

Maternity Guideline for the Care of Women who have been affected by Female Genital Mutilation

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Barking Havering & Redbridge Hospitals NHS Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

Introduction:

These guidelines have been produced to support the policy of asking **all women** at their booking appointment whether they have experienced any form of surgery to their genitals including female genital mutilation.

The World Health Organisation (WHO) defines female genital mutilation as: “all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons – WHO 2010

FGM is a form of violence against women and girls and is an abuse of human rights.

It is sometimes inappropriately referred to as Female Circumcision or Female Genital Cutting. Some communities use local names for this practice, including the term “sunna”. FGM is not a requirement of **any** religion.

The WHO classification of FGM breaks it down into four types:

Type I: Partial or total removal of the clitoris and/ or the prepuce (clitoridectomy).

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

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

Type IV: All other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterising. (NB. the legal status of piercing is unclear in the UK)

Ninety percent are either Type I, II or IV, while Type III (infibulation) is only found in 10% of known cases.

The single most important risk factor determining whether a woman undergoes a ritual procedure is her country of origin. Any woman who comes from an FGM practicing country falls within the at risk group, especially if the prevalence is high e.g. Somalia, Egypt, Sudan.

FGM is practised mainly in Africa (about 30 countries) - the majority of women from Somalia, Sudan, Ethiopia and Sierra Leone will have had some form of FGM, but it is also practised, though to a lesser extent, in the Middle East, India and Indonesia. The global incidence is 130 million with 2 million experiencing a procedure annually.

The law and FGM:

The Female Genital Mutilation Act 2003 made it illegal for UK residents (in England and Wales) and permanent residents to practice FGM within or outside in the UK (there is different legislation for Scotland). The act made also made it illegal for someone to take a British Citizen aboard to perform the operation whether or not it is against the law in that country. It is also illegal to assist in carrying out FGM abroad. The law however appears to allow surgery to the external genitalia for comfort, sexual confidence, body image and self esteem (eg. labial reduction surgery).

Antenatal Period, booking appointment and FGM enquiry:

All clinical staff should be aware of a nominated obstetrician (link-person) in the trust or community with whom cases may be discussed or referred. At BHRUT **Ms Maclaverty is the nominated obstetrician. Advice can also be sought from the consultant midwife (public health).**

Hospitals and clinics in the UK offering specialist FGM services can be found on the FORWARD internet website at:
www.forwarduk.org.uk/resources/support/well-woman-clinics

It is BHRUT maternity guidance that sensitive enquiry at the booking appointment should be made to determine the FGM status of all women.

In addition, it is essential to classify the type and severity of FGM as this will influence **maternity and obstetric care**. Twenty thousand girls in the UK are also at risk therefore child safeguarding advice should be sought for all daughters thought to be at risk (see page 8 for details on safeguarding responsibilities regarding FGM).

All women should be asked sensitively about FGM at booking and the E3 pathway should be followed. See appendix 2 for the FGM E3 pathway.

Factors to remember for the booking appointment:

- Must be in private – follow the time to talk procedure whereby the first part of the booking is undertaken with the woman on her own
- Follow the E3 FGM pathway questions
- Where a woman has a hearing impairment, or her first language is not English, arrangements should be made for an interpreter to be present. Wherever possible it should be ascertained from the woman whether the interpreter is suitable. Family members and friends should **never** be used to interpret interviews of this kind. Download face to face booking form from Intr@net (under further categories), complete and email to [#interpreting_bookings](https://twitter.com/interpreting_bookings). The three way phone may be used in circumstances where the language needs of the woman have not been recognised prior to the AN appointment or in an emergency.

If FGM is identified:

- Use a diagram or medical photography (with consent). This aids communication with the patient and other clinicians, and limits repetitive examinations
- Classify the type of FGM using a preformatted sheet with predrawn diagram (Appendix I)
- Include a psychological assessment and referral to a psychologist (via perinatal mental health team) if deemed necessary and agreed upon by the woman

Following the assessment, if a woman is a primigravida with type III FGM or it is felt that vaginal examination or delivery will be difficult or impossible she should be referred to Ms Maclaverty's antenatal clinic for consideration for antenatal deinfibulation while remaining under the care of her original midwife or obstetrician.

Antenatal deinfibulation should be offered if vaginal access is inadequate, and to all women with type III FGM. It should ideally be performed around 20 weeks gestation (reduces risk of miscarriage and allows time for healing before birth).

Benefits of antenatal deinfibulation:

- Avoids the need to cut scar tissue in labour
- Reduces excessive laceration
- Reduces the risk of fetal asphyxia due to delayed crowning at the point of delivery
- Reduces the incidence of bacterial vaginosis and associated preterm labour

Procedure for antenatal deinfibulation:

- Pre-op: MSU , Group & Save
- Setting: Minor-op Out-Patient Room or Operating Theatre
- The professional undertaking the deinfibulation must have experience
- Ensure adequate analgesia (pre & post-op)
 - usually local/ regional
 - consider psychological needs (G.A. may rarely be indicated)
- Use a blade or scissors for the procedure

- The incision should be made along the vulval excision scar until reaching the point where the urethral meatus is clearly visualised
- Closure of the newly opened edges should be brought together with fine absorbable material (Vicryl Rapide) to reduce the likelihood of infection and bleeding and to keep the opposed edges separated
- Women should be advised that the flow of urine will change as they will pass urine much quicker and with greater volume. A perceived 'lack of control' when emptying the bladder is common
- Women should drink plenty of water after the procedure to help dilute the urine and reduce stinging sensation to the area. They should not use soap or detergent (only plain water) to keep the area clean for the first 3-4 days following the procedure
- Consider prophylactic antibiotics
- Antenatal care continues as for any other woman

Intrapartum deinfibulation (offered if vaginal access is adequate)

Some women would prefer to have the procedure performed during labour (so as to experience only one lot of pain and trauma). This may be normal practice in their country of origin. Counselling by specialist FGM services may be necessary.

Intrapartum care

Potential maternal consequences of FGM:

- Fear of childbirth
- Increased likelihood of caesarean section
- Increased likelihood of postpartum haemorrhage
- Increased likelihood of episiotomy
- Increased likelihood of severe vaginal lacerations (including fistula formation)
- Extended hospital stay
- Difficulty performing vaginal examinations in labour
- Difficulty in applying fetal scalp electrode
- Difficulty in performing fetal blood sampling
- Difficulty in catheterisation of the bladder

1. When defibulation has been performed antenatally:

- Aim for vaginal birth
- Aim for intact perineum
- Episiotomy is recommended if inelastic scar tissue prevents progress
- Episiotomy when indicated should be medio-lateral

2. When no antenatal deinfibulation (unbooked or elected for intrapartum defibulation):

- Birth should be in a unit with immediate access to facilities for emergency obstetric care
- The Labour Ward Coordinator must be informed. The woman should be allocated a Senior Midwife
- Aim for vaginal birth
- Place IV Access; send FBC and Group & Save (risk of PPH)
- Provide adequate analgesia to prevent flashbacks to original procedure
- Inform Registrar (who is experienced at deinfibulation) or Consultant Obstetrician (if the Registrar does not have experience)
- Epidural should be offered, adequate pain relief is essential as vaginal examinations re poorly tolerated, for anterior episiotomy and deinfibulation, and to psychologically reduce flashbacks
- Perform deinfibulation in the first or second stage of labour
- Informed consent is essential prior to deinfibulation is essential
- Infiltrate with local anaesthetic
- Perform an anterior midline incision to expose the urethra and clitoris that are beneath the scar tissue. (If uncertain, stop when the urethral meatus is visible)
- In the 2nd stage of labour perform the incision at the time of the fetal head crowning
- Stretching the fused labia allows a good view of the fusion line and minimises blood loss
- Care must be taken to protect the fetal head from laceration

WHO recommends suturing raw edges to prevent re-infibulation

It is illegal to re-infibulate

Postnatal Care:

- Routine care
- Debrief if deinfibulation was carried out during labour
- Discuss with woman legal status of FGM in the UK (especially if baby girl or girls in the family)
- Inform Health Visitor
- Inform woman of the link between FGM, pain and health problems in later life
- If deinfibulation was carried out in labour, 4-6 week postnatal follow up recommended to assess healing (GP or hospital appointment)
- If deinfibulation was carried out in labour, advise to avoid sexual intercourse until healing has occurred and to use lubrication if necessary
- Advice / counselling may be required in relation to passing urine, menstruation, sexual health needs
- Discuss contraception, IUCD will be a method not previously available
- Cervical smear uptake should also be discussed

Safeguarding girls and FGM:

You have a statutory responsibility to safeguard girls from being abused through FGM.

FGM education information (orange FGM: the facts leaflet) www.fco.gov.uk/resources/en/pdf/travel-living-abroad/when-things-go-wrong/fgm-leaflet-100310 should be provided to all women identified as having some form of FGM through the booking appointment. The legal and safeguarding implications should be sensitively explained to women as part of the booking appointment.

If you have any safeguarding concerns regarding FGM seek advice from the safeguarding midwife, consult and follow the relevant safeguarding procedures (below) and speak with your manager.

Multi agency FGM guidelines:

www.fco.gov.uk/resources/en/pdf/travel-living-abroad/when-things-go-wrong/multi-agency-fgm-guidelines.pdf

The London Child Protection Procedures: Safeguarding Children through risk of abuse through Female Genital Mutilation:

www.londonscb.gov.uk/fgm/

References:

Momoh, C. (2003) Female Genital Mutilation also known as Female Circumcision. Information for Health Professionals. The African Well Women's Clinic at Guys and St Thomas Hospital Trust

RCM (1998) Female Genital Mutilation (Female Circumcision). Position Paper No 21. RCM. London.

Royal College of Nursing (2006) Female Genital Mutilation, An RCN educational resource for nursing and midwifery staff

Royal College of Obstetricians and Gynaecologists (2009) Female Genital Mutilation. RCOG Green-Top Guideline No 53. London.

Sosa, G Clarke, J (2004) Female Genital Mutilation. The African Well Women Clinic at the Whittington Hospital NHS Trust. A Whittington Hospital Clinical Management Guideline.

Toubia, N (1999) Caring for women with circumcision: a technical manual for health care providers. *RAINBO*.

World Health Organisation (2001) Management of pregnancy, childbirth and the postpartum period in the presence of female genital mutilation. London.

Department of Health Taskforce on the Health Aspects of Violence Against Women and Children set up a sub group on Harmful Traditional Practices and Human Trafficking.

The Royal College of Obstetricians and Gynaecologist - Female Genital Mutilation and its management:

www.rcog.org.uk/female-genital-mutilation-and-its-management-green-top-53

APPENDIX 1

Audit/Plan of care for women with FGM/C

Woman's details

DATE:
TIME:
GESTATION FIRST SEEN:

NAME:
D.O.B:
HOSPITAL NO.:
NATIONALITY:

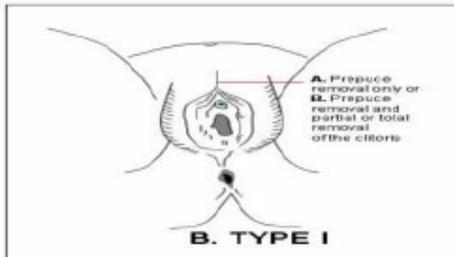
Please circle as appropriate:

SYMPTOMS

Urinary :	Recurrent urinary tract infections:	Yes / No
	Abnormal stream	Yes / No
Menstrual:	Dysmenorrhoea:	Yes / No
	Menorrhagia:	Yes / No
Sexual:	Dyspareunia:	Yes/ No
Other:	Keloid / Abscess / Vaginal infections / Chronic genital pain	

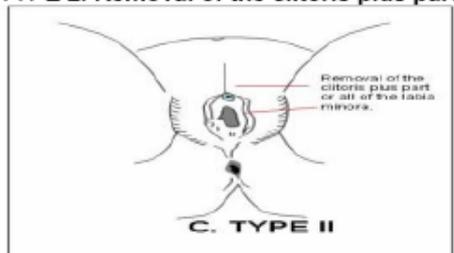
EXAMINATION FINDINGS ON INITIAL ASSESSMENT

TYPE 1: Prepuce removal only or partial or total removal of the clitoris



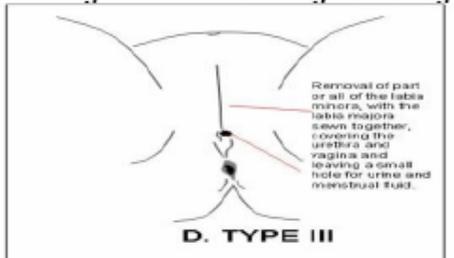
WRITE ANY COMMENTS ABOVE

TYPE 2: Removal of the clitoris plus part or all of the labia minora



WRITE ANY COMMENTS ABOVE

TYPE 3: Removal of part or all of the labia minora with the labia majora either being sewn together covering the urethra and vagina leaving only a small opening for urine and menstrual fluid



WRITE ANY COMMENTS ABOVE

CONSENT:

Informed about inability to re-infibulate ie resew after reversal: Yes/No

Sign & Print

Designation

Date

MANAGEMENT (circle as appropriate)

Reversal (De-infibulation): Antenatal / Labour 1st Stage / Labour 2nd Stage:

Antenatal reversal booked: Yes/No Gest.....wks

Details of booking: Date: ____ / ____ / ____

Place: In room / Theatre

Preference: LA/Spinal

Labour recommendation:

1. Manage labour as normal	Yes / No
2. Inform Registrar (with experience)/Consultant	Yes / No
3. Reversal in labour (anterior midline)	Yes / No
4. Cannulate	Yes/ No
5. Group & Save	Yes/ No

REVERSAL:

Operator (Name & Grade): _____ (Cons / SpR / SHO/ Midwife)

Assistant (Name & Grade): _____ (Cons / SpR / SHO/ Midwife)

Incision: Anterior midline / Other _____

Repair edges: Interrupted / Continuous / Other _____

Suture materials: Vicryl-rapide / Vicryl / Other _____

Anaesthesia/Analgesia: Local / Pudendal block / Regional / Entonox / None

Antibiotics Yes/No

TTA: Codydramol / Paracetamol / Other _____

FOLLOW-UP: Yes / No

Antenatal clinic appointment: Date: ____ / ____ / ____

Other: _____

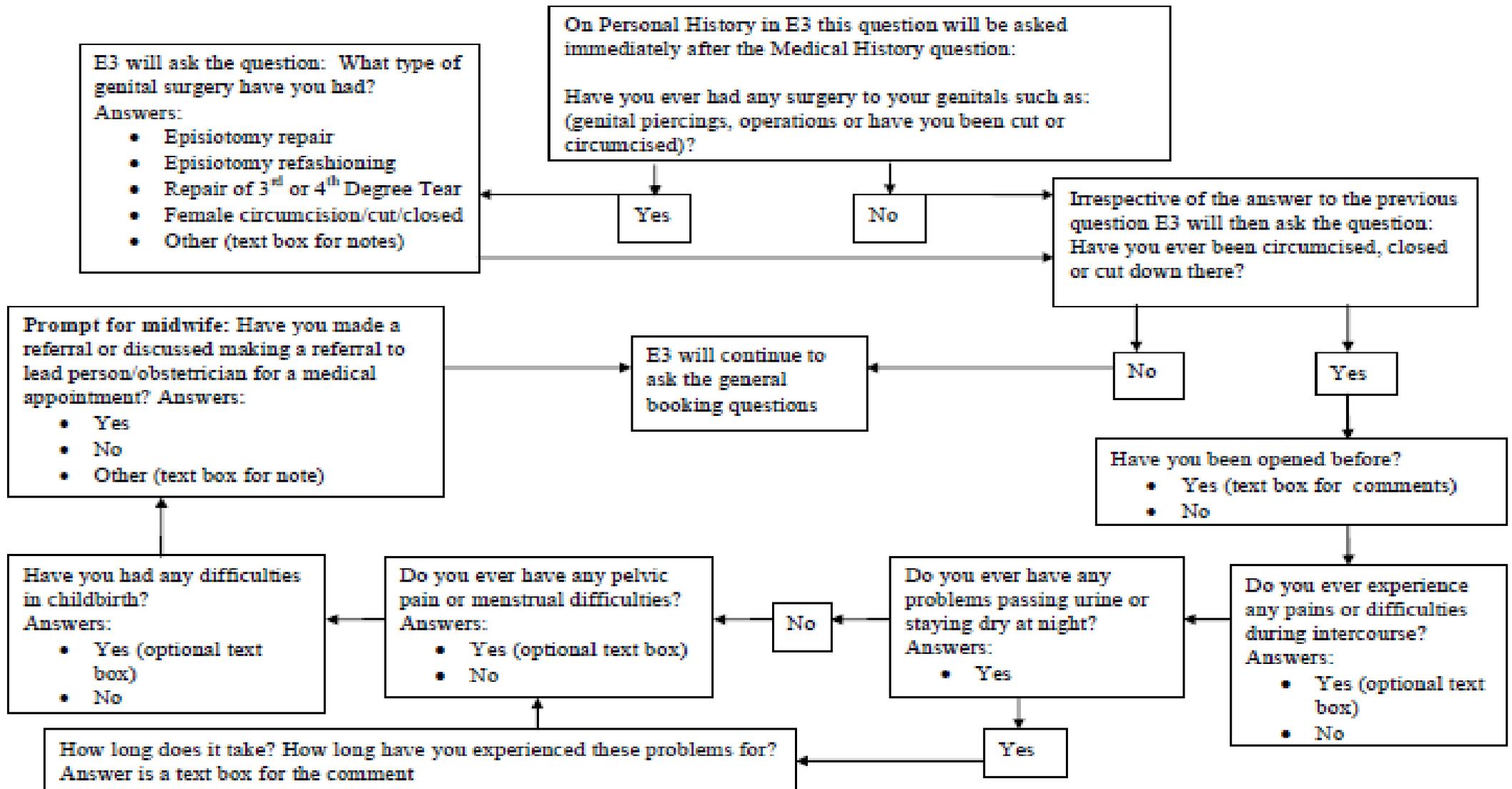
Sign & Print

Designation

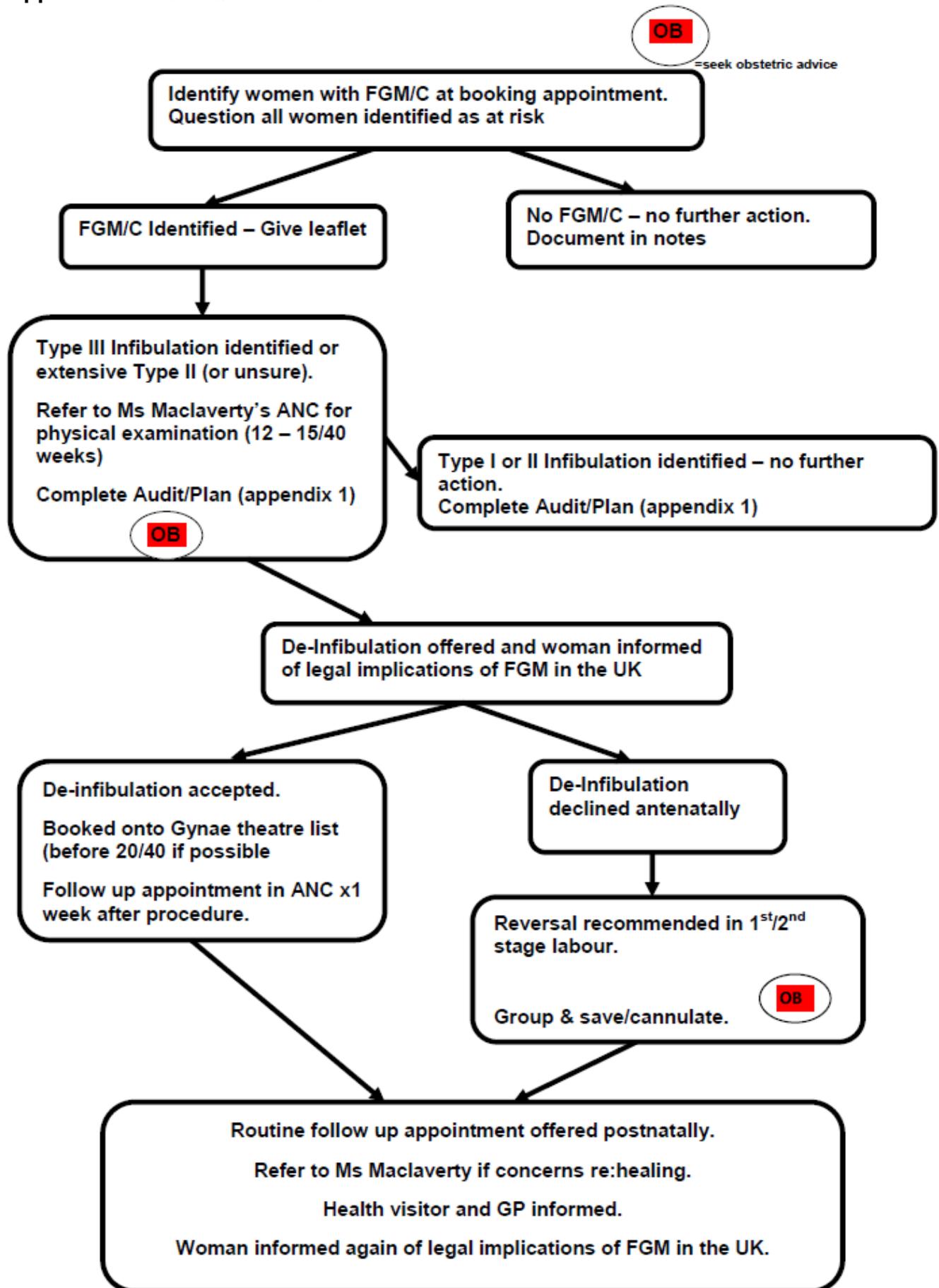
Date

Appendix 2 - FGM E3 Pathway

E3 Flow Chart for Female Genital Mutilation



Appendix 3 - FGM Quick Reference Guide



Appendix 4

Female Genital Mutilation resources and information:

- Clinical guidelines
The Royal College of Obstetricians and Gynaecologist - Female Genital Mutilation and its management:
www.rcog.org.uk/female-genital-mutilation-and-its-management-green-top-53
- Weblink to Foreign and Commonwealth Office FGM page
www.fco.gov.uk/en/travel-and-living-abroad/when-things-go-wrong/fgm/
- Link to multi agency FGM guidelines
www.fco.gov.uk/resources/en/pdf/travel-living-abroad/when-things-go-wrong/multi-agency-fgm-guidelines.pdf
- Weblink to FCO FGM information leaflet
www.fco.gov.uk/resources/en/pdf/travel-living-abroad/when-things-go-wrong/fgm-leaflet-100310
- FGM national clinical group
www.fgmnationalgroup.org/index.htm
- Contact details for specialist FGM support services
www.forwarduk.org.uk/resources/support

Sources of support and advice on FGM:

If you have a concern about FGM happening to someone contact the police as FGM is a crime www.met.police.uk/local/ or contact Metropolitan Police Child Abuse Investigation Command/Project Azure 0207 161 2888, who deal with FGM involving children as this against the law and is a form of child abuse www.met.police.uk/scd/specialist_units/fgm_reward.htm

Advice and Brief Intervention Team (ABIT) 0844 600 1018 provide a range of therapies to people over 18 (you don't have to go through your GP)
abit@nelft.nhs.uk

Black Women's Health and Family Support 020 8980 3503, provides information and support to women and communities affected by FGM
www.bwhafs.com

FORWARD 020 8960 4000, work to improve the health, wellbeing and rights of African women and girls www.forwarduk.org.uk

FGM Foreign and Commonwealth Office 0207 008 1500
www.fco.gov.uk/en/travel-and-living-abroad/when-things-go-wrong/fgm/
fgm@fco.gov.uk

Childline 0800 1111 www.childline.org.uk

The NSPCC Child Protection Helpline 0808 800 5000 , text 88858 (24 hours a day, 7 days a week, 365 days a year it's free and you don't have to say who you are), a service for adults who are concerned about the safety or welfare of a child. They provide advice and support, and can take action on your behalf www.nspcc.org.uk/helpline

Forced Marriage Unit 020 7008 0151 www.fco.gov.uk/en/travel-and-living-abroad/when-things-go-wrong/forced-marriage/

Afruca: Africans unite against Child Abuse 020 7704 2261 info@afruka.org
www.afruca.org

Contact details for children and adult social care teams:

Children's Social Care

Barking & Dagenham Children's Services Duty Team

Office hours 020 8227 3852, 3882, 3860 / Out of Hours 020 8215 3024
www.lbbd.gov.uk/ChildrenAndYoungPeople/ChildProtection/Pages/Home.aspx

Havering Children's Services Duty Team

Office hours 01708 433222 / Out of hours 01708 433999
email: duty-referral@haverling.gov.uk

Redbridge Children's Services Duty Team

Office hours 0208 708 3781 Out of hours 0208 553 5825
www.redbridge.gov.uk/cms/benefits_care_and_health/children_and_families/protecting_and_safeguarding.aspx

Waltham Forest Direct (ask for Children's Safeguarding and Protection Service - Referral & Assessment Services)

Office and out of hours 020 8496 3000
www.walthamforest.gov.uk/index/care/childrenandfamilies/childprotect.htm

Safeguarding Adults

Barking & Dagenham Adult Services Duty Team

Office hours 0208 227 2915 / Out of hours 0208 594 8356

Barking and Dagenham Safeguarding Adults Team

Office hours 0208 724 8863, 8858, 8860, 8859

www.barking-dagenham.gov.uk/AdultSocialCare/SafeguardingAdults/Pages/Team.aspx

Havering Adult Services Duty Team

Office hours 01708 432000 or 01798 433550 / Out of hours 01708 433999
www.havering.gov.uk/Pages/Safeguardingvulnerableadults.aspx

Redbridge Adult Services Duty Team

Office hours 0208 708 7333 Out of hours 0208 553 5825
www.redbridge.gov.uk/cms/benefits_care_and_health/adult_social_services/services_and_support/safeguarding_adults_at_risk.aspx

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Waltham Forest

Office hours 020 8496 3497 or 020 8496 3459
www.walthamforest.gov.uk/index/care/adults-and-older-people/adultprotect.htm

BHRUT Safeguarding Team

01708503892 or 01708 435000 & ask for Dect 6322)

Appendix 5

Table 1 shows the prevalence and type of FGM by country.

Country	Prevalence	Type of FGM performed
Most reliable estimates		
Burkina Faso	72%	Type II
Central African republic	43%	Types I & II
Cote d'Ivoire	43%	Type II
Egypt	97%	Type I (17%) Type II (72%) Type III (9%)
Eritrea	95%	Type I (64%) Type II (4%) Type III (34%)
Guinea	99%	Type II
Kenya	38%	Type I & II Type III practiced in eastern regions
Mali	94%	Type I (52%) Type II (47%), Type III in southern Mali (1%)
Niger	5%	Type II
Nigeria	25%	Type I Type II predominant in south Type III only in north
Somalia	98-100%	Type III
Sudan	89%	Type I (15%) Type II (3%) Type III (82%)
Tanzania	18%	Type I & II
Togo	12%	Type II
Yemen	23%	No data
Other estimates		
Benin	50%	Type II
Chad	60%	Type II Type III only in the north
Ethiopia	85%	Types I & II Type III in regions bordering Sudan and Somalia
Gambia	80%	Type II
Ghana	30%	Type II
Liberia	60%	Type II
Senegal	20%	Type II
Sierra Leone	90%	Type II
Questionable estimates		
Cameroon	20%	Type I & II
Dem Rep Congo	5%	Type II
Djibouti	96%	Type II & III
Guinea-Bissau	50%	Types I & II
Mauritania	25%	Types I & II
Uganda	5%	Types I & II

(Table 1 - adapted from WHO, 2008 & Lovell, 2000)

Table 2 – Maternities to women affected by FGM

Despite the difficulties to obtain accurate figures on the prevalence of FGM in the local community the table below shows the estimated number of maternities to women with FGM and percentage of all maternities to women with FGM (2001 – 2004).

Area	2001 number	%	2002 Number	%	2003 Number	%	2004 Number	%	Total Number
Barking and Dagenham	82	3.42	100	4.15	122	4.74	167	6.8	471
Redbridge	103	3.33	114	3.56	125	3.73	156	4.51	498
Havering	6	0.26	8	0.36	15	0.64	17	0.67	47

(Table 2 - taken from - A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales Summary Report, Forward 2007)