

## FGM POLICY

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## **Background**

Female genital mutilation (FGM), also known as 'female genital cutting', 'female genital mutilation/cutting' or 'cutting', refers to 'all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons'. FGM is practiced for a variety of complex reasons, usually in the belief that it is beneficial for the girl. It has no health benefits and harms girls and women in many ways. FGM is a human rights violation and a form of child abuse, breaching the United Nations Convention on the Rights of the Child, and is a severe form of violence against women and girls.

## **Prevalence**

FGM is practiced in at least 28 African countries. 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. (See Appendix 1 illustration 2)

It is estimated that over 20,000 girls under the age of 15 are at risk of FGM in the UK each year, and that 66,000 women in the UK are living with the consequences of FGM.

## **Types of FGM (World Health Organisation Classification) Appendix 1 see illustration 1**

**Type 1:** Clitoridectomy – partial or total removal of the clitoris. Occasionally only the prepuce (clitoral foreskin) is removed;

**Type 2:** Partial or total removal of the clitoris and labia minora with or without excision of the labia majora;

**Type 3:** Infibulation – removal of the labia minora or labia majora with a seal being formed through healing of opposing wound edges. The clitoris may or may not be removed. A small hole is left to allow the passage of menstrual flow and urine;

**Type 4:** Any other harmful procedure on the female genitalia for non-medical purposes including piercing, scraping, pricking and cauterising.

FGM is performed at different ages and can occur in early childhood (often between the ages of five and eight years), during adolescence, before marriage or during the first pregnancy. There is some evidence that the age is reducing in response to the increased awareness of statutory services and actions of these to prevent FGM.

## The legal and regulatory responsibilities of UK health professionals

### 1. All health professionals must be aware of the Female Genital Mutilation Act 2003 in England, Wales and Northern Ireland and the Prohibition of Female Genital Mutilation (Scotland) Act 2005 in Scotland. Both Acts provide that:

- FGM is illegal unless it is a surgical operation on a girl or woman irrespective of her age: (a) which is necessary for her physical or mental health; or (b) she is in any stage of labour, or has just given birth, for purposes connected with the labour or birth;
- It is illegal to arrange, or assist in arranging, for a UK national or UK resident to be taken overseas for the purpose of FGM;
- It is an offence for those with parental responsibility to fail to protect a girl from the risk of FGM;
- If FGM is confirmed in a girl under 18 years of age (either on examination or because the patient or parent says it has been done), reporting to the police is mandatory and this must be within 1 month of confirmation.

Female genital cosmetic surgery (FGCS) may be prohibited unless it is necessary for the patient's physical or mental health. All surgeons who undertake FGCS must take appropriate measures to ensure compliance with the FGM Acts.

**Re-infibulation is illegal; there is no clinical justification for re-infibulation and it should not be undertaken under any circumstances.**

### 2. Data recording (<http://www.hscic.gov.uk/fgm>)

- Data recording is mandatory for all women identified as having FGM;
- Document FGM diagnosis in medical records (even if FGM is not the reason for presentation);
- If genital examination is performed and type of FGM is identified, record FGM type (WHO classification);\*
- Document further details in accordance with the HSCIC FGM Enhanced Dataset;
- Explain to the woman that her personal data will be transmitted to the HSCIC for the purpose of FGM prevalence monitoring and that the data will not be anonymised;

### 3. Reporting to police and/or social services in the event of risk to a child (<https://www.gov.uk/government/publications/safeguarding-women-and-girls-at-risk-of-fgm>) (see Trust Child Protection Policy and South West Child Protection Policy and Procedures);

- **Children under 18:** If FGM is confirmed (on examination or if the patient or parent says it has been done), refer as a matter of urgency to the police and Somerset Direct (children's social care) and this should be done within 1 month of confirmation;

- **Children under 18:** If FGM is suspected (but not confirmed) or the girl is at risk (but has not had FGM), refer to Somerset Direct and the police. The urgency of the referral depends on the degree of risk;
- Non-pregnant women with FGM: no requirement to report unless a related child is at risk;
- Pregnant women: A member of the clinical team (midwife or obstetrician) must make an individual risk assessment using an FGM safeguarding risk assessment tool and if the unborn child, or any other child in the family, is considered to be at risk of FGM then reporting to Somerset Direct or the police must occur;
- Document maternal history of FGM in the personal child health record ('Red Book') prior to postnatal discharge;
- If delivery of a baby girl, notify the designated nurse for safeguarding, who should inform the GP and health visitor.

\*Genital piercings should be classified as type 4 FGM in accordance with the WHO FGM classification.

#### **4. Health risks**

##### **Acute Complications**

- The most common complication is severe pain, infection, including tetanus and blood born viruses (including HIV and Hepatitis B and C) as well as potential for abscess formation which may lead to septicaemia;
- Haemorrhage;
- Acute retention of urine;
- Injury to adjacent tissues;
- Damage to organs;
- Death.

**Late Complications** - In a study of over 4000 women with genital mutilation (type 3) Shandall reported the following:

- Sexual difficulties with an orgasmia reported in 80% of cases;
- Dyspareunia if the vaginal opening is sufficient to allow penetration;
- Penetration may cause lacerations and haematoma, requiring medical intervention;
- Chronic local irritation and inflammation may lead to further narrowing, resulting in deteriorating flow, retention of urine and haematocolposcopy;
- Variable degrees of urinary outflow obstruction are common, leading to poor flow, painful micturition and recurrent urinary tract infection (UTI). Rarely, vaginal urinary calculi may form;

- Dysmenorrhoea is commonly reported and is not only related to the inhibition of menstrual outflow;
- Retention cysts occur with type 1,2 and 3 and may reach a large size or become infected, presenting with pain, urinary retention and dyspareunia;
- Pelvic infection may occur with subsequent infertility;
- Fistula is rare, but can result in injury at the initial procedure or at defibulation or following laceration in labour;
- Infibulation cysts, neuromas and keloid scar formation;
- Complication in pregnancy and delay in the second stage of childbirth;
- Increased risk of HIV and other sexually transmitted infections.

### **Short Term Consequences**

- Pain;
- Emotional and psychological shock (exacerbated by having to reconsider being subjected to the trauma by loving partners, extended family and friends);
- Fracture or dislocation as a result of restraint.

**Obstetric Complications** - The mechanical barrier posed by infibulation in type 3 leads to prolonged or obstructed labour:

- Caesarean section for fear of laceration and difficult birth;
- Difficulty performing vaginal examination and hence inadequate monitoring in labour;
- Retention of urine and difficulty in catheterising the urethra in labour and prior to caesarean section.

### **Prolonged Labour**

- Defibulation in the first stage of labour, with associated blood loss, or anterior episiotomy in the second stage;
- Lacerations in the scar tissue may cause postpartum haemorrhage (PPH); more severe;
- Lacerations rarely extend to involve the urethra, bladder or rectum.

### **Postnatal complications**

- Wound infection and retention of lochia, leading to puerperal sepsis;
- Difficulty in gynaecological examination and evacuation of the uterus following miscarriage.

## 5. Identification and the way forward

It must be appreciated that these women did not choose mutilation. All staff should be aware of the practice and types of female genital mutilation and the adverse effects on women's sexual and reproductive health. Staff should be sensitive to the traditions of the communities where mutilation is practised.

**Obstetric services** - at the booking clinic, patients at risk should be identified and sensitive enquiry made to establish whether female genital mutilation has been performed. The presence of a female interpreter is desirable as it reduces misunderstanding and women may find it less embarrassing to speak through a third party. Inspection will reveal the type of procedure carried out and an assessment of the likelihood of obstetric complications made. All clinical staff should be aware of a nominated midwife in the Trust with whom cases may be discussed or referred. At Yeovil District Hospital this is the Midwifery Matron for Public Health and Risk. Advice can also be sought from the Named Doctor and Nurse for Safeguarding Children. An obstetrician should classify the type of FGM. Use a diagram or medical photography (with consent). This aids communication with the patient and other clinicians, and limits repetitive examinations. Include a psychological assessment and referral to a psychologist (via perinatal mental health team) if deemed necessary and agreed upon by the woman

**Other Hospital Services:** where FGM is confirmed by observation or disclosure then referral for on-going psychological support should be offered. Psychological support is vital and should be offered through specially trained counsellors, who may also act as interpreters. Identification of any female children/grandchildren/nieces/siblings should be done and safeguarding initiated.

### Referral to a specialist Unit can be offered at:

Bristol Community Rose Clinic at Lawrence Hill Health Centre

Email: [bristolrose.clinic@nhs.net](mailto:bristolrose.clinic@nhs.net) Tel: 07813 016911

This clinic provides support for women experiencing any health problems as a result of FGM. The clinic offers 'opening' surgery under local anaesthetic (or can arrange for the surgery at a local hospital under general anaesthetic. This service is confidential and the reception staff at Lawrence Hill Health Centre cannot take bookings, email the clinic for advice or to make an appointment. 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](http://www.forwarduk.org.uk/resources/support/well-woman-clinics)

## 6. Obstetric Services and pregnant women

**6.1** The obstetric registrar or consultant in antenatal clinic (or on call if the presentation is in labour) should explain the difficulties that may be encountered in the antenatal and intrapartum period and document discussions in the patient's healthcare records: (Refer to the guideline for Maternity Record Keeping including Documentation in Handheld Records).

- An increased risk of urinary tract infection;

- Difficulty in performing vaginal examination antenatally, in the assessment of the cervix prior to induction of labour, carrying out induction of labour and in assessing progress in labour;
  - Catheterising the bladder;
  - Application of a fetal scalp electrode;
  - Delay in the second stage;
  - The risk of spontaneous laceration;
  - The need for an anterior midline episiotomy.
- 6.2** The question of re-infibulation following childbirth should also be raised. The legal position should be explained and the disadvantages of yet more scarring on subsequent sexual and reproductive health.
- 6.3** The patient should be offered elective defibulation at around 20 weeks of gestation, once it has been explained that this will reduce most of the difficulties and increase the likelihood of an uncomplicated, joyful birth.
- 6.4** When the patient presents in late pregnancy or even in labour, defibulation may be carried out in the first stage. Bleeding from the cut edges can be limited by opening the fused labia strictly in the midline and stopping as soon as the urethral meatus is exposed.
- 6.5** In the second stage, the procedure should be carried out as the fetal head distends the vulva, care being taken to protect the head from laceration. Stretching of the fused labia allows a good view of the line of fusion and reduces blood loss; the external urethral meatus tends to be displaced away from the incision line by the fetal head.
- 6.8** Defibulation service - It is vital that a defibulation service be available so that women have easy access and is requested by women when they marry. Defibulation before pregnancy is the ideal but unfortunately many women only come to the attention of doctors and midwives when they are already pregnant. (see information above on The Rose Clinic, Bristol). Elective defibulation in the antenatal period (ideally around 20 weeks) decreases lacerations in labour and avoids defibulation or anterior episiotomy in labour.
- 6.9** **Technique for defibulation: see appendix III illustration 1 from the RCOG green-top guideline no 53**
- Introduce finger under the anterior flap and direct towards the pubis. Incise with scissors over the finger until the anterior meatus is visible;
  - For repair oversew raw edges with vicryl rapide;
  - While local anaesthetic is perfectly adequate from a technical point of view, some women prefer general anaesthesia from a psychological point of view.

**See appendix IV for Flowchart of plan of care for women with FGM in pregnancy RCOG green top guideline no 53**

## References:

Caring for patients and safeguarding children - advice from the British Medical Association July 2011.

Call to End Violence against Women and girls: Action Plan 2014.

Female Genital Mutilation and its management RCOG green- top guideline no 53 July 2015.

Female Genital Mutilation Risk and Safeguarding; Guidance for professionals: DOH March 2015

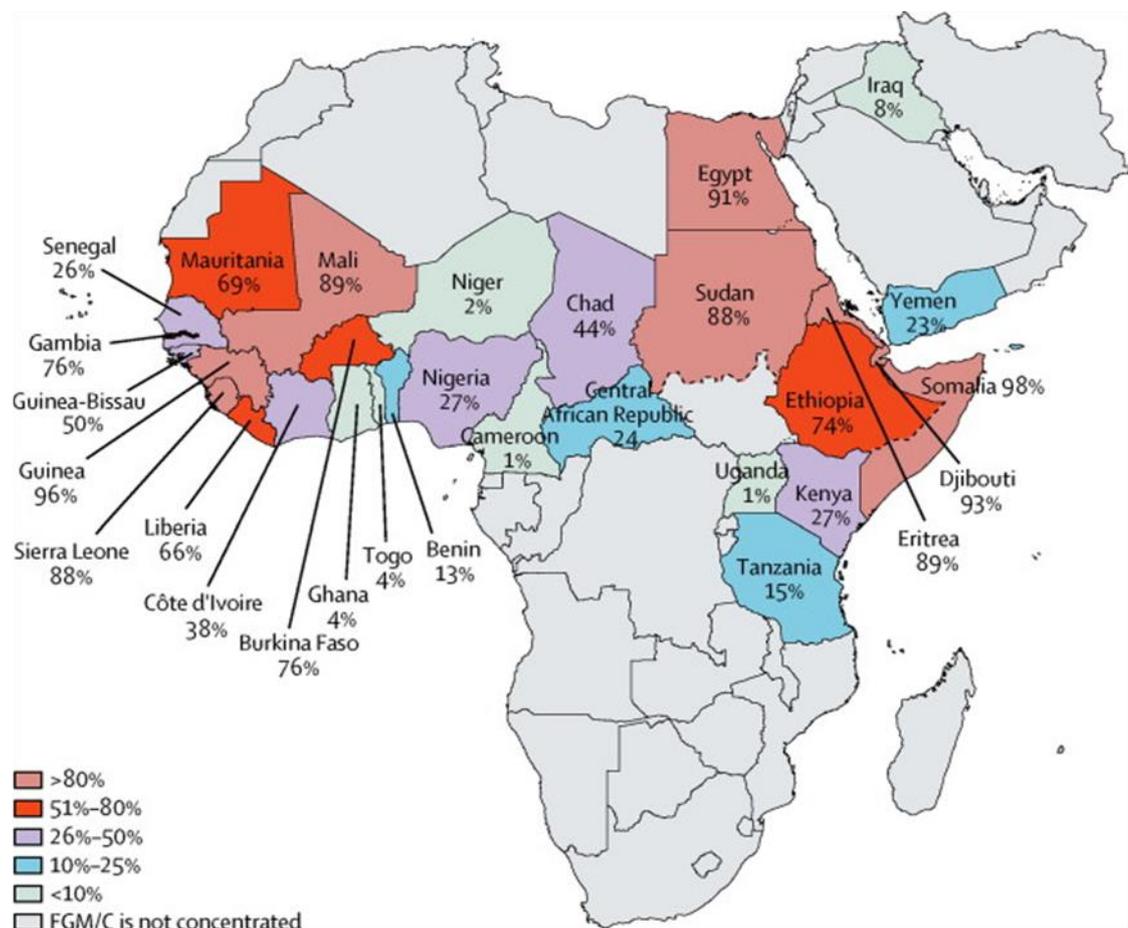
Mandatory Reporting of Female Genital Mutilation – procedural information: Home Office 201

<http://www.forwarduk.org.uk/key-issues/fgm/research> October 2007, FORWARD published 'A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales'

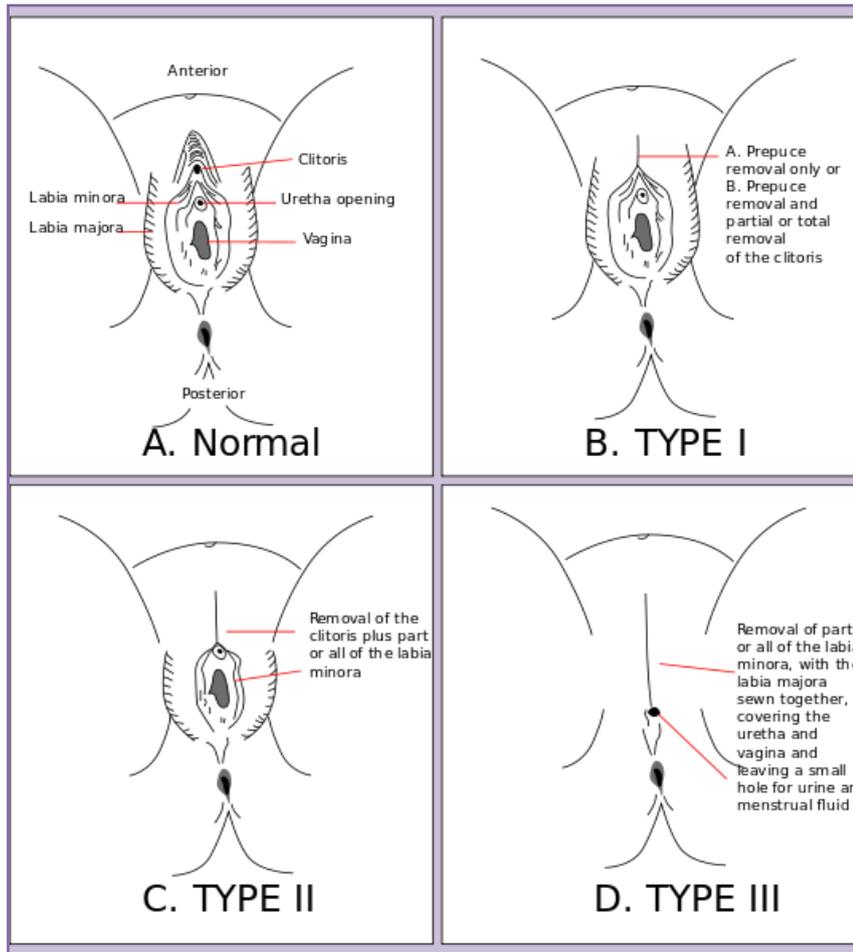
[http://www.nspcc.org.uk/Inform/resourcesforprofessionals/minorityethnic/female-genital-mutilation\\_wda96841.html](http://www.nspcc.org.uk/Inform/resourcesforprofessionals/minorityethnic/female-genital-mutilation_wda96841.html)

[www.who.int/reproductivehealth/publications/fgm/en/index.html](http://www.who.int/reproductivehealth/publications/fgm/en/index.html)

## Appendix I Illustration 1



**Appendix II Illustration 1**

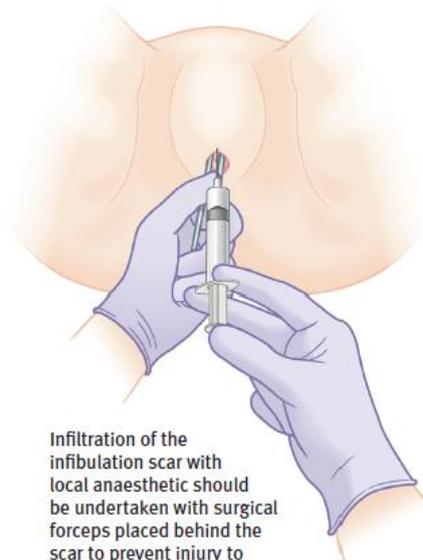


**Appendix III:** One recommended method of performing de-infibulation

**1) Type 3 FGM (infibulation)**

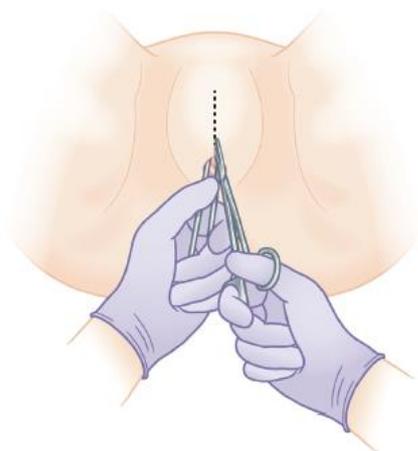


**2) Infiltration of midline scar with local anaesthetic**



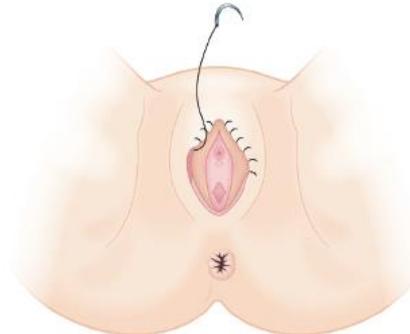
Infiltration of the infibulation scar with local anaesthetic should be undertaken with surgical forceps placed behind the scar to prevent injury to underlying tissues.

**3) Incision of midline scar**



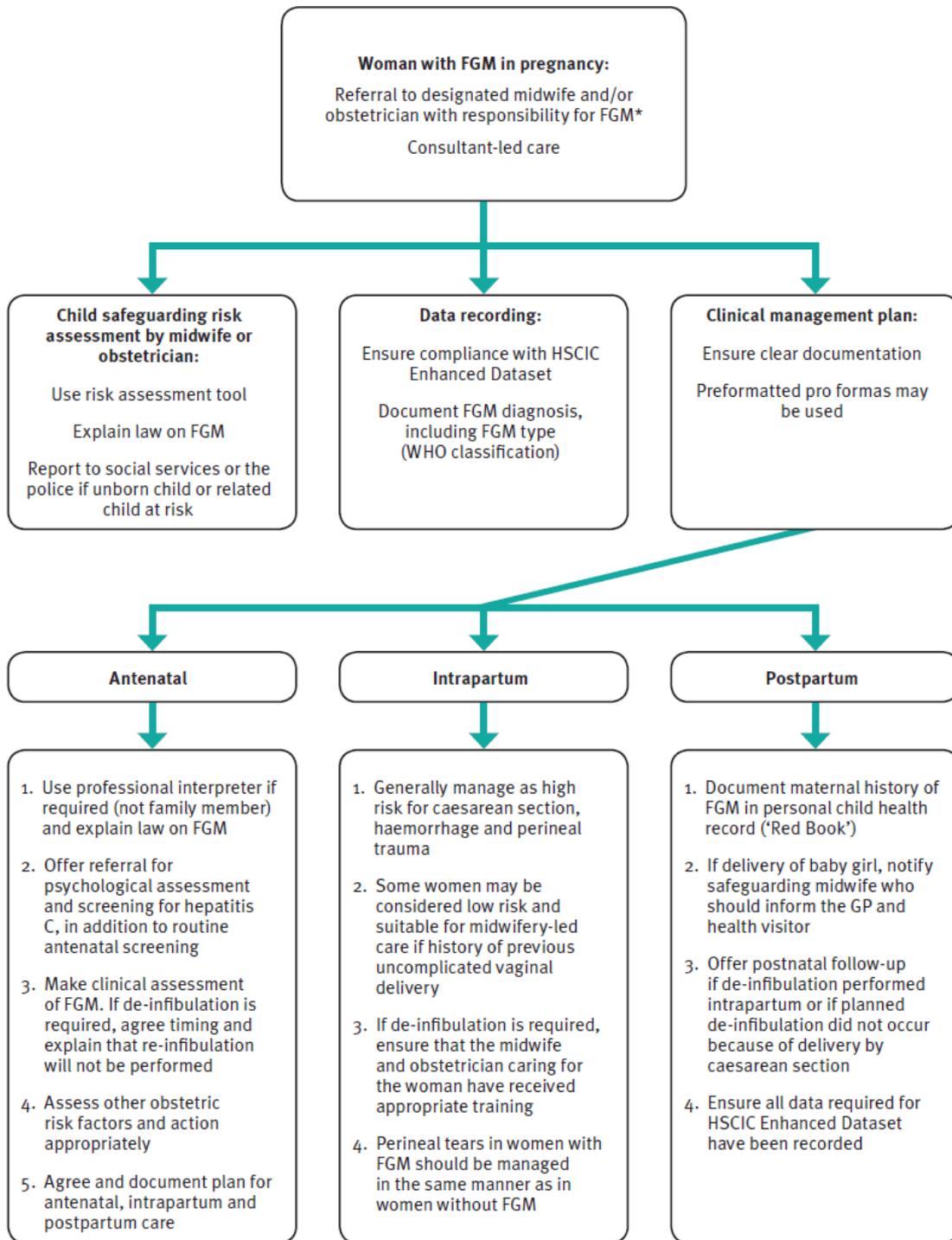
The incision should be made either with scissors or a knife and extended anteriorly until the external urethral meatus is visible.

**4) Suturing of cut edges with absorbable suture**



The cut edges may be oversewn with a fine absorbable suture and a paraffin gauze dressing applied.

**Appendix IV: Plan of care for women with FGM in pregnancy**



\* Local protocols will determine which elements of care (child safeguarding risk assessment, data recording, clinical management plan) should be undertaken by the designated midwife or obstetrician responsible for women with FGM and which may be undertaken by other appropriately trained midwives or obstetricians



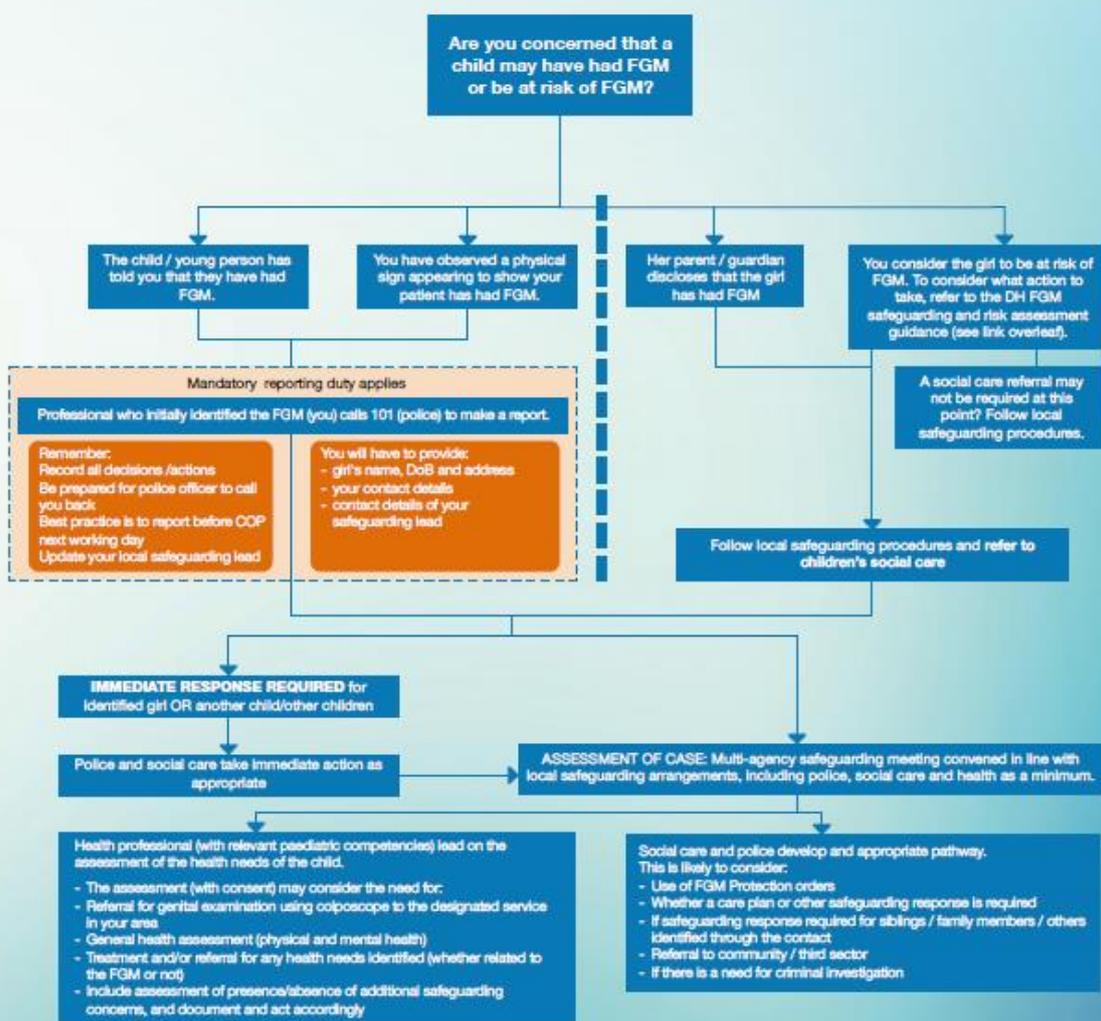
Department of Health



'Care, Protect, Prevent'

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## FGM Mandatory reporting duty



If a girl appears to have been recently cut or you believe she is at imminent risk, act immediately – this may include phoning 999.

**REMEMBER:** Mandatory reporting is only one part of safeguarding against FGM and other abuse. Always ask your local safeguarding lead if in doubt.

## Female Genital Mutilation (FGM) is child abuse and illegal.

Regulated health and social care professionals and teachers are required now to report cases of FGM in girls under 18s which they identify in the course of their professional work to the police.

### How can I prepare?

- Full support pack: [www.gov.uk/government/publications/fgm-mandatory-reporting-in-healthcare](http://www.gov.uk/government/publications/fgm-mandatory-reporting-in-healthcare)
- FGM eLearning: [www.e-lfh.org.uk/programmes/female-genital-mutilation](http://www.e-lfh.org.uk/programmes/female-genital-mutilation)
- Videos: [www.nhs.uk/fgmguidelines](http://www.nhs.uk/fgmguidelines)
- FGM Multi-Agency Practice Guidelines: [www.gov.uk/government/publications/female-genital-mutilation-guidelines](http://www.gov.uk/government/publications/female-genital-mutilation-guidelines)
- [www.workingtogetheronline.co.uk](http://www.workingtogetheronline.co.uk)
- FGM Safeguarding guidance: [www.gov.uk/government/publications/safeguarding-women-and-girls-at-risk-of-fgm](http://www.gov.uk/government/publications/safeguarding-women-and-girls-at-risk-of-fgm)
- Search for guidance from Royal Colleges and regulators

### Remember:

- This is a personal duty; the professional who identifies FGM / receives the disclosure must make the report.
- If a woman is over 18 when she discloses / you identify FGM, the duty does not apply and you should follow local safeguarding processes.
- Do not undertake a genital examination unless this is already part of your role.
- Complying with the duty does not breach data protection rules or other confidentiality requirements.
- Non-regulated healthcare staff should report through existing safeguarding procedures.
- This duty is about reporting a crime. NHS organisations continue to be responsible for collecting and recording data on FGM.

## FAQs

**A girl is using another term which I think is FGM. Do I need to report?**

Yes. Whether she uses the term 'FGM' or any other term or description, e.g. 'sunna' or 'cut', the duty applies.

**Does the duty apply to professionals in private education/healthcare?**

Yes, if working as a regulated professional, the duty will apply.

**Should you only report if you are certain that FGM has been carried out?**

Yes. When you see something which appears to show in your opinion that a girl has FGM, you should make the report. A formal diagnosis will be sought as part of the subsequent multi-agency response.

**I have identified a case but the patient is over 18, what should I do?**

The duty does not apply in this case. You should signpost the woman to services offering support and advice. You may also need to carry out a safeguarding risk assessment considering children who may be at risk or have had FGM.

**Some FGM is very difficult to notice. What if I did not notice signs when I was caring for a patient who is later identified as having had FGM?**

If an allegation of failure to report is made, all relevant circumstances will be taken into account by the regulators, including your experience and what could reasonably have been expected.

**I am treating a girl under 18 with a genital piercing / tattoo. What should I do?**

You should make a report.

**How quickly should I make a report?**

The safety of the girl or others at risk of harm is the priority. You should report ASAP with the same urgency as for all other safeguarding cases. If you believe reporting would lead to risk of serious harm to the child or anyone else, contact your designated safeguarding lead for advice; you may need longer to take action, in exceptional circumstances.

**Should I tell the girl / family about the report?**

Yes, wherever possible you should explain why the report is being made and what it means. If you believe reporting would lead to risk of serious harm to the child or anyone else, do not discuss it but instead contact your local designated safeguarding lead for advice.

**Following a risk assessment for a girl I've identified as being at risk of FGM, it isn't appropriate to refer to social care at this point. What should I do?**

You should share information about the potential risk and your actions with your colleagues across health (GP, school nurse and health visitor as a minimum) and discuss next steps with your local safeguarding lead. A new system to support these cases from January 2015 is the FGM Risk Indicator System. See [www.hscic.gov.uk/fgmris](http://www.hscic.gov.uk/fgmris) for details.

