Instructions for using the Edinburgh Postnatal Depression Scale

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All of the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. Answers must come from the mother or pregnant woman.
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgement. A careful clinical assessment should be undertaken to confirm the diagnosis.

Scoring
Questions 1, 2 and 4 (without an asterisk) are scored 0, 1, 2 or 3, with the top box scored as 0 and the bottom box scored as 3.
Questions 3, 5, 6, 7, 8, 9 and 10 (marked with an asterisk) are reverse scored, with the top box scored as 3 and the bottom box scored as 0.
The maximum possible score is 30.
Possible depression is indicated by a score of ≥ 10.
Always look at item 10 (suicidal thoughts).

2.10 Female genital cutting

Introduction
What is female genital cutting?
Female genital cutting (FGC), also known as female circumcision or female genital mutilation, refers to all procedures involving partial or total removal of the external female genitalia, or other injury to the female organs for non-therapeutic reasons. It ranges from very simple to radical, and may be carried out between birth and puberty, or can be performed just before marriage or childbirth.

FGC varies across cultures, ethnic groups and tribal affiliations; there is also some variation in the types of cutting undertaken within cultures, ethnicity and tribes. The World Health Organization has estimated that 130 million women worldwide have undergone FGC. There are an estimated 2 million infants, girls and women at risk each year.

The European Parliamentary Committee on Women’s Rights and Gender Equality states that around 500,000 women and girls living in Europe have been subjected to FGC.

A practice of performing a symbolic form of infibulation to accompany the usual ceremonies has been recently adopted in Somalia. The procedure consists of applying to the clitoris a small needle (sterile insulin needle) to obtain a drop of blood. The practice is called ‘Sunna’ and is not yet widespread in the country. It is performed only by enlightened women in that society, but hopefully it will attract others to adopt this approach while awaiting a time when all forms of this practice end.

Who performs FGC?
FGC is commonly performed by traditional medicine practitioners, including traditional birth attendants, local women or men, or female family members. Such individuals do not have formal medical training, and usually perform cutting without anaesthesia or asepsis with crude instruments such as kitchen knives or razor blades. It is not uncommon for those who perform FGC to cut or damage more of the genital area than they intended to. Increasingly, doctors are also undertaking these procedures.

The health problems associated with FGC are life-threatening haemorrhage, sometimes death during or shortly after the procedure (from haemorrhage or infection), death during pregnancy, the need for assistance during childbirth due to interference with normal delivery, and the spread of HIV/AIDS and hepatitis due to the frequent use of unclean and unsterile instruments. There are also links to mental illness in the victims and to intimate partner violence.

Prevalence of FGC
FGC is practised in about 28 countries in Africa, Asia and the Middle East. A recent interview by Integrated Regional Information Networks (IRIN) in 2012 confirmed that FGC is still being practised in Pakistan. It is estimated that at least 50–60% of Bohra women undergo FGC; this is usually a symbolic snipping of the clitoris.

<table>
<thead>
<tr>
<th>Country</th>
<th>Estimated prevalence of FGC in girls and women aged 15–49 years (%)</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>16.8</td>
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<tr>
<td>Cameroon</td>
<td>1.4</td>
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<td>Chad</td>
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<td>Djibouti</td>
<td>93.1</td>
<td>2006</td>
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<tr>
<td>Egypt</td>
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<tr>
<td>Ethiopia</td>
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<td>2005</td>
</tr>
<tr>
<td>Eritrea</td>
<td>95.0</td>
<td>1995</td>
</tr>
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</table>
### Section 2.10

<table>
<thead>
<tr>
<th>Country</th>
<th>Estimated prevalence of FGC in girls and women aged 15–49 years (%)</th>
<th>Year</th>
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</thead>
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<tr>
<td>Guinea Bissau</td>
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<td>Ghana</td>
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<td>Guinea</td>
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<td>Gambia</td>
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<td>Ivory Coast</td>
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<td>Liberia</td>
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<td>2001</td>
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<td>Mauritania</td>
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<td>Senegal</td>
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<tr>
<td>Somalia</td>
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</tr>
<tr>
<td>Sudan, northern (approximately 80% of total population in survey)</td>
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<td>2000</td>
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<td>Kenya</td>
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<td>United Republic of Tanzania</td>
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<td>Uganda</td>
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### Types of female genital cutting

The WHO has classified FGC into four types.

- **type 1**: excision of the prepuce, with or without excision of the clitoris, entirely or in part
- **type 2**: excision of the clitoris with partial or total excision of the labia minora
- **type 3**: excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (also known as infibulation). This type is most common in countries in the Horn of Africa, namely Sudan, Eritrea, Djibouti, Ethiopia and Somalia
- **type 4**: unclassified – includes pricking or incising of the clitoris or labia, cauterisation by burning of the clitoris, or introduction of corrosive substances or herbs into the vagina; sometimes the clitoris is buried rather than excised.

Around 90% of FGC is of types 1, 2 and 4, and 10% is of type 3 (infibulation). The type often varies depending on ethnicity.

The age at which FGC is undertaken varies between countries. In Ethiopia, Eritrea and Yemen most girls will have been mutilated in infancy. In Egypt, 90% are mutilated between 5 and 15 years of age.
Implications and complications of FGC

FGC is dangerous to girls’ and women’s health and psychological well-being. It can cause urological, gynaecological and obstetric problems. Around 10% of girls and women are estimated to die from the short-term complications of FGC, such as haemorrhage, shock and infection. Another 25% die in the long term as a result of recurrent urinary and vaginal infections and complications during childbirth, such as severe bleeding and obstructed labour.

Short-term complications
These include the following:
- haemorrhage and anaemia
- severe pain (it is almost always the case that no local anaesthetic is given)
- shock (due to haemorrhage and/or pain)
- death from shock (due to haemorrhage and/or pain)
- difficulty passing urine or faeces
- urinary tract infection
- urethral meatus injuries, prolonged micturition, and dysuria
- injury to adjacent tissues
- damage to other organs
- fractures or dislocation due to restraint during the procedure
- infection due to tetanus, and bloodborne viruses such as HIV and hepatitis B and C
- vulval abscess.

Long-term complications
These include the following:
- chronic pain
- chronic pelvic infection
- haematocolpos (obstruction to menstrual flow, leading to dangerous swelling of the vagina)
- keloid scarring
- decreased quality of sexual life, including pain on intercourse
- complications in pregnancy and childbirth, including obstructed labour (see below)
- psychological damage, including fear and anxiety during labour and delivery, as well as post-traumatic stress disorder and depression
- psychosexual effects; fear of and anxiety about sexual intercourse, difficulties with penetration, marital breakdown and divorce.

Complications during childbirth
Women who have undergone FGC are more likely to experience difficulties during childbirth, and their babies are more likely to die. A WHO study conducted in 2006 in six African countries showed an increased risk of possible obstetric complications in women who had been subjected to FGC compared with women who had not undergone this procedure. The same study showed an increased incidence of maternal death, Caesarean section, postpartum haemorrhage and neonatal resuscitation, as well as prolonged hospital stays, in women who had undergone FGC.

Management during pregnancy, labour and the postnatal period

Antenatal period
All women and girls who have been subjected to FGC should be identified at antenatal booking or the gynaecological clinic by asking questions such as “Have you been closed?” or “Did you have the cut or operation as a child?” Most women will then assume that you know about FGC, and further questions can be asked, such as “Do you have any problems with passing urine or menstruation?” or “How long does it take to pass urine?” Once the issue is raised, the woman may then feel comfortable discussing it further with the midwife or doctor.

Reversal of FGC (de-infibulation)
Reversal (de-infibulation) is best undertaken at 17–18 weeks’ gestation (mid-trimester) by a specialist midwife or surgeon, to enable easy access to the vaginal orifice and urethra during labour. Performing reversal in the second trimester ensures complete healing prior to labour. Reversal is not recommended in the first trimester, as the procedure may be wrongly blamed for fetal loss.

Antenatal reversal is essential to assist in vaginal examinations using a speculum, and in urinary catheterisation. It may also prevent recurrent urinary tract infection. Local anaesthesia is encouraged for reversal, but general anaesthesia may be necessary if the woman suffers from flashbacks to childhood trauma.

Post-reversal care during the antenatal period should include adequate pain relief and promotion of personal hygiene. Some re-education may be necessary, as some women will have forgotten, or may never have known, what normal micturition or menstruation is like.

Labour
The aim is a normal delivery, with Caesarean section only for the usual obstetric indications. The woman should receive standard care in labour.

If the woman has not been seen antenatally, or if she has chosen not to have reversal undertaken, an individual assessment should be made on admission in labour, regarding the need for reversal and/or episiotomy to facilitate delivery.

If she has sustained FGC type 3 (infibulation), a midline incision should be made to expose the introitus and urethra, after infiltration with 1% lignocaine. Infibulated women should have a midline incision and medio-lateral episiotomy only if necessary.

Adequate pain relief is very important, especially as flashbacks may occur.

Bladder care is very important during labour, to avoid damage to the bladder and the urethra (catheterisation is not usually necessary; encourage frequent voiding).

Care following delivery

If suturing is needed, it should occur promptly. Re-infibulation of FGC type 3 must not be carried out at this time.

If a midline incision has been made to open a type 2 or 3 FGC to enable delivery, then each side of the incision is over sewn separately on either side. In this way the FGC is ‘reversed’ and haemostasis achieved.

Postnatal period

Immediate care following delivery should include the following:
- adequate pain relief.
- perineal care
- re-education. Some women will have forgotten or will
never have known what normal micturition or menstruation is like.

Following discharge from the healthcare facility, continued support for the woman should be provided. If reversal is performed in labour, there should be a post-reversal check 4 to 6 weeks later.

If the woman has delivered a baby girl, support and information should be given, encouraging her not to inflict or allow others to inflict the same procedure on her daughter.

Safeguarding children who are at risk of FGC

- The safety and welfare of the child is paramount.
- All agencies must act in the best interests of the rights of the child as stated in the UN Convention on the Rights of the Child (1989).
- In some countries, FGC is illegal.

Laws and FGC

The following countries in Africa have issued laws against FGC, although this does not mean that the prevalence of FGC has been significantly reduced:

- Benin (2003)
- Burkina Faso (1996)
- Central Africa Republic (1966)
- Chad (2003)
- Cote d’Ivoire (1998)
- Djibouti (1994)
- Egypt (Ministerial Decree) (1996)
- Ethiopia (2004)
- Ghana (1994)
- Guinea (1965)
- Kenya (2001)
- Senegal (1999)
- Tanzania (1998)
- Togo (1998)

It is acknowledged that some families see FGC as an act of love rather than of cruelty. However, FGC causes significant harm in both the short and long term, and constitutes physical and emotional abuse of children.

All decisions or plans for the child(ren) should be based on good-quality assessments. They should be sensitive to issues of race, culture, gender, religion and sexuality, and should avoid stigmatising the child or the practising community as far as possible.

Accessible, acceptable and sensitive involvement with the health, education, police, children’s social care and voluntary-sector services may be needed.

All agencies should work in partnership with members of local communities, to empower individuals and groups to develop support networks and education programmes.

Appropriate care for women and girls who have been subjected to FGC

- Provide access to information, support and services.
- Provide care pathways and guidelines for professionals.
- Ensure that information is accurate and up to date.
- Empower women and girls and encourage them to speak out and seek help.
- Engage and mobilise all concerned, and develop an understanding of cultural diversity.
- Be open and supporting, sensitive and non-judgemental.
- Encourage alternative rites to FGC. This is a strategy that retains all of the rites of passage or initiation that the girls would traditionally undergo, except for the genital cutting. The girls are still encouraged to learn essential domestic duties that would be useful when they get married.

Conclusion

FGC is a violation of human rights. It is essential to empower women and girls, to encourage women to have a voice, and to raise awareness of the dangers of FGC. Engagement with all concerned local communities is crucial, including community and religious leaders.

As has been expressed so beautifully by Uche Umeh, ‘When culture kills, when culture silences, when culture is complicit then culture must be changed.’

It is essential to work with all professionals. We all have a duty and a responsibility to safeguard girls who are at risk of FGC, as the welfare of children is paramount.

### 2.11 Domestic/intimate partner violence and pregnancy

#### Introduction

Everyone has a fundamental right to be, and remain, safe from harm. Domestic violence, also described as intimate partner violence, is defined as ‘any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are, or have been, intimate partner or family members, regardless of gender or sexuality’. Family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or step-family.

The main characteristic of domestic violence is that the behaviour is intentional and is calculated to exercise power and control within a relationship.

Domestic violence is reported in up to one in five