



FEMALE GENITAL MUTILATION AND ITS MANAGEMENT

This Guideline, published as an RCOG Statement in 2003 under the same title, has been revised as a Green-top Guideline.

1 Background and introduction

1.1 Definition

Female genital mutilation is defined as all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs, whether for cultural or other non-therapeutic reasons.

There are controversies over the use of the term 'mutilation'. According to a joint WHO/UNICEF/UNFPA statement, the use of the word mutilation reinforces the idea that this practice is a violation of the human rights of girls and women and thereby helps to promote national and international advocacy towards its abandonment. They also state that, at the community and individual level, the term can be problematic. In this spirit, in 1999, the UN Special Reporter on Traditional Practices called for tact when dealing with individual patients and suggests that the term 'cutting' may be more acceptable.

1.2 UK law

The 1985 Act states that it is an offence for any person:

- (a) to excise, infibulate or otherwise mutilate the whole or any part of the labia majora or clitoris of another person; or
- (b) to aid, abet, counsel or procure the performance by another person of any of those acts on that other person's own body.¹

The Female Genital Mutilation Act 2003 made the penalty for a person found guilty of an offence under the Act a prison sentence of up to 14 years.² No offence is committed if the cutting takes place while a woman is giving birth, provided that the purpose is connected with the labour or birth.

Female genital mutilation is prohibited by law in England, Scotland and Wales, whether it is committed against a UK national or permanent UK resident in the UK or abroad. Female genital mutilation is an abuse of human rights and is also a child protection issue.

Currently, the law prohibits the cutting of a woman's labia if the request is driven by tradition or ritual but it appears to allow surgery to the external genitalia for comfort, sexual confidence, body image and self-esteem. Parliament has derogated the responsibility of interpretation of the Act, in the first instance at least, to the medical profession. Parliament (and society) expects doctors to act in good faith in accordance with the law and to provide wise and judicious counsel to women. Practitioners should seek ethical and/or legal guidance for the care of individual women if there is any doubt.

Table 1 – Classification of types of female genital mutilation procedures (WHO)

Type	Definition
I	Partial or total removal of the clitoris and/or the prepuce (clitoridectomy)
II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision)
III	Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation)
IV	All other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, ^a incising, scraping and cauterising

^a *Piercing is part of this WHO classification but the legal status of this is unclear in the UK

1.3 Prevalence and geographical variation

It is estimated by the World Health Organization (WHO) that 130 million women worldwide have undergone genital mutilation and that some two million women undergo some form of genital mutilation annually.³ Traditionally, female genital mutilation is practised mainly in Africa but it is also found, to a lesser extent, in India and Indonesia. With increasing migration, obstetricians, gynaecologists and midwives in other parts of the world are encountering this practice and its complications (both acute and chronic), with increasing frequency. Within these countries, genital mutilation is not limited to any cultural or religious group.

The type of mutilation varies within and between countries.^{3,4} The prevalence and type of mutilation by country is shown in Appendix 1. Recognition of the different types of mutilation is essential, as the complications differ in type and severity, this being particularly relevant to obstetric practice. Current estimates indicate that, worldwide, 90% of female genital mutilation cases include type I, II and IV. Type III procedures account for the remaining 10% (Table 1).⁵

The single most important risk factor determining whether a woman undergoes a ritual procedure is her country of origin. Any woman who comes from a country which practises female genital mutilation falls within the at-risk group, especially if the prevalence is high; for example, in Somalia, Egypt and Sudan. Sensitive enquiry must be made in to the mutilation status of **all women** identified as at risk.

2 Identification and assessment of evidence

This RCOG guideline was developed in accordance with standard methodology for producing RCOG Green-top Guidelines. The Cochrane Library (including the Cochrane Database of Systematic Reviews), DARE, EMBASE, TRIP, Medline and PubMed (electronic databases) were searched for relevant randomised controlled trials, systematic reviews, meta-analyses and reports. The search was restricted to articles published between 2003 and January 2008. The databases were searched using relevant MeSH terms, including all subheadings, and this was combined with a keyword search. The National Library for Health and the National Guidelines Clearing House were also searched for relevant guidelines and reviews. This guideline includes the classification system of female genital mutilation as revised in *Eliminating Female Genital Mutilation, An Interagency Statement*, published in 2008 by WHO.⁶

In 1998, Lovel *et al.* carried out a systematic review of the health outcomes of female genital mutilation.⁷ A Medline search for later years was performed. Many papers are published in local medical journals, which proved impossible to obtain. Most reports on complications are of single cases or small series without reference to the size of the background population. The type of mutilation is not always stated but may be inferred from the known pattern in that geographic location. The difficulties in interpretation and comparison of data is described by Obermeyer.⁸

3 Ethical duty in practice

3.1 What is the conduct expected of a healthcare worker aware of a child at risk?

Urgent guidance should be sought from a child protection expert for children thought to be at risk of female genital mutilation.



Healthcare workers must not undertake or assist with female genital mutilation, even with the intention of lessening the medical impact of the procedure. UK law

Terminology used with individual women should be that which does not cause upset or a sense of disapproval.



In countries in which female genital mutilation is illegal, families wanting the procedure for their young girls are likely to seek a traditional circumciser from their own community but some may approach healthcare workers. To avoid detection, some girls may be taken abroad 'on holiday' and the procedure will be carried out there. There is a clear duty of child protection if a doctor is approached to perform a mutilating procedure or if it becomes known to them that a child is to be taken abroad for that purpose. **It is estimated that 20 000 girls in the UK are at risk.**⁹

Detailed guidance on this issue is published by the British Medical Association.¹⁰

Child Protection advice should also be sought urgently from **the local social services, local police child protection unit or National Society for the Prevention of Cruelty to Children** if a child is admitted after circumcision. This should include consideration of the needs of younger children in the family who have not undergone a procedure.¹⁰

There is evidence from abroad that doctors and nurses are performing an increasing proportion of procedures – so-called 'medicalisation' – in the belief that complications occur less frequently.¹¹⁻¹³ The Female Genital mutilation Act 2003 makes it an offence for anybody to carry out female genital mutilation on UK nationals and permanent UK residents or to aid, abet, counsel or procure the carrying out of female genital mutilation abroad, even where the practice is not illegal. A successful prosecution has been mounted against a doctor in the UK (and against a parent in the USA).

3.2 What is the appropriate attitude to women who have previously undergone female genital mutilation?

Healthcare workers should actively demonstrate knowledge and respect.



It must be appreciated that these women did not choose mutilation. The procedure is carried out in childhood, when they are too young to give consent. Moreover, they come from societies where such practices are traditional and are viewed by some as being normal; they may see it as such themselves. It should be remembered that, as well as any physical and psychological trauma from the procedure, they may have experienced the emotional turmoil of migration, separation from family and, in some cases, experience of civil war, torture and rape. There is, therefore, no place for expression of disapproval or disgust. All women must be treated with kindness and sympathy and they and their relatives should not be judged.

4 Complications and consequences of female genital mutilation

Clinicians must be aware of the high complication rates related to female genital mutilation and these should be taken into account when counselling about place of delivery and assessing the risk of the pregnancy.



4.1 What are the potential acute complications of female genital mutilation?

Females admitted acutely after female genital mutilation should be assessed quickly for signs of acute blood loss and sepsis, offered analgesia and tetanus toxoid vaccination if this had not previously been administered.



Consideration should be given to antibiotic prophylaxis in the absence of overt sepsis.



Consideration should be given to the need for urinary catheterisation.



Healthcare workers should be familiar with the complications of female genital mutilation.



The procedure is usually performed in the girl's home, in unhygienic conditions, by a traditional birth attendant, a midwife or a specialist circumciser and usually without anaesthesia. A recent study in Egypt has suggested that the procedure was performed by non-medical personnel in 64% cases, according to the parents.¹⁴ There is evidence from abroad that doctors and nurses are performing an increasing proportion of procedures; this so-called 'medicalisation' is perhaps in the belief that complications occur less frequently.

Acute complications of female genital mutilation include

- death (including consequence of substandard anaesthesia)
- severe pain
- localised infection and abscess formation
- septicaemia
- tetanus
- haemorrhage
- acute retention of urine
- hepatitis and HIV.

4.2 What are the potential late gynaecological complications and consequences of female genital mutilation?

Gynaecologists and specialist nurses should be aware of the physical and psychological implications of female genital mutilation.



Healthcare workers should be aware the internal pelvic examination (including cervical cytology testing) might be impossible without general anaesthesia.



In a study of over 4000 women attending hospital in Khartoum, Shandall recorded the frequency of complications in obstetric and gynaecological patients.¹⁵ The most frequently encountered problems were sexual difficulties, with anorgasmia reported in over 80% of women. Pain and tenderness may occur in the scar tissue, leading to dyspareunia, even if the vaginal opening is sufficient to allow penetration. Dysmenorrhoea is commonly reported and is not only related to inhibition of menstrual outflow. Obermeyer has published a systematic review of the literature.⁸

Late gynaecological complications and consequences include:

- dyspareunia
- superficial dyspareunia
- sexual dysfunction with anorgasmia
- chronic pain
- keloid scar formation
- dysmenorrhoea (including haematocolpos)

- urinary outflow obstruction
- recurrent urinary tract infections
- HIV and hepatitis infection
- implantation dermoid cysts
- vaginal lacerations during sexual intercourse and rape
- pelvic infection
- post-traumatic stress disorder
- difficulty passing urine and faeces (WHO 2008)
- labial fusion (type II)
- repeated mutilation (type III) owing to unsuccessful healing
- difficulty conceiving (failed intercourse, pelvic infection and obstructed menstruation)
- difficulty in gynaecological examination
- difficulty in cervical cytology screening
- difficulty of evacuation of the uterus following abortion.

A study carried out in south-eastern Nigeria reported that childhood mutilation contributed to appreciable morbidity among girls, a large proportion of whom are not managed in a hospital setting, including clitoral dermoid cysts (62%) and labial fusion (38%), wound infection (5%) and labial adhesions (2%).¹⁶

Urinary outflow obstruction is common, to varying degrees, resulting in poor flow, painful micturition and recurrent urinary tract infection. Shandall found bacteruria in 28% and infection in 16% of infibulated women.¹⁵ Chronic local irritation and inflammation may lead to further scarring and narrowing resulting in deteriorating flow, retention of urine and haematocolpos.

Dermoid cysts occur with types I, II and III and these may reach a large size or become infected. These may present with pain, urinary retention and dyspareunia.¹⁷

Penetration might be difficult and even impossible. This might result in rape, lacerations, haemorrhage and worsening of any psychological problems.

A systematic review of the literature suggests there is no large increase in the likelihood of infertility. However, a case-control study from Sudan showed that there was an association between the rate of difficulty conceiving and type III mutilation when compared with types I and II.¹⁸

Fistulae are rare but can be the result of injury at the initial procedure, following attempts at coitus, or defibulation and after vaginal birth.

A case-control study suggests significantly higher prevalence of post-traumatic stress disorder (30%) and other psychiatric syndromes (48%) than women who had not undergone mutilation. Post-traumatic stress disorder was often accompanied by memory problems.¹⁹

Table 2 – Relative risk of obstetric complications

Mutilation type	I	II	III
Caesarean section	1.03	1.29	1.31
Postpartum haemorrhage	1.03	1.21	1.69
Extended maternal hospital stay	1.15	1.51	1.98
Infant resuscitation	1.11	1.28	1.66
Stillbirth or early neonatal death	1.15 (0.94–1.41) ^a	1.32	1.55

^a 95% confidence interval

4.3 What are the potential obstetric and neonatal consequences of previous FGM?

The more anatomically destructive the mutilation, the greater the risk of obstetric sequelae.²⁰ All aspects of obstetric complications are described in detail in the WHO systematic review⁷ and in a prospective study in six African countries.²⁰ The adjusted relative risks of certain obstetric complications compared with women who have not been mutilated are shown in Table 2. Low birthweight was similar between the groups.

Parity did not significantly affect these relative risks. Female genital mutilation has been estimated to lead to an extra one to two perinatal deaths/100 deliveries.²⁰

Potential maternal consequences of female genital mutilation include:

- 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 electrodes
- difficulty in performing fetal blood sampling
- difficulty in catheterising of the bladder.

Ninety-one percent of the mutilated group required anterior episiotomy in labour.²¹ Perineal tears were more frequent in women with genital mutilation (10.13% compared with 5.73% in the non-mutilated group) and these perineal lesions were more frequent with the nulliparous women and those who had undergone type II and type III procedures.²² In one study in Egypt, episiotomy appeared to be associated with low perineal tears (1.6%).²³

The mechanism by which genital mutilation might cause adverse obstetric outcomes is unclear. Although practices vary from country to country, mutilation is generally performed in girls younger than 10 years and it leads to varying amounts of scar formation. The presence of this scar tissue, which is less elastic than the perineal tissue would normally be, might cause differing degrees of obstruction and tears or episiotomy.¹⁵ A long second stage of labour, together with direct effects on the perineum, could underlie the increased risk of perineal injury, postpartum haemorrhage, resuscitation of the infant, and fresh stillbirth associated with mutilation.²⁴ Furthermore, the increased risk of caesarean section in women with type II or III mutilations could theoretically mask an effect on the length of the second stage of labour in women with these types of mutilation. There is evidence that mutilation is associated with increased rates of genital and urinary tract infection, which could also have repercussions for mothers and babies.^{20,25,26}

There is contradicting evidence as to whether genital mutilation is associated with prolonged or obstructed labour.^{21-23,27} The WHO study did not record the length of the second stage but De Silva showed a significantly longer second stage in a group of 167 (Sudanese) women who had undergone FGM, compared with 2163 women (mainly Saudi) who had not.²¹ ninety-one percent of the mutilated group required anterior episiotomy in labour²³ and needed defibulation to be performed in the first stage of labour, with associated blood loss or anterior episiotomy in the second stage. However, subsequent studies found that prolonged labour is not associated with mutilation in affluent societies with high standards of obstetric care. Essén *et al.*²⁸ compared the duration of labour between 68 mutilated women with 2486 non-mutilated women in a university hospital in Sweden. The authors stated that there was a significantly statistically shorter second stage and a lower risk of prolonged labour than the non-mutilated group.²⁸

5 Antenatal and intrapartum care

Hospitals with a high number of women with female genital mutilation should nominate a specialist midwife and an obstetrician. They can also act as link persons for maternity units with fewer affected women.



All maternity healthcare workers must be familiar with the nature and higher rates of complications related to female genital mutilation and should take this into account when offering advice about antenatal and delivery care, including recommendations about the place of birth.



5.1 *How should women who have undergone genital mutilation be identified and assessed?*

Maternity units should adopt a process for questioning all women born in (or with recent ancestry of) those parts of the world associated with female genital mutilation. This can be based on the family origin questioning (FOQ) used for haemoglobinopathy screening.



Discussions must take into account language difficulties, psychological vulnerability and cultural differences. Healthcare workers should actively demonstrate knowledge and respect.



The consultation should include a psychological assessment and referral to a psychologist should be discussed with the woman.



Physical examination by an obstetrician or appropriately trained midwife or nurse should be strongly recommended to identify whether antenatal surgery would be beneficial.



Physical examination should also be recommended to reassess women who have had a previous defibulation, as some may have undergone a further infibulation.



A diagram or medical photography (with consent) can be used to limit repetitive examinations, to aid explanations to the woman and to communicate with a hospital or clinic that has developed expertise in the assessment and management of women with genital mutilation.



A preformatted sheet, including a predrawn diagram, should be considered for the identification of the type of genital mutilation, the need for antenatal defibulation and for planning of intrapartum care (see Appendix 2).



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

5.2 *Reversal of infibulation (defibulation)*

Where and when should defibulation be carried out and who should undertake the procedure?

Women should be recommended to undergo defibulation before conception, especially if difficult surgery is anticipated.



Gynaecology and maternity units with little experience of genital mutilation should consult with a centre that has developed expertise in the assessment and management of affected women.



It must be remembered that defibulation does not restore physical or emotional normality.



Urine should be screened for bacteriuria before surgery.

Blood should be sent for group and serum save because of the risk of haemorrhage.

Defibulation may be carried out in any suitable outpatient room equipped for minor procedures or in an operating theatre.

Ideally, the surgeon or midwife should have personal experience of defibulation. In emergency situations, senior obstetric help must be called.

5.3 What technique should be used for defibulation?

Before defibulation, identification of the urethra should be attempted and a catheter passed.

Incision should be made along the vulval excision scar.

Cutting diathermy reduces the amount of bleeding.

The use of fine absorbable suture material such as polyglactin 910 (Vicryl® Rapide, Ethicon) is recommended.

Prophylactic antibiotic therapy should be considered.

Defibulation can be carried out in the antenatal period or intrapartum. The decision should be made by a senior obstetrician with adequate experience in this field. If necessary, guidance should be sought from a centre that has developed expertise in the assessment and management of affected women. The technique for defibulation is described in the WHO document, *Management of Pregnancy, Childbirth and the Postpartum Period in the Presence of Female Genital Mutilation*, which includes diagrams and photographs.²⁹ Antenatal surgical correction should ideally be performed around 20 weeks of gestation to reduce the risk of miscarriage and allow time for healing before the birth.

If vaginal access is adequate, then intrapartum defibulation is appropriate. Rouzi *et al.* reported no complications in 158 women who required intrapartum surgical defibulation.³⁰ When necessary, defibulation can be carried out in the first stage of labour by anterior midline episiotomy, with epidural or during the second stage at the time of crowning of the head.

Ideally, a senior person with extensive experience in dealing with reversal of the mutilation should perform the defibulation. In an acute situation, a senior obstetrician should attend.

5.4 What mode of anaesthesia should be recommended for defibulation?

Adequate pain relief is essential to limit the risk of further psychological harm.

The psychological needs of the woman should be taken into account when deciding the best form of pain relief.

The operation should be carried out under adequate anaesthesia. Inadequate pain relief at any time may cause traumatic flashback. This may sometimes need to be general anaesthesia but usually local or regional analgesia is effective. Local anaesthetic can distort the vulval anatomy. Adequate analgesia is also required postoperatively.

5.5 Intrapartum care

What recommendations should be made about mode of delivery?

Genital mutilation is not an absolute indication for caesarean birth unless the woman has such an extreme form of mutilation with anatomical distortion that makes defibulation impossible.



Decisions about delivery must take into account the psychological needs of the woman.



Episiotomy should be recommended if inelastic scar tissue appears to be preventing progress but careful placement is essential to avoid severe trauma to surrounding tissues, including bowel.



In some cases, the procedure is carried out in late childhood or early teenage years, with women having vivid memories of the procedure. This may have such a profound psychological effect that she might request elective caesarean section. However, most women with genital mutilation prefer vaginal births and deliver safely vaginally. Genital mutilation should not be considered to be an absolute indication for caesarean section.

After defibulation, the surrounding tissues may be heavily scarred and less elastic. This increases the risk of serious perineal tears. A low threshold for performing episiotomy should be advised.²³

5.6 What recommendations should be made about vaginal birth for a woman with FGM?

Women with genital mutilation should usually be strongly recommended to deliver in a maternity unit with immediate access to facilities for emergency obstetric care.



Women who have undergone successful defibulation and an uncomplicated vaginal birth (and no repeat procedure) can be considered for birth in midwifery-led units.



Intravenous access and group and save serum should be strongly recommended.



Epidural anaesthesia should be offered to women who find difficulty tolerating vaginal examination.



Epidural anaesthesia should be recommended if anterior episiotomy is needed in labour.



It is possible that obstetricians and midwives may be asked to reinfibulate a woman following vaginal delivery. Any repair carried out after birth, whether following spontaneous laceration or deliberate defibulation, should be sufficient to appose raw edges and control bleeding, but must not result in a vaginal opening that makes intercourse difficult or impossible. The WHO recommends suturing of raw edges to prevent spontaneous reinfibulation.²⁹

6 The way forward

6.1 Provision of services

In general, the population at risk is to be found in large towns and cities. However, the numbers may be so small that individual obstetricians and gynaecologists encounter few cases and gain little experience in the management of complications and labour. It has been shown that dedicated clinics are successful in meeting the needs of these women.³¹⁻³⁴

Similar clinics should be set up in parts of the country with a significant population of women with genital mutilation. The advantages are that trained medical and midwifery staff and interpreters can be brought together to provide obstetrical and gynaecological advice and treatment. Links to psychosexual services are essential.

It is vital that a defibulation service be available and that women have easy access to it. An increasing number of young, teenage women are requesting defibulation with a desire to appear more normal. With increasing awareness of the complications in labour and of the existence of such clinics, it is anticipated that more women will seek help before pregnancy.

6.2 *Eradicating the practice*

Agencies such as WHO, UNICEF and the RCOG condemn the practice of female genital mutilation. They are committed to eradication through pressure on governments and by education of health workers worldwide.

Most European and many African countries have passed legislation forbidding the practice but beliefs are deep rooted in the communities and laws alone will not eradicate it. Moreover, this approach may drive it underground.¹⁴ There has been a shift in the emphasis from a purely health-related issue to one in which the role and sexual and reproductive rights of women in societies is addressed. Increased media coverage, statements by ministers, religious leaders and non-governmental organisations has led to increased discussion of the topic at a local level. Since many women in these communities have little or no formal education, spreading the message by means of pictures, song and drama is more effective. This, when coupled with other forms of development, such as economic development, has been shown to be effective in Senegal.³⁴ Initiative was taken by women working at the local level in connection with the Tostan Project and UNICEF or Population Council evaluation more recently. Since 1997, 1271 villages (600 000 people), some 12% of the practicing population in Senegal, have voluntarily given up female genital mutilation. This has come about through the voluntary efforts of locals carrying the message out to other villages within their marriage networks in a self-replicating process.

6.3 *What resources are available?*

Hospitals and clinics in the UK offering specialist services for women with genital mutilation can be found on the FORWARD website: [www.forwarduk.org.uk/resources/support/well-woman's clinics](http://www.forwarduk.org.uk/resources/support/well-woman%27s-clinics).

Training manuals are available from WHO, including the technique of defibulation.²⁹

WHO. *Female Genital Mutilation Policy Guidelines for Nurses and Midwives: the Prevention and Management of the Health Complications*. 2001 [www.who.int/reproductive-health/publications/rhr_01_18_fgm_policy_guidelines/fgm_policy_guidelines.pdf].

WHO. *Female Genital Mutilation: a Teacher's Guide*. 2001 [www.who.int/reproductive-health/publications/rhr_01_16_fgm_teacher_guide/fgm_teacher_guide.pdf].

WHO. *Female Genital Mutilation: A Student's Manual*. 2001 [www.who.int/reproductive-health/publications/rhr_01_17_fgm_student_guide/fgm_student_manual.pdf].

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A training DVD is available from the Department of Health: Ben Robins, Children, Families and Social Inclusion Programme Health Inequalities and Partnership direct line: +44 (0)20 7972 5976; fax: +44 (0)20 7927 3738; email: Ben.Robins@dh.gsi.gov.uk; address: Department of Health, Area 502a Skipton House, 80 London Road, London SE1 6LH.

7 Auditable standards

Standards for audit of practice should include the following:

- documentation of enquiry into genital mutilation at booking
- proportion of women cared for by specialist midwife
- proportion of women cared for by a specialist obstetrician
- assessment for antenatal reversal procedures
- complications of the patients undergoing defibulation
- standards for audit of documentation
- evidence in medical notes of senior obstetrician involvement.

8 Useful links

The WHO website provides information on femal genital mutilation: www.who.int/topics/female_genital_mutilation/en/.

WHO. *Management of Pregnancy, Childbirth and Postpartum Period in the Presence of Female Genital Mutilation*. 2001 [www.who.int/reproductive-health/publications/mngt_pregnancy_childbirth_fgm/text.pdf]. This document includes a section on the technique of defibulation.

Forward: www.forwarduk.org.uk.

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9 Support groups

- Medconsumer.info. Female genital; mutilation: www.medconsumer.info/topics/fgm.htm
- The Female Genital Cutting Education and Networking Project: www.fgmnetwork.org
- Forward: www.forwarduk.org.uk.

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APPENDIX I

Prevalence and type of female genital mutilation by country (adapted from WHO data)^{6,7}

Country	Prevalence (%)	Type performed
Most reliable estimates		
Burkina Faso	72	Type II
Central African republic	43	Types I & II
Ivory Coast	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 Somalia	85	Types I & II Type III in regions bordering Sudan and
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	98	Type II & III
Guinea-Bissau	50	Types I & II
Mauritania	25	Types I & II
Uganda	5	Types I & II

FEMALE GENITAL MUTILATION

DATE:
 TIME:
 GESTATION FIRST SEEN:

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

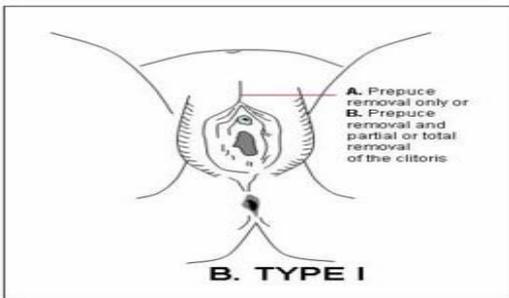
Please circle as appropriate:

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	

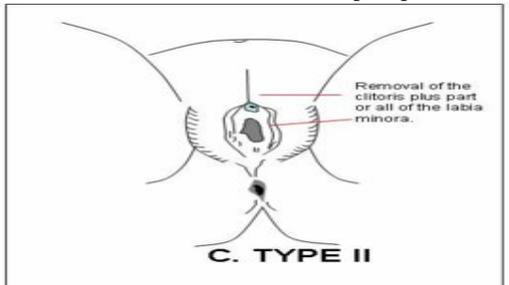
EXAMINATION FINDINGS ON INITIAL ASSESSMENT

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



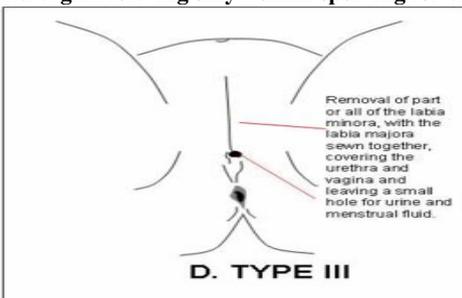
COMMENTS: _____

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



COMMENTS _____

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



COMMENTS: _____

CONSENT:

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

MANAGEMENT (circle as appropriate)

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

Reversal if antenatally booked in labour ward: Yes/No Gest.....wks

Details of booking: Date: ____ / ____ / ____

Place LW: In room / Theatre
Preference LA/Spinal

Labour recommendation:

1. Manage labour as normal	Yes/ No
2. Medio-lateral episiotomy as required	Yes/ No
3. Inform SpR when in labour	Yes/ No
4. Reversal in labour (anterior midline)	Yes/ No

Please put ID sticker in book in ANC for every FGM procedure filled

REVERSAL:

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

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

Incision: Anterior midline/ Other _____

Repair edges: Interrupted/ Continuous/ Other _____

Suture materials: Vicryl-rapide/ Vicryl / Other _____

Anaesthesia/Analgesia: Local / Pudenda 1 block / Regional / Entonox / None

Antibiotics Yes/No

TTO: Codydramol / Paracetamol / Other _____

FOLLOW-UP: Yes/ No

Antenatal clinic appointment: Date: ____ / ____ / ____

Other: _____

APPENDIX III

Clinical guidelines are: 'systematically developed statements which assist clinicians and patients in making decisions about appropriate treatment for specific conditions'. Each guideline is systematically developed using a standardised methodology. Exact details of this process can be found in Clinical Governance Advice No. 1: *Development of RCOG Green-top Guidelines* (available on the RCOG website at www.rcog.org.uk/index.asp?PageID=75). These recommendations are not intended to dictate an exclusive course of management or treatment. They must be evaluated with reference to individual patient needs, resources and limitations unique to the institution and variations in local populations. It is hoped that this process of local ownership will help to incorporate these guidelines into routine practice. Attention is drawn to areas of clinical uncertainty where further research may be indicated.

The evidence used in this guideline was graded using the scheme below and the recommendations formulated in a similar fashion with a standardised grading scheme.

Classification of evidence levels	Grades of recommendations
1++ High-quality meta-analyses, systematic reviews of randomised controlled trials or randomised controlled trials with a very low risk of bias	A At least one meta-analysis, systematic reviews or randomised controlled trial rated as 1++ and directly applicable to the target population; or A systematic review of randomised controlled trials or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population and demonstrating overall consistency of results
1+ Well-conducted meta-analyses, systematic reviews of randomised controlled trials or randomised controlled trials with a low risk of bias	B A body of evidence including studies rated as 2++ directly applicable to the target population and demonstrating overall consistency of results; or Extrapolated evidence from studies rated as 1++ or 1+
1- Meta-analyses, systematic reviews of randomised controlled trials or randomised controlled trials with a high risk of bias	C A body of evidence including studies rated as 2+ directly applicable to the target population and demonstrating overall consistency of results; or Extrapolated evidence from studies rated as 2++
2++ High-quality systematic reviews of case-control or cohort studies or high-quality case-control or cohort studies with a very low risk of confounding, bias or chance and a high probability that the relationship is causal	D Evidence level 3 or 4; or Extrapolated evidence from studies rated as 2+
2+ Well-conducted case-control or cohort studies with a low risk of confounding, bias or chance and a moderate probability that the relationship is causal	Good practice point
2- Case-control or cohort studies with a high risk of confounding, bias or chance and a significant risk that the relationship is not causal	<input checked="" type="checkbox"/> Recommended best practice based on the clinical experience of the guideline development group
3 Non-analytical studies; e.g. case reports, case series	
4 Expert opinion	

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The final version is the responsibility of the Guidelines Committee of the RCOG.

The Guidelines review process will commence in 2012
unless otherwise indicated

DISCLAIMER

The Royal College of Obstetricians and Gynaecologists produces guidelines as an educational aid to good clinical practice. They present recognised methods and techniques of clinical practice, based on published evidence, for consideration by obstetricians and gynaecologists and other relevant health professionals. The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the doctor or other attendant in the light of clinical data presented by the patient and the diagnostic and treatment options available.

This means that RCOG Guidelines are unlike protocols or guidelines issued by employers, as they are not intended to be prescriptive directions defining a single course of management. Departure from the local prescriptive protocols or guidelines should be fully documented in the patient's case notes at the time the relevant decision is taken.