clinical standards for fgm services

introduction

Female Genital Mutilation (FGM) is defined by the World Health Organisation (WHO) as procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons[1]. It is a deeply rooted tradition practiced by specific ethnic groups in Africa, Asia and the Middle East and is increasingly identified in the UK amongst migrants from FGM practising countries. FGM has no health benefits and causes severe short and long term damage to physical and psychological health.

Women affected by FGM should be cared for by health care professionals with relevant skills and experience[2]. In areas with a significant number of affected women, it has been demonstrated that dedicated clinics are successful in meeting the needs of women with FGM[3]. However services are variable throughout the UK with no accepted standards for the provision of care offered[4].

aims of services

There are two aspects of FGM management;

- Provision of sensitive and appropriate services to women
- Safeguarding girls at risk of FGM.

type of service

Women with FGM may be pregnant or non-pregnant. Some clinics will only see pregnant women from antenatal assessment whilst other clinics will offer a wider range of services.

service requirements

The ethos of any service seeing women with FGM is to offer expert health care by a trained health care professional in a sensitive and non-judgemental setting. The following requirements are essential

Access to clinics

- Information on how and where to refer women must be widely available to all local health care providers
- The mode of referral should be clear i.e. e-mail, appointment centre, specific referral sheet
- Waiting times for the clinic should be short especially for women requiring antenatal assessment of FGM
- Women should be able to self refer to the clinic
- Information about appointments must be communicated with care. Women may not speak English and so may not be able to read an appointment letter. Some vulnerable women may prefer that no written information is sent to their home address and will require appointments by telephone.

Clinic Staff

- All clinic staff (including reception and support staff) should be familiar with FGM
- Health care professionals should have specific expertise in the management of FGM
- Clinics are usually run by a specialist midwife or nurse with input from an obstetrician or gynaecologist as required.
- Although the need for training junior medical and midwifery staff is acknowledged, observers in the clinic should be limited to one observer per consultation.

Interpreting Services

- Independent interpreting services should be available for all women if required. It is not acceptable to use a friend or family member
- Interpreting services may be face to face or via Language Line

Information

- Written information should be available to all women attending the clinic. This should contain information about the clinic and staff as well as basic information about the health risks and legal status of FGM. Information about deinfibulation should be available for women undergoing this procedure.
- When women cannot read English, consideration should be given to translation of leaflets into appropriate languages for the local population
- Diagrams of the types of FGM should be available as they may assist in explanation.5
- Peer support is of benefit and contact details should be offered of organisations such as FORWARD, Equality Now and Daughters of Eve.

Genital Examination

- The majority of women will require a genital examination
- The reason for this should be explained in a sensitive manner
- The process should be explained and before the woman undresses and include full information on who will be performing the examination and who will be present.
- A chaperone is required
- Usually a full assessment can be made visually or on parting of any labia present. An internal vaginal examination is not usually required. This should be explained to the woman as she may be anxious about this.
- The findings should be explained to the women. A mirror may be useful to demonstrate the findings if she wishes.

Deinfibulation

- All clinics should have access to a deinfibulation service
- This is often provided by the clinic but if not provided, then a clear referral pathway for deinfibulation should be in place.
- The majority of deinfibulations should be performed under local anaesthetic in an outpatient setting.
- Some women with extensive genital scarring or psychological distress during examination will require deinfibulation under a general or spinal anaesthetic. This will usually require a day case hospital admission
- Post-operative advice about pain relief and wound aftercare should be given and an appointment given for follow up within 3 to 4 weeks of the procedure.

Psychology and Psychosexual Input

- Access to psychology and psychosexual input should be available
- Although this may not be available in the clinic, a clear referral pathway to a psychologist or counsellor familiar with FGM should be in place.

Safeguarding

- All clinical staff should be familiar with the implications for safeguarding and FGM.
- All staff should be familiar with the Multiagency Practice Guidelines
- All consultations should include a discussion about the legal status of FGM and this should be documented in the notes. This is particularly important for pregnant women but non-pregnant women may have children or be in contact with girls at risk
- Contact details for the Trust safeguarding lead should be available in the clinic
- If there are any concerns that a child or young woman is at risk of FGM, the Trust Safeguarding lead must be contacted.

Data Collection and Documentation

- In the case of antenatal patients, a clear plan for management of FGM during labour should be made and documented. If a pregnant women delivers a female child, documentation of the mother's FGM should be included in the child's Personal Child Health Record (red book).
- Coding of the procedure of deinfibulation should be consistent nationally. It is likely OPCS will shortly introduce a specific code for deinfibulation which will facilitate this.
- Information of the number and types of procedures should be standardised and recorded. This would enable a more accurate assessment of incidence and prevalence within the UK.

conclusion

Currently there are no national standards for the provision of care for women who have had FGM. Clinical practice is based upon guidelines issued by the Royal College of Midwives (RCM), Royal College of Obstetricians and Gynaecologists (RCOG) and Royal College of Nursing (RCN).

The aim of this document is to provide an auditable standard of advice and guidance on the minimum care provision for women whom have undergone FGM.

references

1. World Health Organization (WHO). Female genital mutilation and other harmful traditional practices. www.who.int/reproductivehealth/topics/fgm/en/
2. Multi-Agency Practice Guidelines: Female Genital Mutilation. 2011 www.fco.gov.uk/fgm
3. Royal College of Obstetricians and Gynaecologists (RCOG). Female Genital Mutilation and its Management. Green-top Guideline No. 53, May 2009
4. Lavender T, Baker L, Richens Y (2006) Current Service Provision for women in the UK who have undergone FGM British Journal of Midwifery 14 (8) 465-466 Yana/Tina paper BJM
5. FGM NCG booklets

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