University Hospitals Sussex
NHS Foundation Trust

Female Genital Mutilation (FGM)

Maternity protocol: MP027

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Guideline Reviewer:	Fiona Rose
Manager responsible:	John Bell
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Approval Committee:	Women's Safety and Quality Committee
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Cross reference:	**MP001** Provision and Schedule of Antenatal Care **MP035** Care of Women in Labour BSUH FGM Policy

Contents

Key Principles

A protocol is a set of measurable, objective standards to determine a course of action. Professional judgement may be used in the application of a protocol.

Scope

This guideline applies to:

- Women or person who have had female genital mutilation
- This policy needs to be read in conjunction with the BSUH FGM policy.

Responsibilities

Midwives & Obstetricians:

- To access, read, understand and follow this guidance
- To use their professional judgement in application of this protocol

Management:

- To ensure the protocol is reviewed as required in line with Trust and National recommendations
- To ensure the protocol is accessible to all relevant staff

1 Introduction

1.1 Female Genital Mutilation (FGM) is predominantly practiced in North East Africa and parts of the Near East and South East Asia (e.g. Sudan, Somalia, Kenya, Guinea, Gambia, Ethiopia, Egypt, Indonesia) as well as here in the UK.

1.2 The practice of FGM is illegal in England, Wales and Scotland and should be considered as a public health, human rights and a safeguarding children issue

1.3 In England, Wales and Northern Ireland all forms of FGM are illegal under the Female genital Mutilation Act 2003 and in Scotland it is illegal under the Prohibition of FGM (Scotland) Act 2005. The Female Genital Mutilation Act 2003 was amended by sections 70-75 of the Serious Crime Act 2015.

1.4 A person is guilty of an offence if they excise, infibulate or otherwise mutilate the whole or any part of the labia majora, labia minora or clitoris except for operations performed on specific physical and mental health grounds by registered medical or nursing practitioners. It is also an offence to assist a girl to mutilate her own genitalia.

1.5 FGM is an offence which extends to acts performed outside of the UK. Any person found guilty of an offence under the FGM Act 2003 will be liable to a fine or imprisonment up to 14 years or both.

1.6 It is an offence to fail to protect a women or person from risk of FGM.

1.7 Under the Children Act 1989 Local Authorities can apply to the Courts for various Orders to prevent a child being taken abroad for mutilation.

1.8 Under section 5A and schedule 2 of the act provision is made for FGM protection orders. An FGM protection order is a civil law measure which provides a means of protecting actual or potential victims from FGM.

1.9 Applications for an FGM protection order can be made to the High Court or family court in England and Wales with the purpose of protecting a child, woman, person against the commission of a genital mutilation offence or protecting that person where such an offence has been committed.

1.10 The UK Government's Every Child Matters: Change for Children Programme which includes the Children's NSF and is supported by the Children's Act 2004, requires all agencies to take responsibility for safeguarding and promoting the welfare of every child to:

- Be Healthy
- Stay Safe
- Enjoy and achieve
- Make a positive contribution
- Achieve economic well being

Working with this policy framework, professionals and volunteers from all agencies have a statutory responsibility to safeguard children from being abused through FGM

Any information or concern that a child is at immediate risk of, or has undergone FGM should result in a child protection referral to social care in accordance with the Sussex child protection procedures.

2 Types of FGM (See Appendix C)

2.1 The procedure has obvious implications for women and people in pregnancy, during childbirth and post-natally

2.2 According to the World Health Organisation (WHO) there are 4 types of FGM

2.2.1 Excision of the prepuce with or without excision of part or all of the clitoris.

2.2.2 Excision of the clitoris with partial or total excision of the labia minora.

2.2.3 Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).

2.2.4 Unclassified – includes applying corrosive substances for narrowing the vagina, pricking, piercing, incising, stretching, scraping or other harming procedures performed on the clitoris and/or labia.

https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation 2018

2.3 Recording of FGM is a mandatory requirement. (See Appendix D and E) Regardless of the reason for presentation women should be informed that "personal data is submitted in order to prevent duplication, but is anonymised at the point of analysis". This will be completed by the midwifery safeguarding team

3 FGM-IS

3.1 The FGM-IS is a national IT system that supports the early intervention and ongoing safeguarding of girls and people, under the age of 18, who are potentially at risk of female genital mutilation (FGM).

3.2 The FGM-IS is part of the NHS Spine. Healthcare professionals and approved administrative staff can view, add and remove the FGM risk indicator, and it can be accessed via the Summary Care Record Application (SCRa), or with a local clinical system integrated with FGM IS.

3.3 Access is controlled via NHS smartcards and the appropriate Role Based Access Codes (RBAC), so only authorised healthcare professionals and administrative staff with the relevant security permissions can access the FGM risk information.

3.4 UHSFT has been part of this National scheme within the maternity department since April 2018. If staff have any questions please call the safeguarding children team on ext 62363

4 Antenatal Care

4.1 Problems may arise because of the unfamiliarity of the medical and midwifery staff with the procedure, as well as the culture and traditions of the relevant community.

4.2 Midwives are responsible for recognising women at risk of having had FGM early in the antenatal period. See MP001 Provision and Schedule of Care for details on accessing translators.

4.3 To avoid discrimination all women and people should be asked by the midwife if they have been circumcised / cut. Their answer should be documented on BadgerNet which leads to the risk assessment which triggers the safeguarding midwives to be notified.

4.4 Since 31 October 2015, regulated health and social care professionals and teachers in England and Wales have been legally required to report 'known' cases of FGM in under 18s, which they identify in the course of their professional work, to the police.

4.5 Any woman who discloses that they have been 'cut' must be given an information leaflet (appendix G) about the fact that in the UK FGM/circumcision/cutting is illegal.

4.6 The FGM flow chart risk assessment (appendix E&F) should be completed & discussed with the women and person. This risk assessment and flow chart will sign post professionals for the need for a children services referral. Consent should be obtained prior to referral. Discussion with the women and person should be made regarding FGM is and what will happen if the infant is female.

4.7 The safeguarding children team (01273 696955 ext 2363) need to be informed and will discuss the results of the flow chart risk assessment and support the referral to the children's services if required, support the possibility of a strategy meeting & completing the University Hospital Sussex database.

4.8 Women and people from countries where FGM is a common practice may not have a good command of English, and if so Interpreter services should be utilised during counselling.

4.9 Women and people from countries where FGM is undertaken may have just fled war and violence and might be separated from their families. They will therefore need empathy and support.

4.10 **Primigravid** women and people: the midwife should provide information about her birth options and ask them about their preferred method of birth which may depend on the degree of FGM.

4.11 **Multigravid** women and people may have had previous vaginal birth with large episiotomies. If they have given birth in their country of origin they may have been re-infibulated following birth. This information must be documented on BadgerNet.

4.12 All women and people who have FGM must be informed any tear from the scar tissue from circumcision will not be re-sutured following birth, as it is illegal in this country. This should be documented clearly on BadgerNet. The only suturing that will be carried out would be to stop bleeding or to repair a tear from birth in line with usual indications.

4.13 All women and people with FGM should be offered an appointment with a consultant obstetrician as early as possible in the pregnancy, to discuss their general health status and the impact of having had FGM performed in potentially non sterile environment, birth options, and postnatal care to develop an individualised plan of care. Midwives should complete a referral for an appointment at the antenatal clinic specifying reason for referral. If women request a female consultant review, this should be supported and facilitated.

4.14 An examination should be carried out by an experienced obstetrician, with informed consent, to assess the extent of damage.

4.14.1 If the urethra is visible and/or 2 fingers can be inserted into the vagina comfortably, then it is unlikely that birth will be complicated by any physical obstruction that requires management.

4.14.2 Women and people who had a more extensive form of FGM will need counselling whether to have defibulation during pregnancy or not. They also need counselling about the need to perform an anterior episiotomy at the time of birth. Counselling may need to include husbands and family, as women may fear adverse culturally influenced issues in the event of defibulation.

4.14.3 Women with significant degree of FGM may suffer from urinary tract infection, as a result of voiding difficulty and/or vaginal contamination. Urine should be checked with dipstick at each visit and if infection is suspected, a urine sample should be sent for culture and sensitivity and antibiotic treatment should be provided accordingly. Recurrent urinary tract infection in pregnancy may necessitate defibulation.

5 Antenatal Defibulation

5.1 Antenatal defibulation offers a number of advantages including;

5.1.1 Ability to obtain uncontaminated urine sample.

5.1.2 Ability to perform vaginal examination.

5.1.3 Easy application of fetal scalp electrode and obtaining of fetal blood sample during birth , and thus avoidance caesarean section for uncertain fetal condition.

5.1.4 Avoidance of obstruction and tearing at the time of birth as per ORB (perineal protection)

5.1.5 The indications for antenatal defibulation include;

- Repeat urinary tract infection.
- Obstructed access to the vagina, precluding vaginal examination.

5.2 Ideally defibulation should be offered and undertaken as early in pregnancy as possible, but can be done at any time. Defibulation should be carried out under local or spinal anaesthesia but the woman may prefer it under general anaesthesia, to avoid the emotional distress of being awake during the procedure. If the procedure is to be carried out under general anaesthetic this should be undertaken after the 2nd trimester. This procedure can be undertaken on labour ward or on a gynaecology list as appropriate and after discussion with the women and obstetrician. Defibulation should be undertaken by a Consultant Obstetrician or Registrar with appropriate training.

5.3 The steps of antenatal defibulation are;

5.3.1 Informed consent should be obtained and documented on BadgerNet.

5.3.2 Local, regional or general anaesthesia should be offered and discussed.

5.3.3 If an all gender inclusive team is requested by the woman this should be facilitated where possible

5.3.4 The woman and people should be placed in lithotomy position with 15◦ lateral tilt.

5.3.5 The fetus should be monitored before and after surgery.

5.3.6 The perineum and vestibule should be cleaned with an antiseptic solution.

5.3.7 Local anaesthesia should be used to infiltrate the area even if procedure is carried out under GA or spinal as this improves post-operative analgesia

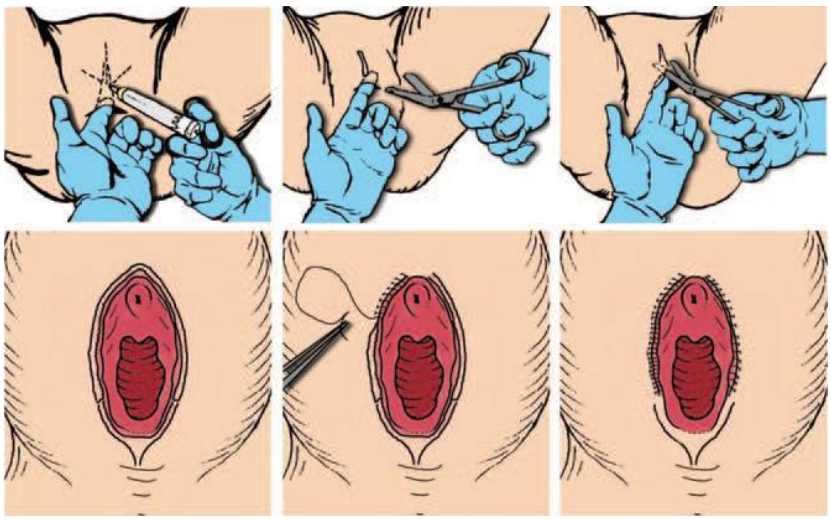
5.3.8 An incision is made in the midline separating the labia on either side, reaching the clitoris and exposing the urethra.

5.3.9 The edges on each side should be closed with vicryl rapide 2/0 (or similar material), keeping both labia apart from each other.

5.3.10 Consider applying 'jelonet' to the edges as this can help to prevent the edges sticking together immediate post procedure

5.3.11 Ideally the sutures should be inverted to avoid discomfort from knots.

5.3.12 Adequate pain relief should be provided after defibulation, as pain can be severe. Women need support to accept their new body image.



6 Intrapartum Care

6.1 Women and people should be offered privacy and dignity as for all service users. Where possible offer a side room if an inpatient antenatally, to ensure confidentiality and privacy of any discussion about FGM

6.2 If FGM is known and could lead to complications of birth or defibulation would be required at birth a hospital birth should be recommended. Women and people who have undergone successful defibulation and are assessed as having low risks for vaginal birth then home birth should be supported as an option. Where unplanned homebirths occur with women who have not been defibulated midwives are expected to provide appropriate care and respond as per their roles and responsibilities.

6.3 Women who request female birth attendants should be supported in this where possible

6.4 Refer to individualised birth plan

6.5 The midwife providing care should inform the on call registrar of the woman's labour progress and agree and document a plan the care for the time of birth including who is able to perform an anterior episiotomy and suturing afterwards. A consultant obstetrician should be informed if the on call middle grade has insufficient knowledge / experience of this procedure.

7 Planned Vaginal Birth

7.1 A full plan of care should be made with the woman and the obstetrician (and midwife) prior to the onset of labour. All plans of care should be documented clearly in the maternal notes.

7.2 Informed consent must be gained and documented for all procedures and interventions. Women must be kept informed at all times of any issues arising, any discussions must be fully documented and women must be involved in their care planning.

7.3 An epidural should be discussed for women planning a vaginal birth. This will facilitate defibulation at the time of birth if required.

7.4 Defibulation can be carried out early in labour to enable fetal scalp electrode insertion and fetal blood sampling. This is best done with the woman in a labour room and under epidural anaesthesia. The woman should be in the lithotomy position with 15 ◦ lateral tilt.

7.5 If the woman and person does not have an epidural then defibulation can be carried out under local anaesthetic.

7.6 Defibulation can be carried out at the time of birth , alongside standard episiotomy if required.

7.7 Aseptic technique should be used and the woman should be draped.

7.8 Infiltration with local anaesthesia should be made, even if epidural anaesthesia is in situ and topped up. This enables good tissue dissection and helps haemostasis.

7.9 The incision is made in the midline separating both labia to the clitoris and exposing of the urethra.

7.10 The edges of the labia on each side should be sutured with vicryl rapide 2/0. If defibulation is carried out at the time of birth, the repair of raw surface can be left till after birth of the baby, alongside the repair of episiotomy.

7.11 Defibulation may be performed, with consent, carefully to free the structures underneath without damaging them further. The bud of the clitoris may still be intact and can be saved. The urethra can be freed from its sheath of skin.

7.12 Defibulation should be performed by a trained clinician.

7.13 Any suturing after birth must not involve re-infibulation. Opposing sides of the remaining labia should be sutured separately to prevent the wound from re-closing. The suturing should be performed by a trained clinician with knowledge, and ideally experience, of this procedure.

7.14 Women and their partners (if present) should have any suturing requirements and postnatal care of their perineum explained to them both verbally and in written form.

8 Postnatal Care

8.1 Midwives should offer to check the perineum and anterior part of the as per routine postnatal care unless clinically indicated otherwise.

8.2 Midwives providing care should encourage mobilisation and give information about care and hygiene to promote healing.

8.3 The female infant of a woman and person who herself underwent FGM is at risk of FGM. If the baby is a girl, the midwife providing care should inform the Safeguarding Midwife prior to discharge and inform the parents that this will be done.

8.4 Maternal FGM must be included in the discharge summary to Community Midwives so that this can be handed over to and documented by the Health Visiting Team.

8.5 All discussions and referrals must be clearly documented on BadgerNet. The midwifery safeguarding team to be informed and support any on-going work required by the maternity obstetric team.

8.6 Community postnatal visiting should be targeted and individualised

8.7 The midwife who discharges the woman and person to the heath visiting service should ensure the health visitor is aware of the FGM. In the antenatal period this can be communicated by completing a HV communication form. If the women and people are considered very high risk this should be completed as soon as possible via a one to one conversation with the named Health Visitor.

9 References

Bikoo M, Davies M, Richens Y, Creighton S (2006) Female genital mutilation: A growing challenge for midwives in the UK. British Journal of Midwifery 14:403–5.

Chalmers B, Hashi KO (2000) Somali women's experiences in Canada after earlier female genital mutilation, Birth 27:227–34.

Criminal Justice Unit (2004) The Female Genital Mutilation Act 2003. Circular 010 / 2004. Home Office, London, UK.
https://www.gov.uk/government/publications/female-genital-mutilation-resource-pack/female-genital-mutilation-resource-pack (2019)

HM Gov (2016) Multi-agency statutory guidance on female genital mutilation

World Health Organization (2004): Female Genital Mutilation, Fact Sheet No 241, WHO: Geneva, Switzerland.
https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation 2018

Prohibition of FGM Act, 2005 (Scotland)-
http://www.legislation.gov.uk/asp/2005/8/pdfs/asp_20050008_en.pdf

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

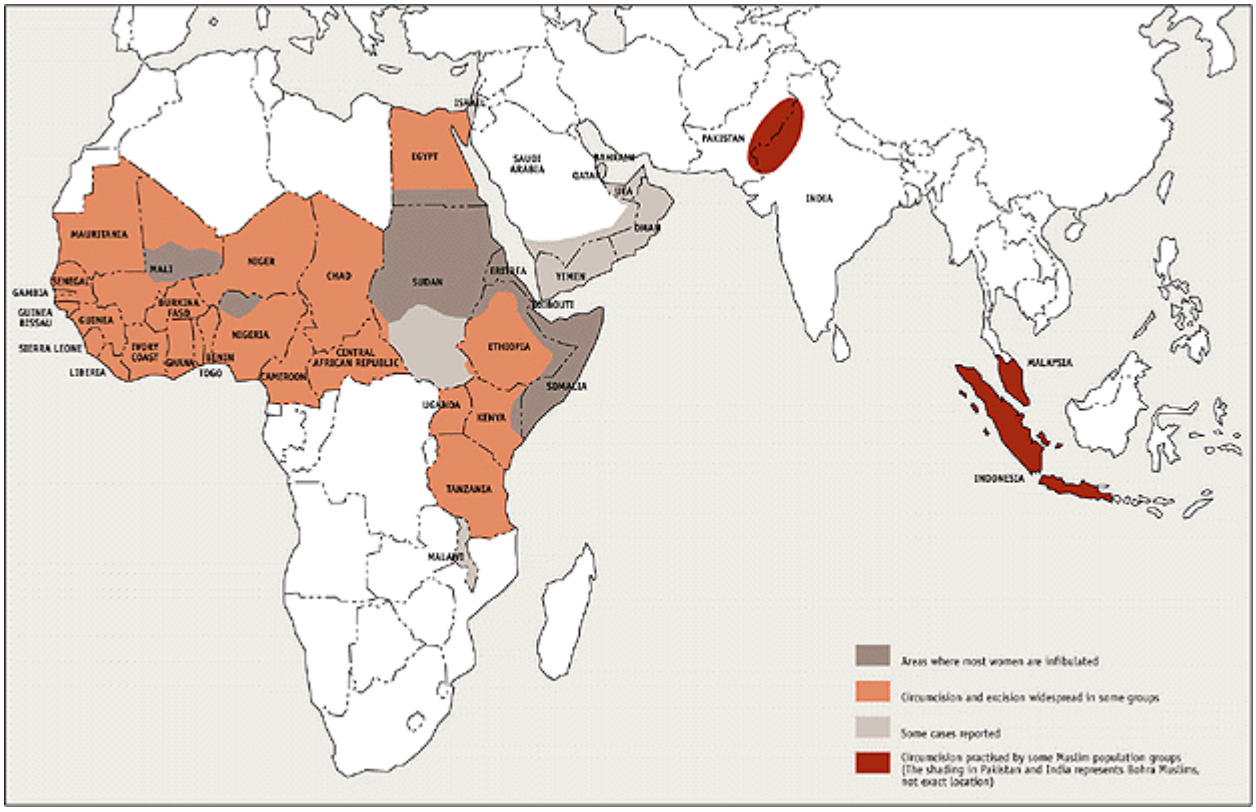
http://www.nhs.uk/Conditions/female-genital-mutilation/Pages/Introduction.aspx

10 Appendix A - Female Obstetrician

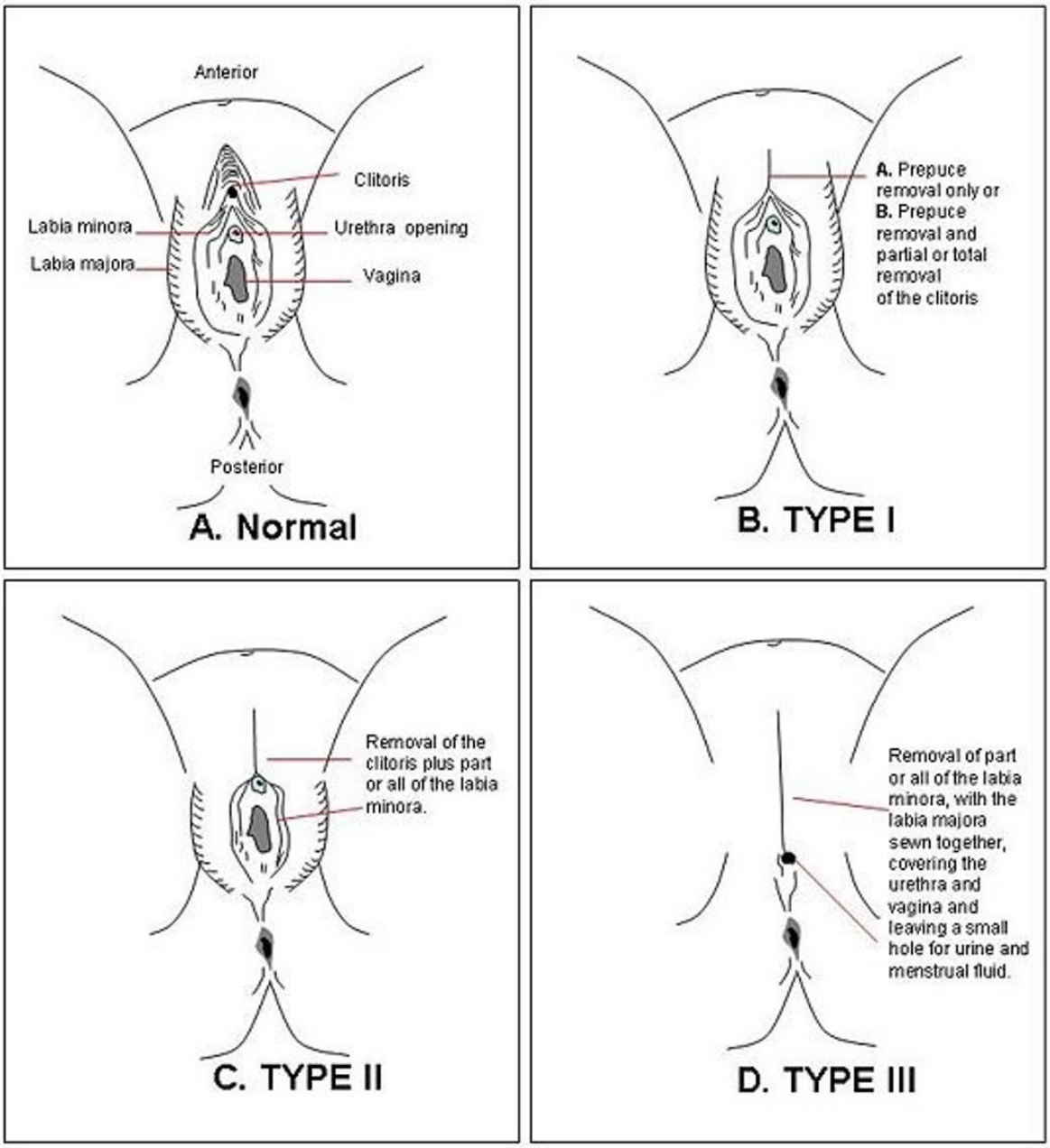
If requesting a female obstetrician, women can be offered a referral to a Consultant Obstetrician for a Antenatal Clinic review during the first trimester pregnancy (or as early as possible in pregnancy).

Please contact the Antenatal Clinic to make an appointment.

11 Appendix B - Incidence of FGM



12 Appendix C - Diagrams Of Types of FGM



13 Appendix D: UHS FGM documentation

FGM documentation (to be kept in the patients records)			
Name & address of Women and Person		DOB	Age
		Patient hosp number	
		Patient NHS number	
		Name of referrer	
If pregnant EDD	FGM Type 1 2 3 4 unknown	Dept	Extension

Key family members			
	Name	Contact number	
Partner			
Children		dob	Male / female
Children		dob	Male / female
Children		dob	Male / female
Children		dob	Male / female

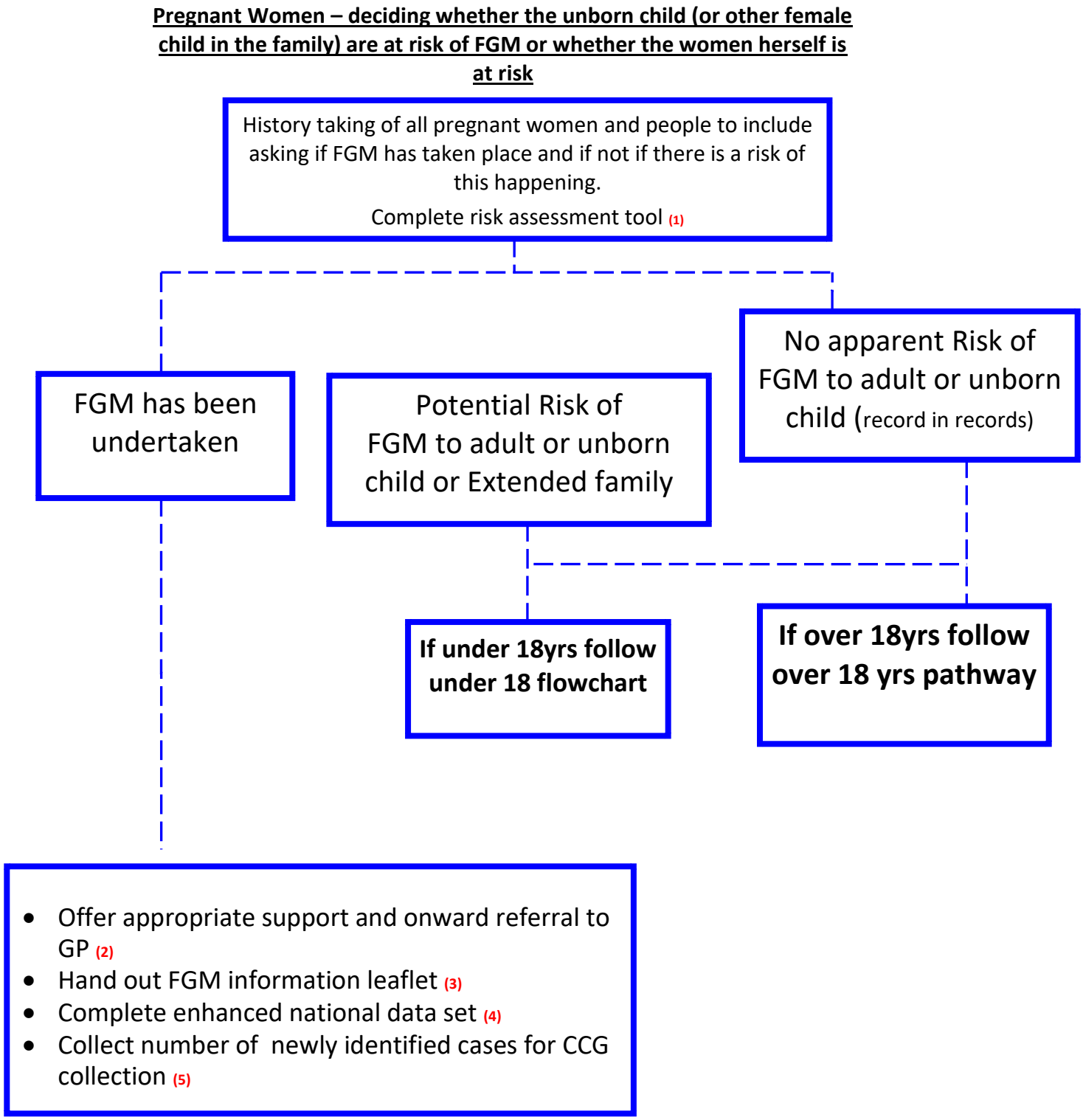
Key individuals involved		
	Name	Contact number
Cons		
GP		
HV		
School nurse		
SW		
Police		

Actions taken	
☐ Risk assessment form completed ☐ Safeguarding team informed (ext 2363) ☐ Leaflet/ Information given to lady & partner ☐ MASH/SW alerted ☐ Police informed (if under 18)	☐ HV informed ☐ School nurse informed ☐ GP informed Strategy meeting required yes no

Discussion & plan		
Date		Signature

14 Appendix E: Risk Assessment Tool Flow Chart

This Flow Chart is to be used in conjunction with Risk Assessment tool contained within the Department of Health Female Genital Mutilation Risk and Safeguarding: Guidance for professionals 2015



15 Appendix F: Risk Assessment Tool for Pregnant Women

Part 1 (A) Pregnant Women

This is to help you make a decision as to whether the unborn child (or other female children in the family) are at risk of FGM or whether the woman herself is at risk of further harm in relation to FGM.

Date:_____
Completed by:_____
Initial/On-going Assessment

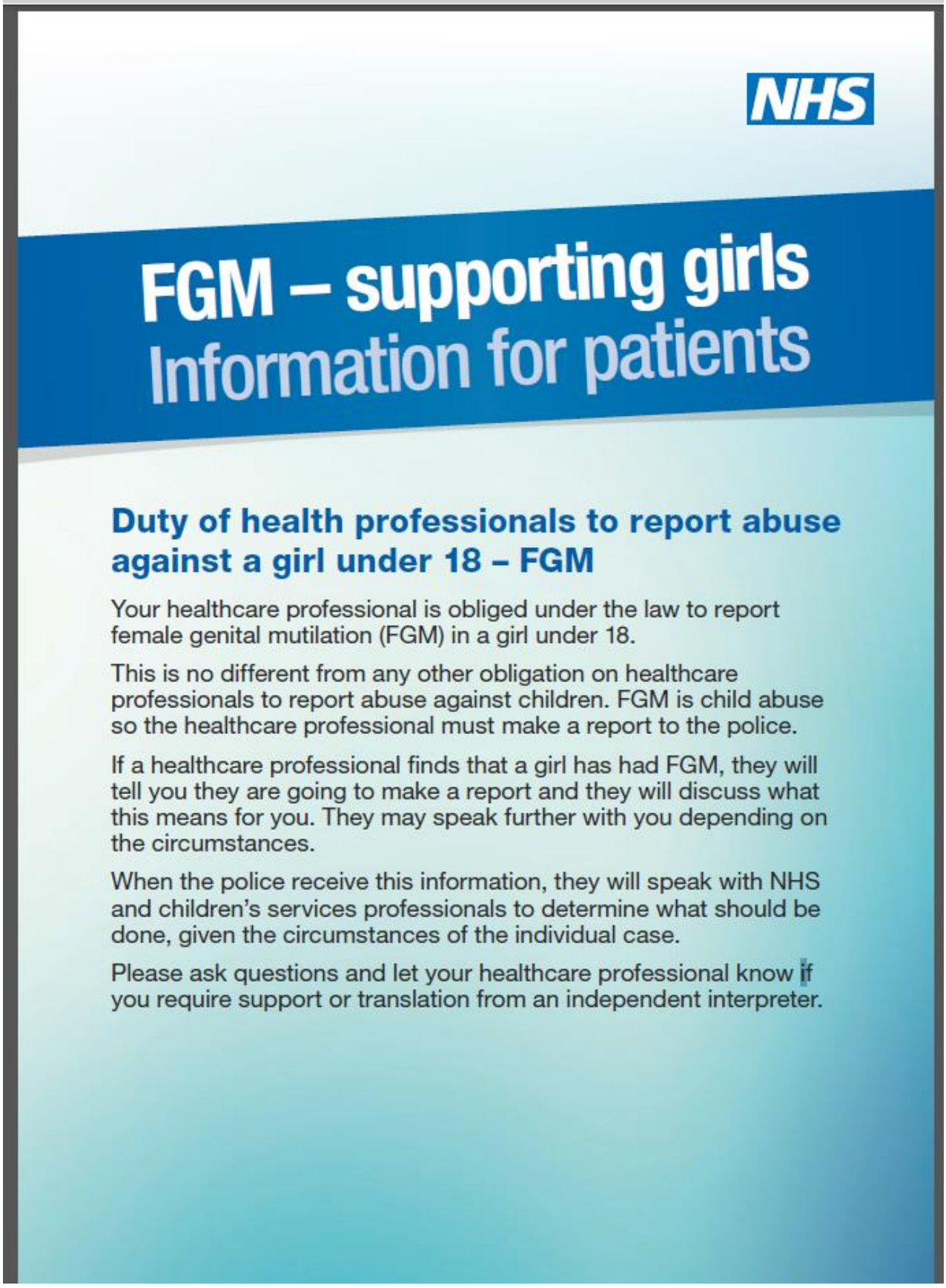
Indictor	Yes	No	Details
CONSIDER RISK			
Woman or person comes from a community known to practice FGM.			
Woman or person has undergone FGM herself.			
Husband/partner comes from a community known to practice FGM.			
A female family elder is involved/will be involved in care of children /unborn child or is influential in the family.			
Women/family has limited integration in UK community.			
Women and persons husband/partner have limited or no understanding of harm of FGM or UK law.			
Women's or persons nieces or siblings and/or in-laws have undergone FGM.			
Woman and person has failed to attend follow-up appointment with an FGM clinic/FGM related appointment.			
Woman's husband/partner/other family members are very dominant in the family and have not been present during consultations with the woman.			
Womanand person is reluctant to undergo genital examination.			
SIGNIFICANT OR IMMEDIATE RISK			
Woman already has daughters who have undergone FGM.			
Woman and personhas requesting reinfibulation following child birth.			
Woman and person is considered to be a vulnerable adult and therefore issues of mental capacity and consent should be considered if she found to have FGM.			
Woman and person who says that FGM is integral to cultural or religious identity.			
Family are already known to social care services – if known, and you have identified FGM within a family, you must			

ACTION

Ask more questions - if one indicator leadss to potential area of concern, continue the discussion in this area.
Consider risk – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/designated safeguarding lead.
Significant or immediate risk – if you identify one or more serious or immediate risk, or the other risks are, by your judgment, sufficient to be considered serious, you should look to refer to Social Services/CAIT Team/Police/MASH, in accordance with your local safeguarding procedures.
If the risk of harm is imminent, emergency measures may be required and any action taken must reflect the required urgency.
In all cases:-
• Share information of any identified risk with the patient's GP.
• Document in notes.
• Discuss the health complications of FGM and the law in the UK.

2. Client may need referral for counselling, surgery etc. make referral to GP
3. Information Leaflet
4. For further information on hscic FGM enhanced dataset visit www.hscic.gov.uk/isce/publication/scci2026
5. Inform your named nurse/safeguarding lead that you have seen newly identified case of FGM. Named Nurses/Lead for Safeguarding to submit numbers to Designated Nurses bi- monthly

16 Appendix G: Government Leaflet



17 Appendix H: FGM Leaflets different language versions

For FGM leaflet in the following languages please go to web page

http://www.nhs.uk/NHSENGLAND/ABOUTNHSSERVICES/SEXUAL-HEALTH-SERVICES/Pages/fgm-resources.aspx

ስለ ኤፍ ጂ ኤም ተጨማሪ መረጃ - Amharic version

مزيد من المعلومات حول ختان الإناث - Arabic version

FGM اطلاعات بیشتر درباره - Farsi version

Renseignements complémentaires sur les MGF - French version

FGM زانیاری زیاتر دەربارەی - Kurdish Sorani version

Macluumaad dheeraad ah ee ku saabsan FGM - Somali version

Habari zaidi kuhusu ukeketaji wa wanawake - Swahili version

ብዛዕባ ኤፍ ጂ ኤም ተወሳኺ ሓበሬታ - Tigrinya version

ایف جی ایم کے بارے میں مزید معلومات - Urdu version

Mwy o wybodaeth am FGM - Welsh version

More about FGM - English version

Brighton and Sussex University Hospitals NHS Trust

16 Appendix I: Genital piercings

Genital piercing is a form of body piercing that involves piercing a part of the gentalia therefore creating a place for wearing different types of jewellery. This can involve clitoral piercing which can be through the clitoral hood either vertical or horizontal. This form of piercing legally is for over 18 year olds. It is mentioned in this policy because it is described in section 2 (2.2.2 Types of FGM) but this is not a safeguarding concern unless the women or person has been coerced.