

Female Genital Mutilation (FGM) in 37 Health Facilities, 2013-2016:

**An assessment of data quality,
obstetric and delivery
complications and their
management**

DO NOT
CUT ME!
I AM GOOD
THE WAY GOD
CREATED ME

FINAL VALIDATED REPORT

Ministry of Health and Social Welfare and UNFPA, Banjul, The Gambia

August 24, 2017

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List of Abbreviations/Acronyms

BAFROW	Foundation for research on women health productivity and the environment
CBC	Community Birth Champions
CHN	Community Health Nurse
CRR	Central River Region
C/S	Caesarean Section
CSPRO	Census and Survey data processing
DHS	Demographic and Health Survey
EFSTH	Edward Francis Small Teaching Hospital
FGM	Female Genital Mutilation
GAMCOTRAP	Gambia Committee against Traditional Practices
GBoS	Gambia Bureau of Statistics
HMIS	Health Management Information System
KIIs	Key Informant Interviews
LGA	Local Government Area
LRR	Lower River Region
MICS	Multiple Indicator Cluster Survey
MoHSW	Ministry of Health and Social Welfare
NBER	North Bank East Region
NBWR	North Bank West Region
NGO	Non-Government Organization
OIC	Officer-in-Charge
RPNO	Regional Principal Nursing Officer
SPSS	Statistical Package for the Social Sciences
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children’s Fund
URR	Upper River Region
WR 1	Western Region 1
WR 2	Western Region 2

Terms and Definitions

Augmentation: This is the act of introducing drugs to stimulate contractions in labour.

Birth asphyxia: This is a condition that occurs when a baby doesn't get enough oxygen during the birth process.

Breech: This is a delivery of a fetus (unborn baby) hind end first. The breech position is a potentially dangerous situation.

Caesarean section: A cesarean section, also called a C-section, is surgery to deliver a baby through the abdomen.

Clitoridectomy (Type I): Partial or total removal of the clitoris and/or the clitoral hood.

De-infibulation: This is the surgical procedure to open up the closed vagina of FGM type III and is often performed multiple times such as; on the wedding night, when the husband goes away for any significant period of time and returns, and prior to childbirth. This process is usually followed by re-infibulation.

Delayed second stage: This is said to be delayed if there is no delivery of the baby even after 2 hours of full dilation of the cervix.

Episiotomy: This is the tearing of the perineum to widen the birth canal for easy passage of the fetus.

Excision (Type II): Partial or total removal of the clitoris and labia minora, with or without excision of the labia majora.

Fistula: This is a permanent abnormal passageway between two organs in the body or between an organ and the exterior of the body.

Fresh stillbirth: Refers to the death of the fetus occurring before the complete expulsion or extraction from its mother.

Infibulation (Type III): Narrowing of the virginal orifice with creation of a covering seal by cutting and placing together the labia minora and/or the labia majora, with or without excision of the clitoris.

Live birth: This is a birth in which the baby shows signs of life and cried at least once.

Macerated stillbirth: This is the intrauterine death of a gestational product, with retention of the fetus for more than 48 hours.

Normal delivery: This is a delivery which was completed without any difficulties or complications.

Obstetric: The branch of medical science concerned with childbirth and caring for and treating women in connection with childbirth.

Obstructed labour: Also known as labour dystocia is when, even though the uterus is contracting normally, the baby does not exit the pelvis during childbirth due to being physically blocked.

Packing/pack: The introduction of gauze into the birth canal to control bleeding after delivery.

Parity: The number of children previously born alive to a woman.

Prolonged labour: This is when the total duration of childbirth is greater than 24 hours.

Stillbirth: This is a birth that shows no signs of life during the process of birth.

Suturing/repair: This is the stitch formed using a fine thread or other material to surgically close a wound or join tissue.

Tear: This is a spontaneous (unintended) laceration of the skin and other soft tissue structures.

Third degree tears: This is a tear in the vaginal tissue, perineal skin, and perineal muscles that extend into the anal sphincter (the muscle that surrounds the anus).

Vacuum delivery: A method of assisting childbirth used as an alternative

Foreword

An assessment of the obstetric and delivery complications associated with FGM and the management of such complications is a study piloted in 37 government and private health facilities throughout The Gambia from 2013-2016. This study was conducted by the Ministry of Health with financial support from UNFPA. This is the first such study to be conducted by the Ministry of Health.

The main objective of the study is to provide country specific data and information on the obstetric complications of FGM in The Gambia. This will be useful information during educational activities on FGM complications as well as advocacy activities geared towards changing beliefs, attitudes and behavior for the abandonment of the practice of FGM through social norm change.

The government of The Gambia adopted legislation against FGM in 2015. Since then the UN Agencies with their Government and Non-Government Organization (NGO) partners are engaged in creating awareness on the harmful effects of FGM while at the same time popularizing the law. The law cannot be a stand alone, more intensive sensitization on the health complications of FGM as well as its human rights violation must continue side by side with awareness creation on the contents of the law, in order to achieve the desired attitudinal and behavior change required for the total abandonment of the practice of FGM. The abandonment will be more effective and sustainable once people decide to stop the practice because they are convinced that the practice is harmful to the health of women and girls. The results of this pilot study provide some insights into complications associated with FGM.

This pilot study looked at the three different types of FGM practiced in The Gambia, obstetric complications related with each of them and how they were managed at the level of the health facilities.

The Ministry of Health extends appreciation to UNFPA for supporting the study. This is the first time the Ministry is undertaking such a study and because of the importance associated with it, the Ministry is now contemplating including data collected on obstetric complications associated with FGM in the Health Management Information System (HMIS) database, the data are expected to be collected from all the health facilities in the country. The information will be disseminated through a periodic newsletter published by the Ministry of Health.

Acknowledgements

The wisdom, commitment, and effort of many people and organizations made this FGM register review a reality. Therefore, we wish to express sincere thanks and appreciation to UNFPA, The Gambia office for financing this exercise. Similar sentiment is extended to the Ministry of Health and Social Welfare (MoHSW) through the Reproductive and Child Health (RCH) Unit for opening their doors to the consultancy team throughout the exercise. A profound gratitude is registered to the entire staff of the Gambia Bureau of Statistics (GBoS) for providing the necessary technical support to the Consultant for this exercise.

Finally, profound thanks and appreciation is extended to the entire staff of the RCH Unit for their valuable support. We are grateful to all the Regional Health Teams and their working staff and all health facilities in the country including the private clinics which were involved in the data collection, and also for making their staff available for the individual interviews and Focus Group Discussions during this assignment.

With the involvement and full participation of all, the analysis and report writing of the pilot study on FGM complications was a success.

Executive Summary

Background

The UNFPA and UNICEF-Gambia Country Offices have been supporting a joint programme for the accelerated abandonment of FGM in The Gambia since 2009. With financial support from the UNFPA in 2012, the MoHSW developed and maintained registers in 37 health facilities (35 public and 2 private) for recording data on FGM obstetrics and reproductive health complications and its management.

Objectives

In late 2016, the UNFPA funded a consultancy; (i) to assess and analyse the data quality from the registers on the FGM obstetrics and reproductive health complications and its management in 37 health facilities covering the period 2013-2016 and (ii) to produce a report on the FGM obstetrics and reproductive health complications and its management at health facility levels, documenting challenges of the FGM registers (i.e. data gaps, weaknesses etc.) and to make recommendations on how to improve the data collection system.

Methods

Both quantitative and qualitative data were collected for the assessment. For the quantitative data, a specially designed form similar in content and format to the FGM registers was used to transcribe data from the registers. Key informant interviews (KIIs) of service providers associated with the FGM at the health facilities were conducted to provide the qualitative data.

Findings

Clinical data on 7,813 girls and women aged 10-49 years who had undergone FGM and delivered in the 37 health facilities from 2013-2016 were found. The mean ages for women with type I FGM is 24.9 years, type II (24.8 years) and type III (23.1 years). The overall mean age is 24.9 years. Mandinka, Fula and Jola ethnic groups constitute 42.3%, 30.6% and 9.7% respectively. This is followed by Wollof (8.4%), Sarahule (5.2%), Serere (1.1%), other (1.1%), Bambara (0.9%), Manjago (0.5%), Aku Marabout (0.2%) and ethnicity was not recorded for 1.4% of the women.

Overall, excision (type II) was the most common FGM women have undergone (51.5%), followed by clitoridectomy (type I), 35.9% and infibulation (type III), 5.2% and FGM status was not recorded for 7.4% of the women. Among women who have undergone type III FGM, the practice was highest among the age group 15-19 years, 7.3% and 20-24 years, 6.0%. In fact, a most worrying finding from this assessment is that type III FGM, which was a rarity in The Gambia, is now on the increase. Over 400 cases of type III FGM and counting were found in this data set. The data suggest that all ethnic groups do practice type III FGM (see Table 2.2.2). Type III FGM is more practiced in the Central River Region (CRR), 8.9%, followed by Western Region 1 (WR 1), 7.2% and Western Region 2 (WR 2), 5.4%. It is least practiced in the Upper River Region (URR), 0.5%. This may be due to under-reporting as the URR has the worst FGM register coverage rate of 4.2%.

Prolonged labour and haemorrhage are the leading obstetric conditions experienced by girls and women who had undergone FGM. Overall, 13.6% of women experienced prolonged labour. It is highest among women aged 10-14, 15-19 and 20-24 years with 22.2%, 19.2% and 16.7% respectively and among older women aged 45-49 years (13.3%). Overall, haemorrhage accounts for 2.5% with the highest rates among women aged 40-44, 6.7%, followed by women aged 30-34 and 35-39 years each with 2.7% and women aged 15-19 years, 2.5%. Tears, overall, accounts for 0.8% and is highest among women aged 10-14 years, 5.6% and lowest among

women aged 25-29 years, 0.4%. Fistula, overall, accounts for 0.3% and is highest among the Bambaras, 1.4% and lowest among Jolas, 0.1%. The Manjagos have uniquely the highest birth asphyxia rate of 2.7% among all the ethnic groups. With the exception of the Creole/Aku Marabout with 8.3%, prolonged labour, in general, is high among all ethnic groups, ranging from 18.5% among the Sereres to 10.5% among the Fulas. For FGM complications, tears, account for the highest overall proportions, 10.4%. The age-specific rates for tears are 12.8%, 12.2% and 11.1% respectively for women aged 20-24, 15-19 and 10-14 years. The above figures on the obstetrics and FGM complications (e.g. haemorrhage, prolonged labour, birth asphyxia and tears) should be treated with caution due to high rates of “not recorded” categories ranging from 40.9% to 51.5%, which certainly affect the results. The knowledge of FGM among service providers is high. Here are some quotes from the KIIs on the health effects of FGM e.g. prolonged labour, tears and haemorrhage.

“It (FGM) causes prolonged labour during deliveries and perennial tears, fresh still births, episiotomies, septic tears or epis after delivery. It also causes a lot of pain to the woman undergoing labour, repeated urinary tract infections, irregular bleeding, and vaginal bleeding and also causes fetus distress” (Kerewan Health Centre). Another service provider from Bansang Hospital made similar remarks;

“It (FGM) can cause health complications during labour and delivery and prolonged delivery can cause tears. I have seen certain complications like growth/keloids around the clitoris. Infections can also happen because the knife/razor blades were not sterilized and because of that FGM victims are prone to infections. Sometimes these infections can lead to infertility. I have seen a girl who reported to me that she does not enjoy sex because she was opened up when she got married” (Bansang Hospital).

The results on the type of FGM management at the health facilities are quite alarming. Overall, suturing/repair; account for more than half (50.9%), followed by episiotomy, 7.8%, de-infibulations, 2.3% and augmentation 1.1%. The results are similar across age, ethnicity and region. The following two quotes from the KIIs describe in detail the type of FGM management undertaken by the service providers.

“We first of all prepare them very well in order to avoid complications by assessing those who can deliver without problems. Those who are found to likely develop complications such as tears and excessive bleeding, are given episiotomy which is easier to suture and less likely to bleed excessively. Women who cannot be helped at all are referred for C/S to be done to save the baby from distress due to prolonged labour and to avoid the mother having a deep tear which could be difficult to repair” (Jammeh Foundation Hospital).

“During delivery, I advise the nurses to do episiotomy to every woman who has a severe form of FGM, in order to prevent tears and also to give more space for the baby to pass easily. Because it is difficult to repair natural tears, we train our nurses on how to give episiotomy and stitch. In other ways were episiotomy cannot be done because the baby does not descend well and labour could be delayed, I do C/S. For women who have infertility due to FGM, I advise them do exercise” (Serekunda Hospital).

Conclusion

The FGM register can serve as a useful tool for monitoring the reproductive health of girls and women and should be improved and maintained.

CHAPTER 1: Overview of FGM

1.1 Background

Female genital mutilation (FGM) comprises all procedures that involve the partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons (WHO, 2008a). Slack (1988), cited in Allen, K et al (2015) reported that FGM has been practiced for more than 2000 years. According to new data from UNICEF (2016), globally, over 200 million girls and women have undergone some type of FGM and each year, about 3 million girls are exposed to the risks of FGM in 29 countries mostly in sub-Saharan African (stretching from Senegal in Western Africa, Egypt in Northern Africa, Somalia and Kenya in Eastern Africa to the Democratic Republic of the Congo (DRC) in Central Africa and Southern Africa); including parts of Asia, the Middle East and among diaspora communities in the USA, Australasia and Europe. Several reasons have been advanced for the practice of FGM. These include the rites to adulthood, marriageability, purity and sexual control, among others.

Nevertheless, numerous studies have shown that FGM is associated with increased risk of health complications such as urinary tract infections, bacterial vaginosis, painful sexual intercourse and obstetric difficulties (see for example, WHO, 2008a, PRB, 2008; Kaplan et al; 2011, Kaplan et al; 2013; Berg RC, Underland V, Odgaard-Jensen J, et al; 2014, Allen et al; 2015 and UNICEF, 2016). Also, the deliveries of women who had undergone FGM were significantly more likely to be complicated by C-section, postpartum haemorrhage and prolonged maternal hospitalization than those women who had not (WHO, 2008b).

FGM is internationally recognized as a violation of the human rights of girls and women and constitutes an extreme form of discrimination against women due to the severe health consequences and the pain and risks involved (WHO, 2008a). In this regard, there have been calls over the years to ban the practice in several African countries, including The Gambia.

The WHO (2008a), classified FGM into the following four broad categories:

Clitoridectomy (Type I): Partial or total removal of the clitoris and/or the clitoral hood.

Excision (Type II): Partial or total removal of the clitoris and labia minora, with or without excision of the labia majora.

Infibulation (Type III): Narrowing of the vaginal orifice with creation of a covering seal by cutting and placing together the labia minora and/or the labia majora, with or without excision of the clitoris.

Unclassified (Type IV): All other harmful procedures to the female genitalia for non-medical purposes, for example, pricking, piercing, incising, scraping and cauterization.

FGM is widely practiced in all the regions of The Gambia and among most ethnic groups. The first nationally representative survey to measure the prevalence and attitude towards the practice of FGM in the country was in the 2005/6 UNICEF supported Multiple Indicator Cluster Survey (MICS). According to the results, the overall prevalence rate was 78.3% and 71.1% of women aged 15–49 years believe that the practice of FGM should continue. FGM prevalence was highest in the Basse and Mansakonko Local Government Areas (LGAs), 99% and 95.9% respectively and lowest in the Kerewan and Banjul LGAs (60.8% and 44.8% respectively).

The 2013 Demographic and Health Survey (DHS), which is the most recent, showed an overall prevalence of 74.9% with 65% of women aged 15-49 years who believed in the continuation of FGM. Prevalence was highest in the Basse LGA (90.5%) and Mansakonko (81.7%) and lowest in the Kuntaur LGA (40.8%) and Banjul (38.5%).

The Gambia is the 27th sub-Saharan African country to legislate against FGM. On November 24th 2015, the country joined 18 sub-Saharan African countries, including Nigeria; to ban the practice of FGM. The National Assembly passed a bill on December 28th 2015 criminalizing the practice of FGM in The Gambia. This is consistent with the WHO (1982) policy of zero tolerance against the practice of FGM.

UN Joint Programming on FGM

Since 2009, the UNFPA and UNICEF-Gambia Country Offices have been supporting a joint programme for the accelerated abandonment of FGM in The Gambia with stakeholders from the Ministry of Health and Social Welfare (MoHSW), the Women’s Bureau and Non-Governmental Organization (NGO) partners, such as the Gambia Committee against Traditional Practices (GAMCOTRAP) and the Foundation for Research on Women’s Health, Productivity and the Environment (BAFROW). The MoHSW is responsible for the coordination and training of health personnel on the health and reproductive complications of FGM and its overall management. The Women’s Bureau under the Office of the Vice President and Ministry of Women’s Affairs is responsible for the coordination of legislative, policy and programme initiatives to address FGM; whilst the GAMCOTRAP uses the cluster approach in its social mobilization activities with radio programmes as complements. BAFROW also uses a cluster approach to their interventions in the campaign against FGM in addition to mass public sensitization against the practice; they do fistula repairs and rehabilitation of treated fistula patients.

The Wassu Gambia Kafo is an international NGO operating in The Gambia since 2008 to promote the abandonment of FGM. The NGO emphasises the need to preserve the cultural value of FGM practice with knowledge and respect as core values. Thus, Wassu Gambia Kafo uses a scientific approach where applied research on the “socio-cultural reality of FGM/C and its health consequences are conducted and the knowledge is transferred in a culturally respectful way to key social agents for them to be the ones transferring it to the society”. In addition to preventive work on FGM and knowledge transfer, Wassu Gambia Kafo is promoting an alternative rite of passage called initiation without mutilation (<http://www.mgf.uab.es/eng/index.html>).

With funding from the Joint UNFPA and UNICEF Programme on FGM, the Wassu Gambia Kafo in 2011 supported the MoHSW to train 35 health professionals in the Central River Region (CRR) on the obstetrics, health and reproductive complications of FGM and its management; including strategies for the prevention of FGM. In partnership with the Reproductive and Child Health Unit (RCH) of the MoHSW, the Wassu Gambia Kafo conducted similar trainings for health professionals on FGM in five different regions of the country for two weeks in January 2015 (<http://www.mgf.uab.es/eng/index.html>).

Purpose of the Consultancy

Since 2012, the MoHSW with financial support from the UNFPA developed and maintained registers in 37 health facilities (35 public and 2 private) for recording data on FGM obstetric and reproductive health complications and its management.

While the prevalence of FGM among women aged 15-49 years and attitudes to its continuation are available from the household surveys cited above, very little is known about FGM obstetrics and reproductive health complications and its management at health facility levels. Thus, the data collected in the FGM registers would provide useful insights into the obstetrics and reproductive health complications and its overall management at health facility levels.

1.2 Objectives of the Assessment

- To assess and analyse the data quality from the registers on the FGM obstetrics and reproductive health complications and its management in 37 health facilities in The Gambia from 2013-2016; and,
- To produce a report on the FGM obstetrics and reproductive health complications and its management at health facility levels, documenting challenges of the FGM registers (i.e. data gaps, weaknesses etc.) and make recommendations on how to improve the data collection system

1.3 Methods

For the purpose of the assessment, the following tools were designed to collect quantitative and qualitative data from the 37 health facilities (35 public and 2 private) in the country.

1). A specially designed form similar in content and format to the FGM registers

The enumerators used this pre-coded form to transcribe the data from the FGM registers. At the central level, the coders reviewed and verified the filled in forms for completeness and added or deleted codes where necessary. Database was created using the census and survey data processing (CSPPro) software. The data entry clerks entered the data in the database, which was then cleaned and exported to Statistical Package for the Social Sciences (SPSS) for data analysis (i.e. production of tables, graphs etc.). The quantitative data was generated from the SPSS dataset. The FGM transcription form used for extracting data can be found in Appendix D.

2). Key Informant Interviews (KIIs) of service providers associated with the FGM registers at the health facilities

In order to enrich the data collected in the health facilities through the FGM registers, KIIs were conducted with the following category of service providers (Midwife, Nurse, Gynaecologist, Community Health Nurse (CHN) Tutor/Regional Principal Nursing Officer (RPNO), Officer-in-Charge (OIC) and the Officers responsible for entering data in the FGM registers at the health facilities. In addition, it was recommended to interview Dr. Hassan Azadeck, Gynae Consultant, Edward Francis Small Teaching Hospital (EFSTH). The interviews were aimed at gauging their general knowledge on FGM and also their individual experiences as medical practitioners who delivered a number of babies in the course of their medical practice. The qualitative data, which would enhance and enrich the analysis, was derived from the KIIs. The KII questions per category of service provider can be found in Appendix A.

1.3.1 Training of field staff

A total of 12 field workers (9 enumerators and 3 supervisors) were trained for two days -- from November 4-5, 2016. The training included an overview of FGM with particular reference to The Gambia, concepts and definitions used in the FGM registers and practical exercises on how to transcribe the data from the FGM registers to the specially designed form.

During the training, the KII questions for each category of health service providers were thoroughly reviewed and discussed to rid them of any ambiguities and to ensure that the desired outcomes are achieved. In all, the training was interactive with discussions on FGM and the strategies to be adopted to accomplish the data collection in good time.

1.3.2 Data collection

There were three teams of four persons (a supervisor and three enumerators) who were tasked with the responsibility of data collection. For the KIIs, a total of 12 health facilities were selected using a three-stage (i.e. tertiary, secondary and primary facilities) systematic sampling procedure. The enumerators transcribed the data from the FGM registers and the supervisors administered the KIIs. The data were collected in all 37 health facilities (35 public and 2 private) in the country. The data collection lasted for a period of 6 days (i.e. from November 7-12, 2016). The list of fieldworkers and other data management personnel is in Appendix C.

1.3.3 Data Management

Following the finalization of the FGM transcription form, data entry screen was developed and tested using the Census and Survey data processing software (CSPRO version 6.1). According to the work plan, the data coding and entry were scheduled for 5 days each i.e. from November 10-14, 2016 and November 11-15, 2016 for the coding and entry respectively. However, the workloads for both activities were grossly underestimated. For instance, during the coding it was found that there were no standardized ways of data entry into the registers. The entries varied from one health facility to the other including the misclassification of entries, terms etc. It was time consuming to correct these errors. Thus, the coding for the 37 health facilities took more days than anticipated i.e. another 5 additional days to complete. This delay in the data

coding had a knock-on effect on the data entry and cleaning, which started in earnest from November 16-25, 2016.

1.3.4 Data cleaning and analysis

The data were cleaned for structural and erroneous entries and codes. Prior to the data analysis, an analysis plan showing the types of ‘dummy tables’ (i.e. layout and format) and a draft outline of the report were produced and shared with the UNFPA and the Reproductive and Child Health (RCH) Unit for their comments and inputs. Using STATA version 14, a total of 24 tables were produced for the preparation of this report.

1.4 Limitations of the Assessment

This assessment has a number of limitations, which are likely to affect the findings. The results should therefore be viewed with caution. These limitations are as follows:

- 1) One of the major limitations is the absence of a control group (i.e. girls and women who have not undergone FGM) in the registers to compare with those who had undergone FGM. Despite the abundance of data on the health and FGM obstetric complications and its management in the registers, the absence of a control group has greatly hampered the analysis;
- 2) There are huge data gaps in the registers. Most of the registers were not filled in on regular basis for 12 calendar months. The records were incomplete for most variables resulting in large categories of “not stated” ranging from 40.8% to 51.5% in Tables 2.3.1, 2.4.1, 2.4.2, 2.4.3, 2.4.4 and 2.4.5.

Table 1.4 below shows the percentage distribution of health facilities with records on FGM by month and year. About 17% of the 37 health facilities had zero record in the FGM registers for the entire years of 2013 and 2014. There was an improvement in 2015 when only about 3% of the health facilities had zero record. However, 2016 is the worst year, 19.4% of the 37 health facilities have zero record in the FGM registers. The modal class is between 1-3 months with about 39% and 31% of health facilities respectively for 2013 and 2014 that have records in the FGM registers. Although the health facilities with 10-12 months of records increased from 8.3% in both 2013 and 2014 to 25.0% each in 2015 and 2016, it is worrying that in general, the records have not improved in 2016 compared to 2014 and 2015 for the classes in the 4-6 and 7-9 months (Table 1.4 below).

It is also noteworthy that only four health facilities had 12 calendar months of complete records of 2 and 3 cases respectively for 2014 and 2015. For further details on the coverage of records in the FGM registers in the 37 health facilities see Appendix B.

Table 1.4: Percentage distribution of 37 health facilities (primary, secondary and tertiary) with records on FGM by number of month, 2013-2016

Months	2013	2014	2015	2016
< 1	16.7	16.7	2.8	19.4
1-3	38.9	30.6	22.2	22.2
4-6	22.2	22.2	22.2	16.7
7-9	13.9	22.2	27.8	16.7
10-12	8.3	8.3	25.0	25.0
Total	100.0	100.0	100.0	100.0

- 3) There are no standardized ways of data entry into the FGM registers. Huge variations in data entry from one health facility to the other; including the misclassification of entries, terms etc. The coders corrected the misclassification of entries, terms and other errors before the data entry.

CHAPTER 2: Findings of the Assessment

2.1 Characteristics of the population

The population consists of 7,813 girls and women aged 10-49 years; clinically examined as having undergone FGM and delivered in the 37 health facilities from 2013-2016. The mean age of women with type III FGM (23.1 years) is 1.8 and 1.7 years younger for women with type I (24.9 years) and women with type II (24.8 years) respectively. The overall mean age of the women is 24.9 years (Table 2.1 below).

Mandinka, Fula and Jola ethnic groups constitute 42.3%, 30.6% and 9.7% respectively. This is followed by Wolof (8.4%), Sarahule (5.2%), Serere (1.1%), other (1.1%), Bambara (0.9%), Manjago (0.5%), Aku Marabout (0.2%) and ethnicity was not recorded for 1.4% of the women (Table not shown).

Table 2.1: Characteristics of women with FGM types I, II and III

Age (years)	Clitoridectomy (Type I FGM)	Excision (Type II FGM)	Infibulation (Type III FGM)	Not Stated	Total
Range	12-49	10-49	15-40	N/A	10-49
Mean	24.9 years	24.8 years	23.1 years	N/A	24.9 years
Total (N)	2,829	4,040	401	543	7,813

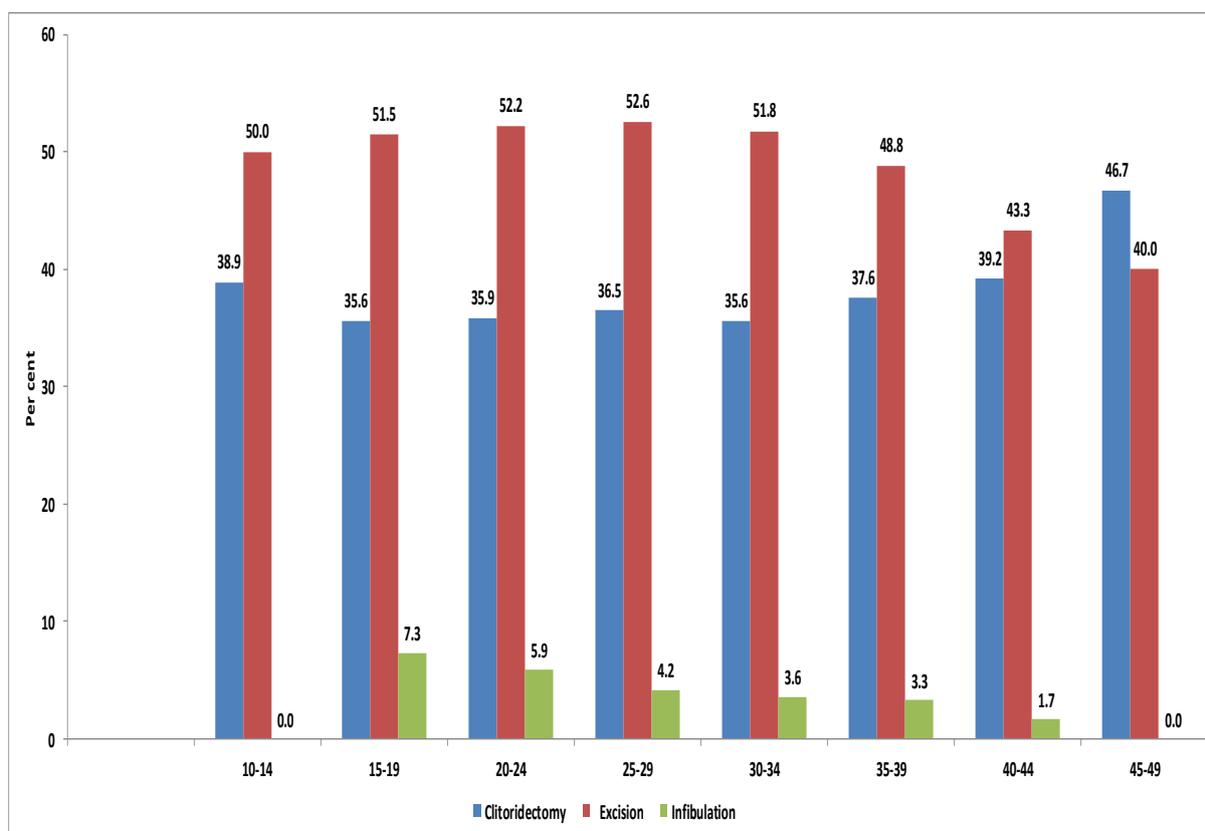
2.1.1 FGM Type by Age

Table 2.1.1 below presents the prevalence of FGM among women by type and five-year age group. The findings of the assessment shows that overall, excision was the most common type of FGM the women have undergone, 51.5%. This is followed by women who have undergone clitoridectomy, 35.9%. Women who have undergone infibulation accounted for the lowest proportion, 5.2% and 7.4% did not state the type of FGM. It can be observed from the Table that women who have undergone excision were highest among the younger age groups. The proportion ranged from 40.0% among women aged 45-49 years to 52.6% among women aged 25-29 years. The proportion of women who had undergone clitoridectomy was highest among older women (i.e. those aged 35-49 years) compared to the younger age cohorts. Interestingly, women aged 10 –14 and 45–49 years were found not have undergone FGM. The practice of infibulation was highest among the age group 15–19 and 20-24 years with 7.3 and 6.0% respectively. This finding is quite worrying given the fact that infibulation is the extreme type of FGM, which was rarely practiced in The Gambia (Table and Figure 2.1.1 below).

Table 2.1.1: Percentage distribution of women aged 10-49 years who have undergone FGM by type

Age of women	FGM Type				Total	Number
	Clitoridectomy	Excision	Infibulation	NS		
10-14'	38.9	50.0	0.0	11.1	100.0	18
15-19	35.6	51.5	7.3	5.6	100.0	1,618
20-24	35.9	52.2	6.0	5.9	100.0	2,421
25-29	36.5	52.6	4.2	6.7	100.0	1,805
30-34	35.6	51.8	3.6	9.1	100.0	1,234
35-39	37.6	48.8	3.3	10.3	100.0	514
40-44	39.2	43.3	1.7	15.8	100.0	120
45-49	46.7	40.0	0.0	13.3	100.0	15
NS	20.6	26.5	4.4	48.5	100.0	68
Total	36.0	51.5	5.2	7.4	100.0	7,813

Figure 2.1.1: Percentage distribution of women aged 10-49 years who have undergone FGM by type



During this survey key informants were asked what FGM was and how many types they knew. It has been generally observed that respondents had a wide knowledge of FGM and the types performed in the country. Respondents, in general, defined FGM as a surgical procedure involving the partial or total removal of the clitoris and/or labia minora. At the Bansang

Hospital an informant defined FGM as; "... the surgical procedure that is performed on young girls by cutting the clitoris. This can be a total or partial removal. In some cases the labia majora and minora are removed and the area sealed". At Serekunda Hospital a key informant defined FGM as the cutting of the clitoris, labia majora and minora of a woman or girl. Similar definitions were given by most of the other key informants interviewed.

On the type of FGM performed, there was general consensus that four types were performed in the country. The types were identified as; Type 1: is when the clitoris is cut, Type 2: clitoris, the minora are cut, Type 3: clitoris, the labia minora and majora are cut and Type 4: is the total removal of the clitoris and sealing of the vaginal canal leaving a small hole for menstrual flow. Descriptions of the types of FGM performed in the country by key informants were clearly indicative of appreciably high levels of knowledge on types of FGM amongst the key informants interviewed.

Testimonies from the key informant interviews are indicative that the most common types of FGM seen by service providers are types 1, 2 and 3. Types 2 and 3 were the most reported types of FGM seen by the service providers interviewed.

2.2.2 FGM Type by Ethnicity

Most people who practice FGM in The Gambia often have a cultural justification for the practice. This assertion seems to be corroborated by the views of most key informants interviewed during this exercise. Respondents generally agreed that there is an ethnic dimension to the practice of FGM with the practice more prevalent amongst certain ethnic groups than others. Most respondents to the question of the linkage between FGM and ethnicity opined that the practice is more common amongst the Mandinka, Fula, Jola and Serahule ethnic groups. Ethnic groups that either do not do it at all or seldom do it were identified as Serer, Manjago and Wollof ethnic groups. It was however observed that the types of FGM performed on girls varied across ethnic groups. These were some of the responses of key informants to the question of linkages between FGM and ethnicity:

"Yes there is a link between FGM and ethnicity. There are tribes like the serere, manjago and Wollof who are not known for practicing FGM, whilst the Mandinkas, Fulas, Jolas, and the Sarahules mainly practice it" (Essau Health Centre).

"Well I think it has. In certain communities (like Wollof and Serere) they don't practice it. Although where I come from the Wollof practice it. In this region it is the Fulas and Mandinkas who practice it" (Bansang Hospital).

"Yes there is clear linkage of FGM to ethnicity. Those ethnic groups who are well known for the practice have cultural beliefs that every woman must have to be cut for one to be pure or clean. The following tribes are found to be profoundly practicing FGM; Mandinka, Sarahules, Fulas and Jolas" (Jammeh Foundation Hospital).

It is evident that there is an ethnic dimension to the practice from the point of view of the key informants interviewed in this survey. It is also apparent that the practice is largely premised on cultural beliefs and practices as is evident in the following views of some key informants:

"People are still performing FGM in the communities because of the strong beliefs and cultures associated with it. Many believe that the practice is meant to purify girls and women,

safeguard girls' virginity, prevent promiscuity, discipline girls and women and teach them how to exercise respect and submission to elders as well as their future husbands. However, it's clear to everyone that FGM is not a religious practice because even some Christians are doing it and the Prophet (PBUH) has none of his wives or children done it that alone is enough evidence that it is not sanctioned by Islam"(**Jammeh Foundation Hospital**).

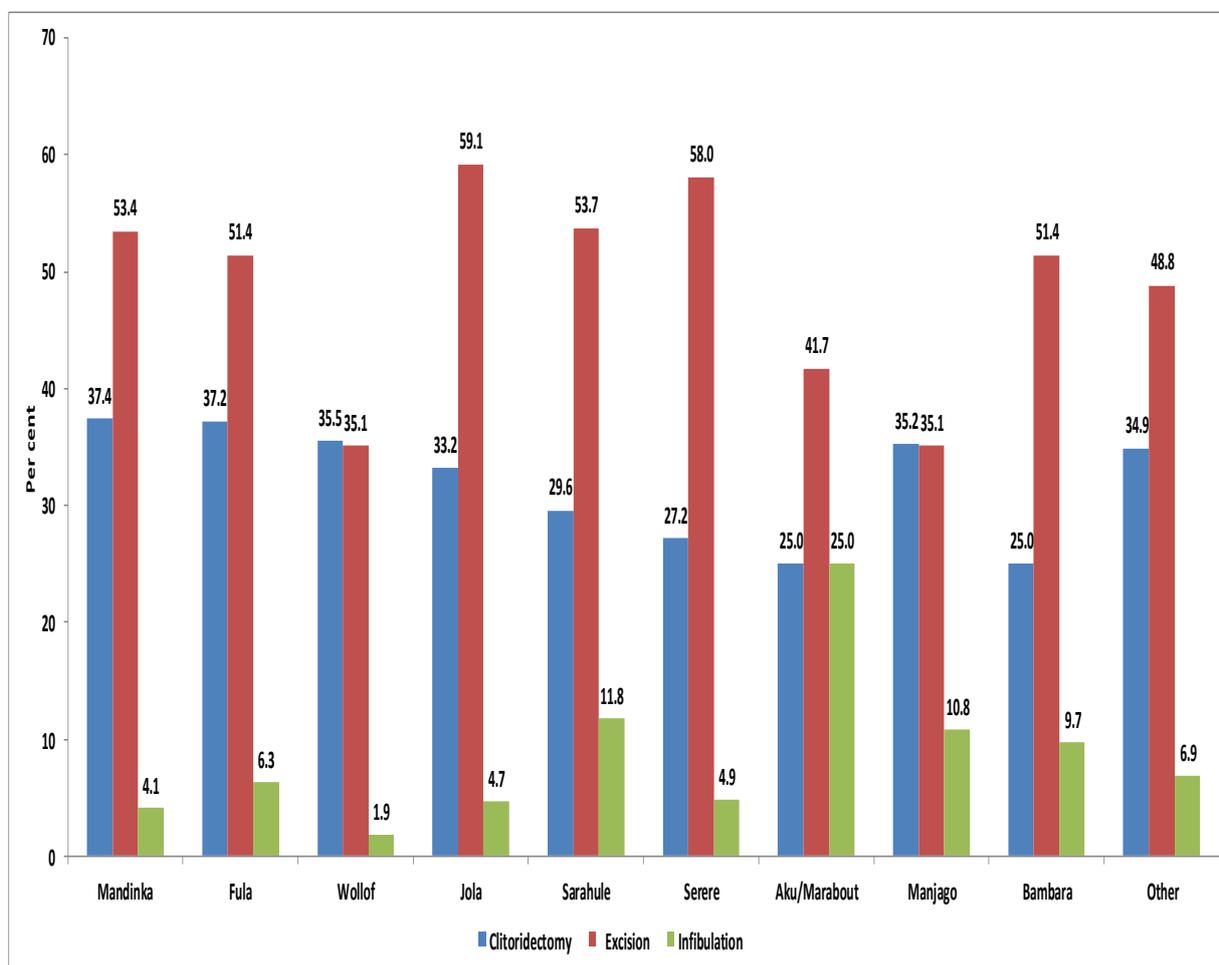
"People are still performing FGM because it is a deeply rooted cultural practice. Others do it because they link it to religion; some of those who perform the practice/procedure (circumcisers) do it because of the economic gains" (**Soma Major Health Centre**).

Table 2.2.2 below presents the type of FGM the women have undergone by ethnicity. The Table shows that the Jolas and Sereres have the highest proportions among the women who have undergone excision, 59.1% and 58.0% respectively. The proportions were lowest among the Wollofs and the Manjagos both with proportions lower than the national average. The practice of clitoridectomy was more common among the Mandinkas and the Fulas (37.4% and 37.2% respectively) than the other ethnic groups and lowest among the Creole/Aku Marabouts and the Bamabaras each with 25.0%. Women who have undergone infibulation were highest among the Creole/Aku Marabouts, 25.0%, Sarahule, 11.8% and Manjagos, 10.8%. The practice was lowest among the Wollofs, 1.9%. The results also suggest that all ethnic groups in some small measure now practice infibulation. This is indeed another worrying trend (Table and Figure 2.2.2 below).

Table 2.2.2: Percentage distribution of women who have undergone FGM by ethnicity and type

Ethnicity	FGM Type				Total	Number
	Clitoridectomy	Excision	Infibulation	NS		
Mandinka	37.4	53.4	4.1	5.2	100.0	3,261
Fula	37.2	51.4	6.3	5.1	100.0	2,357
Wollof	35.5	35.1	1.9	27.5	100.0	648
Jola	33.2	59.1	4.7	2.9	100.0	744
Sarahule	29.6	53.7	11.8	4.9	100.0	406
Serere	27.2	58.0	4.9	9.9	100.0	81
Creole/Aku Marabout	25.0	41.7	25.0	8.3	100.0	12
Manjago	35.2	35.1	10.8	18.9	100.0	37
Bambara	25.0	51.4	9.7	13.9	100.0	72
Other	34.9	48.8	6.9	9.3	100.0	86
NS	29.4	36.7	1.8	32.1	100.0	109
Total	35.9	51.5	5.2	7.4	100.0	7,813

Figure 2.2.2: Percentage distribution of women who have undergone FGM by ethnicity and type



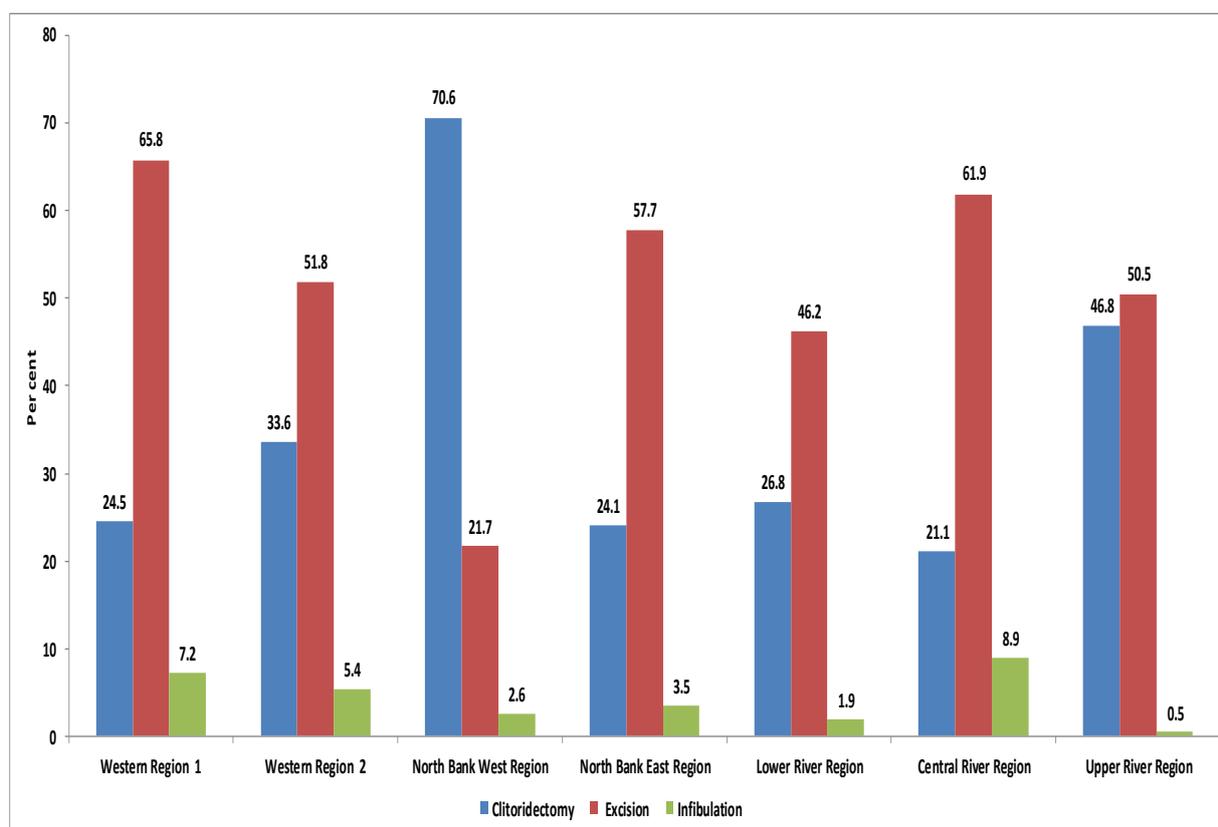
2.3.3 FGM Type by Health Region

According to Table 2.3.3 below the North Bank West Region (NBWR) has the highest proportion of women who had undergone clitoridectomy, 70.6% followed by the Upper River Region (URR), 46.8% and the proportion was lowest in the North Bank East Region (NBER), 24.1%. The practice of excision is more common in the Western Region 1 (WR 1), 65.8% and the Central River Region (CRR), 61.9% than in the other regions. The practice of infibulation is more common in the CRR (8.9%) and the WR1 (7.2%) and the Western Region 2 (WR2), 5.4%. Less than one per cent of the women were infibulated in the URR (Table and Figure 2.3.3 below).

Table 2.3.3: Percentage distribution of women who have undergone FGM by type and Health Region

Health Region	FGM Type				Total	Number
	Clitoridectomy	Excision	Infibulation	NS		
Western Region 1	24.5	65.8	7.2	2.4	100.0	3,400
Western Region 2	33.6	51.8	5.4	9.2	100.0	967
North Bank West Region	70.6	21.7	2.6	5.1	100.0	1,640
North Bank East Region	24.1	57.7	3.5	14.7	100.0	170
Lower River Region	26.8	46.2	1.9	25.1	100.0	1,038
Central River Region	21.1	61.9	8.9	8.0	100.0	412
Upper River Region	46.8	50.5	0.5	2.2	100.0	186
Total	35.9	51.5	5.2	7.4	100.0	7,813

Figure 2.3.3: Percentage distribution of women who have undergone FGM by type and Health Region



2.3 Type of delivery and delivery outcomes

The assessment revealed that haemorrhage continues to be the leading obstetric condition experienced by girls and women. Table 2.3.1 below shows that out of 120 women aged 40-44 years, 6.7% had experienced haemorrhage due to FGM. These are women who must have had multiple deliveries and their uterus had stretched beyond limit resulting in weak uterine muscles. For such women, little delays in labour can cause haemorrhage. Tears are very common in girls who have undergone FGM. The results show that out of 18 girls aged 10-14 years, 5.6% had tears during labour and deliveries. These young girls who have no experience in labour and deliveries are usually much susceptible to tears. Girls aged 10-14 years also experienced prolonged labour (22.2%), 15-19 years, 19.2% and 20-24 years, 16.7% compared to 13.3% among women aged 45-49 years who had prolonged labour due to FGM. Delayed second stage was prevalent among women aged 15-19 years and 20-24 years with 2.6 and 2.2% respectively. Delayed second stage can be caused by inexperienced in labour, scarring and virginal tightness. According to Adriana et al (2013), FGM in The Gambia is seen as women's affairs since very few men are involved in the decision-making for their young girls to be circumcised. Therefore, with this alarming rate of complications women should be adequately sensitized on the effects of FGM and there should be greater involvement of men to eradicate the practice in The Gambia. The results should be viewed with caution due to the high proportion (40.9%) of "not stated" categories (Table 2.3.1).

2.3.1: Percentage distribution of women aged 10-49 years who have undergone FGM by obstetric complications

Age of woman	Obstetric Complications										Total	Number
	Haemorrhage	Tears	Fistula	Birth asphyxia	Delayed 2nd stage	Prolonged Labour	Ruptured Uterus	None	NS	Other		
10-14	0.0	5.6	0.0	0.0	0.0	22.2	0.0	22.2	0	0.0	100.	18
15-19	2.5	1.0	0.6	0.4	2.6	19.2	0.1	28.7	3	0.8	100.	1,618
20-24	2.4	0.8	0.2	0.2	2.2	16.7	0.0	37.3	5	0.8	100.	2,421
25-29	2.0	0.4	0.1	0.1	0.9	11.7	0.0	44.2	1	1.3	100.	1,805
30-34	2.7	0.8	0.2	0.1	0.8	7.5	0.1	48.4	7	0.7	100.	1,234
35-39	2.7	1.2	0.4	0.0	1.0	4.9	0.0	46.9	6	0.4	100.	514
40-44	6.7	1.8	0.0	0.0	0.8	5.8	0.0	39.2	2	1.7	100.	120
45-49	0.0	0.0	0.0	0.0	0.0	13.3	0.0	40.0	7	0.0	100.	15
NS	5.9	0.0	0.0	0.0	0.0	8.8	0.0	10.3	5	1.5	100.	68
Total	2.5	0.8	0.3	0.2	1.6	13.6	0.0	39.2	40.	0.9	100.	7,813

Prolonged labour and haemorrhage continue to be the major problems in girls and women of all ethnic groups. Prolonged labour is highest among the Sereres, 18.5% followed by the Manjagos, 16.2%, Mandinka, 15.8%, Jolas, 15.1%, Wollofs, 13.4%, Bambaras, 11.1% and Sarahules, 10.8%. By contrast, haemorrhage is highest among the Fulas, 3.0%, followed by the Bambaras, 2.8%, Wollofs, 2.5, Mandinkas, 2.4% and lowest among the Sereres, 1.2%.

The Manjagos who constitute only 37 women and girls in this assessment had (2.7%) of their babies born asphyxiated (meaning short of enough oxygen to breath). There is a clear evidence for their babies to be asphyxiated since 2.7% of them had haemorrhage and 16.2% went through prolonged labour. These two conditions do affect oxygen supply in labour from the mother to the baby. Although the Creole/Aku Marabouts comparatively did not experience any obstetric complications, 8.3% of them had prolonged labour. Overall, 13.6% of the women had prolonged labour (Table 2.3.2).

2.3.2: Percentage distribution of women who have undergone FGM by obstetric complications and Ethnicity

Ethnicity	Obstetric Complications										Total	Number
	Haemorrhage	Tear	Fistula	Birth asphyxia	Delayed 2nd stage	Prolonged Labour	Ruptured Uterus	None	NS	Other		
Mandinka	2.4	0.7	0.2	0.2	1.8	15.8	0.0	41.5	36.4	1.0	100.0	3,261
Fula	3.0	0.9	0.3	0.1	1.4	10.5	0.0	39.4	5.0	0.8	100.0	2,357
Wolof	2.5	1.4	0.2	0.2	2.0	13.4	0.0	27.0	1.0	0.3	100.0	648
Jola	1.6	0.1	0.1	0.4	1.1	15.1	0.0	41.1	39.0	1.1	100.0	744
Sarahule	1.7	1.0	0.3	0.0	1.2	10.8	0.3	44.1	40.0	0.3	100.0	406
Serere	1.2	0.0	0.0	0.0	1.2	18.5	0.0	38.3	40.0	0.0	100.0	81
Creole/Aku Marabout	0.0	0.0	0.0	0.0	0.0	8.3	0.0	16.7	75.0	0.0	100.0	12
Manjago	2.7	2.7	0.0	2.7	5.4	16.2	0.0	27.0	43.0	0.0	100.0	37
Bambara	2.8	0.0	1.4	0.0	5.6	11.1	0.0	36.1	38.0	4.2	100.0	72
Other	1.2	1.2	1.2	2.3	1.2	24.4	0.0	33.7	34.0	0.0	100.0	86
NS	3.7	0.9	0.0	0.0	1.8	8.3	0.0	23.9	58.0	2.8	100.0	109
Total	2.5	0.8	0.3	0.2	1.6	13.6	0.0	39.2	40.0	0.9	100.0	7,813

Table 2.3.3 below shows obstetric complications caused by FGM practice within the regions. In the CRR, out of 412 women (10.2%) had haemorrhage while the WR 1 had the lowest haemorrhage complication (1.8%) out of 3,400 women. Delayed second stage was also another problem. The WR 2 had (5.4%) out of 967 women, the LRR, 4.1%, URR, 1.6%, NBWR, 1.4% and the NBER, 1.2%.

There are regional differentials in prolonged labour with WR 2, 26.0%, followed by the NBER, 19.4%. The URR has the least proportion of women with prolonged labour, 10.2% Overall, 13.6% experienced prolonged labour. Fistula is prevalent among women in the NBER, 2.4%, and the CRR, 2.0%. Tears account for 5.9% in the URR, 2.7% in the CRR and both in the LRR and NBWR with 1.1% each (Table 2.3.3 below).

Table 2.3.3: Percentage distribution of women who have undergone FGM by obstetric complications and region

Health Region	Obstetric Complications										Total	Number
	Haemorrhage	Tears	Fistula	Birth asphyxia	Delayed 2nd stage	Prolonged labour	Ruptured uterus	None	NS	Other		
Western Region 1	1.8	0.2	0.1	0.0	0.1	9.9	0.0	48.4	38.6	0.7	100.0	3,400
Western Region 2	4.2	0.2	0.2	1.2	5.4	26.0	0.2	18.7	42.6	1.2	100.0	967
North Bank West Region	1.4	1.1	0.1	0.1	1.4	14.5	0.1	54.5	26.0	0.9	100.0	1,640
North Bank East Region	2.4	0.6	2.4	0.0	1.2	19.4	0.0	30.6	43.5	0.0	100.0	170
Lower River Region	1.7	1.1	0.0	0.1	4.1	13.0	0.0	16.6	62.0	1.4	100.0	1,038
Central River Region	10.2	2.7	1.7	0.0	0.7	12.4	0.0	5.8	66.0	0.5	100.0	412
Upper River Region	1.1	5.9	0.5	0.0	0.5	10.2	0.0	52.7	28.5	0.5	100.0	186
Total	2.5	0.8	0.3	0.2	1.6	13.6	0.0	39.2	40.9	0.9	100.0	7,813

Some of the findings from the data compiled from the health facility FGM registers seem to be corroborated by the key informants interviewed during the assessment.

2.4 FGM Complications

From the viewpoint of key informants interviewed in the course of this assessment, a number of complications can be identified with the practice of FGM. According to the key informants, the health effects of FGM on women and girls have been identified as follows in the various health facilities; anaemia due to excessive bleeding, infection after going through the procedure, painful sexual intercourse and loss of sexual libido, obstructed labour due to the narrowing of the vaginal passage which leads to tears and fetus distress and the potential for transmission of STIs due to use of the same cutting tool in the circumcision of several girls. From the point of view of a key informant in Sulayman Junkung Hospital, the health effects of FGM on women and girls can be identified as:

“Firstly, it affects them in their marital homes sexually by reducing their sexual libido. Secondly it also affects them during the time of labour and delivery. The type 3 can cause pain to them due to infibulation of the vagina orifice which can cause infections. It can also cause anaemia due to profuse bleeding which can lead to death” (Sulayman Junkung Hospital).

At the Kerewan Health Centre a key informant described the health effects of FGM on women and girls as follows:

“It causes prolonged labour during deliveries and perennial tears, fresh still births, episiotomies, septic tears or epis after delivery. It also causes a lot of pain to the woman

undergoing labour, repeated urinary tract infections, irregular bleeding, and vaginal bleeding and also causes fetus distress” (Kerewan Health Centre).

Similar effects were identified by a key informant at Bansang Hospital as follows:

“It can cause health complications during labour and delivery and prolonged delivery can cause tears. I have seen certain complications like growth/keloids around the clitoris. Infections can also happen because the knife/razor blades were not sterilized and because of that FGM victims are prone to infections. Sometimes these infections can lead to infertility. I have seen a girl who reported to me that she does not enjoy sex because she was opened up when she got married” (Bansang Hospital).

It is evident from the viewpoint of key informants that in addition to the identified health effects, there are negative social consequences related to marital disputes caused by relative low appetite for sex amongst some women who underwent the FGM practice. As indicated by this key informant, painful sex as a result of FGM could affect women’s matrimonial lives:

“They may have prolonged labour which can affect them psychologically, because they will be afraid to have sex with their husbands. In society discrimination will also come into effect” (BAFROW Clinic).

“For girls when they newly get married, their husbands find it difficult to penetrate them and they always bring them here to the clinic for us to open them again, which is very painful some girls also develop Keloids which make them difficult to have a stable marriage” (ASB Clinic).

“Most women complain of pain during sexual intercourse because they don’t eventually have sexual pleasure and most women will have to move from one man to another looking for sexual pleasure. Because of the pain and lack of arousal during sex, women often deny their husbands sex and therefore some report to the facility to see if something is wrong with their wives because they refuse to have sex” (Serekunda Hospital).

A reflection on the potentials for delivery complications for women who underwent FGM in comparison with those who have not amongst key informants revealed that most key informants were of the view that women who underwent the practice are more prone to delivery complications than those who were not exposed to the procedure. The complications observed for women who were circumcised related to obstructed and prolonged labour, preterm deliveries and third degree tears. According to the key informants women who underwent types 2, 3 and 4 FGM are more prone to delivery complications than those who went through other types of FGM.

Some of the testimonies of key informants are as follows;

“Normally during the second stage of labour when a patience is fully dilated, the perineum is very tight to allow it to stretch, so the only option is to make episiotomy to avoid tear or VVF/RVF, compare to those who did not undergo FGM their perineum can stretch, so there is limited complications” (Faji Kunda Major Health Centre).

“Usually delivery complications are seen among those who underwent FGM. Usually the circumcision scar tears when the head is crowned. This can cause heavy bleeding. If they

happen to deliver at home we receive post-partum women who deliver at home and come in unconscious or in a state of shock as a result of bleeding at the scar area”(Bansang Hospital).

“Women who underwent FGM have more complications than women who did not. During labour, women who went through FGM spend longer times in labour because there is not enough space for the baby to pass easily. This can lead to birth asphyxia or the baby can even die. The women also often have a deep tear which if not sutured properly, can lead to severe bleeding” (Faji Kunda Health Centre).

Notwithstanding the general consensus amongst key informants of women who went through FGM experiencing complications during delivery, there was a key informant who was of the view that it may be difficult to associate delivery complications with FGM in the testimony below;

“Most of the time it is difficult to pinpoint who has undergone FGM and who didn’t, because some might undergo and deliver fast without any problem but most of the time those with delivery complications are women who underwent the type 3 FGM, which causes the orifice to be too small for the baby to come out and it needs an operation to deliver the baby most of time” (Brikama Major Health Centre).

Among women aged 10-14 years, 11.1% had tears during labour and deliveries compared to 12.2% among women aged 15-19 years. Interestingly, 15 women aged 45-49 years had 6.7% tears. These are women who are not expected to have tears since they are multigravidas with spacious birth canals for delivery to take place without any tear. However, due to their FGM complications they are susceptible tears. Scarring is a major contributing factor in FGM complications. Out of 1,618 of girls aged 15-19 years, (2.1%) had scarring complication compared to 1.6% among women aged 20-24 years. Haemorrhage during labour and delivery account for 1.7 % among women aged 40-44 years. According to the WHO (2012), all types of FGM have consequences that undermine the health and well-being of newborns, girls, and women, exposing a situation that deserves attention in the world’s sexual and reproductive public health agenda. This assessment has shown that every woman and girl who had undergone FGM has in one way or other experienced a complication. Overall, tears constitute 10.4%. However, the results should be viewed with caution due to the high proportion (51.5%) of “not stated” category (Table 2.4.1 below).

2.4.1: Percentage distribution of women aged 10-49 years who have undergone FGM by FGM complications

Age of women	FGM Complications										Total	Number
	Haemorrhage	Tears	Prolonged labour	Birth asphyxia	Delayed 2nd stage	Other	Excessive Scarring	None	NS	Fracture		
10-14	0.0	11.1	0.0	0.0	0.0	0.0	0.0	22.2	67.0	0.0	100.0	18
15-19	0.7	12.2	1.7	0.2	0.2	1.8	2.1	21.7	59.4	0.0	100.0	1,618
20-24	0.7	12.8	1.5	0.0	0.4	1.4	1.6	30.8	50.8	0.0	100.0	2,421
25-29	0.4	9.7	1.1	0.0	0.1	1.1	0.8	38.1	48.7	0.0	100.0	1,805
30-34	0.2	7.9	0.7	0.0	0.3	0.8	0.6	44.3	45.4	0.0	100.0	1,234
35-39	0.2	4.9	0.2	0.0	0.0	0.2	0.2	44.6	49.8	0.0	100.0	514
40-44	1.7	2.5	2.5	0.0	0.0	1.7	0.0	37.5	54.2	0.0	100.0	120
45-49	0.0	6.7	0.0	0.0	0.0	0.0	0.0	33.3	60.0	0.0	100.0	15
NS	2.9	8.8	0.0	0.0	0.0	0.0	2.9	10.3	75.0	0.0	100.0	68
Total	0.6	10.4	1.2	0.1	0.2	1.2	1.3	33.6	51.5	0.0	100.0	7,813

Tears are the major problem in the FGM complications faced by women and girls during labour and delivery. The proportions range from 4.9% among the Sereres, Manjagos, 8.1%, Creole/Aku Marabouts, 8.3%, Wollofs, 8.5%, Mandinkas and Sarahules, 9.9% each, Fulas, 11.0%, Jolas, 13.7% to an all high 16.7% for the Bambaras. With regards to scarring, the Bambaras (4.2%) and the Manjagos (2.7%) bear the brunt most. It is also interesting to note that among the ethnic groups only the Manjagos had birth asphyxia (2.7%). This shows that the Manjagos are the only ethnic group who experienced birth asphyxia in both obstetric and FGM complications. The reasons for this are not clear and further research is required. Haemorrhage (1.2%) was experienced by the Sereres. Overall, tears constitute 10.4%, prolonged labour (1.2%), excessive scarring (1.3%) and 33.6% had no FGM complications. The results should however be viewed with caution due the high proportion (51.5%) of “not stated” category (Table 2.4.2 below).

2.4.2: Percentage distribution of women who have undergone FGM by FGM complications and Ethnicity

Ethnicity	FGM Complications										Total	Number
	Haemorrhage	Tears	Prolonged labour	Birth asphyxia	Delayed 2nd stage	Other	Excessive Scarring	None	NS	Fracture		
Mandinka	0.6	9.9	1.2	0.0	0.3	1.2	1.5	34.1	51.1	0.0	100.0	3,261
Fula	0.5	11.0	1.7	0.0	0.1	1.4	1.1	35.0	49.3	0.0	100.0	2,357
Wollof	0.2	8.5	0.2	0.0	0.2	0.5	0.6	28.6	61.4	0.0	100.0	648
Jola	0.9	13.7	0.9	0.1	0.4	1.3	0.5	33.6	48.4	0.0	100.0	744
Sarahuli	0.5	9.9	1.2	0.0	0.3	1.2	2.0	34.2	50.7	0.0	100.0	406
Serere	1.2	4.9	1.2	0.0	0.0	1.2	0.0	28.4	63.0	0.0	100.0	81
Aku Marabut	0.0	8.3	0.0	0.0	0.0	0.0	0.0	41.7	50.0	0.0	100.0	12
Manjago	0.0	8.1	0.0	2.7	0.0	5.4	2.7	29.7	51.4	0.0	100.0	37
Bambara	0.0	16.7	0.0	0.0	0.0	1.4	4.2	26.4	58.4	0.0	100.0	72
Other	0.0	12.8	1.2	0.0	0.0	0.0	3.5	24.4	63.1	0.0	100.0	86
NS	0.0	6.4	0.9	0.0	0.0	0.9	0.0	28.4	63.3	0.0	100.0	109

Total	0.6	10.4	1.2	0.1	0.2	1.2	1.3	33.6	51.5	0.0	100.0	7,813
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The severity of tears as FGM complication continues to affect women and girls in the NBER bearing the brunt of the burden. A total of 29.4% had tears during labour and deliveries. This region is followed by the WR 1, 14.1%. In fact, tears among women who had undergone FGM are found in all the regions. This finding is consistent with Adriana et al (2013), who reported that FGM is practiced in both rural and urban areas of the country. In the CRR, 1.2% of women and girls had haemorrhage followed by WR 2, WR 1 and the NBWR with 0.9, 0.6 and 0.5% respectively. The assessment revealed that scarring complication was highest in the URR (6.5%) followed by the NBER (4.1%), the LRR (2.3%), W 1, 2 and NBWR each with 0.9% and lowest in the CRR (0.2%). Prolonged labour complications are highest in the CRR (7.0%), the URR (4.3%) and lowest in the WR 2 (1.9%) and the NBWR (0.4%). By contrast, the NBER has zero cases of prolonged labour. Overall, tears constitute 10.4%, prolonged labour (1.2%) and excessive scarring 1.3 % (Table 2.4.3 below).

2.4.3: Percentage distribution of women who have undergone FGM by FGM complications and Health Region

Health Region	Haemorrhage	Tears	Prolonged labour	FGM Complications		Other	Excessive Scarring	None	NS	Fracture	Total	Number
				Birth asphyxia	Delayed 2nd stage							
Western Region 1	0.6	14.1	0.9	0.0	0.3	1.5	0.9	41.7	40.0	0.0	100.0	3,400
Western Region 2	0.9	7.1	1.9	0.1	0.6	0.9	0.9	13.6	73.9	0.0	100.0	967
North Bank West Region	0.5	7.0	0.4	0.0	0.0	1.3	0.9	47.9	42.0	0.1	100.0	1,640
North Bank East Region	0.0	29.4	0.0	0.6	0.0	0.6	4.1	21.6	44.1	0.0	100.0	170
Lower River Region	0.0	4.6	0.5	0.1	0.1	0.1	2.3	16.0	76.3	0.0	100.0	1,038
Central River Region	1.2	9.7	7.0	0.0	0.2	1.2	0.2	5.8	74.8	0.0	100.0	412
Upper River Region	0.0	7.5	4.3	0.0	0.0	3.2	6.5	32.8	45.7	0.0	100.0	186
Total	0.6	10.4	1.2	0.1	0.2	1.2	1.3	33.6	51.5	0.0	100.0	7,813

The parity distribution is more skewed on tearing than any other complications. Out of 2,225 primates, (13.8%) had tears during labour and delivery. The same primates had (2.3%) scarring and (1.7%) prolonged labour. This result may not be a surprise because women and girls of this category are inexperienced in labour and deliveries and most of the time their delivery canal may be tight. Among the second gravid, 12.8% had tear and 1.3% had excessive scarring during labour and delivery. Tear is also found among women with parities 3, 4, 5 and 6 with 9.5%, 4.5%, 3.7% and 2.3% respectively; and then increased among women with 7 parities and above (5.7%). Thus, with FGM in women and girls, any complications can occur during labour and delivery at any level of parity. A study conducted by Ceesay, H (2013), revealed that FGM is associated with a variety of long-term health consequences, which women with FGM are four times more likely to suffer complications during delivery, and the newborn is four times more likely to have health complications if the parturient has undergone FGM. Overall, 33.6% of the women had no FGM complications (Table 2.4.4 below).

2.4.4: Percentage distribution of women aged 10-49 years who have undergone FGM by parity and FGM complications

Parity	FGM Complications										Total	Number
	Haemorrhage	Tears	Prolonged labour	Birth asphyxia	Delayed 2nd stage	Other	Excessive Scarring	None	NS	Fracture		
1	0.8	13.8	1.7	0.2	0.3	2.1	2.3	22.7	56.1	0.0	100.0	2,225
2	0.4	12.8	1.3	0.0	0.2	1.1	1.3	26.8	56.0	0.0	100.0	2,483
3	0.6	9.5	0.6	0.0	0.4	0.9	0.4	41.9	45.6	0.1	100.0	1,129
4	0.0	4.5	0.6	0.0	0.0	0.3	0.6	75.5	18.5	0.0	100.0	314
5	0.6	3.7	0.8	0.0	0.0	0.2	0.2	55.9	38.6	0.0	100.0	485
6	0.3	2.3	1.0	0.0	0.0	0.7	0.7	58.6	36.5	0.0	100.0	304
7+	0.6	4.1	0.8	0.0	0.3	1.1	0.6	42.2	50.4	0.0	100.0	365
NS	0.2	5.7	0.8	0.0	0.2	0.6	0.6	27.2	64.8	0.0	100.0	508
Total	0.6	10.4	1.2	0.1	0.2	1.2	1.3	33.6	51.5	0.0	100.0	7,813

Obstetric complications are very common in women of child bearing age and teenage mothers. Some of these complications become worst if the individual mother has undergone FGM. Table 2.4.5 below shows that haemorrhage, tear, delayed second stage and prolonged labour are all very common. Prolonged labour is highest among women with parities 1, 2 and 3 with 19.5%, 16.4% and 10.8% respectively compared to women with parity 5 (5.0%) and parity 7 and above (5.8%). Delayed second stage is highest among women with parity 1 (3.2%) followed by parity 2 and parity 7 and above women with 1.5% and 1.4% respectively. Similarly, women with parity 7 and above had haemorrhage (5.2%) and tear (1.1%). These results show that FGM causes more harm than good to women (Table 2.4.5 below).

2.4.5: Percentage distribution of women aged 10-49 years who have undergone FGM by parity and obstetric complications

Parity	Obstetric Complications										Total	Number
	Haemorrhage	Tear	Fistula	Birth asphyxia	Delayed 2nd stage	Prolonged Labour	Ruptured uterus	None	NS	Other		
1	2.0	1.0	0.3	0.3	3.2	19.5	0.04	32.0	40.0	1.03	100.0	2,225
2	2.5	0.7	0.3	0.2	1.5	16.4	0.0	31.9	45.6	0.8	100.0	2,483
3	2.1	0.4	0.2	0.1	0.5	10.8	0.0	47.7	37.2	1.1	100.0	1,129
4	1.6	0.3	0.0	0.0	0.6	2.6	0.0	76.4	17.8	0.6	100.0	314
5	1.7	1.0	0.2	0.0	0.8	5.0	0.0	56.3	34.6	0.4	100.0	485
6	3.3	1.3	0.0	0.0	0.0	3.0	0.3	57.2	33.6	1.3	100.0	304
7+	5.2	1.1	0.3	0.0	1.4	5.8	0.0	44.7	40.8	0.8	100.0	365
NS	3.7	0.6	0.6	0.2	0.6	8.1	0.0	32.9	52.8	0.6	100.0	508
Total	2.5	0.8	0.3	0.2	1.6	13.6	0.0	39.2	40.8	0.9	100.0	7,813

2.5 Management of FGM

Having had wealth of experiences in the management of delivery complications from FGM, key informants were asked questions on the management of such complications. According to the responses of key informants on measures they institute in the management of FGM complications, the nature of the complication determines the measures taken. In general the informants interviewed claimed that minor complications are often treated at the facility level whilst complicated cases are either referred to a doctor or gynecologist within the health facility or referred to tertiary facilities. The delivery complication case management ranges from the conduct of episiotomy, suturing of tears, the performance of Caesarean Section (C/S), administration of antibiotics to the referral of severely complicated deliveries. It is evident that action taken on a delivery complication depends on the severity of the complication but also on the cadre of health personnel conducting the delivery. This is evident in the utterances of some of these key informants interviewed during the assessment;

“We first of all prepare them very well in order to avoid complications by assessing those who can deliver without problems. Those who are found to likely develop complications such as tears and excessive bleeding, are given episiotomy which is easier to suture and less likely to bleed excessively. Women who cannot be helped at all are referred for C/S to be done to save the baby from distress due to prolonged labour and to avoid the mother having a deep tear which could be difficult to repair (Jammeh Foundation Hospital)”.

“Sometimes when we have a tear that does not involve the cervix, we repair them in the labour ward but in instances where the cervix is affected, we call the doctor or an experienced midwife for possible repairs in the theatre or labour ward. I also saw a woman with keloid which was growing big and we later referred her to Bansang Hospital where she was operated but could not survive it. There was another case of a woman whose husband nearly divorced her as a result of a keloid she developed in her genitalia. The woman does not have sex with her husband because he was afraid of her keloid” (Fatoto Health Centre).

“During delivery, I advise the nurses to do episiotomy to every woman who has a severe form of FGM, in order to prevent tears and also to give more space for the baby to pass easily. Because it is difficult to repair natural tears, we train our nurses on how to give episiotomy and stitch. In other ways were episiotomy cannot be done because the baby does not descend well and labour could be delayed, I do C/S. For women who have infertility due to FGM, I advise them to exercise” (Serekunda Hospital).

Findings from the FGM registers show that in order to be able to take good care of teenagers in labour, the service provider must be very skillful. This is the only way to alleviate pain and suffering in labour and delivery among teenagers who had undergone FGM. Table 2.5.1 below shows that among girls aged 10-14 years (61.5%) had their tears sutured or repaired, (7.7%) had their labour augmented, while a similar percentage had been de-infibulated under the management course line and (15.4%) were managed by episiotomy. Within the ages of 15-19 years, the following is worth noting, (61.6%) had repair by suturing, (16.3%) episiotomy and the number of referred cases (2.5%) all undertake to make sure lives are saved. The women referred constitute 6.1% aged 40-44 years. Overall, over half (50.9%) of all women aged 10-49 years had suturing/repair, 7.8% episiotomy, 2.3% de-infibulated; whilst 1.8% were referred and 1.1% had augmentation (Table and Figure 2.5.1 below).

Table 2.5.1: Percentage distribution of women aged 10-49 years by type of FGM management

Age group	Suturing/ repair	Augmentation	Episiotomy	Health Education	Packing/ Pack	Referred	none	De- infibulations	Not specified	Total
	8	1	2	0	0	0	2	1	0	13
10-14	61.5	7.7	15.4	0.0	0.0	0.0	15.4	7.7	0.0	
	658	13	174	22	5	27	159	24	2	1,068
15-19	61.6	1.2	16.3	2.1	0.5	2.5	14.9	2.2	1.8	
	803	12	101	34	6	17	407	27	3	1,410
20-24	57.0	0.9	7.2	2.4	0.4	1.2	28.9	1.0	2.0	
	409	7	25	20	6	8	375	24	26	879
25-29	46.5	0.8	2.8	2.3	0.7	0.9	42.7	2.7	3.0	
	161	7	13	15	4	12	291	13	16	523
30-34	30.8	1.3	2.5	2.9	0.8	2.3	55.6	2.5	3.1	
	44	5	5	8	3	7	111	4	4	189
35-39	23.3	2.6	2.6	4.2	1.6	3.7	58.7	2.1	2.1	
	10	1	0	2	0	2	16	2	0	33
40-44	30.3	3.0	0.0	6.1	0.0	6.1	48.5	6.1	0.0	
	1	0	0	0	0	0	0	1	0	2
45-49	50.0	0.0	0.0	0.0	0.0	0.0	0.0	50.0	0.0	
Total	50.9	1.1	7.8	2.5	0.6	1.8	33.1	2.3	2.3	100.0
Number	2094	46	320	101	24	73	1361	96	93	4,117

Note: Data on this table are based on multiple responses

Figure: 2.5.1: Percentage distribution of women aged 10-49 years by overall type of FGM management

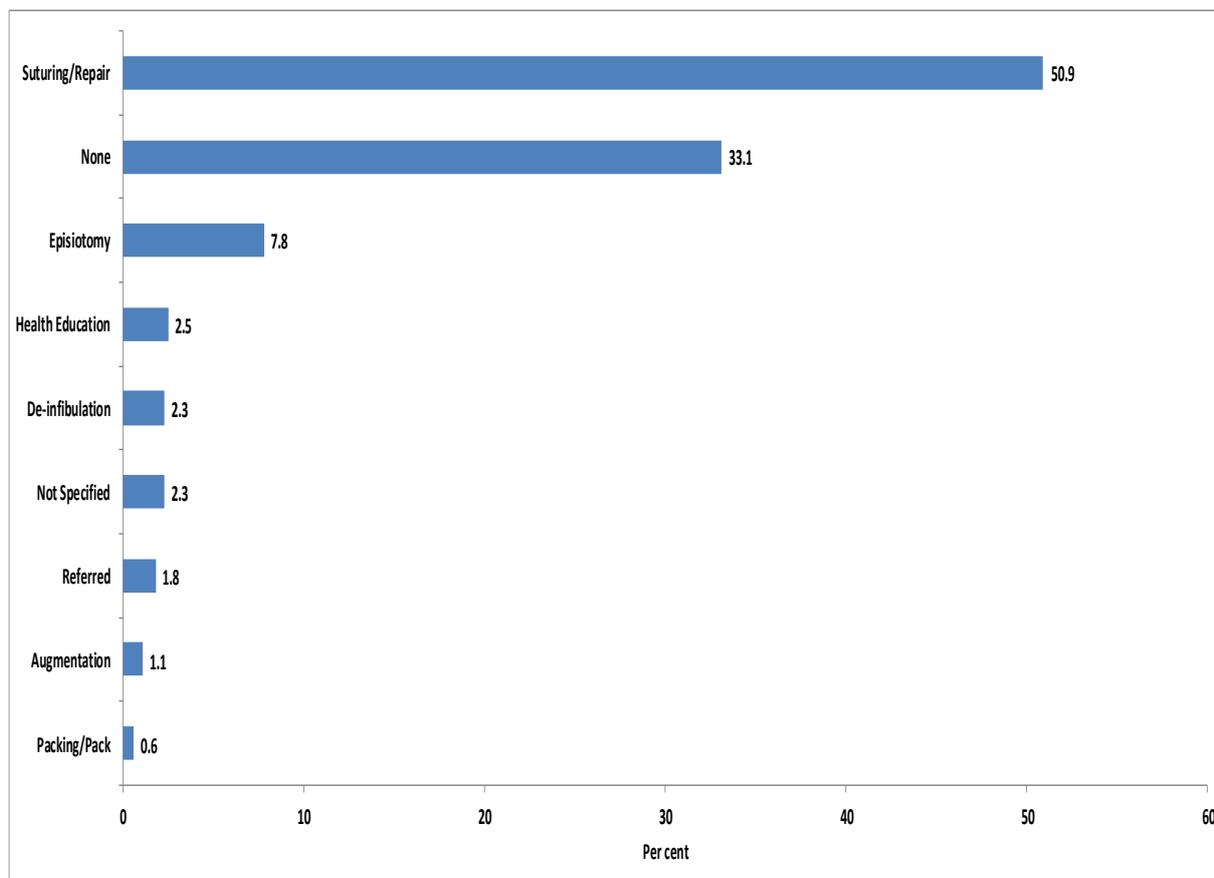


Table 2.5.2 below shows that overall, 51.1% of women had tears during the process of labour and delivery and were repaired by suturing. The prevalence of suturing among Jolas is (53.7%), Mandinkas (52.7%), Fulas (52.7%) and Sarahules (42.1%). Two things emerged from this high prevalence of suturing i.e. either the women came to deliver when labour had reach its advance (second stage) or the women failed to cooperate with the service provider during labour and delivery. The Sarahules (17.1%) and the Wollofs (16.3%) had the highest rates of episiotomy. Interestingly, the referral rate is low since the highest was among the Fulas, 2.6%. This is because most of the health facilities are not offering emergency obstetric care. Therefore, the issues surrounding referral require further attention for redress. The Table also shows that the use of de-infibulations to manage FGM was alarming with 2.2% of Mandinka women and girls, 3.0% of Fulas, 7.5% of Sarahules and 4.1% of Sereres were de-infibulated during labour and delivery. This shows that infibulation (Type III FGM) which is not commonly practiced in the Gambia is now on the increase. Further studies are needed on the increase in infibulation. Overall, over half (51.1%) of the women had suturing/repair, 7.7% had episiotomy, 2.3% had de-infibulations and 1.1 had augmentation (Table and Figure 2.5.2 below).

Table 2.5.2: Percentage distribution of women by ethnicity and type of FGM management

Ethnicity	Suturing/ repair	Augmentation	Episiotomy	Health Education	Packing/ Pack	Referred	none	De- infibulations	Not specified	Total
Mandinka	893	19	93	48	14	22	552	37	45	1,694
	52.7	1.1	5.5	2.8	0.8	1.3	32.6	2.2	2.7	
Fula	635	21	108	24	7	31	357	36	24	1,204
	52.7	1.7	9.0	2.0	0.6	2.6	29.7	3.0	2.0	
Wollof	131	1	53	8	1	3	125	0	4	326
	40.2	0.3	16.3	2.5	0.3	0.9	38.3	0.0	1.2	
Jola	248	3	7	15	0	3	190	0	1	460
	53.1	0.7	1.5	3.3	0.0	0.7	41.3	0.0	0.2	
Sarahule	101	2	41	1	0	1	76	18	10	240
	42.1	0.8	17.1	0.4	0.0	0.4	31.7	7.5	4.2	
Serere	21	0	3	1	0	1	21	2	2	49
	42.9	0.0	6.1	2.0	0.0	2.0	42.9	4.1	4.1	
Aku Marabout	5	0	0	0	0	0	2	0	0	7
	71.4	0.0	0.0	0.0	0.0	0.0	28.6	0.0	0.0	
Manjago	19	0	1	1	0	0	8	0	0	29
	65.5	0.0	3.4	3.4	0.0	0.0	27.6	0.0	0.0	
Bambara	12	1	6	4	0	1	14	0	4	40
	30.0	2.5	15.0	10.0	0.0	2.5	35.0	0.0	10.0	
Other	32	0	3	0	0	1	15	0	0	51
	62.7	0.0	5.9	0.0	0.0	2.0	29.4	0.0	0.0	
Total Number	51.1	1.1	7.7	2.5	0.5	1.5	33.2	2.3	2.2	100.0
	2,097	47	315	102	22	63	1,360	93	90	4,100

Note: Data on this table are based on multiple responses

Figure: 2.5.2: Percentage distribution of women by ethnicity and overall type of FGM management

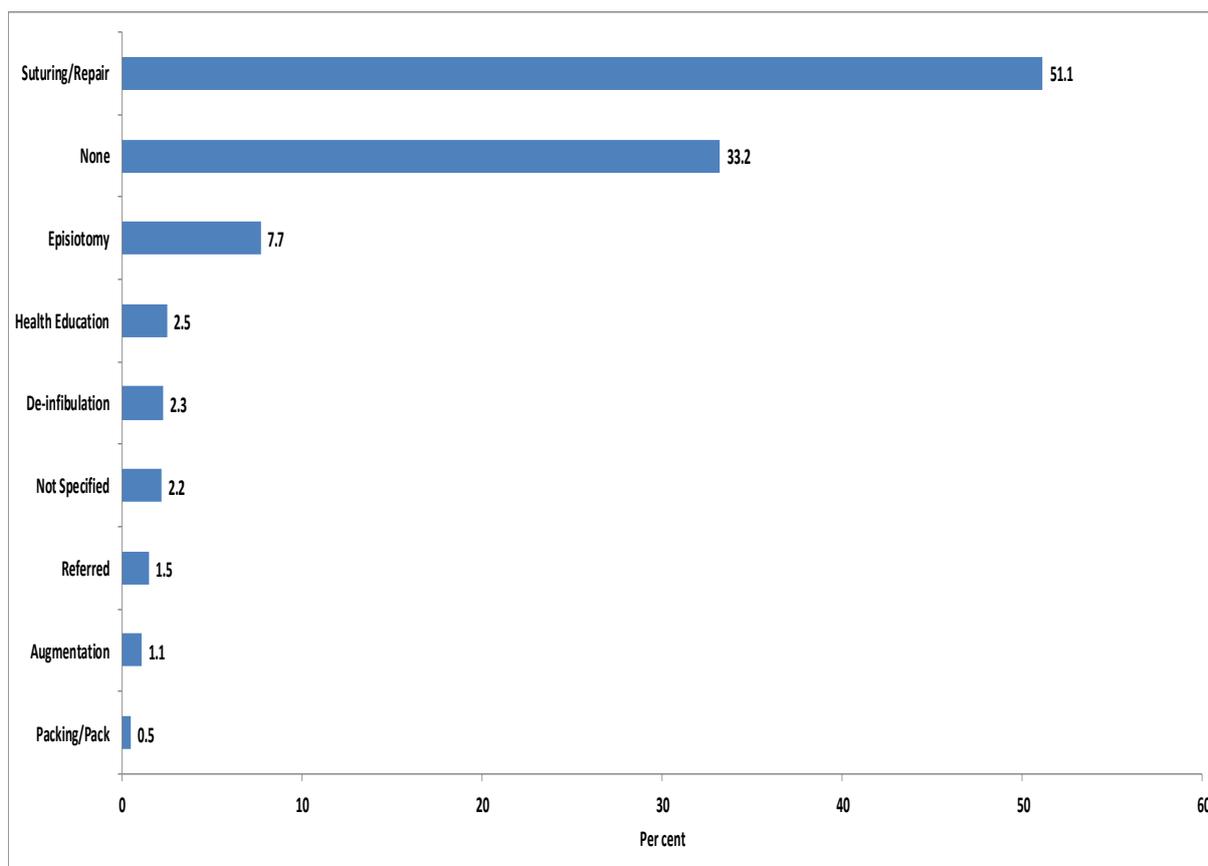


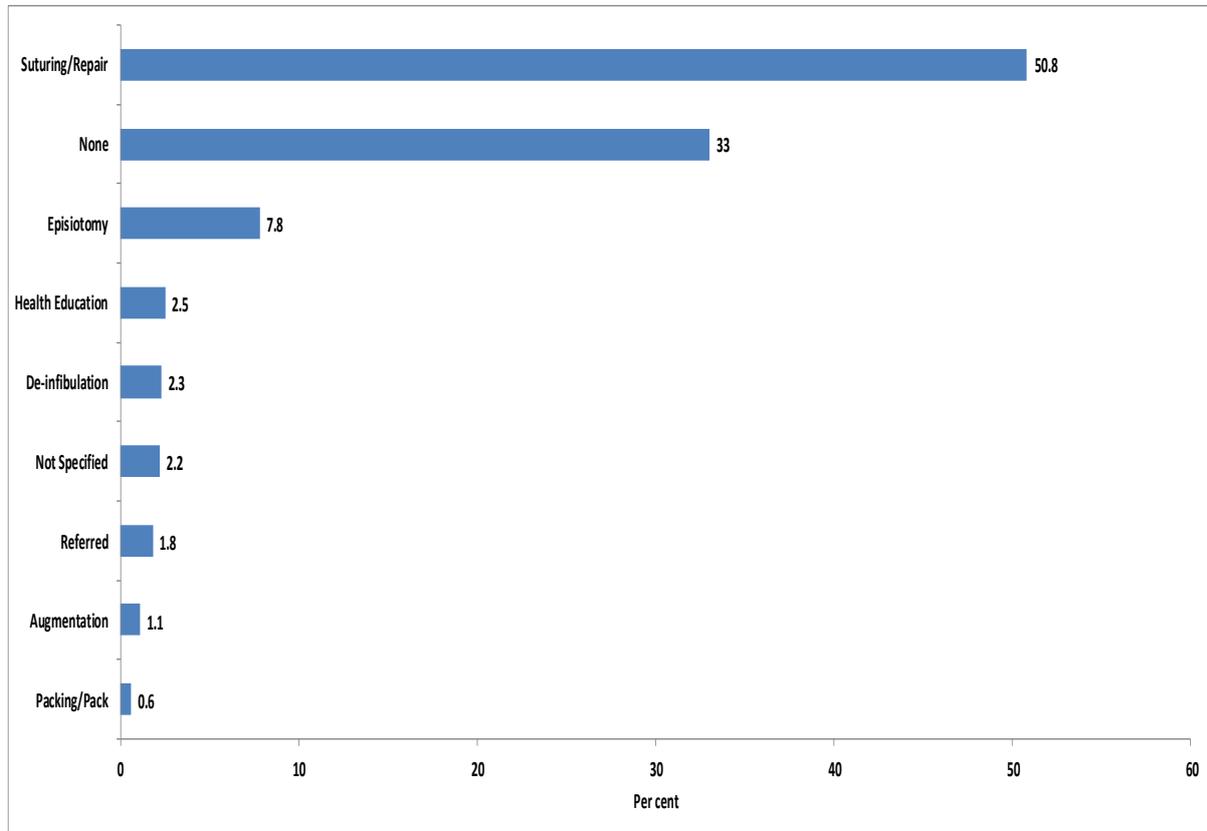
Table 2.5.3 below shows that the WR 2 (85.5%) and the NBWR (65.4%) have the highest prevalence of suturing/repair among women who had undergone FGM. Not much augmentation had been undertaken. The highest is in LRR (2.5%). However, there is an alarming rate of de-infibulations in the URR (25.2%) and the CRR (19.5%). According to Kaplan et al. (2011) the third type of FGM was just at 7.5% in The Gambia. Thus, if one region is registering over 25% of de-infibulation, then FGM type III is on the increase. The URR also has the highest percentage of episiotomy (49.5%) followed by the NBER (28.1%). For referrals, the trend continues to get lower. Out of the seven regions, only the NBWR had referred (7.7%) of their women and girls to the next level for further management. Overall, over half (50.8%) of the women had suturing/repair, 7.8 had episiotomy, 2.3 had de-infibulations and 1.1 had augmentation (Table and Figure 2.5.3 below).

Table 2.5.3: Percentage distribution of women by region and type of FGM management

Health Region	Suturing/ Repair	Augmentation	Episiotomy	Health Education	Packing/ Pack	Referred	None	De- infibulations	Not specified	Total
Western Region 1	876	7	27	23	1	8	1,283	12	7	2,223
	39.4	0.3	1.2	1.0	0.0	0.4	57.7	0.5	0.3	
Western Region 2	465	7	18	15	1	11	14	7	19	544
	85.5	1.3	3.3	2.8	0.2	2.0	2.6	1.3	3.5	
Lower River Region	416	15	88	1	19	33	38	17	9	607
	68.5	2.5	14.5	0.2	3.1	5.4	6.3	2.8	1.5	
North Bank West Region	51	1	0	16	0	6	4	1	0	78
	65.4	1.0	0.0	20.5	0.0	7.7	5.1	1.3	0.0	
North Bank East Region	199	6	119	44	2	5	16	1	34	423
	47.0	1.4	28.1	10.4	0.5	1.2	3.8	0.2	8.0	
Central River Region	80	10	19	3	1	5	10	31	4	159
	50.3	6.3	11.9	1.9	0.6	3.1	6.3	19.5	2.5	
Upper River Region	21	1	53	0	0	5	0	27	20	107
	19.6	0.9	49.5	0.0	0.0	4.7	0.0	25.2	18.7	
Total	50.8	1.1	7.8	2.5	0.6	1.8	33.0	2.3	2.2	100.0
Number	2,108	47	324	102	24	73	1,365	96	93	4,141

Note: Data on this table are based on multiple responses

Figure 2.5.3: Percentage distribution of women by region and overall type of FGM management



2.6 Perceived linkages between FGM and HIV/AIDS

There is general agreement amongst key informants of linkages between FGM and HIV/AIDS. Most respondents opined that the use of the same knife/razor blade in the circumcision of numerous girls provided the potential for transmission of infections across the circumcised. They indicated that instruments used to circumcise girls are often not sterilized and are repeatedly used on different individuals, hence the potential for widespread cross infection of girls with STIs. These opinions are evident in the following testimonies when key informants were asked whether there were linkages between FGM and HIV/AIDS;

“Yes; there is obvious linkage between FGM and HIV. Most often, FGM is conducted on an array of children when the same knife is used without proper cleaning; talk less of sterilization (because those old women who carry out the practice don’t even know sterilization). Therefore, if there is one among the children who is HIV positive, all the subsequent children stand a high risk of being infected with HIV from the contaminated knife (Jammeh Foundation Hospital)”.

“Yes, if the same knife is used for two or more people there is likelihood of infection and even the hot water on which the children are made to sit in could also be a means of transmission. There is a likelihood of a mother to child transmission during delivery when there is tight orifice and episiotomy is conducted on a HIV positive mother. As the child is coming out of the orifice, there is possibility of infection (Sulayman Junkung Hospital)”.

Another mode of transmission of HIV explained by a key informant was the transmission of infection through mother to child. As explained below this occurs when an HIV positive mother transmits the infection to her child during delivery. When asked whether there is any linkage between FGM and HIV this was the response of a key informant interviewed in Faji Kunda Health Centre;

“Yes! If the mother is HIV positive and she has undergone circumcision, the perineum is so tight that we have to cut it, it becomes a wound and bleeding occurs, the born child umbilicus is cut and there is contact and the virus can flow and enter the child, which can lead to infection (Faji Kunda Major Health Centre)”.

From the views of most key informants interviewed in this assessment it can be inferred that HIV and other STIs can be transmitted from one person to another as a result of FGM.

2.7 Criteria for posting midwives

The criteria for posting midwives according to most of the key informants interviewed is largely premised on services delivered by the health facility and the number of women attending antenatal and post-natal clinics and the number of deliveries conducted in the facility. This implies that need is a key determinant of the posting of midwives to health facilities. It also evident from the views of key informants that the health sector endeavours to post at least one midwife to all health facilities that conduct deliveries. Below are some of the views expressed by key informants on the criteria for posting midwives;

“Midwives can work at any level of the healthcare system. However, we post the midwives to facilities which are conducting deliveries; the busiest facilities are considered first, we also follow the general staffing norm of the various types of facilities” (Fatoto Health Centre).

“As a Principal Nursing Officer (PNO), I am not directly involved with central posting but rather people are posted to us at the central level (ministerial level) by the chief nursing officer (CNO). However, when possible we do our own internal posting (hospital level) on need basis; units that are short of manpower are given staff from other units which have more manpower” (Jammeh Foundation Hospital).

“I give priority to busy facilities and I make sure that every health facility has a midwife. Sometimes midwives are posted to community clinics that are busy and in hard-to-reach areas” (Soma Major Health Centre).

“We give priority to major health facilities and the minor health facilities because they are the busiest and they are the receiving centres. All the village clinics are under a minor health facility where they normally refer their cases” (Essau Health Centre).

During supervisory visits what to do in case there is a woman in labour?

Regarding the measures prescribed by key informants should they come across a woman in labour during their supervisory visits and there is no skilled attendant, most informants indicated that they would step in and conduct the delivery. Apparently, most of the informants interviewed are skilled in conducting deliveries and have generally indicated preparedness to step in to conduct deliveries if the need arises. Some have gone further to indicate that they would also try to establish why there is not skilled attendant and address the problem immediately. There were some respondents who indicated that they would even try to identify inadequacies in the skills to the personnel manning the delivery ward and try to provide some guidance. Below are some of the views of the key informants;

“I will always step in by taking care of the woman because once a midwife always a midwife come rain come shine. After taking care of the woman and ensuring that she had a safe delivery and that she and her baby are stable, I check from the other units that have more skilled attendants in other to fill in the gap immediately after my supervisory tour, I will write recommendations to the Ministry to the Chief Nursing Officer (CNO) to post more midwives to the affected facility or facilities” (Jammeh Foundation Hospital).

“I will assess the woman’s need at that juncture and perform any necessary action that needs to be taken. This is because I am a trained midwife and cannot walk away from a critical condition” (AFPRC Hospital).

“I will assist and also show the attendant how to go about the delivery next time; he/she has a case like that. This hardly happens in the health facilities as one of them are with one/two midwives and a midwife is always on call” (Soma Major Health Centre).

“On our monitoring when we come across a labour case, we do the delivery then after we sermon a meeting to find out why that delivery was not done by a trained nurse. After knowing the problem we will call the in-charge to make sure that it will not happen again” (Essau Health Centre).

Considering the potential need for supervisory teams to respond to emergencies during monitoring visits, it is obvious that such teams should comprise adequately trained personnel in the area of midwifery. This would ensure that team members are able to identify the needs of women in labour and either assist them during delivery or refer them to tertiary facilities for appropriate care.

After the ban on FGM what should be done to eradicate the practice?

Since the ban on FGM came into effect in December 2015, campaigners against the practice have been wondering how the ban would affect the practice and what additional measures should be instituted to ensure that the practice is eradicated. To contribute to the wealth of ideas being discussed on how to consolidate the gains made in the fight against FGM, some key informants were asked about what should be done to eradicate the practice. The general consensus of key informants is that the ban on the practice is not enough to eradicate it. The belief is that, efforts aimed at sensitizing the public on the negative health consequences of FGM need to be intensified. Use of various sensitization channels have been prescribed ranging from use of maternal and child health clinics, peer health educators to mass community-based sensitization meetings were identified by key informants as fora for sensitization. These were some of the views of key informants from various health facilities;

“FGM can be banned in the Gambia, but people can still be practicing it in the neighboring countries. I think we need to have serious sensitization on the complications and its effects through the media and advise the masses at the community level to make best use of their RCH and antenatal services to discuss with women and they can even invite me, who can play a vital role in that because the complications are only known at the labour ward and this is a no go area for men in particularly (Brikama Major Health Centre)”.

“Continuous massive sensitization especially of health care providers. Community advocacy – trying to involve key people within the community to head the campaign. Interpersonal communication needs to be strengthened - one on one or group discussions needs to be encouraged. Social behavioral communication for change, village support groups, drama groups etc. need to be involved in the sensitization efforts. Mass media involvement will also go a long way - both print and electronic media” (AFPRC Hospital).

There were some key informants who believed that circumcisers should specifically be targeted for sensitization and also for support for them to be involved in alternative income generation activities. Below are some of the views in this area;

“I think organizing workshops, to give knowledge to the circumcisers (“N’GANG SING BA’S”) about the dangers involved in circumcision. This knowledge sharing should not target only circumcisers but also helpers during the time of the cutting. TBA’s/GBC’s (community birth champions), religious leaders and men especially the fathers should also be targeted during sensitization on the consequences of FGM. If they know the dangers around it they will not allow their daughters to be circumcised” (Essau Health Centre).

“We need to enforce the ban. We also need to continue health education and sensitization on FGM. We can also train the circumcisers on income generating activities. After such training they can be given seed money or capital to enable them set up businesses as alternative sources of income” (Soma Major Health Centre).

“I think organizing workshops, to impart knowledge to the circumcisers and helpers during the cutting about the dangers of FGM. TBAs and CBC’s (community birth champions), religious leaders and men especially the fathers should also be targeted for sensitization. If they know the dangers around it they will not allow their daughters to be circumcised” (Essau Health Centre).

Apparently, enforcing the law on the FGM may serve as a deterrent to the practice of FGM but this may not be enough for the practice to be eradicated. It is of critical importance that public awareness on the negative health consequences of the practice be raised for people to be convinced to abandon the practice on their own volition.

What should be done for women with delivery complications as a result of FGM

As indicated earlier by key the informants, FGM does have negative health consequences which could be both physical and psychological. Key informants interviewed during this assessment prescribed the treatment of medical conditions for women who develop complications related to FGM but they also believed such victims of FGM should be counseled and sensitized to increase their knowledge on the causes of their conditions. Such sensitization should also be aimed at dissuading them from exposing their children to the practice. According to them the counseling should also target their spouses for them to better understand the effects of FGM. Below are some of the statements recorded from the key informant interviews;

“There should be on-going counseling of the women, their spouses as well as all their family members. Some women encounter short-term complications whereas others encounter long-term complications. Those who develop short-term complications can be cared for immediately and if possible reverse their problems. When they are totally stable, health education is given to allow them understand the relationship between FGM and their complications. On the other hand those with long-term complications need to directly involve their families in their care in order to make future plans for their care e.g. in the case of the fistula which needs future operation and which is sometimes critical” (Jammeh Foundation Hospital).

“Educate and support them and highlight to them the reasons why they are experiencing these complications, this could help them prevent their children from undergoing the same procedures. Most of the complications they develop during labour and delivery are manageable at the level of the maternity wards. We even receive referrals from minor health

centres to deal with e.g. 3rd degree tears. We stand by our vision to provide quality health care to the communities we are serving” (**AFPRC Hospital**).

“During delivery, I advise the nurses to do episiotomy to every woman who has this type of mutilation, in order to prevent tears and also to give more space for the baby to pass easily. Because it is difficult to repair natural tears, we train our nurses on how to give episiotomy and stitch. Where episiotomy cannot be done because the baby does not descend well and labour could be delayed, I do C/S for the woman. For women who have infertility due to FGM, I advise them to exercise” (**Serekunda Hospital**).

“Depending on the type and degree of complications the following methods are used viz; tears – are required by suturing. Bleeding – This is managed by arresting the bleeding then taking specimens to the lab to check for HB level. If the HB level is below 7, transfusion is done. Prolonged labour and a tight orifice – this is managed by episiotomy and later suture in layers. Birth asphyxia – resuscitated and suctioned. Oxygen is given if necessary and women admitted in severe cases and put on antibiotics” (**Sulayman Junkung Hospital**).

Should women who underwent FGM be provided counseling for psycho-social support?

On the question of whether women who underwent FGM need to be provided counseling or psycho-social support, most key informants were unanimous in their view that such women require support. Regarding the rationale for the provision of these support, the informants’ views differed. There are some who thought women who underwent the FGM procedure require counseling because of the trauma and pain they might have suffered or continue to suffer from as a result. For others psycho-social support is needed because of the repeated episodes of infections these women might have suffered from as a result of FGM and for others women would need such support because of the infertility they suffered as a result of FGM. Below are some of the views expressed by key informants on this issue;

“It depends on the individual and the effect of FGM on that person. People in continuous pain after undergoing FGM, those experiencing repeated urinary tract infections, those who cannot conceive as a result of FGM, those who suffer from keloids and other conditions which makes them not to enjoy sexual intercourse because they experience a lot of pain in the process and those with fistula (VVF and RVF) are mainly the ones that I would need counseling for psycho-social support” (**Kerewan Health Centre**).

“Yes, because sometimes they suffer from pain the memory of which last with them for ages so anytime they remember that moment, they can become terrified. Therefore, it is very important to offer them psycho-social support” (**Bansang Hospital**).

There are those who are of the view that due to loss of appetite for sex amongst some women as a result of painful sexual intercourse due to FGM, such women would require counseling as articulated below;

“Yes they should be given psycho-social support and counseling. Some of them have low libido and are not interested in sex. They are most of the time not ready for sex, when the man is fully erected. None the less if they have sex it could be very traumatizing and painful, therefore these people need to be educated on what to do in such instances e.g. lubricating the vagina. Sometimes presence of keloid makes the husband abandon the woman on the bed and this can be a devastating and difficult time for the woman. You have to give them psycho-social support as counseling” (**Fatoto Health Centre**).

At least one key informant was of the view that women who underwent FGM needed counseling because deformities around their genitalia as a result of FGM discourages them from seeking health care due to the embarrassment they experience as indicated below;

“Of course some of the women have been traumatized because some of them when it is done to them they didn’t consent. FGM scars causes some of them to avoid visits to health clinics because they are embarrassed about the way the vagina was tempered with” (Brikama Major Health Centre).

CHAPTER 3: Policy implications of the findings and the way forward

First, in the absence of a control group to compare with, most of the findings from the registers on the health, obstetric and FGM complications are inconclusive. Second, there is the issue of data quality with “not stated” categories ranging from 40.9% to 51.5%, which also affect the reliability of the estimates.

In spite of these shortcomings, there are huge potentials in the FGM registers. From this assessment, clinical data on 7,813 women and girls who had undergone the three types of FGM were found. This is by far the largest FGM cases compared to the entire peer reviewed published studies on The Gambia (see for example, Morison et al; 2001, Kaplan et al; 2011 and Kaplan et al; 2013 with sample sizes of 1,157, 871 and 570 cases respectively). More importantly, the assessment has shown that infibulation (type III FGM), the extreme form of FGM, which is rarely practiced in The Gambia is on the increase. Over 400 cases were found and the results from the assessment suggest that all ethnic groups in a small way or other practice type III FGM. According to the data, the practice also cuts across all ages except the 10-14 and 45-49 age groups. FGM type III is mostly practice in the CRR, 8.9% and the WR 1 and WR 2 with 7.2 and 5.4% respectively; and lowest in the URR, 0.5%. The low prevalence in the URR is a result of the poor coverage rates of 4.2% during the period 2013-2016.

This finding is quite worrying in that there are also cases of de-infibulations with all the severe long-term health consequences for girls and women who have undergone FGM. The finding has policy implications and calls for concerted efforts on all stakeholders, including the UNFPA, UNICEF, the government and NGOs to consolidate the gains achieved in the abandonment of FGM. This is all the more urgent given that FGM is banned and practitioners are now more likely to go underground including the medicalization of FGM.

Here are some responses from the KIIs on the way forward with the banning of FGM:

“FGM can be banned in the Gambia, but people can still be practicing it in the neighboring countries. I think we need to have serious sensitization on the complications and its effects through the media and advise the masses at the community level to make best use of their RCH and antenatal services to discuss with women and they can even invite me, who can play a vital role in that because the complications are only known at the labour ward and this is a no go area for men in particularly (Brikama Major Health Centre)”.

“Continuous massive sensitization especially of health care providers. Community advocacy – trying to involve key people within the community to head the campaign. Interpersonal communication needs to be strengthened - one on one or group discussions needs to be encouraged. Social behavioral communication for change, village support groups, drama groups etc. need to be involved in the sensitization efforts. Mass media involvement will also go a long way - both print and electronic media” (AFPRC Hospital).

“We need to enforce the ban. We also need to continue health education and sensitization on FGM. We can also train the circumcisers on income generating activities. After such training they can be given seed money or capital to enable them set up businesses as alternative sources of income”(Soma Major Health Centre).

In conclusion, with the banning of FGM, the battle has now begun in earnest. We must not rest on our laurels. Although banned, the scars, wounds, tears and sutures of FGM would continue

to affect the reproductive health of girls and women for many generations to come. The FGM registers are excellent planning, monitoring and evaluation tools for the reproductive health of women and girls and should be maintained at all cost.

CHAPTER 4: Conclusion and Recommendations

Despite the data limitations highlighted in section 1.4 of this report, the FGM registers have great potentials as a planning, monitoring and evaluation tool. Towards this end, the following recommendations are made to strengthen the data collection system, regular update, thus, resulting in improved data quality:

- Include a control group (i.e. girls and women who have not undergone FGM) in the registers to compare with those who had undergone FGM. This can be done by simply adding a column in the register and ask: “**Has woman undergone FGM?**” **1. Yes 2. No** (*Circle as appropriate*).
- Allow all women (i.e. irrespective of their FGM status) to deliver in the health facilities.
- For monitoring trends in FGM obstetric complications and other reproductive issues of women and girls, the data from the registers should be analysed on a bi-annual basis
- Add another column to collect data on the educational attainment of girls and women
- All health facilities rendering maternity care services should use the national FGM register in the labour wards
- Service providers should be trained on how to fill the national FGM registers used in the labour wards. This training should emphasise the need for standardized data entry and to reduce data gaps and minimize missing cases. Also, terms and definitions should be thoroughly explained to avoid misclassification of entries into the registers
- Training and re-training should be on continuous basis considering the high staff turnover in the health sector.
- Provide instructions on the cover page on how to fill the register.
- Synchronize all the registers used in the labour ward to make life easy for the midwives since they have too much registers to fill at a time.
- The RCH office should be supported to conduct quarterly follow-up monitoring of the trained service providers.

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APPENDIX A: Key Informant Interviews (KIIs) Questions

Gender: M F

Health Region:

Official Designation:.....

Health Facility:

Date of interview:

Name of Interviewer:

QUESTIONS FOR SERVICE PROVIDER (MIDWIFE/ NURS / GYNAECOLOGIST)

1. What is FGM?
2. How many types of FGM do you know?
3. Which type of the FGM's do you receive most?
4. Which of the FGM types lead to more complications?
5. How does FGM affect the health of women and girls?
6. Where do you experience more complications during labour and deliveries for women who underwent FGM compared to those who did not undergo FGM?
7. Is there any linkage between FGM and HIV?
8. How do you manage FGM complications?

Gender: M F

Health Region:

Official Designation:.....

Date of interview:

Name of Interviewer:

QUESTIONS FOR THE CHN TUTOR/REGIONAL PRINCIPAL NURSING OFFICER

1. What is FGM?
2. Why do you think people are still performing FGM in our communities?
3. Does FGM have any linkage to ethnicity?
4. Considering that human resources are limited, what criteria do you use in posting midwives in your region?
5. During your routine supervision, if you find a woman in labour and there is no skilled attendant what do you do?
6. Knowing that FGM is banned in The Gambia, what efforts can be done to eradicate FGM?
7. What do you think can be done for women who underwent FGM and developed complications during labour and delivery?

Gender: M F

Health Region:

Official Designation:.....

Date of interview:

Name of Interviewer:

QUESTIONS FOR THE OFFICER-IN-CHARGE (OIC)

1. What is FGM?
2. How many types of FGM do you know?
3. How does FGM affect the health of women and girls?
4. Where do you experience more complications during labour and deliveries for women who underwent FGM compared to those who did not undergo FGM?
5. Is there any linkage between FGM and HIV?
6. How do you manage FGM complications?
7. Does FGM have any linkage to ethnicity?
8. Knowing that FGM is banned in The Gambia, what efforts can be done to eradicate FGM?
9. What do you think can be done for women who underwent FGM and developed complications during labour and delivery?

Gender: M F

Official Designation:.....

Date of interview:

Name of Interviewer:

QUESTIONS FOR DR HASSAN AZADECK, Gynae Consultant

1. Do you believe that FGM is a religious practice?
2. Knowing how deeply rooted FGM is in our tradition and culture, do you think the community would adhere to the ban?
3. Can FGM lead to any psychological trauma to women and girls?
4. Can FGM have any effect in the marital affairs of women?
5. What are your thoughts on the medicalization of FGM?
6. Do you think women who have undergone FGM should be provided with counseling for psycho-social support?
7. What do you think should be the way forward now that FGM is banned in The Gambia?

APPENDIX B: Coverage of records in the FGM registers in the 37 health facilities

Name of Health Facility	H/F Code	Extent of Coverage in the Registers					% Covered
		2013	2014	2015	2016		
Edward Francis Small Teaching Hospital	1	6/12	7/12	9/12	11/12	68.8	
Serekunda Hospital	2	3/12	0/12	3/12	1/12	14.6	
Serekunda Health Centre	3	3/12	4/12	10/12	0/12	35.4	
BAFROW Clinic	4	11/12	3/12	0/12	0/12	29.2	
ASB Clinic	5	1/12	12/12	11/12	0/12	50.0	
Faji Kunda Health Centre	6	0/12	2/12	7/12	11/12	41.7	
Jammeh Foundation Hospital	7	0/12	0/12	3/12	5/12	16.7	
Sukuta Health Centre	8	5/12	5/12	7/12	7/12	50.0	
Brufut Health Centre	9	2/12	0/12	8/12	0/12	20.8	
Banjulinding Health Centre	10	1/12	7/12	12/12	9/12	60.4	
Gunjur Health Centre	11	0/12	2/12	3/12	7/12	25.0	
Brikama Major Health Centre	12	4/12	11/12	5/12	7/12	56.3	
Kafuta Health Centre	13	2/12	4/12	6/12	5/12	35.4	
Essau Health Centre	14	3/12	6/12	5/12	3/12	35.4	
Kerr Chern/ Medina Bafuloto H/C	15	3/12	1/12	12/12	4/12	41.7	
Albreda Health Centre	16	2/12	5/12	4/12	6/12	35.4	
Kerewan Health Centre	17	0/12	3/12	10/12	10/12	60.5	
Iliasa Health Centre	19	6/12	0/12	10/12	10/12	54.2	
Njaba Kunda Health Centre	20	10/12	3/12	3/12	1/12	35.4	
AFPRC Hospital	21	0/12	0/12	5/12	2/12	14.6	
Kaur Health Centre	22	6/12	9/12	3/12	2/12	41.7	
Kuntaur Health Centre	23	6/12	8/12	1/12	2/12	35.4	
Sintet Health Centre	24	3/12	0/12	9/12	0/12	25.0	
Sulayman Junkung Hospital	25	7/12	1/12	10/12	7/12	52.1	
Kwinella Health Centre	26	3/12	7/12	10/12	11/12	64.6	
Kaiaf Health Centre	27	9/12	12/12	12/12	11/12	91.7	
Soma Major Health Centre	28	6/12	5/12	5/12	9/12	52.1	
Bureng Health Centre	29	9/12	8/12	8/12	11/12	75.0	
Pakaliba Health Centre	30	1/12	3/12	5/12	11/12	41.7	
Dankunku Health Centre	31	1/12	3/12	3/12	1/12	16.7	
Kudang Health Centre	32	5/12	7/12	9/12	11/12	66.7	
Brikamaba Health Centre	33	10/12	5/12	9/12	4/12	58.3	
Bansang Hospital	34	9/12	6/12	8/12	6/12	60.4	
Gambisara Health Centre	35	7/12	9/12	4/12	1/12	43.8	
Basse Health Centre	36	0/12	1/12	1/12	0/12	4.2	
Fatoto Health Centre	37	3/12	3/12	7/12	0/12	27.1	

APPENDIX C: FGM Register Assessment Personnel

Supervisors (Fieldwork)

1. Ousman Janneh
2. Ousainou Mbaye
3. Basiru Drammeh

Enumerators (Fieldwork)

1. Mariama Koteh
2. Amie Njie
3. Penda Jallow
4. Basiru Sarr
5. Sekou Sonko
6. Momodou Lamin S. Dibba
7. Saikou Jawara
8. Sukai Suso
9. Maja Sonko

Coders

1. Antou Faal
2. Amie Njie

Data Entry Clerks

1. Fatou Jobarteh
2. Nancy Jow
3. Bubacarr Camara
4. Ansumana Singhateh
5. Morro Sanyang

KIIs' Analysts

1. Mohammed L Janneh
2. Awa Nagib
3. Madi Mangan
4. Omar Drammeh
5. Ebrima Suso
6. Alagie Fanneh

Data Analyst

Mohammed L. Janneh

APPENDIX D: FGM Transcription Form, 2013-2016

FGM TRANSCRIPTION FORM 2013-2016 FOR THE ASSESMENT OF OBSTERIC AND FGM COMPLICATIONS UNFPA / MOHSW

Type of FGM
1 -Clitoridectomy
2 - Excision
3 - Infibulation

Supervisor Code: /_/_/_/
Enumerator Code:

H/R Code: /_/_/
H/F Code: /_/_/_/_/
Date of Collection:

									1=Normal 2=Vacuum 3=Caesarean section 4=Breech 5=Other	1=life birth 2= macerated still birth 3=fresh still birth	Complications			
Date	Serial No:	Name	ID	Address	Age	Ethnicity	Parity	FGM Type	Type of Delivery	Delivery Outcome	Obstetric	FGM	Management	Remark

Ethnicity

1=Mandinka / Jahanka 2=Fula/Tukulur/Lorobo 3=Wollof 4=Jola/Karonika 5=Sarahuli
6=Serere 7=Creole / Aku Marabout 8= Manjago 9=Bambara 10= Other

Management:

1=Suturing/repair 2=Augmentation 3= Episiotomy
4= Health education (HE) 5=Packing/pack 6=Referred 7=None 8= Refused suturing

Complications

Obstetric : 1=Haemorrhage (excessive bleeding) 2=Obstructed labour 3=Birth asphyxia 4=Tears 5=Third degree tears 6= Other
FGM: 1=Haemorrhage (excessive bleeding) 2=Tears 3= Fistula 4= Prolonged labour 5= Birth asphyxia 6= Delayed 2nd stage 7=Other

Remark:

1= Home with treatment 2= Health Education /Advice
3=Discharged against medical advice 4= Referred 5=Stable