Policy, Procedures and other Written Control Documents Template

Aneurin Bevan University Health Board

Female Genital Mutilation Guideline

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

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Contents:

1. Introduction/Overview

Female genital mutilation, 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, sometimes known as circumcision or female circumcision. The widely accepted classification of FGM developed by the World Health Organization (WHO) in 1995 and updated in 2007 is shown below. FGM is practised 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.

2. Policy Statement

What is the commitment of the Health Board?
What is the statement of intent?
Cross reference to relevant Health and Care Standards Wales.

3. Aims/Purpose

This local guideline has been written to ensure that care and support for pregnant women with FGM is standardised and accessible. It follows the RCOG green top guideline Number 53 for Female genital mutilation and its management, and the All Wales clinical pathway for female genital mutilation. Both documents are embedded in the guideline.

4. Objectives

This document aims to achieve standardisation and best evidence based care and support for women with FGM.

5. Scope

The document related to all staff within Maternity Services, under the Family and Therapies division at ABUHB.

6. Roles and Responsibilities

Who is responsible for implementation? All health care professionals involved in the care of women with FGM and responsible for the implementation of this document.

All women should be referred to the lead Consultant Obstetrician for female genital mutilation, Mrs Sajitha Parveen, and the lead midwife for safeguarding.

7. Main Body

The All Wales Clinical Pathway – Female Genital Mutilation (FGM) should be followed for all women. This guides professionals on mandatory reporting. For the care and management of women with FGM in pregnancy and for birth, the RCOG guidelines should be followed.

Useful links

https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwiY_5bzma3uAhU9tXEKHeOoD-oQFjAAegQIBBAC&url=https%3A%2F%2Fphw.nhs.wales%2Fservices-and-teams%2Fnational-safeguarding-team-nhs-wales%2Fguidance-key-topics%2Ffemale-genital-mutilation-fgm-all-wales-clinical-pathway-guidance%2F&usg=AOvVaw0-rwSIIXXYZI1JKzgFrQAk

https://www.rcog.org.uk/globalassets/documents/guidelines/gtg-53-fgm.pdf

The legal and regulatory responsibilities of health professionals FGM and UK law

All health professionals must be aware of the Female Genital Mutilation Act 2003 in England, Wales and Northern Ireland. The Act states 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. (See All Wales Guideline attached for reporting process and forms).

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

Identifying women with FGM:

- All women, irrespective of country of origin, should be asked for a history of FGM at their booking antenatal visit so that FGM can be identified early in the pregnancy. This should be documented in the hand held notes on each antenatal contact (box provided).

When a woman with FGM is identified:

- The health professional must explain the UK law on FGM.

- The health professional must understand the difference between recording (documenting FGM in the medical records for data collection) and reporting (making a referral to police and/or social services.

- The health professional should be aware that it is not mandatory to report all pregnant women to social services or the police. An individual risk assessment should be made by a member of the clinical team (midwife or obstetrician) using the FGM safeguarding risk assessment tool (as above).

- If the unborn child, or any related child, is considered at risk then a report should be made.

Management in obstetric and gynaecological practice

- All women should be referred to the lead Consultant Obstetrician for FGM, Mrs Sajitha Parveen.

- All gynaecologists, obstetricians and midwives should receive mandatory training on FGM.

- Lead consultant obstetrician and/or team should offer information and advice about FGM; in relation to child safeguarding risk assessment; gynaecological assessment; de-infibulation; and access to other services.

- Health professionals should ensure that, in consultations with women affected by FGM, the consultation and examination environment is safe and private, their approach is sensitive and non-judgemental and professional interpreters are used where necessary. Family members should not be used as interpreters.

How recent FGM should be managed?

- Healthcare professionals should be vigilant and aware of the clinical signs and symptoms of recent FGM, which include pain, haemorrhage, infection and urinary retention.

- Examination findings should be accurately recorded in the clinical records. Some type 4 FGM, where a small incision or cut is made adjacent to or on the clitoris, can leave few, if any, visible signs when healed. Consideration should be given to photographic documentation of the findings at acute presentation.

- Legal and regulatory procedures must be followed (See above); all women and girls with acute or recent FGM require police and social services referral.

- Clinicians should be aware that psychological sequelae and impaired sexual function can occur with all types of FGM.

- Examination should include inspection of the vulva to determine the type of FGM and whether de-infibulation is indicated, as well as to identify any other FGM-related morbidities, e.g. epidermoid inclusion cysts.

- All women should be offered referral for psychological assessment and treatment, testing for HIV, hepatitis B and C and sexual health screening. Where appropriate, women should be referred to gynaecological subspecialties, e.g. psychosexual services, uro-gynaecology.

- Gynaecologists should be aware that narrowing of the vagina due to type 3 FGM can preclude vaginal examination for cervical smears and genital infection screens. De-infibulation may be required prior to

gynaecological procedures such as surgical management of miscarriage (SMM) or termination of pregnancy (TOP).

- Women with FGM are more likely to have obstetric complications and consultant-led care is recommended. However, some women with previous uncomplicated vaginal deliveries may be suitable for midwifery-led care in labour. This should be discussed fully with the woman and the lead obstetrician for FGM.

- Referral for psychological assessment and treatment should be offered.

- The vulva should be inspected to determine the type of FGM and whether de-infibulation is indicated. If the introitus is sufficiently open to permit vaginal examination and if the urethral meatus is visible, then de-infibulation is unlikely to be necessary.

- Screening for hepatitis C should be offered in addition to the other routine antenatal screening tests (hepatitis B, HIV and syphilis).

- De-infibulation may be performed antenatally, in the first stage of labour or at the time of delivery and can usually be performed under local anaesthetic in a delivery suite room. It can also be performed preoperatively after caesarean section (See RCOG Green top guidelines no. 53 as above).

- The midwife or obstetrician should discuss, agree and record a plan of care.

- Women should be informed that re-infibulation will not be undertaken under any circumstances.

- If a woman requires intrapartum de-infibulation, the midwife and obstetrician caring for her should have completed training in de-infibulation or should be supervised appropriately.

- If de-infibulation planned for the time of delivery is not undertaken because of recourse to caesarean section, then the option of perioperative de-infibulation (i.e. just after caesarean section) should be considered and discussed with the woman.

- Labial tears in women with FGM should be managed in the same manner as in women without FGM. Repairs should be performed

where clinically indicated, after discussion with the woman and using appropriate materials and techniques.

- A woman whose planned de-infibulation was not performed because of delivery by caesarean section should have follow-up in a gynaecology outpatient or FGM clinic so that de-infibulation can be offered before a subsequent pregnancy.

- The discharging midwife should ensure that all legal and regulatory processes have been adhered to prior to discharge.

8. Resources

The lead midwife for safeguarding is responsible for reporting the monthly figures of women with FGM, known to maternity services, on the maternity dashboard, to Welsh Government.

9. Training

All professionals are responsible for attending mandatory training and accessing the ABUHB equality and diversity training online. In addition all staff are encouraged to seek the support and advice of the safeguarding lead midwife and encouraged to access the All Wales FGM training package.

10. Implementation

Implementing the guidelines will be reviewed by notes audits, and through the clinical governance framework.

11. Further Information Clinical Documents

The All Wales Clinical Pathway – Female Genital Mutilation (FGM) (2018)
The Royal College of Obstetricians and Gynaecologists (RCOG) green top guideline Number 53 for Female genital mutilation (updated 2018)

12. Health and Care Standards Wales

This guideline follows the All Wales Clinical Pathway- FGM (2018) Safe and effective care

13. Equality

The MBRRACE-UK : Saving Lives, Improving Mothers' Care 202: Lessons to inform maternity care from the UK and Ireland Confidential Enquiries in Maternal Death and Morbidity 2016-18 (2021) highlights minority ethnic groups, Non UK citizens, non-English speaking, and women born outside the UK as being in a higher risk group. This guideline aims to address inequalities in care for these women, by standardising management and care pathways.

Explain how the document promotes equality of opportunity and/or good relations between different groups.

14. Environmental Impact

An environmental assessment does not need to be carried out.

15. Audit

Discussion and approval by the maternity services clinical effectiveness forum

16. Review

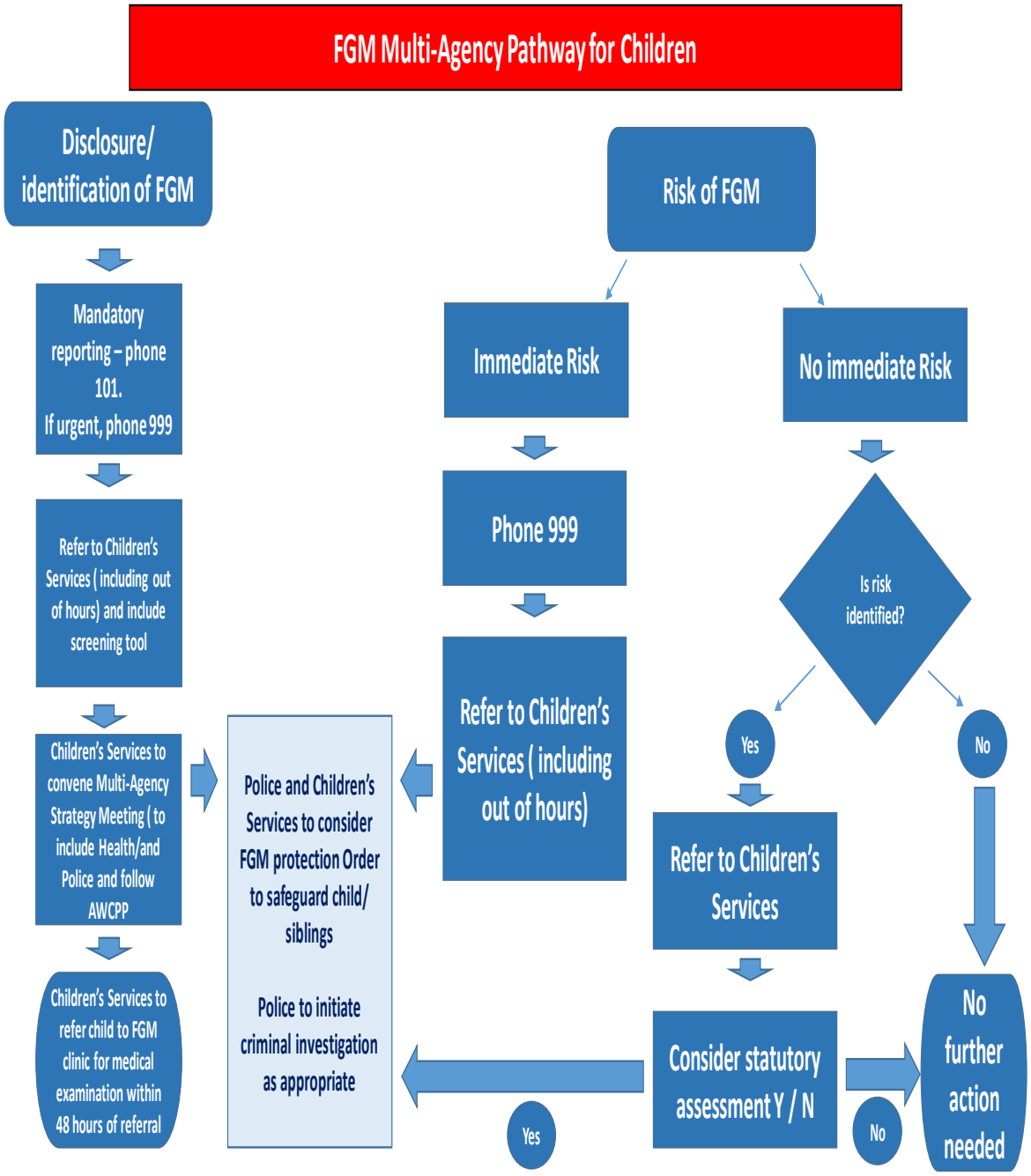
Every three years through the maternity services Clinical Effectiveness Forum

17. References

MBRRACE-UK Saving Lives, Improving Mothers' Care (2016-2018) www.npeu.ox.ac.uk Accessed 14/01/2021
RCOG Green Top Guideline No.53 Female Genital Mutilation and its Management www.rcog.org.uk Accessed 14/01/2021
All Wales Clinical Pathway – Female Genital Mutilation (FGM) www.phw.nhs.wales Accessed 14/01/2021

18. Appendices – Flow Chart

Flow chart reproduced from Cardiff and Vale University Health Board FGM pathway (2021)



19. Appendices

Management of Female Genital Mutilation (FGM)

Complications

Short term :
Haemorrhage (5-62%), Urinary Retention (8-53%), Genital Swelling (2-27%)

Long Term
UTI, Dyspareunia, Bacterial Vaginosis, Genital scarring

Obstetrics
Prolonged Labour, PPH, Perineal trauma, LSCS, Stillbirth, NND

Types of FGM

Partial or total removal

Type 1: Clitoris /prepuce (clitoridectomy).
Type 2: Clitoris and the labia minora, +/- excision of the labia majora.
Type 3: Narrowing of the vaginal orifice by appositioning the labia minora / labia majora, +/- Clitoridectomy.
Type 4: Harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterization.

Obstetric care for Women with FGM

1. Book the patient under the consultant led care
2. Previous uncomplicated vaginal deliveries may be suitable for midwifery-led care in labour.
3. Family members should not be used as interpreters
4. Check Hep B, C and HIV status of patient
5. Access the type of FGM by pelvic examination
6. Access the psychological wellbeing of patient. If any concerns then refer to PNMHT
7. Check whether de-infibulation needed in the ante-natal period or intrapartum under local or regional anaesthesia. Decision should be made by the consultant obstetrician
8. UK Female Genital Mutilation Act 2003 should be explained to the patient
9. All children with FGM or suspected FGM should be seen within child safeguarding services.
10. Refer the patient to Jo Plaster (Lead midwife for safeguarding) regarding social services referral
11. Re-infibulation should NOT be offered
12. Clear documentation- recording and reporting should be done
13. If de-infibulation planned for the time of delivery is not undertaken because of recourse to caesarean section, then the option of perioperative de-infibulation just after caesarean section should be considered and discussed with the woman
14. Labial tears repaired as normal
15. A woman whose planned de-infibulation was not performed because of delivery by caesarean section should have follow-up in a gynaecology outpatient so that de-infibulation can be offered before a subsequent pregnancy.
16. The discharging midwife should ensure that all legal and regulatory processes have been adhered

UK Female Genital Mutilation Act 2003

1. FGM is illegal unless it is a surgical operation on a girl or woman irrespective of her age
2. 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.
3. It is an offence for those with parental responsibility to fail to protect a girl from the risk of FGM.
4. If FGM is confirmed in a girl under 18 years of age reporting to the police is mandatory within 1 month.