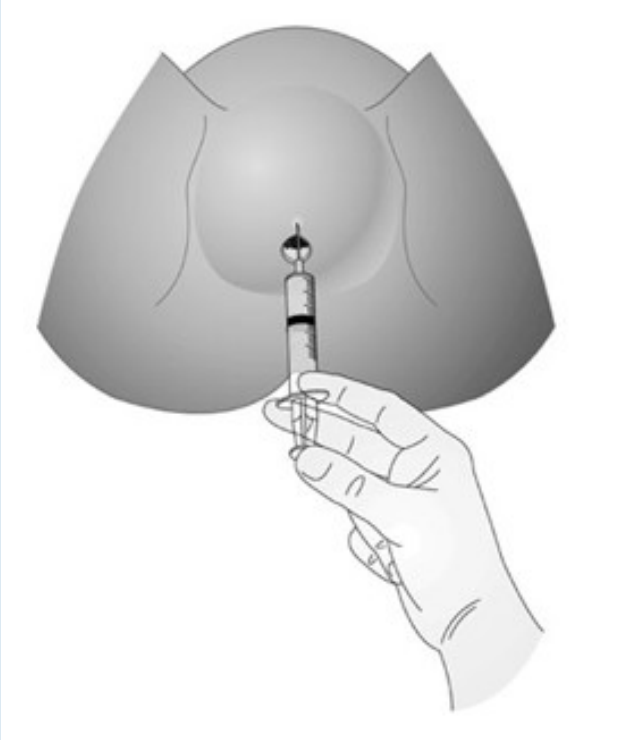
Deinfibulation During Labour

STEP ONE:
INFILTRATE AREA WITH LOCAL ANAESTHESIA

The anterior flap of skin is lifted using one or two fingers (index or index and middle). Local anaesthesia (such as 1% Xylocaine) is infiltrated along the line of skin stretched between the fingers.

A superficial angle on the needle is recommended to avoid the baby's head.

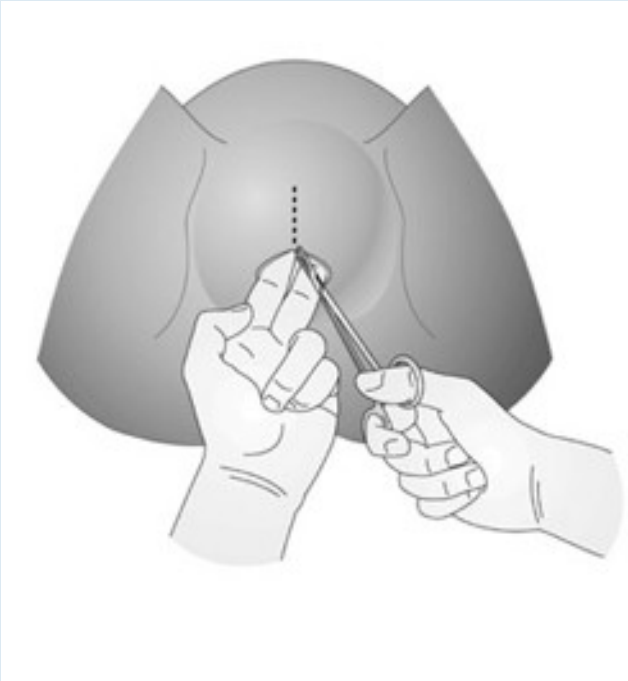
Good positioning of the woman is important and in some cases this may be facilitated by placing the woman in the lithotomy position.



STEP TWO:
INSERT FINGERS

One or two fingers are inserted to ensure clearance from the emerging head prior to inserting surgical scissors. Lift and slightly pull anterior flap of skin.

A scalpel or surgical scissors are inserted in front of the fingers.



STEP THREE:
INCISE SCAR TISSUE

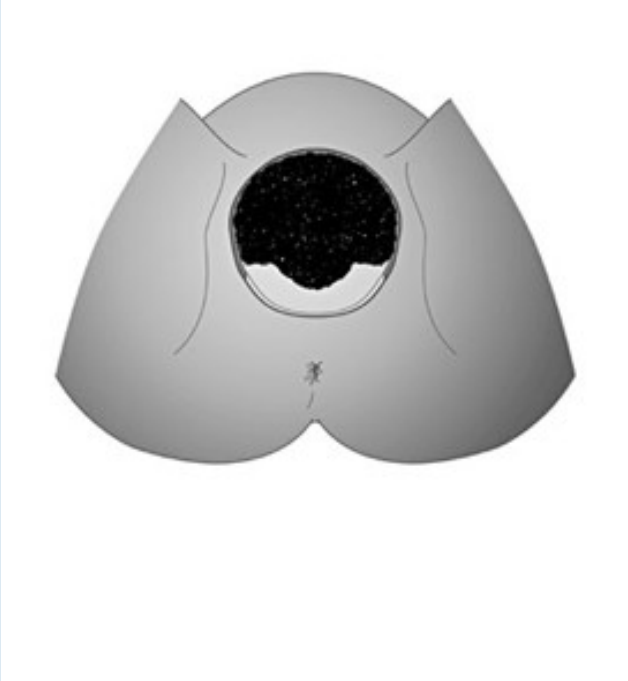
The skin in incised anteriorly (up the midline).

STEP FOUR:
PERINEAL ASSESSMENT

Raw edges will retract and the baby's head will begin to crown.

Care must be taken to ensure the perineum is stretching adequately. FGM Scar tissue may not stretch under pressure of the baby's crowning head. Should the perineum appear tight consider performing a medio-lateral episiotomy.

*Note: posterior episiotomies **alone** are not recommended as the anterior scar tissue and anterior vaginal wall may tear and cause excessive perineal trauma.*



Control the birth of the emerging head to avoid a precipitate birth.

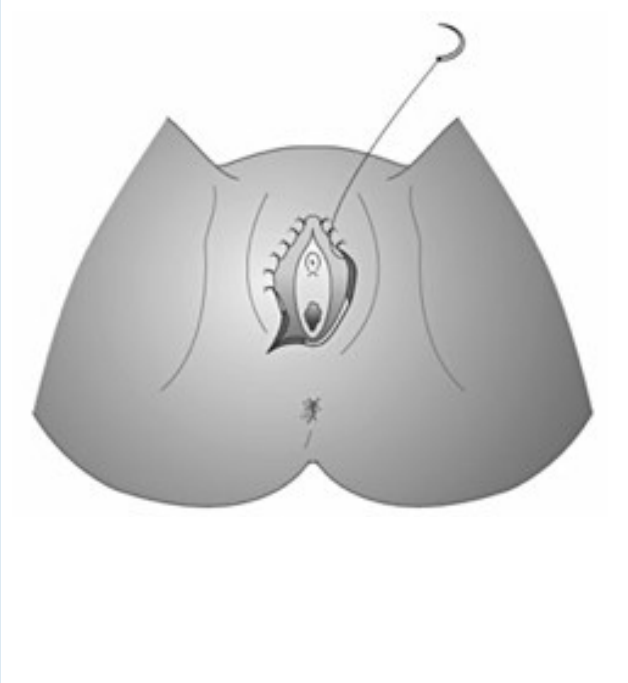
Continuous assessment of perineal stretching is required throughout this stage.

POST BIRTH

STEP FIVE:
APPLY HAEMOSTATIC INTERRUPTED OR CONTINUOUS ABSORBABLE SUTURES

The raw edges on either side are sewn with an absorbable suture material such as 3/0 catgut or Vicryl Rapide.

STEP SIX:
DOCUMENT PROCEDURE IN WOMAN'S NOTES



Images supplied by The Royal Women's Hospital, Victoria, Australia.

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Postnatal Guidelines

These Postnatal Guidelines are intended for use in conjunction with *Female Genital Mutilation in New Zealand - A Guide for Health and Child Protection Professionals* (2004) available from www.fgm.co.nz

Woman admitted to postnatal ward

↓

Has the woman undergone deinfibulation during labour?

↓ Yes

In addition to routine postnatal care the following is recommended:

- assess deinfibulation site for bleeding, infection and healing
- if pain relief is required, recommend regular paracetamol use
- discuss physiological changes following deinfibulation including changes in urination, menstruation and sexual intercourse
- provide an *FGM in New Zealand* pamphlet containing information relating to FGM and the New Zealand law if the baby is a girl
- if required offer debriefing regarding birth experience
- if necessary, refer to culturally appropriate refugee support services. See www.refugeehealth.govt.nz for contact details.

↓ No

Continue routine postnatal care

REFERRAL CONTACTS

GYNECOLOGICAL OUTPATIENTS
CURRENT IN 2009

AUCKLAND
Auckland District Health Board
Gynecological Outpatients
Private Bag 92189
Auckland Mail Centre
Auckland 1142
Phone: (09) 367-0000
Fax: (09) 631-0728

WELLINGTON
Capital and Coast District Health Board
Women's Clinic
Private Bag 7902
Wellington South
Phone: (04) 385 5999
Fax: (04) 385 5856

WAIKATO
Referral Coordination Centre
Waikato Public Hospital
Private Bag 3200
Hamilton 3240
Phone: (07) 839 8839
Fax: (07) 839 8757

CHRISTCHURCH
Christchurch Women's Hospital
Gynaecological Outpatients
Private Bag 4711
Christchurch 8011
Phone: (03) 364 4699
Fax: (03) 364 4423