SERVICE EVALUATION OF THE WOMEN'S WELLBEING CLINIC AND AUDIT OF FGM LABOUR PRACTICES IN THE UNIVERSITY HOSPITAL OF WALES

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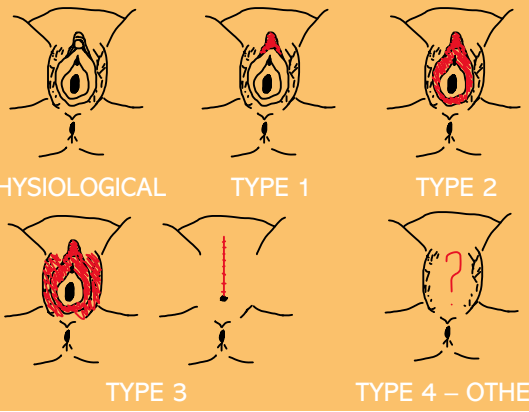


INTRODUCTION

Female genital mutilation (FGM) is a human rights violation that involves cutting, injuring, or altering the female genitalia for non-medical reasons. People affected often suffer consequences ranging from PTSD, dysuria, and dyspareunia, to severe pain, haemorrhage, infection and death. The Women's Wellbeing Clinic (WWC) in Cardiff was opened in April 2018 as a pilot for Wales's first specialist FGM clinic to help women affected. This is the first service evaluation of the clinic, aiming to assess its efficacy between May 2018 to Mid-April 2019, and the need for improvements or recommendations. Many women referred to the WWC are pregnant, so an audit of whether midwives and obstetricians in UHW have received enough training to manage women with FGM according to the RCOG Green-top Guideline No.53 was also carried out. The guidelines state that 'all gynaecologists, obstetricians and midwives should receive mandatory training on FGM and its management, including the technique of de-infibulation' (1).

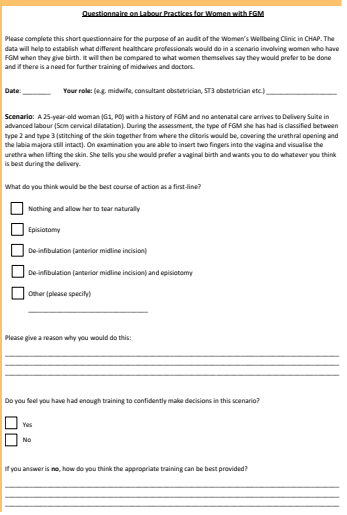
OBJECTIVES

The primary aims were to

- evaluate the efficacy of the WWC since its first clients in May 2018
- compare preferred labour practices of midwives and obstetricians for women with FGM type 2/3 to RCOG Green-top Guideline No. 53 (1) and patient preferences in order to assess need for training

METHOD

Over 6 weeks, 31 different categories of data from May 2018 to mid-April 2019 of women who attended the WWC was collected from paper records stored in the clinic, and digital records from Cardiff and Vale Clinical Portal and E3. In conjunction to this, a questionnaire (figure 1) for midwives and obstetricians about labour practices was distributed in the Delivery Suite in UHW between 11th March to 15th April 2019. This was updated and replaced based upon informal feedback after 3 weeks. The questionnaire scenario was inspired by a woman with type 2/3 FGM who delivered at UHW; she was not deinfibulated despite requesting it, had an episiotomy and sustained an anterior midline labial tear. Ethical approval was not required as no research was conducted.



Questionnaire on Labour Practices for Women with FGM

Please complete this short questionnaire for the purpose of an audit of the Women's Wellbeing Clinic in CHAP. The data will help to establish what different healthcare professionals would do in a scenario involving women who have FGM when they give birth. It will then be compared to what women themselves say they would prefer to be done and if there is a need for further training of midwives and doctors.

Date: _____ **Your role:** (e.g. midwife, consultant obstetrician, ST3 obstetrician etc.) _____

Scenario: A 25-year-old woman (G1, P0) with a history of FGM and no antenatal care arrives to Delivery Suite in advanced labour (5cm cervical dilatation). During the assessment, the type of FGM she has had is classified between type 2 and type 3 (stitching of the skin together from where the clitoris would be, covering the urethral opening and the labia majora still intact). On examination you are able to insert two fingers into the vagina and visualise the urethra when lifting the skin. She tells you she would prefer a vaginal birth and wants you to do whatever you think is best during the delivery.

What do you think would be the best course of action as a first-line?

- ☐ Nothing and allow her to tear naturally
- ☐ Episiotomy
- ☐ De-infibulation (anterior midline incision)
- ☐ De-infibulation (anterior midline incision) and episiotomy
- ☐ Other (please specify)

_____

Please give a reason why you would do this:

_____
_____
_____

Do you feel you have had enough training to confidently make decisions in this scenario?

- ☐ Yes
- ☐ No

If you answer is **no**, how do you think the appropriate training can be best provided?

_____
_____
_____

Figure 1: Updated questionnaire

RESULTS

A total of 117 women were referred to the WWC between May 2018 and mid-April 2019, with 102 of them attending an initial appointment. Only 12.8% of women did not attend (DNA), for reasons such as not wanting the appointment, communication difficulties, and being dispersed out of area. The cohort was diverse, with 16 different nationalities and 18 different places where FGM took place (Sudan being the commonest). Interestingly, only 6.9% of clinic attendees were Somalian, despite Public Health Wales reporting that 19% of newly reported FGM cases in Wales between April 2017 and March 2018 were in Somalian women (2). One potential reason for this disparity is the feeling of stigmatisation and distrust of FGM services amongst Wales's Somalian population due to mandatory Social Services and Police 101 referrals for children.

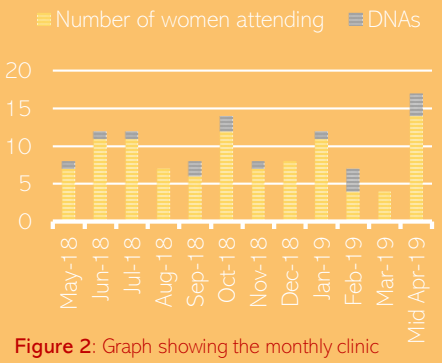


Figure 2: Graph showing the monthly clinic attendance between May 2018 – mid-April 2019, including the number of DNAs.

Psychosexual counselling is offered at the clinic, but only 6.5% of women had attended an appointment, despite 28.6% of women offered it accepting to be referred. This could partly be explained by some women still waiting for an appointment, but ultimately the figures highlight a high DNA rate – the reasons why are uncertain.

Although there are officially four recognised types of FGM, clinically there is variation that can be difficult to classify within those parameters. Type 2 FGM was the most common type seen at WWC, followed by type 1 and type 2/3. Two women who attended after being referred said they had no history of FGM at all so were not assessed any further.

81.4% of attendees were referred due to pregnancy and 29 female infants had been born and referred to Social Services. For 14 of those infants there was no evidence of a referral being made on E3, however the Safeguarding Midwife confirmed all 14 had been referred, demonstrating that a lack of clear documentation was a greater problem than a lack adherence to legal requirements.

The data collection also recorded obstetric outcomes for women who presented antenatally or postnatally. Only 12.5% of women who delivered during the 6 weeks had a spontaneous vaginal delivery, whereas 57.5% experienced either a labial, vaginal, or perineal laceration of varying degrees. Women who were identified as having type 2/3 or type 3 were offered deinfibulation at UHW. Of those who were pregnant, 10 requested deinfibulation at delivery, 8 have not yet delivered, and 2 have delivered but were never deinfibulated. On the other hand, 10 women were referred for deinfibulation antenatally or for gynaecological reasons outside of pregnancy, with 50% having been deinfibulated so far. Many women expressed fear regarding deinfibulation, so it is important that they are counselled well leading up to and during the procedure.

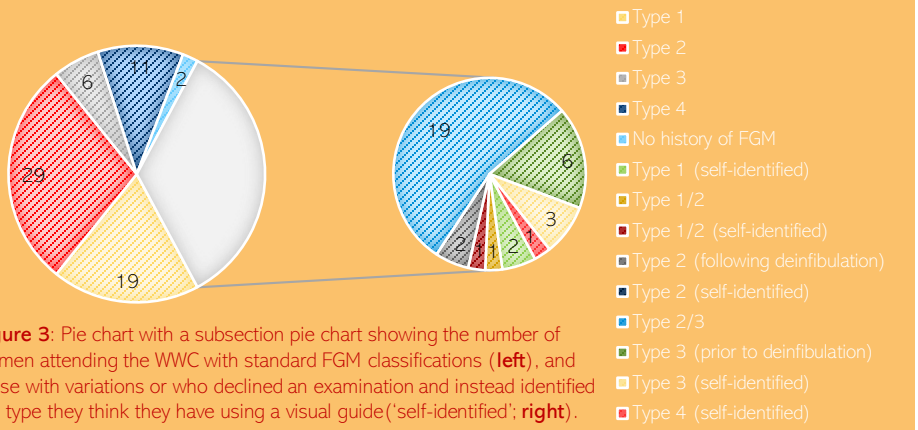


Figure 3: Pie chart with a subsection pie chart showing the number of women attending the WWC with standard FGM classifications (**left**), and those with variations or who declined an examination and instead identified the type they think they have using a visual guide('self-identified'; **right**).

A total of 53 questionnaires were filled out, mostly by midwives. Deinfibulation would be the preferred action plan in the scenario given that the urethral meatus is covered by skin. In the initial questionnaire, 17% of midwives chose deinfibulation compared to 67% of doctors, favouring 'nothing and allow her to tear naturally' or 'other' (e.g. seeking senior opinion) instead. The updated questionnaire had different results, with 57.1% of midwives choosing deinfibulation. This may have been due to different respondents, the change of wording, or increased knowledge as the topic of FGM became a discussion point since the initial questionnaire was distributed. Most significantly, an average of only 22.7% of midwives and 66.5% of doctors felt that they had received enough training to confidently make decisions in the scenario. Suggested methods of delivery included mandatory study days (27.8%), e-learning (16.7%), and clinical exposure (16.7%).

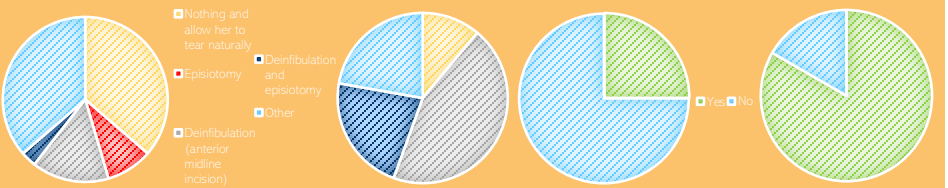


Figure 4: Pie charts of midwife and doctor responses to the first questionnaire. **Far left;** pie chart showing midwife responses to 'what would you plan to do at delivery'. **Middle left;** pie chart showing doctor responses to 'what would you plan to do at delivery?'. **Middle right;** pie chart showing midwife responses to 'do you feel you have had enough training to confidently make decisions in this scenario?'. **Far right;** pie chart showing doctor responses to 'do you feel you have had enough training to confidently make decisions in this scenario?'.

CONCLUSION | ACKNOWLEDGMENTS | REFERENCES

Overall, the WWC has had a successful first year in establishing itself. Nonetheless, the value of psychosexual counselling should be reviewed, and more needs to be done to engage with Wales's Somalian community in the interest of health equality. In order for FGM services to be most effective, all relevant medical specialties need to be adequately trained, thus midwives and obstetricians at UHW (and across Wales) require more training on FGM and its management. This is imperative for ensuring that women achieve the best possible birth outcomes and that their wishes for deinfibulation are respected, with proper documentation. Furthermore, more detailed FGM classifications should be used in the AWCP to better define the variability that exists.

With special thanks to Dr Zaher, Tatiana, and the staff on Delivery Suite, without all of whom this wouldn't have been possible, and above all to the patients who presented at the WWC for their strength, openness, and trust in us.

(1) Royal College of Obstetricians and Gynaecologists. 2015. *Female Genital Mutilation and its Management: Green-top Guideline No. 53.* Available from: https://www.rcog.org.uk/globalassets/documents/guidelines/gtg-53-fgm.pdf. [Accessed 29/03/2019].
(2) Mott, A. Female genital mutilation (FGM) health leads report April 2017 – March 2018. Public Health Wales. Report No. 1, 2018.