

1 ANTEPARTUM CARE

1.3 FEMALE GENITAL MUTILATION

Date Issued: December 2008
Date Revised: September 2011
Review Date: September 2014
Authorised by: OGCCU
Review Team: OGCCU

1.3 FGM
Section B
Clinical Guidelines
King Edward Memorial Hospital
Perth Western Australia

1.3 FEMALE GENITAL MUTILATION

BACKGROUND INFORMATION

The World Health Organisation (WHO) defines Female genital Mutilation (FGM) as “all procedures involving partial or total removal of the female external genitalia, or other injury to the female genital organs for non-medical purposes”.¹ It estimates that there are approximately 130-140 million women have undergone FGM²; commonly performed between the ages of 4 to 10 years.³ In some communities the procedure is performed just before marriage³, during pregnancy, or post birth.⁴

The motivation for communities to practice FGM varies widely but includes psychosexual and sociological reasons, hygiene and aesthetic reasons, myths and religious beliefs.³

FGM is illegal in Western Australia. The WA Criminal Code amendment bill came into effect in 2004 identifying FGM as a crime, and states “a person performing FGM or taking a person from WA for the purpose of subjecting a child to FGM is liable for imprisonment”.⁵

Type I, type II and type IV FGM account for approximately 90% of all cases, and the remaining 10% are classified as type III.⁴ A recent study has revealed that women with FGM are at higher risk for caesarean section, postpartum haemorrhage (PPH), episiotomies, longer hospital stays, increased resuscitation of the infant, and inpatient perinatal death.⁶ Women with type 1 and II FGM are unlikely to experience antepartum, intrapartum or postpartum difficulties unless there is significant scarring because a large amount of tissue has been removed, but type III usually leads to complications due to the narrow introitus.⁷

KEY POINTS

- If deinfibulation is likely to be necessary for childbirth, it is usually performed just prior to birth, but may be performed late in the second trimester.⁹
- KEMH is prevented by law (Criminal Code Amendment Bill 2003) from resuturing the FGM closed (re-infibulation). A woman with FGM should be advised of this legislation during the antenatal period.

COMMUNITIES PRACTICING FGM

- Western, eastern and north-eastern regions of Africa²
- Some countries in Asia²
- Some countries in the Middle-east²

Type 1 FGM is more commonly performed in Ethiopia, Eritrea and Nigeria.⁷

Type II FGM is performed mainly in Sierra Leone, Gambia and Guinea.⁷

Type III FGM is predominantly performed in Somalia and Northern Sudan,⁷ Djibouti, parts of Egypt, Ethiopia, Eritrea, Kenya, Mali, Mauritania, Niger and Senegal.⁵

CLASSIFICATION OF FGM¹

Type 1 – Partial or total removal of the clitoris and/or the prepuce.

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

Type III – 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 (infibulation).

Type IV – All other harmful procedures to the female genitalia for non-medical purposes e.g. pricking, piercing, incising, scraping and cauterization.

COMPLICATIONS OF FGM

ACUTE COMPLICATIONS

Severe pain²

Shock²

Haemorrhage²

Sepsis or tetanus²

Urinary retention²

Injury to nearby genital tissue²

Bony fractures³

LONG-TERM COMPLICATIONS

Bladder dysfunction and urinary tract infections^{2, 3}

Infertility^{2, 3}

Cysts²

Increased risk for obstetric complications^{2, 3}

Increased uro-gynaecological surgical procedures²

Abscess and fistula formation³

Chronic pelvic infections³

Keloid scar formation³

Sexual dysfunction³

Recurrent vaginal infections³

Psychological disorder e.g. post traumatic stress

ANTENATAL MANAGEMENT

1. Provide a culturally sensitive environment when discussing FGM e.g. female interpreters and the presence of a female midwife/doctor during examination when possible.
2. All women from high risk areas practicing FGM should be assessed for FGM at the booking visit by asking whether they have been cut or circumcised.
3. Women who disclose they have FGM, or are unsure if they have had FGM performed should have an inspection of the genitalia early in the antenatal period to determine the type.
4. Women attending a midwives clinic at the booking visit with FGM should have the antenatal visit at 24 weeks gestation with the obstetric team. If a woman attends late for the booking visit the next appointment should be made with the obstetric team to provide counselling and have a management plan formulated and documented on the MR004.
5. Women who are considered to have an inadequate vaginal introitus for childbirth may be offered the option of antenatal de-infibulation late in the second trimester³ after consultation with the team consultant. It is essential that the woman's husband or partner is involved in the discussions. If de-infibulation is performed the woman should be warned about voiding

changes that may result i.e. a direct stream of urine rather than dribbling, and also of sexual changes⁹.

6. During the antenatal period discussion should include:
 - potential difficulty in performing vaginal examination in some women¹⁰
 - the possible need for an anterior episiotomy and/or a medio-lateral posterior episiotomy¹⁰ Advise the woman that anterior episiotomy or deinfibulation will normally be required during birth (usually with Type III).⁹
 - bladder management¹⁰
 - increase risk for urinary tract infections¹⁰
 - application of a fetal scalp electrode when required¹⁰
 - risk for spontaneous laceration¹⁰
 - delay in the second stage of labour¹⁰
7. When speculum examination is performed the size of the speculum is determined by the size of the introitus. Consider the use of a paediatric speculum.^{3,7}

INTRAPARTUM MANAGEMENT

PERFORMING AN ANTERIOR EPISIOTOMY

When an anterior episiotomy is required it should be performed before the presenting part distends the perineum.⁹ The timing to perform an anterior episiotomy may be determined by the ability to perform procedures e.g. catheterisations and vaginal examinations. The decision to perform an early anterior episiotomy earlier in labour shall be done in consultation with the medical team.

An anterior episiotomy shall be performed by midwifery or medical personnel familiar with the procedure, or by an accoucheur supervised by personnel competent in performing the procedure.

1. Gently lift the skin flap with a pair of forceps or fingers.
2. Infiltrate with local anaesthetic along the midline where the anterior episiotomy is to be performed, and also either side in a fan shape. Allow time for local anaesthesia to take effect.⁹
3. Assess the length of the incision by inserting a finger under the skin flap when possible. If not possible use a pair of forceps to guide the posterior blade of the Mayo scissors carefully avoiding the urethral meatus.⁹
4. Perform an anterior incision along the centre of the skin flap until the urethral meatus can be visualised and the anterior flap is opened completely.⁹
5. Apply gentle pressure to control any bleeding.⁹
6. Assess to see if a mediolateral episiotomy is also required.⁹
7. After the birth the skin edges are apposed with fine interrupted sutures or continuous subcuticular suture.⁹
8. For repair of a mediolateral episiotomy see Clinical Guideline [Section B 5.15.1 Suturing an Episiotomy / Genital laceration](#)
9. Provide advice regarding vulval/ perineal hygiene and healing.⁹

POSTPARTUM MANAGEMENT

1. Monitor the urine output. See Clinical Guideline [Section B 6.2.2.2.1 Bladder care](#)
2. Advise the woman who has had an anterior episiotomy of changes in the voiding stream.⁹
3. Parents with the birth of a girl should be advised of the legal implications regarding FGM in Western Australia.

REFERENCES

1. World Health Organisation. Classification of female genital mutilation. 2008 [cited; **Available from:** <http://www.who.int/reproductive-health/fgm/terminology.htm>
2. World Health Organisation. Female genital mutilation. Fact sheet 241 2008 [cited; **Available from:** <http://www.who.int/mediacentre/factsheets/fs241/en/>
3. Braddy CM, Files JA. Female Genital Mutilation: Cultural Awareness and Clinical Considerations. **Journal of Midwifery & Women's Health**. 2007;52(2):158-63.
4. World Health Organisation. Female Genital Mutilation (FGM). Prevalence and age. 2008 [cited; **Available from:** <http://www.who.int/reproductive-health/fgm/prevalence.htm>
5. Women's Health Policy Unit. **Female Genital Mutilation (FGM). Educational brochure**. Perth: Department Health Western Australia; 2007.
6. WHO study group. Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries. **Lancet**. 2006;367:1835-41.
7. Nour NM. Female genital cutting: Clinical and Cultural Guidelines. **Obstetrical and Gynecological Survey**. 2004;59(4):272-79.
8. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. Female genital mutilation/cutting. **College Statement No C-Gyn 1**. 2010.
9. Jenkins G, Nanayakkara S. Female genital mutilation. **O & G Magazine**. 2008;10(2):29-32.
10. Royal College of Obstetricians and Gynaecologists. Female Genital Mutilation. **Green Top Statement No 53**. 2009.