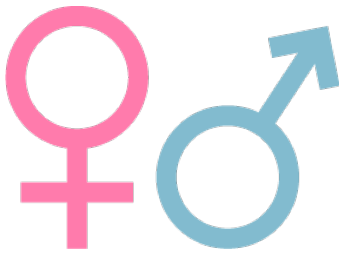
Integrated approach to the care of women and girls at risk of FGM

A training module devised by
Prof Sarah Creighton and Dr Dan Reisel,
University College London Hospital

A RIGHTS-BASED APPROACH

Female genital mutilation (FGM) violates the following human rights



The right to be free from gender discrimination

The right to life and physical integrity

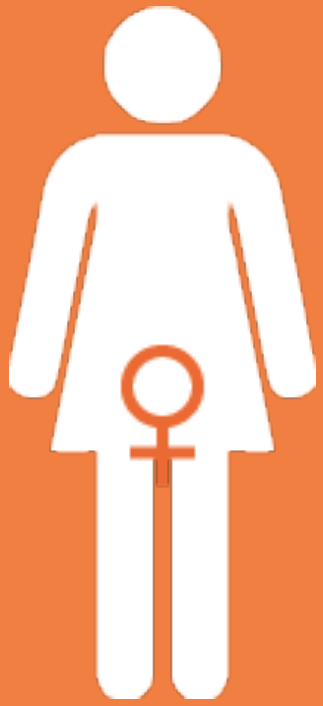
The right to health

The rights of the child

> *All children shall enjoy special protection, and shall be given opportunities and facilities, by law and by other means, to enable them to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity*

Declaration of the Rights of the Child, 1959

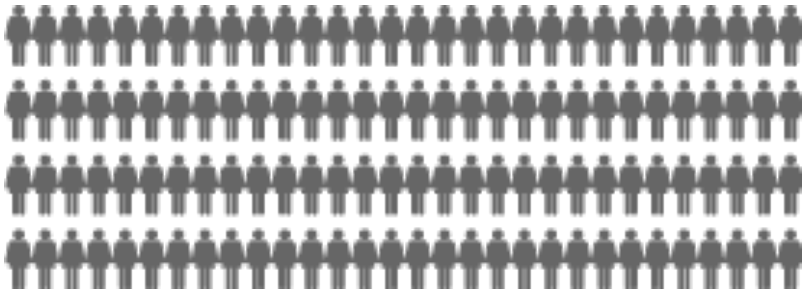
DEFINITION OF FGM



FGM refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for cultural or other non-medical reasons

World Health Organisation, 2014

INCIDENCE AND PREVALENCE



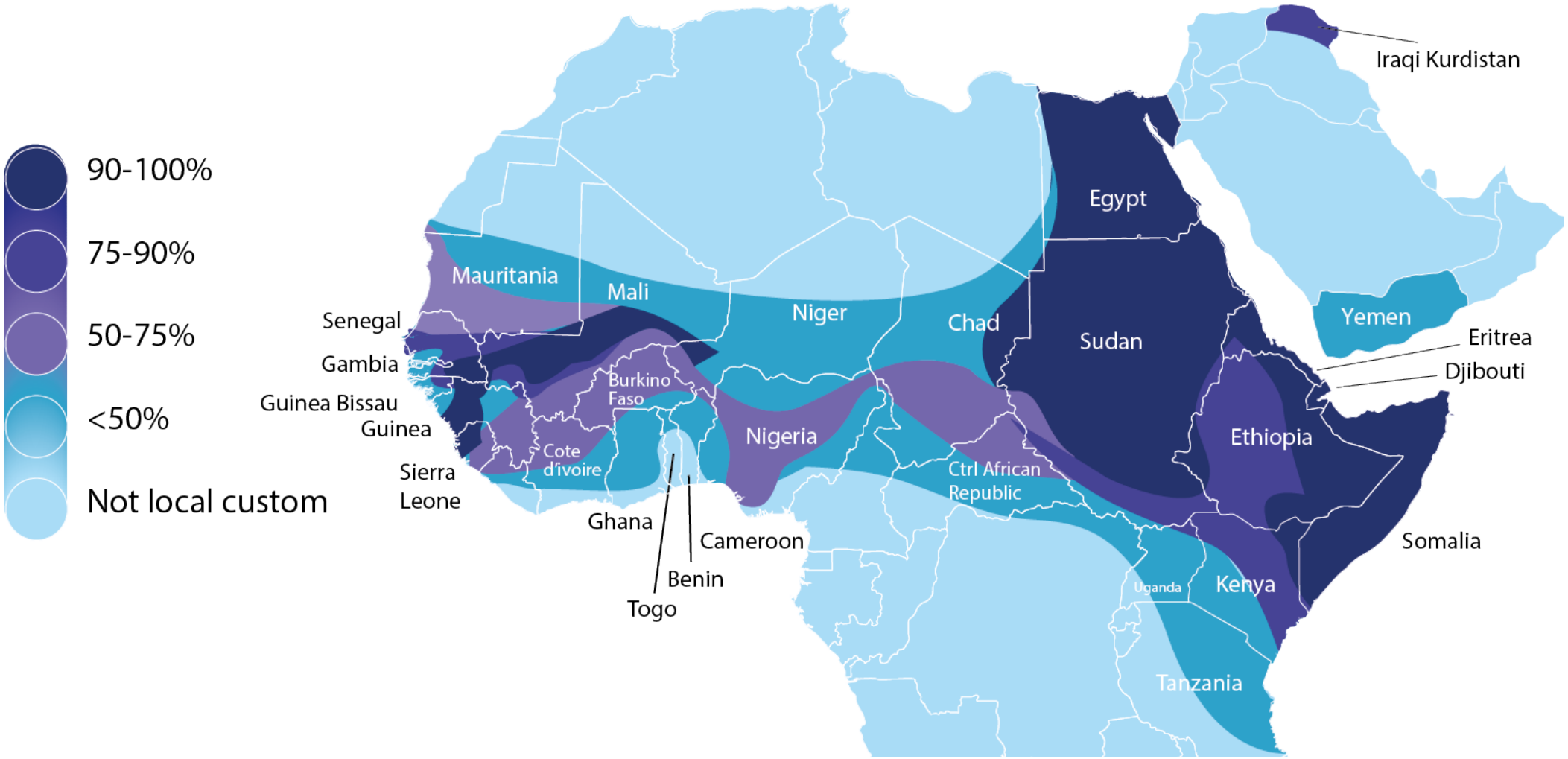
Approximately **100-140 million** African women have undergone FGM worldwide

Each year, a further **3 million** girls are estimated to be at risk of the practice in Africa alone

Most live in **African countries**, some live in the Middle East, Asia, Europe, Australia, New Zealand, USA and Canada

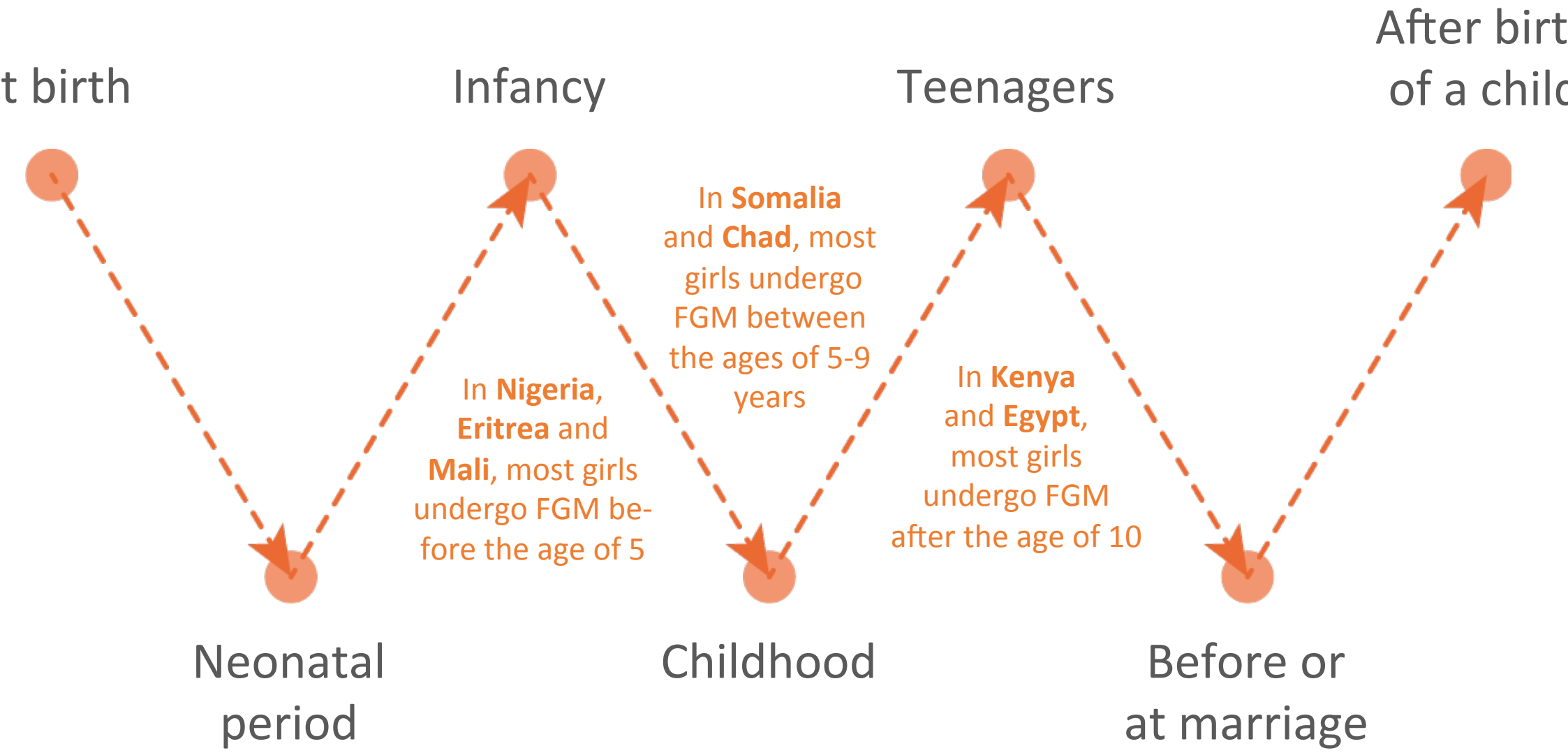
FGM is increasingly identified in the UK amongst migrants from FGM practising countries

KEY COUNTRIES OF ORIGIN



Countries with the highest prevalence are Somalia (98%), Guinea (96%), Djibouti (93%), Egypt (91%), Eritrea (89%) Mali (89%), Sierra Leone (88%), Sudan (88%), Gambia (76%), Burkina Faso (76%) and Ethiopia (74%) - UNICEF

WHEN AT RISK OF FGM



RISK OF FGM IN THE UK

There are likely over **130,000** women in the UK who have undergone FGM

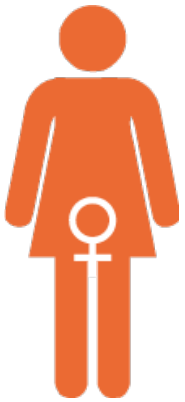
Over **35,000** women with FGM are thought to have given birth in London

Since 2009, nearly **4,000** women and girls in London have been treated for FGM-related complications

Figures are likely to be an underestimate as not all hospitals record numbers accurately

THE UK LAW

Female Genital Mutilation Act 2003 makes it a **criminal offence** for any



national or permanent resident
mutilate the whole or any part
of a girl or woman's genitalia

Or to aid, abet, counsel
or procure the carrying
out of FGM in the UK

As well as to have it carried out
abroad, even in countries where
the practice may be legal

MISSED OPPORTUNITIES

"All four of my girls were born in London hospitals but not once during any of the births or check-ups did anyone ask me when and where I had FGM done, or whether I intended to have my daughters cut.

Nobody in this country has ever talked to me or any of my daughters about FGM at all. I find that very disturbing because it's very obvious I've been through the process — everything was removed.

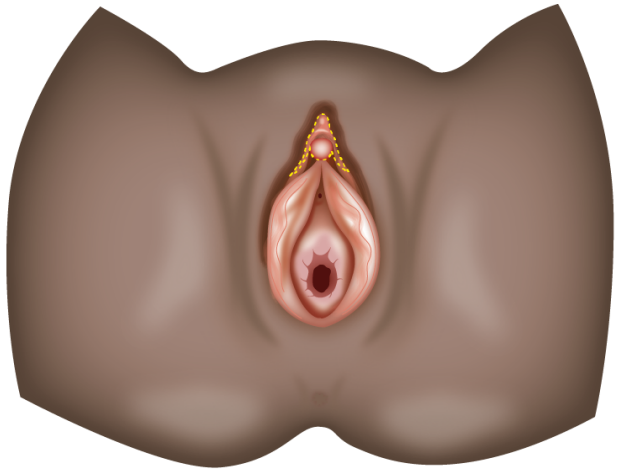
You see people mumbling among themselves. I don't know if it's out of fear or because they don't want to upset me that nobody says anything."

Sarian Kamara, London Community Development Worker and FGM Activi

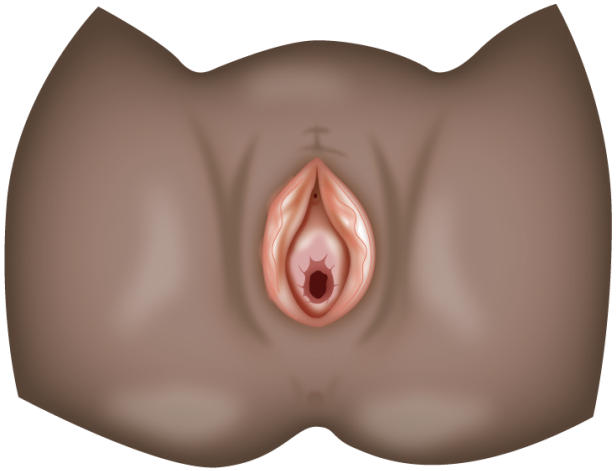
WHO CLASSIFICATION – TYPE 1

Type 1

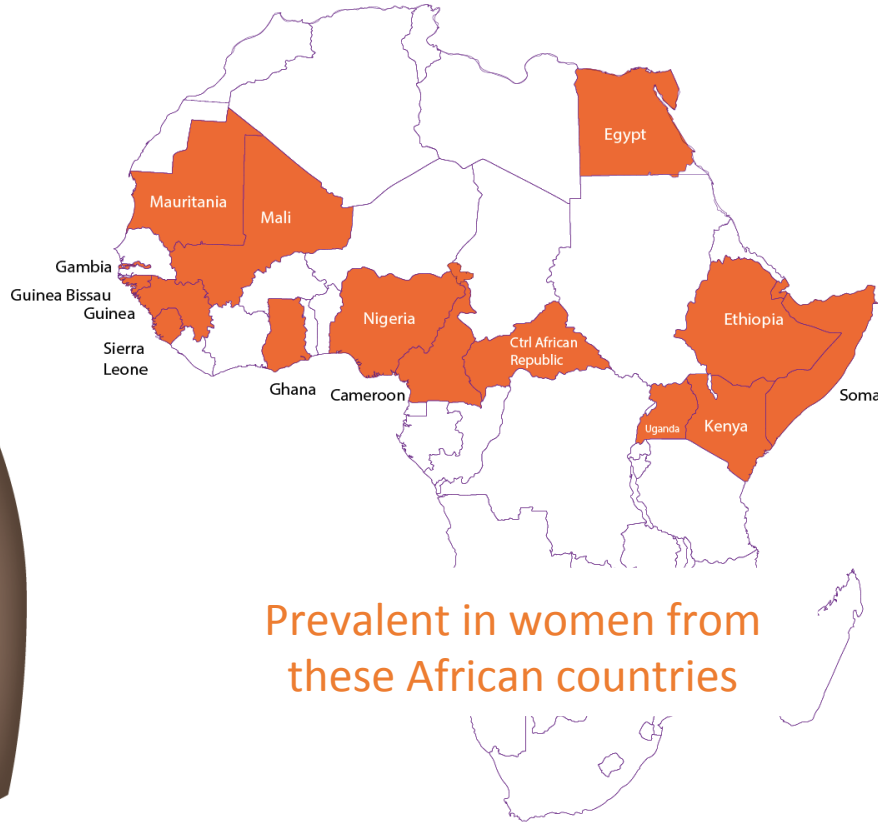
Excision of the prepuce with or without excision of part or all of the clitoris.



Area cut



Adult anatomy

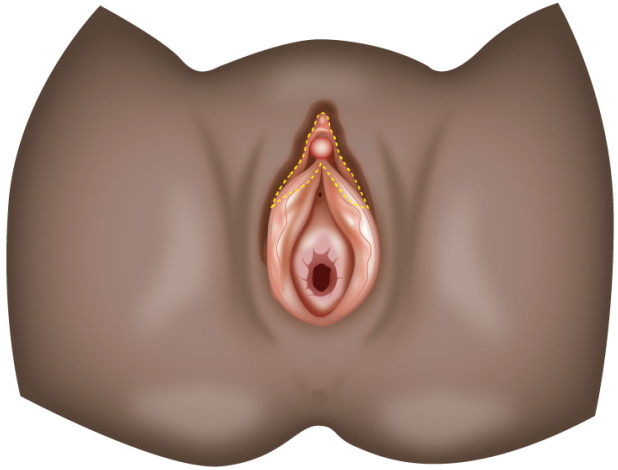


Prevalent in women from these African countries

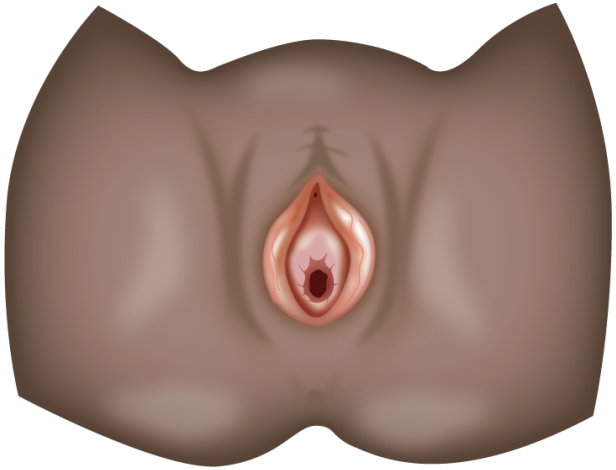
WHO CLASSIFICATION – TYPE 2

Type 2

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



Area cut



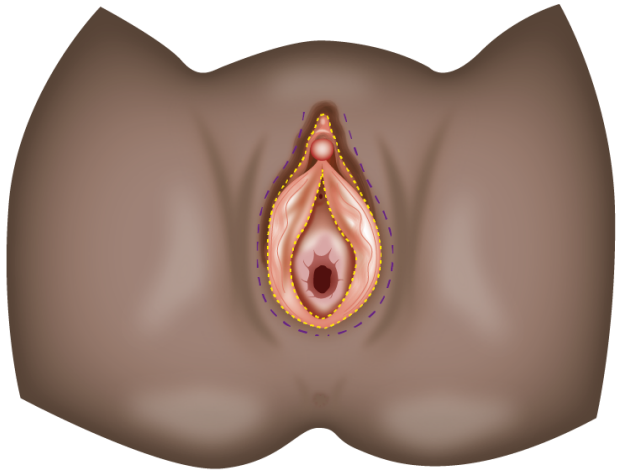
Adult anatomy

Prevalent in women from these African countries

WHO CLASSIFICATION – TYPE 3

Type 3

Excision of part or all of the external genitalia and stitching or narrowing of the vaginal opening, this is often referred to as infibulation.



Area cut

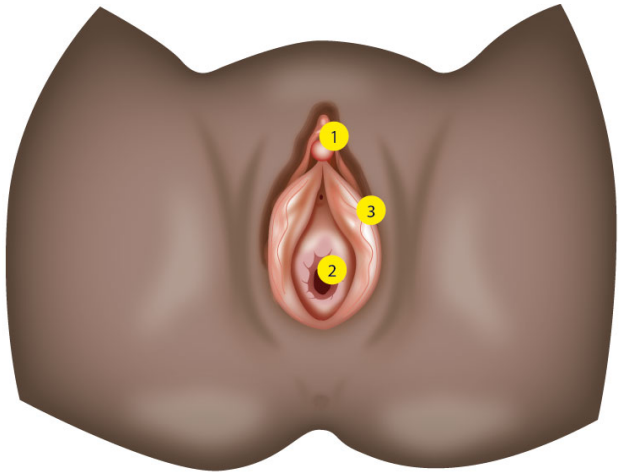
Adult anatomy

Prevalent in women from these African countries

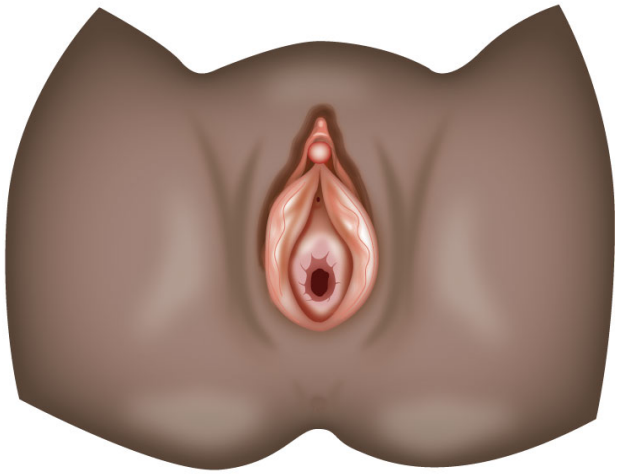
WHO CLASSIFICATION – TYPE 4

Type 4

All other harmful procedures, including pricking or cauterising the clitoris (1), cutting or scarring the vaginal opening (2), or stretching the labia (3).



Area cut



Adult anatomy
(may appear normal
or scarred)

Prevalent in women from these African countries

COMPLICATIONS OF FGM

- Haemorrhage
- Sepsis
- Death
- Urinary retention
- Tetanus and gangrene
- Infections (e.g., HIV, Hepatitis)

mediate/short-term consequences

Long-term consequences

- Recurrent urinary infections
- Painful menstruation
- Pain during intercourse
- Keloid scarring and cysts
- Complications in pregnancy
- Infertility

FGM is also a risk factor for domestic violence and post-traumatic stress disorder

KEY ASPECTS OF CARE

Provision of **sensitive services** to women with FGM

The **safeguarding** of girls at risk of FGM

BROACHING THE TOPIC

Using the term mutilation may be upsetting to some patients

Try to be **sensitive** and use value-neutral terms

- *Have you been cut down there?*
- *Were you circumcised?*
- *Have you been closed?*

Safeguarding women with FGM and girls at risk of undergoing FGM is everyone's responsibility

REFERRAL PATHWAY

Woman identified with FGM

Need for support/follow-up

Community Support + Referral

Following a discussion with patient, make a referral to **UCLH Adult FGM Clinic,** by email to **fgmsupport@uclh.nhs.uk** with short description and contact details. Ensure accurate **documentation**, relevant **complications**, and an agreed **plan for follow-up**.

Are any under 18s at risk?

Urgent Safeguarding Need

Any girl under 18 years identified with FGM **must be referred to the police via 101** by end of the next working day. If FGM only suspected, discuss the case with your local designated **Child Protection Lead** and/or refer to the **UCLH Paediatric FGM Clinic**.

For further support, consider contacting FORWARD UK (0208 960 4000) or NSPCC (0800 028 3550)

MANDATORY REPORTING

- **Girls Under 18**
  - If a child discloses FGM or has been found to have FGM on examination, she must be referred to the police by dialling 101.
  - Referral ideally by end of next working day but definitely within 1 month of diagnosis.
  - If a child is at risk of FGM but not confirmed, a referral must be made to social services
  - Genital piercing is regarded as Type 4 FGM
  - Failure to report will mean referral to regulatory body i.e. FTP panel at GMC
  - NB. It has **always** been our duty to report child abuse

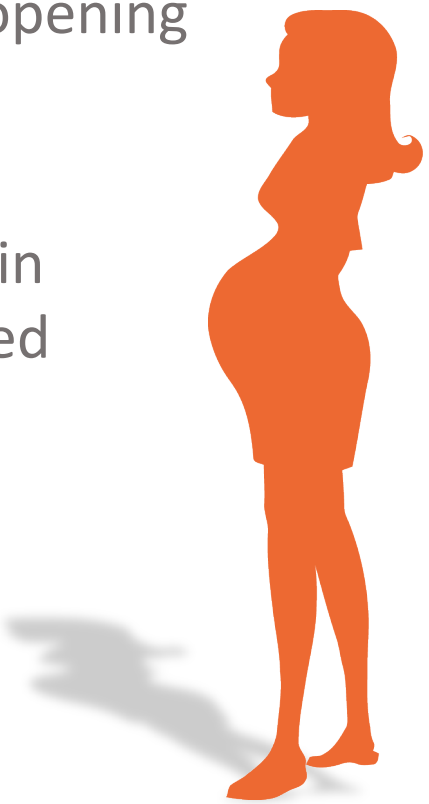
- **Women over 18**
  - Reporting to police or social services is **not** mandatory for all women
  - Social services referral when an associated child is at risk
  - Risk assessment document available from Department of Health
    - *FGM Risk and Safeguarding – Guidance for professionals*, March 2015.

FGM IN PREGNANCY

Pregnant women who have undergone FGM need a **genital assessment** to determine whether or not **deinfibulation** (opening of vagina) is required for safe delivery.

Ideally, deinfibulation should be performed in the **mid-trimester** by an appropriately trained midwife or obstetrician.

After delivery **tissue repair** is usually required to stop bleeding and damage. Care should be taken **not to close** the vagina to its previous infibulated state.



CONCLUSIONS

FGM offers **no health benefits** and carries severe immediate and life-long **risks**.

Girls born within practising communities are at risk of FGM both **abroad and in the UK**.

Direct referral to the Police (101) is now **mandatory for any under-18 year** olds found to have FGM.

It is essential that health care professionals remain **vigilant** about FGM and are **aware** of the appropriate steps to take when they suspect a child is at risk.

FURTHER INFORMATION

British Medical Association bma.org.uk
Female Genital Mutilation: Caring for patients and safeguarding children.

Royal College of Obstetricians and Gynaecologists rcog.org.uk
Female Genital Mutilation and its Management, Greentop Guideline (No. 53).

Royal College of Midwives rcm.org.uk
Tackling FGM in the UK: Intercollegiate recommendations for identifying, recording and reporting, 2013.

Department of Health gov.uk
Female Genital Mutilation Risk and Safeguarding - Guidance for professionals, 2015.

For more information about this resource, contact d.reisel@ucl.ac.uk