

Female Genital Mutilation (FGM) Guideline

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INTRODUCTION

Female Genital Mutilation (FGM) is a practice prevalent in many African countries. As a result of the normal geographical demography of immigrants, the major cities like London have the greatest proportion of affected women. The population of Somali women is high within the Queen Charlotte's & Chelsea Hospital (QCCH) catchment area. Therefore there needs to be increased knowledge amongst the staff of the issues surrounding FGM to enable them to provide culturally aware and sensitive clinical care.

The practice became illegal in the UK in 1985, The Prohibition of Circumcision Act (1985). The law was updated in 2003 which involved an increased penalty for being involved in organisation or execution of the practice and incorporated extraterritoriality whereby it is now illegal to take a child abroad to have the procedure performed the more recent law is called the Female Genital Mutilation Act (2003).

The Royal College of Midwives (RCM, 1998), the Royal College of Nurses (RCN, 2006) and the Royal College of Obstetricians and Gynaecologists (RCOG, 1997) all have position papers on the issue.

DEFINITIONS

Female genital mutilation (FGM) has been defined as "any procedure involving partial or total removal of the external female genitalia and/or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons" (WHO, 2000)

The World Health Organisation (WHO), describe 4 classifications of FGM: -

- 1) **Type 1** – Excision of the prepuce, with or without excision of part or the entire clitoris.
- 2) **Type 2** – Excision of the clitoris with partial or total excision of the labia minora.
- 3) **Type 3** – Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening. Otherwise known as 'infibulation'. This type is most common in Somalia and Sudan
- 4) **Type 4** – Unclassified: pricking, piercing, incising, stretching, burning or cauterising of the clitoris or surrounding tissue. Scraping of the vaginal orifice or the introduction of corrosives or herbs into the, to cause bleeding or for the purpose of tightening or narrowing it. (See Fig 1)

Sometimes the clitoris is buried rather than excised (WHO, 1997).

Infibulation – Type 3 mutilation also known as 'Pharonic circumcision'

De-infibulation – Surgical procedure to open up the closed vagina of type 3 FGM

Re-infibulation – Re-suturing of type 3 FGM, illegal in the UK

Complications of FGM

Immediate complication

Haemorrhage, pain, surgical shock, infection, urine retention, injury to adjacent tissue, ulceration, HIV transmission and death.

Intermediate complications

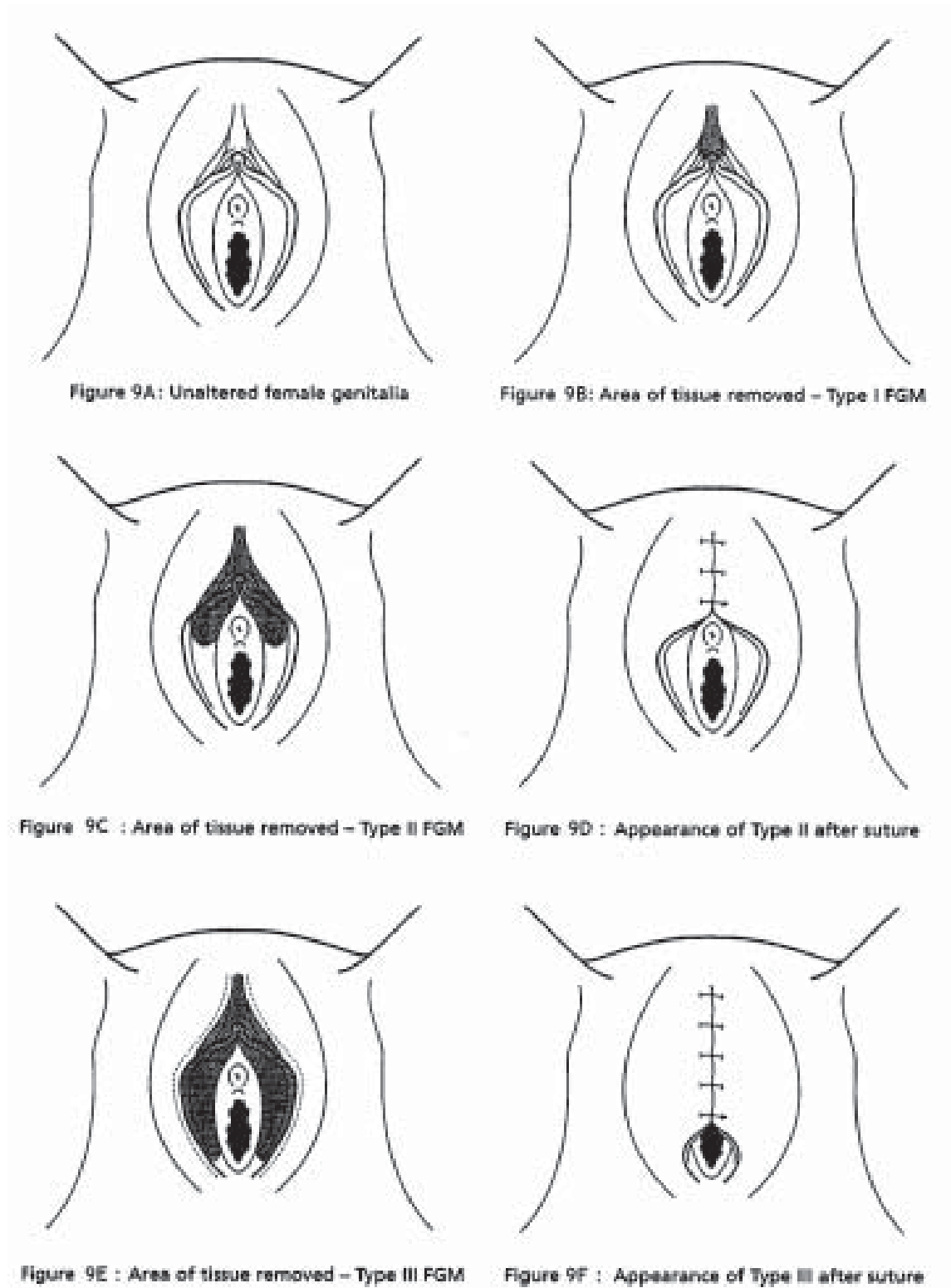
Pelvic infections, scarring/keloid formation, delayed healing, retention cyst and abscess formation, neuromata.

Long Term Complications

Recurrent urinary tract infections, painful intercourse, infertility, haematocolpos, increased maternal and fetal mortality/morbidity in childbirth, psychological problems.

Types of Female Genital Mutilation

Figure 2



SCOPE

This guideline applies to all women affected by FGM who have booked to have their baby at this Trust. It applies to all staff involved with their care.

This guideline can also be used by staff in the Gynaecology departments.

CORE ELEMENTS

The Guideline

[FGM Flowchart](#)

Psychological

It is important to note that psychological trauma and physical morbidity associated with the original act may lead to fear of childbirth; therefore any discussion needs sensitive and careful handling on the part of medical and midwifery practitioners (Birmingham Heartlands, 2004)

The original act of FGM can be carried out without explanation, analgesia, anaesthesia or qualified medical supervision. It is often performed on young girls who are being held down by female relatives. The psychological effects can be lifelong instilling fear, anxiety and depression. It is not uncommon for women to experience “flash backs” during birth. It is therefore imperative that all birth attendants are aware of this and always act always in a sensitive manner (Birmingham Heartlands, 2004)

Antenatal

The aim is to offer and carry out reversal of female genital mutilation in the second trimester to enable easy access to the vaginal orifice and urethra during labour.

Booking

Patient Identification

The GP referral letter may indicate that a woman has had FGM. These women can be sent an FGM information leaflet with their booking appointment. Those who cannot be identified from the referral letter can be given the leaflet at their first hospital appointment.

All women who go under the category of “Black African” and computer code “N” must ask whether or not they have been circumcised at their first booking appointment by the midwife taking their medical history. The following phrases can be used:

“Have you been circumcised? Are you open or closed?” or “Did you have a cut or operation (on your vagina) as a child?”

Midwives/Doctors should be aware that some women from Asia and Indonesia are also affected by this practice.

Women may not disclose this information unless actually asked. Once the question has been asked they will often feel comfortable with further discussions.

A skilled non-related interpreter may be required due to language barriers.

If the midwife taking the history does not feel confident to discuss FGM she/he should seek support and training from a colleague who is confident.

If the woman says that she has not had FGM, this should be clearly documented in her notes. No further action is needed.

If the woman discloses that she has undergone FGM, it is important for her to be examined by a competent practitioner (Doctor/Midwife), to identify:

- Whether she has already had 'reversal' of FGM
- The type of FGM
- Whether or not 'reversal' or de-infibulation is necessary.

Clear documentation should be made in the case-notes. A diagram is often helpful.

FGM type 1 and II do not usually impede labour and it is likely that no further action is necessary.

FGM type III, infibulation or an extensive type II requires de-infibulation. They should see their assigned Consultant for this procedure or should be offered an appointment with to see Miss Dhanjal, Consultant Obstetrician and Gynaecologist as soon as possible.

All women who have an FGM should be given information on the legal implications of organising or performing on female children.

Organising Reversal of Female Genital Mutilation

If the woman accepts reversal of FGM period she needs to be counselled, given full information about anaesthetic, procedure and aftercare. Local anaesthetic is adequate for some women, but others will require a spinal particularly if they suffer from flashbacks due to childhood trauma. General anaesthetic is usually reserved for non-pregnant women.

- She should be booked for the operation as a day case, preferably before 20 weeks gestation, to allow full healing prior to labour. In certain cases, reversal of FGM can be performed up to 32 weeks gestation.
- A pre-operative check list needs to be completed by the midwife.
- An interpreter should be arranged to attend on the day of her admission if necessary.
- If the client is <20 weeks gestation when the procedure is performed, she will need to attend the Gynaecology Ward.
- If she is >20weeks, she will attend the Antenatal Ward.
- She can eat a light breakfast on the day of surgery, but should be nil by mouth from 7am.
- On admission the vital signs should be recorded. The fetal heart should be auscultated with a hand held Doppler. She must be consented for the procedure.
- She should be accompanied home by a relative or friend after the procedure.
- She should be advised on hygiene and information should be given on the difference in urination and menstruation. She will usually be advised to wait for 4 weeks for healing prior to resuming sexual intercourse.
- She should be discharged with codydramol analgesia.

A post operative appointment should be organised for one week in the Antenatal Clinic to check on wound healing and for further counselling.

Labour

The main aim is to promote a normal vaginal birth and avoid caesarean section, unless otherwise indicated. If reversal has been performed antenatally, the woman is to be treated as a normal 'low risk' antenatal unless there are other problems.

Some women will decline reversal in the antenatal period. It is recommended that women, who have not been reversed, are reversed in the first stage of labour. This will allow vaginal examination and urinary catheterisation if necessary. If possible, this should be done with an epidural for analgesia.

Some women may decline reversal is declined in first stage of labour. In this instance, or if the woman arrives in advanced labour, reversal should be carried out in second stage. A midline incision to expose the urethra, following adequate infiltration with local anaesthetic (1% lidocaine), should be performed by someone experienced with the procedure. It may be a little more difficult to perform the reversal during second stage, when the fetal head is distorting/distending the area.

The ipsilateral labial edges should then be 'over sewn' to prevent them healing closed together again and to minimise bleeding.

If the woman has been informed, and consent gain, reversal should be performed in theatre if the woman requires an operative birth.

Staff should not do a medio-lateral episiotomy and leave the infibulation intact.

Postnatal Care

If the woman has had the FGM reversed during labour, she will be offered an appointment at Acton African Well Woman Clinic (AAWWC) for one week after the birth.

The woman's GP and Health Visitor should be informed. An evaluation form should be given to all the women to allow for feedback and service improvement.

Social Care

Any female infants born to mothers affected by FGM are considered to be at risk. It is important to reiterate with the family the information about the legal aspects of FGM in the UK. The Children's Act of 1989, Section 47(1) protects children thought to be at risk of FGM. The maximum sentence is 14 year imprisonment. The aim is to change attitudes within their community and protect children at risk.

It is recommended that staff should document normal female genitalia in the infant's case-notes. This information could prove important in future child protection cases. If when questioned, the woman discloses plans to have her female child mutilated. A social services referral should be made.

MONITORING / AUDIT

The FGM Working Party will be instrumental in reviewing the evaluation sheets and adjusting care accordingly.

REVIEW

The Female genital mutilation (FGM) Working Party will review these guidelines at regular intervals.

REFERENCES

Ball, T & Hughes, A. (2004) *Female Genital Mutilation Guidelines* Birmingham Heartlands Hospital Trust.

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