Female Genital Mutilation

	V2	Version Date	November 2019
Policy Owner	Dawn Sherry		
Author	Piet Van Hensbergen (Named Doctor Safeguarding Children) & Dawn Sherry (Named Midwife Safeguarding Children)		
First approval or date last reviewed	November 2019		
Staff/Groups Consulted	Obstetricians, maternity teams, safeguarding teams ,FGM lead		
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Discussed by Policy Group	Yes		
Approved by [Committee Name]	Maternity Guideline Ratification Sub Committee		
Next Review Due [6 month prior to expiry date]	May 2022		
Policy Expiry Date	November 2022		
Policy Audited			
Equality Impact Assessment Completed	Yes		

Contents

Key points

- FGM is a form of child abuse and is recognised as a human rights violation by the UN; there is no justification for it under any circumstances.
- FGM has been illegal in the UK since 1985 and it is also illegal to take a girl abroad to undergo FGM if they are a British citizen or habitually resident in the UK.
- You have a statutory responsibility to safeguard girls from being abused through FGM.
- You have a duty to report all cases of FGM to the DOH, refer to children's social care and utilise the FGM-IS alert system when you identify a child / unborn at risk of FGM.

1.0 Introduction

The World Health Organisation (WHO) defines female genital mutilation as: "all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons (WHO 2010).

In 2014 it was estimated that 137,000 women and girls living in the UK have experienced FGM. There are no local authorities in the UK free from FGM (City University London 2015).

2.0 Classifications and prevalence

2.1 The WHO classification of FGM breaks it down into four types:

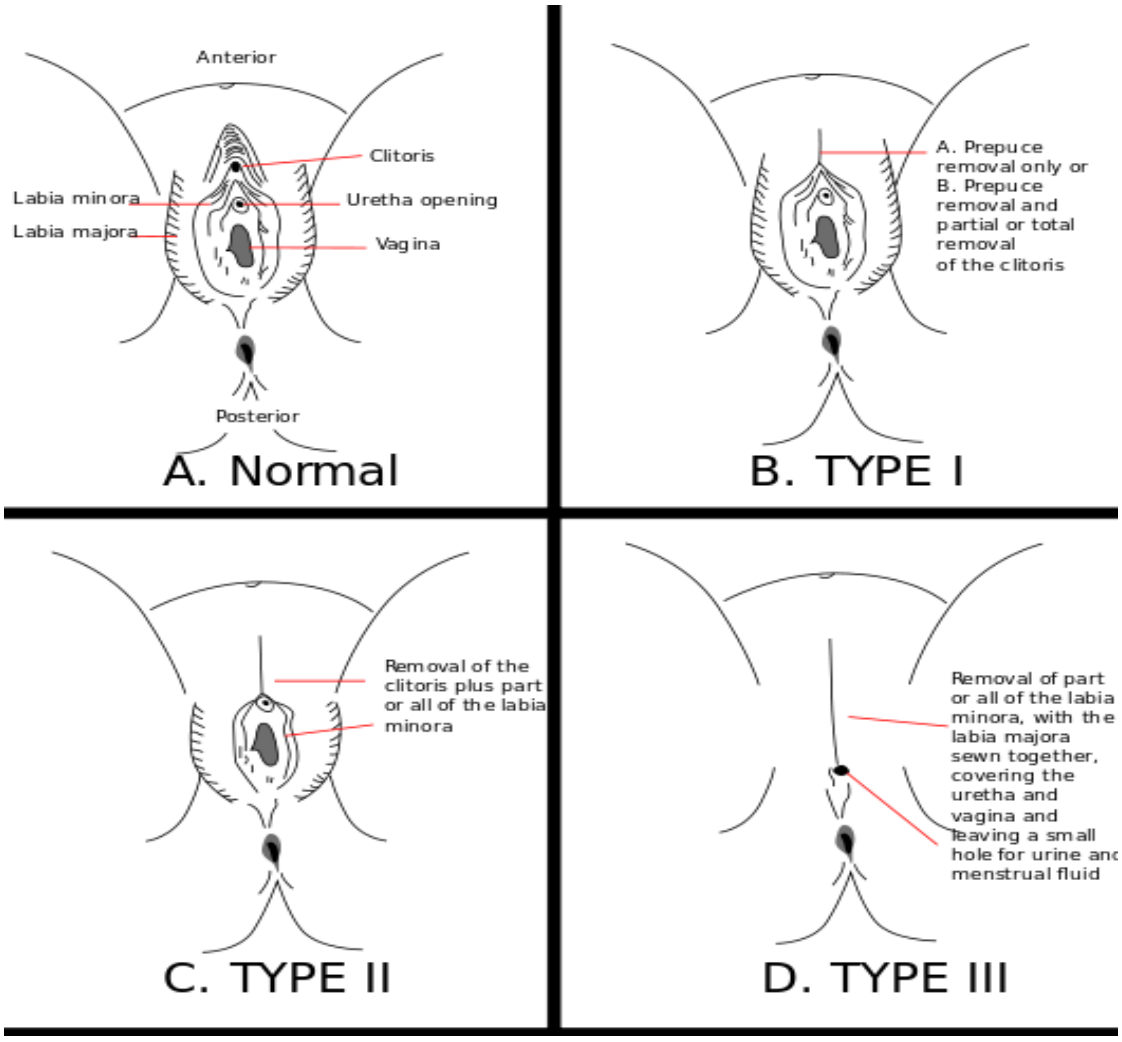
Type I: Partial or total removal of the clitoris and/ or the prepuce (clitoridectomy).

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

Type III: (Infibulation) 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.

Type IV: All other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterising. (NB. the legal status of piercing is unclear in the UK).

Ninety percent are either Type I, II or IV, while Type III (infibulation) is only found in 10% of known cases.



2.2 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.

FGM is not a requirement for any religious doctrine, but it serves as a complex form of social control of women's sexual and reproductive rights.

2.3 FGM is also known as "female genital cutting", "circumcision" or "initiation". Cutting is the common term used at community level, but given the different nationalities practicing FGM, there are clearly also a number of foreign language words for FGM (see Multiagency Practice Guidelines: Female Genital Mutilation 2014 www.gov.uk/fgm).

3.0 The Law and FGM

The Female Genital Mutilation Act 1984 made FGM an offence to be carried out in the UK on any female.

The Female Genital Mutilation Act 2003 consolidates the 1984 Act making it not only an offence to perform FGM in England, Wales or Northern Ireland, but also an offence to:

- assist a female in carrying out FGM on herself in England, Wales or Northern Ireland or
- assist a non-UK national from carrying out FGM outside the UK on a UK national or permanent UK resident

NB: if mutilation takes place in England, Wales or Northern Ireland, the nationality or residence status of the victim is irrelevant.

Section 4 of the 2003 Act makes it an offence for a UK national or permanent resident:

- to perform FGM abroad
- to assist a girl to perform FGM on herself outside the UK and
- to assist a non-UK person to carry out FGM outside the UK on a UK national or permanent UK resident.

4.0 Reporting and recording FGM

4.1 From September 2014 it became mandatory for all acute Trusts to report FGM to the DOH every month. The purpose of this obligation on hospitals is to provide more information on the prevalence of FGM than ever before. This will help develop the national response to FGM and to use the data to commission services.

4.2 In April 2019 the national information sharing system FGM-IS was implemented at Taunton and Somerset NHS Foundation Trust. This system:

- Enables a medical professional to record when a girl under 18 has a family history of FGM
- Shares that information with other professionals who treat her as she grows up
- Prompts the clinicians to consider if they need to take safeguarding/other action.

With immediate effect for any female infant who is identified as being at risk of FGM i.e: family member has had FGM an alert will be added to the child's summary care record (on the NHS spine). An alert will also be placed on the child's record on the Maxims system. (See appendix 1 for FGM-IS quick guide).

5.0 Talking about FGM

5.1 All women should be asked sensitively about FGM at booking (maternity only).

5.2 Where a woman has a hearing impairment, or her first language is not English, arrangements should be made for an interpreter to be present. Wherever possible it should be ascertained from the woman whether the interpreter is suitable. Family members and friends should never be used to interpret interviews of this kind.

5.3 Simple language should be used including direct questions such as: have you been closed? Were you circumcised? Have you been cut down below?

5.4 It is important to ensure the family/young person understand the illegality of this practice whilst being sensitive to FGM as an embedded custom.

5.5 It is important to take detailed notes particularly of the country of origin, type of FGM, the age at which FGM was carried out, who by and in which Country. This must be carefully documented including details of discussions with the parent/carer.

6.0 Safeguarding responsibilities and FGM

If you are worried about a child under 18 (including potential risk to an unborn) who is at risk of FGM or has had FGM, you have a legal obligation to share this information with Children's Social Care or the Police. They will then convene a strategy meeting and will investigate, safeguard and protect any girls involved. Safeguarding in these circumstances is a challenge because the families may give no other cause for concern i.e. in every other way they may be loving families who are simply doing what they feel is best (or are told what is best for their child). Where professionals believe that an individual has undergone FGM, they must also consider the risk to other girls in the extended family.

For further support contact Named Midwife, Nurse or Doctor for Safeguarding or out of hours contact the emergency duty team.

7.0 Maternity guidance

7.1 Antenatal Period

All clinical staff should be aware of the nominated obstetrician (link-person) in the Trust or community with whom cases may be discussed or referred.

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

It is YDH maternity guidance that sensitive enquiry at the booking appointment should be made to determine the FGM status of all women.

7.2 If FGM is identified:

- Inform complex care team (Acorn) using communication form.
- Complete a referral to children's social care (following confirmation of a viable pregnancy via USS).
- Refer to the nominated obstetrician antenatal clinic
- Inform the nominated obstetrician and Named Midwife for Safeguarding and they will ensure that the DOH return is completed.

8.0 Deinfibulation

8.1 Antenatal de-infibulation

Antenatal de-infibulation should be offered if vaginal access is inadequate, and to all women with type III FGM. It should ideally be performed around 20 weeks gestation (reduces risk of miscarriage and allows time for healing before birth).

Benefits of antenatal de-infibulation:

- Avoids the need to cut scar tissue in labour
- Reduces excessive laceration
- Reduces the risk of fetal asphyxia due to delayed crowning at the point of delivery
- Reduces the incidence of bacterial vaginosis and associated preterm labour

8.2 Procedure for antenatal de-infibulation

- Pre-op: MSU, Group & Save
- Setting: Room 9 or Operating Theatre on Labour Ward
- The professional undertaking the de-infibulation must have experience
- Ensure adequate analgesia (pre & post-op) usually local/ regional
  consider psychological needs (G.A. may rarely be indicated)
- Use a blade or scissors for the procedure
- The incision should be made along the vulval excision scar until reaching the point where the urethral meatus is clearly visualised
- Closure of the newly opened edges should be brought together with fine absorbable material (Vicryl Rapide) to reduce the likelihood of infection and bleeding and to keep the opposed edges separated
- Women should be advised that the flow of urine will change as they will pass urine much quicker and with greater volume. A perceived 'lack of control' when emptying the bladder is common

- Complete Plan of Care/ audit tool (appendix 2)
- Women should drink plenty of water after the procedure to help dilute the urine and reduce stinging sensation to the area. They should not use soap or detergent (only plain water) to keep the area clean for the first 3-4 days following the procedure
- Consider prophylactic antibiotics
- Antenatal care continues as for any other woman

8.3 Intrapartum de-infibulation (offered if vaginal access is adequate)
Some women would prefer to have the procedure performed during labour (so as to experience only one lot of pain and trauma). This may be normal practice in their country of origin. Counselling by specialist FGM services may be necessary.

9.0 Intrapartum Care

9.1 Potential Maternal Consequences of FGM:

- Fear of childbirth
- Increase likelihood of caesarean section
- Increase likelihood of postpartum haemorrhage
- Increase likelihood of episiotomy
- Increase likelihood of severe vaginal lacerations (including fistula formations)
- Extended hospital stay
- Difficulty performing vaginal examinations
- Difficulty in applying fetal scalp electrode
- Difficulty in performing fetal blood sampling
- Difficulty in catherisation of the bladder

9.2 When de-infibulation has been performed antenatally:

- Aim for vaginal birth
- Aim for intact perineum
- Episiotomy is recommended if inelastic scar tissue prevents progress and should be medio-lateral.

9.3 When no antenatal de-infibulation (unbooked or elected for intrapartum De-infibulation):

- Birth should be in a unit with immediate access to facilities for emergency obstetric care
- The Labour Ward Coordinator must be informed.
- The woman should be allocated a Senior Midwife
- Aim for vaginal birth
- Place IV Access; send FBC and Group & Save (risk of PPH)

- Provide adequate analgesia to prevent flashbacks to original procedure
- Inform Consultant Obstetrician
- Epidural should be offered, adequate pain relief is essential as vaginal examinations are poorly tolerated, for anterior episiotomy and de-infibulation, and to psychologically reduce flashbacks
- Perform de-infibulation in the second stage of labour
- Informed consent is essential prior to de-infibulation
- Infiltrate with local anaesthetic
- Perform an anterior midline incision to expose the urethra and clitoris that are beneath the scar tissue. (If uncertain, stop when the urethral meatus is visible)
- In the 2nd stage of labour perform the incision at the time of the fetal head crowning
- Stretching the fused labia allows a good view of the fusion line and minimises blood loss
- Care must be taken to protect the fetal head from laceration

IT IS ILLEGAL TO REINFIBULATE

WHO recommends ~ suturing raw edges to prevent re-infibulation

10.0 Postnatal Care

10.1 Routine care

- Debrief if de-infibulation was carried out during labour
- Discuss with woman legal status of FGM in the UK (especially if baby girl or girls in the family)
- Inform Health Visitor
- Inform woman of the link between FGM, pain and health problems in later life
- If de-infibulation was carried out in labour, 4-6 week postnatal follow up recommended to assess healing (GP or hospital appointment)
- If de-infibulation was carried out in labour, advise to avoid sexual intercourse until healing has occurred and to use lubrication if necessary
- Advice / counselling may be required in relation to passing urine, menstruation, sexual health needs
- Discuss contraception, IUCD will be a method not previously available
- Cervical smear uptake should also be discussed

11.0 Paediatric guidance

11.1 Indicators that a child may be at risk of FGM:

- Country of origin
- Mother or older sibling having FGM
- Girls withdrawn from personal & social education lessons (the rationale for this being that the families do not wish their children to be educated about normal female anatomy, normal sexual practices, or the empowerment and self-determination of women).
- Girls trying to travel to their country of origin particularly at the beginning of the school holidays.
- Visiting female elder.
- Mention of a “special ceremony” or becoming a women.

There is no doubt that FGM is carried out on girls and young women in the UK as well as those that are taken overseas. There is emerging evidence that because of the increased awareness of society (and safeguarding partners in particular) to the risks of FGM, that armies of “cutters” are visiting the UK during school holidays to perform FGM. It is therefore important to be alert to visiting family elders at the beginning of the school holidays.

11.2 Indicators that FGM may have taken place:

- Walking difficulties
- Trouble sitting for prolonged periods (e.g. in school).
- Long periods in the loo as they struggle to pass urine.
- Repeated absences from school.
- Not brought to hospital/health appointments
- Behaviour change
- Frequent urinary tract infections.
- Period problems.
- Disclosure

11.3 Follow up care:

Support should always be offered in the form of information, a specialist clinic, counselling and support groups. An interpreter may be required, do not use a family member and ensure that the interpreter has received appropriate training in FGM matters and understands the illegality. Be aware that the communities in which FGM is practiced tend to be very close and care must

be taken to ensure that the translator is not someone with close links to this particular community.

Consideration should also be made regarding referral to psychological services to access appropriate counselling and support services to manage the long-term psychosocial FGM and sequelae.

12.0 Audit and Monitoring

Due to the very small numbers of cases of FGM identified at Yeovil District Hospital NHSFT each case will be audited by the Named Midwife, Named Nurse or Named Doctor as they occur.

References

References (Maternity)

RCM (1998) Female Genital Mutilation (Female Circumcision). Position Paper No 21. RCM. London.

Royal College of Obstetricians and Gynaecologists (2009) Female Genital Mutilation. RCOG Green-Top Guideline No 53. London.

Toubia, N (1999) Caring for women with circumcision: a technical manual for health care providers. RAINBO.

World Health Organisation (2001) Management of pregnancy, childbirth and the postpartum period in the presence of female genital mutilation. London.

Department of Health Taskforce on the Health Aspects of Violence Against Women and Children set up a sub group on Harmful Traditional Practices and Human Trafficking.

The Royal College of Obstetricians and Gynaecologist - Female Genital Mutilation and its management:
www.rcog.org.uk/female-genital-mutilation-and-its-management-green-top-53

References (Paediatric)

HM Government Multi-Agency Practice Guidelines – Female Genital Mutilation 2014 at www.gov.uk/fgm

13.0 Further information and resources

The London Child Protection Procedures: Safeguarding Children through risk of abuse through Female Genital Mutilation:
www.londonscb.gov.uk/fgm/

https://www.gov.uk/government/publications/female-genital-mutilation-guidelines

https://www.gov.uk/government/publications/safeguarding-women-and-girls-at-risk-of-fgm

Weblink to BAVA (Bristol against violence and abuse)
http://www.bava.org.uk/types-of-abuse/female-genital-mutilation/

Appendix 1

FGM-IS Quick Guide

What is the FGM-IS system?

National Safeguarding System to share information, which:

- Enables a medical professional to record when a girl under 18 has a family history of FGM
- Shares that information with other professionals who treat her as she grows up
- Prompts the clinicians to consider if they need to take safeguarding/other action.

The FGM-IS tab is accessible on the Summary Care Record application (SCRa) (on the NHS Spine Portal) for girls under the age of 18.

How is the system accessed?

FGM-IS can be accessed directly on the internet via the Summary Care Record Application (SCRa) – a web portal.

1. Insert Smartcard and log in using passcode
2. Click on 'systems and services' on trust internet page
3. Click on 'S' and choose 'Summary care record'
4. Search 'find a patient' by using NHS number or patient details
5. The FGM-IS tab will be present for all girls under 18. Click on the tab to see if there is an active alert.

This alert will also be added to Trakcare once the FGM-IS alert is created.

How does the system support safeguarding?

- Family history is known to be relevant when considering potential risk to a girl of undergoing FGM.
- The user will record when a family history has been identified using the FGM-IS.
- When a professional sees the FGM-IS indicator, they know a family history of FGM has been identified and they can treat the child accordingly.

When should an FGM indicator be used?

When you identify a girl has a family history of FGM

- Consider both parents and grandparents (if possible)
- Good practice to discuss with the family but do not need consent to add/share information

- ALWAYS document any conversation and actions taken in the girl's case notes.
- This becomes part of her medical record

When you have identified a family history of FGM

Discussion with parents and girl:

- Explain that you'll be sharing information about her family history in her record to other healthcare professionals who will treat her as she grows up
- This is a protective measure and is part of working together to try and reduce the risk of FGM happening as she grows up
- You DO NOT need to gain parents' consent
- If parents object to the record being added, discuss with your Safeguarding lead. The rationale may be misunderstanding - or it may need to be considered in more depth
- Feedback from live sites is to include FGM-IS as part of the discussion about sharing information with the GP
- Document this discussion
- REMEMBER wider safeguarding responsibilities

Who can add / decide to add the indicator?

Indicator is added to a girl's record by a clinician who is directly caring for her OR by someone delegated to add this to the record on behalf of the clinician who identified the family history.

Clinicians who identify a family history for a girl who is not in their care can still share this information with her GP and request they consider adding the indicator themselves.

Midwife **cannot** add for older sister who visits newly born girl.

At YDH the Named Midwife for Safeguarding (and in her absence the Named Nurse) will be responsible for adding the alert.

When you consider if you need to take action under your safeguarding procedures, you need to consider all aspects:

- Are there wider / other safeguarding concerns?
- Are you worried about something you've been told?
- Do you think that there are other risk factors you can identify?
- Do you need to share information?
- Do you need to refer her?
- **You should discuss this with your safeguarding lead.**
- **REMEMBER – if you have identified this family history you must share this information with GP / HV / relevant professionals working with the family.**

ANNEX A – EQUALITY IMPACT ASSESSMENT TOOL

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Somerset Equality Impact Assessment

Before completing this EIA please ensure you have read the EIA guidance notes – available from your Equality Officer			
Organisation prepared for	**Yeovil District Hospital**		
Version	**1**	**Date Completed**	
Description of what is being impact assessed			
Yeovil Maternity service recognises that all policies and guidelines pertaining to clinical care need to ensure respect within the documentation for people's human rights and for their diversity, and to promote action to reduce inequalities in people's health and experiences of healthcare. Any adverse impact on protected groups as a result of this guideline will be subject to wider consultation and action planning to rectify any inequality. The impact of this guidelines on any groups with protected characteristics is assessed through this EIA			
Evidence			
What data/information have you used to assess how this policy/service might impact on protected groups? Sources such as the Office of National Statistics, Somerset Intelligence Partnership, Somerset's Joint Strategic Needs Analysis (JSNA), Staff and/ or area profiles,, should be detailed here			
Somerset intelligence profile – South Somerset District, - housing, health, age profile, Data Shine Census			
Who have you consulted with to assess possible impact on protected groups? If you have not consulted other people, please explain why?			
Guideline ratification sub-committee of Maternity Clinical Governance committee – no impact identified			

Analysis of impact on protected groups				
The Public Sector Equality Duty requires us to eliminate discrimination, advance equality of opportunity and foster good relations with protected groups. Consider how this policy/service will achieve these aims. In the table below, using the evidence outlined above and your own understanding, detail what considerations and potential impacts against each of the three aims of the Public Sector Equality Duty. Based on this information, make an assessment of the likely outcome, before you have implemented any mitigation.				
Protected group	**Summary of impact**	**Negative outcome**	**Neutral outcome**	**Positive outcome**
Age	No impact identified	☐	☐x	☐x
Disability	No impact identified	☐	☐x	☐
Gender reassignment	This policy supports the care of those with gender reassignment & FGM.	☐	☐	☐x
Marriage and civil partnership	No impact identified	☐	☐x	☐

Pregnancy and maternity	This policy supports the care of pregnant women	☐	☐	☐x
Race and ethnicity		☐	☐x	☐
Religion or belief	FGM may be considered a recognised practice within some cultures and religions but remains unlawful in the UK. This policy applies to UK practice only.	☐	☐	x☐
Sex		☐	☐x	☐
Sexual orientation		☐	☐x	☐
Other, e.g. carers, veterans, homeless, low income, rurality/isolation, etc.		☐	☐x	☐x

Negative outcomes action plan
Where you have ascertained that there will potentially be negative outcomes, you are required to mitigate the impact of these. Please detail below the actions that you intend to take.

Action taken/to be taken	Date	Person responsible	How will it be monitored?	Action complete
	Select date			☐
	Select date			☐
	Select date			☐
	Select date			☐
	Select date			☐
	Select date			☐
	Select date			☐
	Select date			☐

If negative impacts remain, please provide an explanation below.

Completed by:	**Helen Williams**
Date	**27 November 2019**
Signed off by:	**Sallyann Batstone**
Date	**27 November 2019**
Equality Lead/Manager sign off date:	**Elaine Cox / Debbie Matthewson 6 Feb 2020**

To be reviewed by: (officer name)	**Not required unless any change to the guideline**
Review date:	