Female Genital Mutilation

What's New

FGM Multi-Agency Risk Assessment Form to be completed when FGM disclosed / identified

Obtaining GP consent for sharing of information purposes

Definition & Background:

Female genital mutilation (FGM; also referred to as 'cutting') is defined as all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs, whether for cultural or other non-therapeutic reasons.

All forms of FGM carry serious health consequences including death.

There are both immediate risks following the procedure and long-term medical problems, including major complications during childbirth. (See RCOG Green top guideline no 53).

No religion requires FGM, and the practice is not limited to any religious group.
The age at which girls undergo FGM varies according to the ethnic group practising it. The procedure may be carried out when the girl is new born, during childhood, adolescence, at marriage or during the first labour. In some FGM practising cultures, women are re-infibulated (re-stitched) following childbirth as a matter of routine.

The WHO estimates that between 100 and 140 million girls and women have been subjected to FGM and that each year a further 2 million girls are at risk. Most of these women and girls live in 28 African countries, a few in the Middle East and Asia and among immigrant communities in Europe, Australia, New Zealand, the United States of America and Canada. Systematic surveys have not been undertaken in all FGM - practising communities.

There is little evidence that this practice is currently being carried out within communities in Scotland, although evidence is hard to establish because FGM is a private practice which is not reported. There is, however, some anecdotal evidence of FGM amongst the Somali community in Glasgow.

WHO Classification of types of female genital mutilation procedures:

Type I	Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
Type II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).

Type III Narrowing of the vaginal orifice with creation of a covering seal by cutting and aPpositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).

Type IV All other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing*, incising, scraping and cauterizing.

*Piercing is part of this WHO classification but the legal status of this is unclear in the UK

The Law: (prohibition of Female Genital Mutilation (Scotland) Act July 2005) Female genital mutilation is illegal in Scotland.

It is illegal for UK nationals to perform FGM or to aid and abet the practice whether in or outside the UK. If convicted sentences handed down may be 5-14 years. Anyone found guilty of failing to protect a girl from risk of FGM faces up to 7 years in prison, a fine, or both.

It is NOT an offence for a medical practitioner (or midwife) to perform a surgical procedure that is necessary for that person's physical or mental health, or that is necessary in labour or after birth or at other times for purposes associated with the birth.

Re-infibulation post-delivery is a crime and affected clients need to be aware of this.

Sensitive Enquiry and Documentation:

All clients from areas with a high prevalence of FGM should be asked if they have had genital cutting - in a sensitive way.
High risk countries include (Djibouti, Egypt, Guinea, India, Indonesia, Iraq, Jordan, Kurdistan, Mali, Saudi Arabia, Sierra Leone, Somalia, Sri Lanka and Sudan)

Suggested questions include "It is common in some countries to have been cut, has this happened to you?" or "It is common in your country to have been cut, are you open or closed?" Clients may not disclose this and you may see it on examination only.

FGM must be recorded in:

- Clinical notes.
- Medical history page (Medical Conditions, enter FGM and select from drop down list.
- Social history page under the violence and abuse section> click yes for gender based violence > other and document FGM in comments box.

If using an interpreter it may be worth exploring the interpreter's understanding and views on FGM prior to the consultation.

If clients disclose FGM they should be asked if they have any sexual or gynaecological worries or concerns and some direct questioning on their sexual functioning may be needed to elicit problems.

Where FGM is disclosed / identified, the FGM Risk Assessment form should be completed. This can be found within the Sandyford Inclusion Team Protocols on Team Site.
Any identified risk or concerns should be discussed with the Inclusion Team by completing an internal referral. Any urgent risk or concerns should be discussed with DOD.

Permission should be sought to share information with the clients GP for safeguarding purposes and a letter requested on NASH informing the GP of disclosure / examination findings. Discuss with senior clinician/SRH DoD if any issues.

Clients who have experienced FGM may have difficulty being examined due to physical and emotional issues.

If you are concerned re genital appearances during an examination ensure a review by a senior clinician/SRH DoD.

Referral for psychosexual counselling should also be considered.

Child Protection Issues:
Clients should have a family history taken including a discussion about any children they have or that they are looking after to assess for other girls at risk of FGM.

It is important to document full names, gender, and ages of all children in the family, the school they attend should be recorded where possible.

Any cases of FGM should be shared with the Inclusion team (by completing an internal referral on NaSH) for referral/discussion with social work if there is any risk to other women or girls; this is only possible if adequate information is recorded as above.

Any urgent Child Protection concerns, discuss with DOD / senior clinician.

Requests for examination as part of a claim for asylum:
Although not common this is occasionally requested by Lawyers. These requests should be forwarded to the service manager.

Requests for revision (deinfibulation) / resection of scarring:
Clients should be offered an appointment with SRH for a discussion prior to onward referral to tertiary care for surgery as many women have limited anatomical knowledge and Gynaecological issues perceived to be as a result of FGM may not be. Deinfibulation is best offered before conception.

This could be discussed with SRH DOD whether referral to acute gynaecology is appropriate.

Support Groups:

FORWARD (Foundation for Women's Health Research and Development) Need Help? | FORWARD (forwarduk.org.uk)

Plan International
http://www.plan-uk.org/because-i-am-a-girl/female-genital-mutilation-fgm/
(Accessed: January 2024)

Saheliya
Specialist mental health and well-being support organisation for black and minority ethnic (BME) women and girls (12+) in Scotland. www.saheliya.co.uk
(Accessed: January 2024)

Glasgow office: 0141 552 6540

References

Female genital mutilation | FORWARD (forwarduk.org.uk) (Accessed: January 2024)

Female Genital Mutilation (FGM): support - mygov.scot (Accessed: January 2024)

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Responding to female genital mutilation: multi-agency guidance - gov.scot (www.gov.scot) (Accessed: January 2024)

World Health Organisation. Female Genital Mutilation Factsheet 2023. Female genital mutilation (who.int) (Accessed January 2024)