



ANTEPARTUM CARE

FEMALE GENITAL MUTILATION (FGM)

Keywords: FGM, deinfibulation, traditional female surgery, female cutting, female circumcision

AIM

- To guide [antenatal](#), [intrapartum](#) and [postnatal](#) management of a women with FGM.

KEY POINTS

- If deinfibulation is required to facilitate 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 re-suturing the FGM closed (re-infibulation).^{1,2} A woman with FGM should be advised of this legislation during the antenatal period.

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”.³ The WHO estimates there are more than 125 million girls and women who have undergone FGM;⁴ commonly performed between the ages of 4 to 10 years.⁵ In some communities the procedure is performed just before marriage⁵, during pregnancy, or post birth.⁶

The motivation for communities to practice FGM varies widely but includes psychosexual and sociological reasons, hygiene and aesthetic reasons, and myths,³ and it is a practice that is deeply entrenched in cultural heritage and traditions. It is also important to note that FGM is associated with gender based violence and family and domestic violence.

FGM is illegal in Western Australia.⁷ 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”.⁸ RANZCOG condemns the practice of FGM as a violation of the human rights of girls and women.⁷

Type I, type II and type IV FGM account for approximately 90% of all cases, with the remaining 10% classified as type III.⁶ A recent study 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.⁹ Women with type I and II FGM are unlikely to experience antepartum, intrapartum or postpartum difficulties unless there is significant scarring. Type III usually leads to complications due to narrowing of the introitus.¹⁰

COMMUNITIES PRACTICING FGM

- Western, eastern and north-eastern regions of Africa^{4,7}
- Some countries in Asia and the Middle-East^{4,7}
- Type I FGM is more commonly performed in Ethiopia, Eritrea and Nigeria.¹⁰
- Type II FGM is performed mainly in Sierra Leone, Gambia and Guinea.¹⁰

- Type III FGM is predominantly performed in Somalia and Northern Sudan,¹⁰ Djibouti, parts of Egypt, Ethiopia, Eritrea, Kenya, Mali, Mauritania, Niger and Senegal.⁸

CLASSIFICATION OF FGM³

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

There are no known positive health benefits associated with FGM.⁷ Women who present with complications should receive care that is culturally responsive and non-judgmental.⁷ Referral to Psychological Services or counselling may be required depending on the individual clinical situation.⁷

Acute complications

- Severe pain^{4, 11}
- Shock⁴
- Haemorrhage^{4, 11, 12}
- Infection¹²; Sepsis or tetanus^{4, 11}
- Urinary retention^{4, 11}
- Bony fractures⁵
- Injury to nearby genital tissue⁴
- Death^{11, 12}
- Hepatitis and HIV¹¹

Long-term complications

- Bladder dysfunction and urinary tract infections^{4, 5, 7}
- Chronic localised neuropathic pain⁷
- Menstrual problems (e.g. retained menstrual clots)⁷
- Infertility^{4, 5} & Increased risk for obstetric complications^{4, 5}
- Increased uro-gynaecological surgical procedures⁴
- Difficulty with minor gynaecological procedures (e.g. Pap smear)⁷
- Abscess and fistula formation⁵
- Chronic pelvic infections⁵
- Sexual dysfunction^{5, 7}
- Recurrent vaginal infections^{5, 7}
- Keloid scar formation^{5, 7} and Cysts^{4, 7, 11}
- Psychological disorders e.g. post traumatic stress,¹¹ anxiety, depression⁷

IDENTIFYING A CHILD AT RISK OF FGM²

- Any female born to a woman, or who has sisters who have been subjected to FGM must be considered at risk, as must other female children within the extended family.

- Although FGM is performed at any age, the majority of FGM appears to take place between the ages of 5 to 8 years. Girls within that age bracket would therefore be at higher risk.
- The specific age FGM was performed for each female member should be recorded as a reference to identifying the risk period for unaffected females within the family.
- Those families less integrated into the community or where children or mothers have limited contact outside the immediate family, and have limited access to information on FGM are more likely to be subjected to FGM.

ANTENATAL MANAGEMENT

1. Provide a culturally sensitive environment when discussing FGM e.g. the presence of a female midwife/doctor during examination when possible. It is recommended that a female interpreter be engaged.
2. All women are asked at booking visit if they or any family members have been “knicked”, cut or circumcised.
3. Document in Women’s Pregnancy Record and patients notes including special instruction sheet.
4. All women who have been identified with FGM are referred to Social Work to discuss Australian legal requirements.
5. Women who disclose FGM, or are unsure if FGM was performed should have an inspection of the genitalia early in the antenatal period to determine the type.
6. Women attending a midwives clinic at the booking visit with FGM should have the antenatal visit at 24 weeks gestation with the medical staff. If a woman attends late for the booking visit the next appointment should be made with the medical staff to formulate a management plan and to provide counselling. Documentation for this visit is recorded on the MR004.
7. 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 trimester⁷ 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 changes.¹³
8. During the antenatal period discussion should include FGM maternal consequences, such as:
 - potential difficulty in performing vaginal examination in some women¹¹
 - the possible need for an anterior episiotomy and/or a medio-lateral posterior episiotomy¹¹ Advise the woman that anterior episiotomy or de-infibulation will normally be required during birth (usually with Type III).¹³
 - bladder management and increase risk for urinary tract infections¹¹
 - difficult application of a fetal scalp electrode or fetal blood sampling, when required¹¹
 - risk for spontaneous laceration, including possible fistula formation¹¹
 - delay in the second stage of labour.¹¹

9. 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.^{5, 10}

INTRAPARTUM MANAGEMENT

Intrapartum epidural can be offered to women who find vaginal examinations difficult to tolerate.¹¹

PERFORMING AN ANTERIOR EPISIOTOMY

When an anterior episiotomy is required it should be performed before the presenting part distends the perineum.¹³ 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 and either side of the fan shape. Allow time for local anaesthesia to take effect.¹³
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.¹³
4. Perform an anterior incision along the midline of the skin flap until the urethral meatus can be visualised and the anterior flap is opened completely.¹³
5. Apply gentle pressure to control any bleeding.¹³
6. Assess to see if a mediolateral episiotomy is also required.¹³
7. After the birth the skin edges are apposed with fine interrupted sutures or a continuous subcuticular suture.¹³
8. For repair of a mediolateral episiotomy see Clinical Guideline [Suturing an Episiotomy / Genital laceration](#)
9. Provide advice regarding vulval/ perineal hygiene and healing.¹³

POSTPARTUM MANAGEMENT

1. Monitor the urine output. See Clinical Guideline [Bladder care](#)
2. Advise the woman who has had an anterior episiotomy of changes in the voiding stream.¹³
3. Parents, with the birth of a girl, should be advised of the legal implications regarding FGM in Western Australia (WA) and throughout Australia.
 - This should include advising that FGM is illegal, and that a person who takes a child or arranges for a child to be taken from WA with the intention of having them subjected to FGM is liable to imprisonment for 10 years. Additionally, a person who performs FGM on another person is guilty of a crime and liable to imprisonment for 20 years, and it is not a

defence that the person or their parent or guardian consented to the mutilation.¹⁴

- When a child is at risk of being subjected to FGM (e.g. a female born to a woman with FGM or who has sisters with FGM), information on health issues associated with FGM should be provided to parents.²
- A health professional who suspects a person has been subjected to FGM in Australia should contact [Legal and Legislative Services](#) for information.¹⁵
- Women should be seen by a Social Worker prior to discharge.
- Document in STORK- free text in Child Health and Discharge summary.

REFERENCES (STANDARDS)

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National Standards – 1- Care provided by the clinical workforce is guided by current best practice

Legislation - [Criminal Code Amendment Bill 2003](#) (Section 306)

Related Policies -

Other related documents –

- Clinical Guideline [Suturing an Episiotomy / Genital laceration](#)
- [WNHS FGM e-Learning package](#)
- [United Nations Convention on the Rights of the Child](#) (1989) (articles 19, 24 and 34)
- [Convention on the Elimination of All Forms of Discrimination against Women](#) (1979) (articles 1, 2, 5 and 12)

RESPONSIBILITY

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