| **Female Genital Mutilation: Management of women who have undergone FGM** | University Hospitals of Leicester NHS Trust<br>C32/2008 |
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## Introduction and who the guideline applies to:

This guideline applies to midwives and medical staff working within the Directorate of Women's, Perinatal & Sexual Health Services who may be involved in the care of women who have undergone female genital mutilation (also known as female circumcision).

## Legal Liability (standard UHL statement):

Guidelines issued and approved by the Trust are considered to represent best practice. Staff may only exceptionally depart from any relevant Trust guidelines providing always that such departure is confined to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where, in the judgement of the responsible health professional' it is fully appropriate and justifiable – such decision to be fully recorded in the patient's notes.

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## Background:

Female genital mutilation/cutting is defined as the partial or total removal of the female external genitalia or intentional injury to the female genital organs for non-medical reasons. The WHO classification of FGM is outlined later on.

According to the World Health Organisation (WHO) Female Genital Mutilation (FGM) is practiced in approximately 30 countries in Africa, some parts of Asia and the Middle East.

In the United Kingdom it is often seen among immigrants from:

- Somalia
- Eritrea
- Mali
- Sudan
- Ethiopia
- Sierra Leone
- Nigeria

FGM is usually carried out on girls between the age of 2 and 12 years, but occasionally later before marriage. FGM is practised for a variety of complex reasons, usually in the belief that it is good for the girl and a rite of passage to womanhood. It is a deeply rooted tradition. However it has no health benefits, but to the contrary can have serious health consequences. FGM is a human rights violation and a form of child abuse.
FGM has short and long term complications and health professionals should be aware of those (8).

Short term complications:

- Haemorrhage
- Urinary retention
- Infection
- Death

Long term complications:

- Recurrent UTI's
- Dyspareunia, sexual dysfunction
- Menstrual difficulties/ dysmenorrhoea
- Genital infections, PID
- HIV, Hepatitis B
- Inclusion cysts
- Infertility
- Obstetric complications (see below)
- Psychological sequelae (anxiety, flash backs, PTSD)

## Possible complications during labour and delivery:

- Retention of urine, difficulties in catheterising
- Prolonged / obstructed labour
- Difficulty if performing vaginal examinations, hence inadequate monitoring in labour
- Increased number of episiotomies and/or perineal lacerations
- Increased incidence of postpartum haemorrhage
- Increased neonatal morbidity (because of obstructed or prolonged labour)
- Postpartum wound infections
- Maternal death from obstructed labour and postpartum haemorrhage

## Types of FGM and WHO classification:

The types of FGM vary within and between countries.

Four main types of FGM can be identified:

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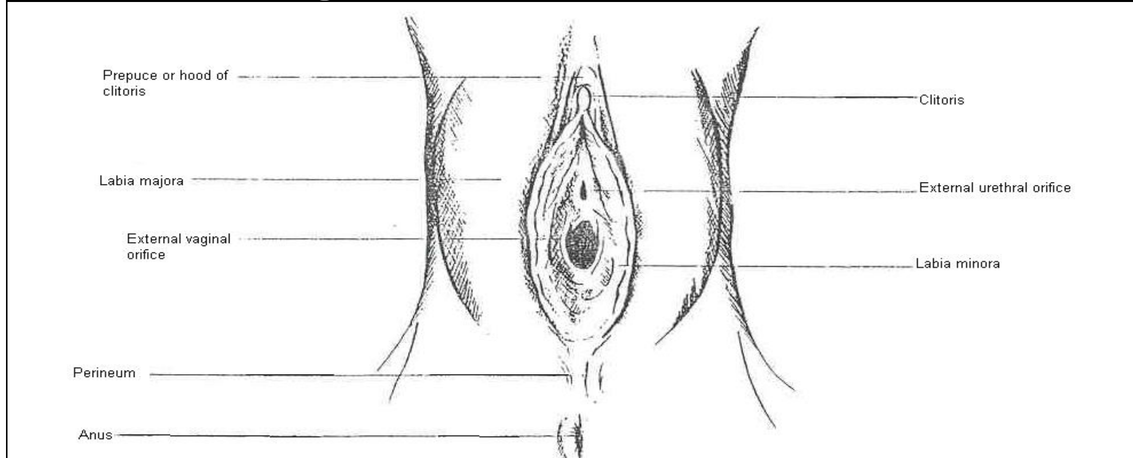
|---|---|
| **Type 1 (clitoridectomy)** | Excision of the prepuce, with or without excision of part or the entire clitoris. |
| **Type 2** | Partial or total excision of the clitoris and the labia minora, with or without excision of the labia majora. |
| **Type 3** | Excision of part or all of the external genitalia and stitching / narrowing of the vaginal opening (this is known as infibulation). |
| **Type 4** | Unclassified: Includes pricking, piercing or incising of the clitoris and / or labia; stretching of the clitoris and / or labia, cauterization by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice or cutting of the vagina to cause bleeding or for the purposes of tightening or narrowing it. |

**Type 3 has most implications on childbirth.**

## Diagram 1: Normal Female Genitalia




## Diagram 2: Types of FGM

### Type 1: Clitoridectomy

Area removed

Type 1
Clitoridectomy

### Type 2

Areas removed

Type 2

### Type 3: Infibulation

Areas removed

Stitched or closed area

Type 3
Infibulation

## 2. GUIDANCE:

### 2a) FGM and the law:

It is illegal to perform female circumcision in the UK under the Prohibition of Female Circumcision Act 1985. This has been replaced by the “Female Genital Mutilation Act 2003”. This act also states that:

- Re-infibulaltion (to close back to its original state the anterior midline incision performed during childbirth) is illegal.

It is an offence for UK nationals or permanent UK residents to carry out FGM abroad, or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where the practice is legal.

### 2b) Safeguarding

Female Genital Mutilation is usually carried out on young females between the age of infancy and 15, prior to puberty (NHS, 2016). FGM is internationally recognised as a violation of the human rights of girls and women. The maximum sentence for carrying out FGM or helping it to take place is 14 years in prison (LSCB, 2017)

The Female Genital Mutilation Act was introduced in 2003 and came into effect in March 2004. The Act:

- Makes it illegal to practice FGM in the UK;
- Makes it illegal to take girls who are British nationals or permanent residents of the UK abroad for FGM whether or not it is lawful in that country;
- Makes it illegal to aid, abet, counsel or procure the carrying out of FGM abroad;
- It is an offence for those with parental responsibility to fail to protect a girl from the risk of FGM.
- Has a penalty of up to 14 years in prison and/or a fine.

Health professionals must have a clear understanding of the law on FGM so they can explain it to their patients and understand the basis for reporting concerns to the police and/ or social care.

The Serious Crime Act 2015 reinforced existing FGM legislation and introduced mandatory reporting of FGM in girls under 18 years by healthcare workers, teachers and social workers to the police. [6]

All health professionals should be aware of the Department of Health’s guidance on FGM risk assessment and safeguarding. [7]

### 2c) Risk assessment:

If the woman is pregnant, the welfare of her unborn child or others in her extended family must be considered at this point, as these children are potentially at risk and safeguarding action must be taken accordingly. Risk Assessment Form Part One (a) Pregnant Women: Female Genital Mutilation Risk and Safeguarding. Guidance for professionals Department Health 2015 (Appendix 1) is to be completed to determine the level of risk and whether a referral to Children's Social Care is required.

However if the family are already known to social care services and FGM is known or identified within the family then the referral must be made (regardless of the outcome of the risk assessment). (LSCB, 2017)

Health professionals must be familiar with the HSCIC FGM Enhanced Dataset and explain its purpose to the woman. The requirement for her personal data to be submitted without anonymization to the HSCIC, in order to prevent duplication of data, should be explained as well as that all personal data are anonymised at the point of statistical analysis and publication.

### 2d) Antenatal management of women with FGM:

Clinical staff MUST record in the health care records at the first contact when it is identified that a woman has FGM. If it can be determined what type of FGM the woman has this also MUST be recorded or recorded as "not known" This is a mandatory requirement within the NHS.

Data will be submitted via a FGM Prevalence Dataset on a monthly basis. This is an anonymised return which will be coordinated by the central information team. To enable gathering of the data a local reporting tool is available on INsite and this is the form that should be completed. If the woman does not need to attend the clinic then it should be completed by the midwife at booking.

A safeguarding form should be completed at booking for all women with FGM.

Where a woman with FGM attends the FGM clinic the clinic specific tool should be completed by the Consultant or Midwife working within that clinic.
Where a woman attends another clinic or is being cared for within the community then the tool should be completed by the hospital Doctor / Midwife or Community Midwife.

Pregnant women with FGM should be referred to the specialist FGM clinic at LRI led by a Midwife and Consultant Obstetrician and Gynaecologist. The FGM Risk Assessment form within the hand held notes should be completed by the Midwife at booking. Women who previously had a vaginal birth or who have been defibulated or been seen in the above clinic in a previous pregnancy do not need to be referred.

All physical and psychological aspects of FGM will be addressed in the FGM clinic as well as safe guarding issues.

Psychological support should be offered to women who are psychologically traumatised.

Defibulation (reversal) and the legal situation must be discussed antenatally.
Defibulation is a minor procedure and can be performed with local anaesthetic in the FGM clinic, unless the woman expressly wishes a spinal anaesthetic.

## Defibulation:

Ideally defibulation is performed antenatally around 20 weeks. Some women do not wish to have this done antenatally in which case an intrapartum care plan needs to be made. It can also be performed at Caesarean section.

## Intrapartum Management of women with TYPE 3 FGM:

These women have to be treated sensitively, in a non-judgemental way and with respect for the cultural differences.

It is important to remember that apart from the physical and psychological trauma of the procedure they often experienced the emotional upset of migration, separation of their family and civil war.

**If the woman presents in labour, defibulation should be performed during the 1st stage unless vaginal examination and catheterisation is easily possible. In these women defibulation should be performed in 2nd stage**.

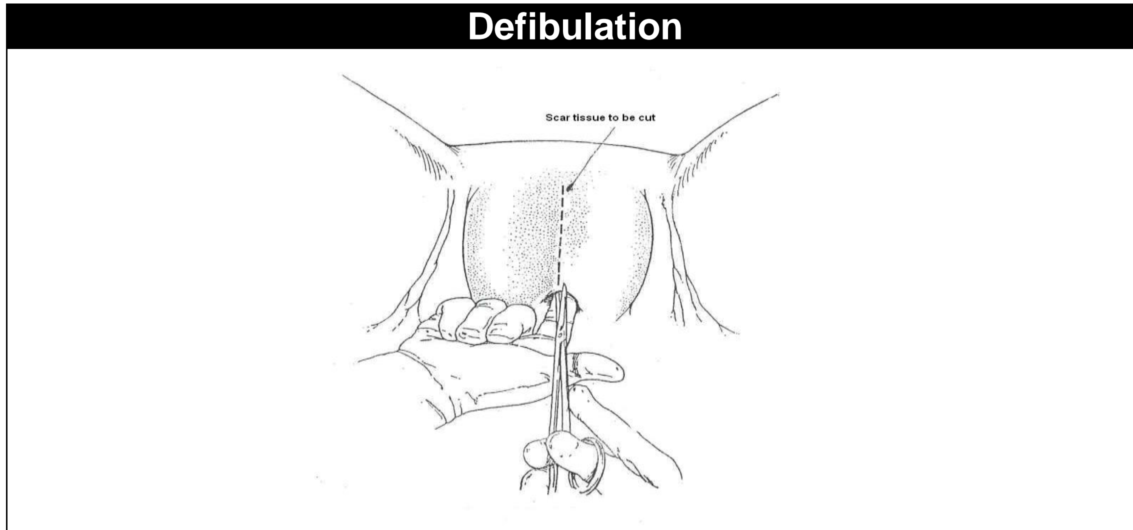
This is achieved by performing an anterior midline incision with adequate pain relief.

**Adequate pain relief is important to avoid flash-backs in some women**.

**If the woman does not want an epidural for labour, defibulation can be performed with local anaesthetic.**

## Method:

**Defibulation**

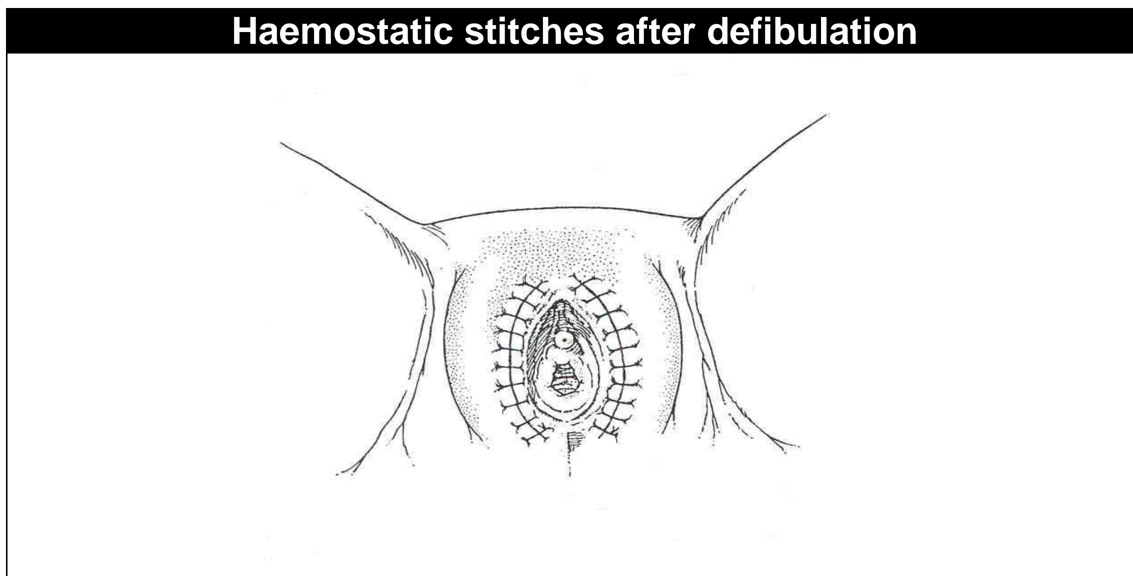



Give an anterior midline incision to expose the urethra. As with all procedures, informed consent in essential.

Following delivery, prompt assessment regarding suturing should be made. **Re-infibulation (i.e. stitching back to previous state) is illegal and MUST NOT be carried out.**

The edges of the labia should be oversewn with Vicryl Rapide 3/0. This can be done immediately, if bleeding, or after delivery.

**Haemostatic stitches after defibulation**



## Postpartum Management:

- Adequate analgesia has to be prescribed.
- Women who have had defibulation in labour a postnatal follow-up appointment should be arranged for 6 weeks in the FGM clinic at LRI.

## 2e) FGM in Non-Pregnant women

- Women may be referred by their GP or a sexual health clinic. The referral should be directed to the FGM clinic.
- Women should be able to self-refer.
- Women who are likely to benefit from de-infibulation should be counselled and offered the procedure before pregnancy, ideally before first sexual intercourse.

## References: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| DEVELOPMENT AND APPROVAL RECORD FOR THIS DOCUMENT | | |
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| **Author / Lead Officer:** | C Wiesender and A Buckley | **Job Title:** Consultant Obstetrician and Senior Midwife |
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| 9.14 | V2 | As above | Insertion of section about completion of local tool which ensures all women with FGM are on a national database |
| January 2018 | V2 | As above | General update. Clarification of roles. Risk assessment in hand held notes should be completed. |
| March 2021 | V3 | C Wiesender | Short term and long term complications added. Reformatted. References updated. Safeguarding and the law sections updated. FGM in non-pregnant women added in. |

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