Department of Health

Commissioning services to support women and girls with female genital mutilation

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Commissioning services to support women and girls with female genital mutilation

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Chapter 1. Summary

FGM services and commissioning overview

FGM healthcare services in England have been developed by those responsible for commissioning, without reliable data on the actual number of patients who require FGM services. In areas of high FGM prevalence, dedicated professionals and campaigners recognised a gap in needs and developed specialist/dedicated services often in response to women presenting in need of immediate care and support. A number of FGM clinics have been established to date, but there is limited awareness of how to approach the commissioning of services within this area.

Newly available statistics are now starting to provide a clearer picture of the number of patients in an area requiring and receiving FGM services, and future developments in data collection will increase the information available. Given this development and the increased awareness of the care needs of women and girls with FGM, NHS commissioners must ensure that standard commissioning processes can be used to take account of this need, and provide FGM services as required.

This documents sets out some key considerations when embarking upon the process to commission services to support FGM survivors. It reflects the standards and characteristics which have developed where commissioning in this area has been successful, and sets out particular elements which should either always be considered or provided.

Summary

FGM is illegal in the UK,[1] is child abuse and a form of extreme harm against women and girls. FGM leads to severe short and long term physical and psychological consequences, and survivors may have not have spoken about their experience for many years.

No single agency or statutory body can meet the multiple needs of someone affected by FGM, so a multi-agency response is required. However, NHS England are responsible to ensure the provision of sufficient, safe and high quality health services which meet the needs of survivors, and that these services also have provision to work with multi-agency partners, notably the police and social services.

1 Female Genital Mutilation Act 2003 www.legislation.gov.uk/ukpga/2003/31/pdfs/ukpga_20030031_en.pdf

Women and girls where FGM is found or suspected need evaluation by health professionals experienced in FGM who are able to determine the need for further treatment and perform a risk assessment for potential safeguarding issues.

FGM services must focus on two linked aspects of care:

(i) Provision of sensitive and appropriate services for survivors of FGM.

(ii) Safeguarding girls at risk of FGM.

The nature of FGM services will vary depending on local prevalence of FGM. In low prevalence areas there must be clear referral pathways to FGM services.

FGM is prevalent in 28 African countries as well as in parts of the Middle East and Asia. It is estimated that approximately 103,000 women aged 15-49 and approximately 24,000 women aged 50 and over who have migrated to England and Wales are living with the consequences of FGM. In addition, approximately 10,000 girls aged under 15 who have migrated to England and Wales are likely to have undergone FGM. In the period September 2014 to January 2015, over 2600 patients were treated in the NHS for whom it was newly identified that they have undergone FGM.[2]

FGM is practised by families for a variety of complex reasons. There are complex needs around the use of interpreters, health advocates and links with the third sector and community groups should be explored and recognised within care pathways as appropriate.

[2] www.hscic.gov.uk/fgm

Chapter 2. National/local context and evidence base

What is FGM?

FGM comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. It has no health benefits and harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue, and hence interferes with the natural function of girls' and women's bodies. The practice causes severe pain and has several immediate and long-term health consequences, including difficulties in childbirth also causing dangers to the child.

Types of FGM

FGM has been classified by the World Health Organisation into four types:

Type 1 – Clitoridectomy: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).

Type 2 – Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are the 'lips' that surround the vagina).

Type 3 – Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.

Type 4 – Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterising the genital area.

Consequences of FGM

Many men and women in practising communities can be unaware of the relationship between FGM and its harmful health and welfare consequences as set out below, in particular the longer-term complications affecting sexual intercourse and childbirth.

Short-term implications for a girl's health and welfare

The short-term consequences following a girl undergoing FGM can include:

- severe pain;
- emotional and psychological shock (exacerbated by having to reconcile being subjected to the trauma by loving parents, extended family and friends);
- haemorrhage;
- wound infections, including tetanus and blood-borne viruses (including HIV and Hepatitis B and C);
- urinary retention;
- injury to adjacent tissues;
- fracture or dislocation as a result of restraint;
- damage to other organs; and
- death.

Long-term implications for a girl's or woman's health and welfare

All types of FGM are extremely harmful and cause severe damage to health and wellbeing. World Health Organisation research has shown that women who have undergone FGM of all types, but particularly Type 3, are more likely to have complications during childbirth.

The long-term health implications of FGM can include:

- chronic vaginal and pelvic infections;
- difficulties with menstruation;
- difficulties in passing urine and chronic urine infections;
- renal impairment and possible renal failure;
- damage to the reproductive system, including infertility;
- infibulation cysts, neuromas and keloid scar formation;
- obstetric fistula;
- complications in pregnancy and delay in the second stage of childbirth;
- pain during sex and lack of pleasurable sensation;
- psychological damage, including a number of mental health and psychosexual problems such as low libido, depression, anxiety and sexual dysfunction; flashbacks during pregnancy and childbirth; substance misuse and/or self-harm;
- increased risk of HIV and other sexually transmitted infections; and
- death of child during childbirth.

Pregnant women with previous FGM have an increased risk of haemorrhage, perineal trauma, caesarean section and perinatal death.[3]

Psychological and mental health problems

Case histories and personal accounts taken from women indicate that FGM is an extremely traumatic experience for girls and women, which stays with them for the rest of their lives. Young women receiving psychological counselling in the UK report feelings of betrayal by parents, incompleteness, regret and anger.[4] There is increasing awareness of the severe psychological consequences of FGM for girls and women, which can become evident in mental health problems. The results from research[5] in practising African communities are that women who have had FGM have the same levels of Post-Traumatic Stress Disorder (PTSD) as adults who have been subjected to early childhood abuse, and that the majority of the women (80 per cent) suffer from affective (mood) or anxiety disorders. The fact that FGM is 'culturally embedded' in a girl's or woman's community does not protect her against the development of PTSD and other psychiatric disorders. Local commissioners at CCG and NHS England area team level must ensure that mental health support is made available to assist girls and women who have undergone FGM, as well as treatment for any physical symptoms or complications.

International Prevalence of FGM

FGM is a deeply rooted tradition, widely practised mainly among specific ethnic populations in Africa and parts of the Middle East and Asia. The World Health Organisation estimates that between 100 and 140 million girls and women worldwide have experienced female genital mutilation and around 3 million girls undergo some form of the procedure each year in Africa alone. See Annex 1 for African countries' prevalence. FGM has also been documented in communities including Iraq, Israel, Oman, the United Arab Emirates, the Occupied Palestinian Territories, India, Indonesia, Malaysia and Pakistan.

Prevalence of FGM in the UK

FGM's prevalence in the UK is difficult to estimate because of the hidden nature of the crime. However, a recent study[6] estimated that:

- approximately 60,000 girls aged 0-14 were born in England and Wales to mothers who had undergone FGM; and
- approximately 103,000 women aged 15-49 and approximately 24,000 women aged 50 and over who have migrated to England and Wales are living with the consequences of FGM. In addition, approximately 10,000 girls aged under 15 who have migrated to England and Wales are likely to have undergone FGM.

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3 WHO Study Group on Female Genital Mutilation and Obstetric Outcome. Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries. Lancet 2006 367:1835–1841.

4 Haseena Lockhat (2004) Female Genital Mutilation: Treating the Tears, London: Middlesex University Press.

5 Behrendt, A. et al (2005) Posttraumatic Stress Disorder and Memory Problems after Female Genital Mutilation, American Journal of Psychiatry 162:1000–1002, Ma.

6 Macfarlane A, Dorkenoo E. Female Genital Mutilation in England and Wales: Updated statistical estimates of the numbers of affected women living in England and Wales and girls at risk. Interim report on provisional estimates. London: City University London and Equality Now, 2014.

There is likely to be an uneven distribution of cases of FGM around the country, with more occurring in those areas of the UK with larger communities from the practising countries.

Since October 2014, the Health and Social Care Information Centre have regularly published official statistics relating to the number of patients treated in the NHS. All reports are published at www.hscic.gov.uk/fgm and since January 2015, these have included some statistics relating to patient numbers at local acute trust level.

There is a significant difference between the published prevalence rates and the number of women treated in the NHS who have been identified as having FGM. The number of patients treated will always be significantly lower than the prevalence across the population as the whole population does not access healthcare services within a given period (be that monthly or quarterly). However, they can still represent an important indicator and are indicative of the number of patients for whom services should be commissioned. Again this is a potentially complicated issue however, as the provision of services may lead to a subsequent increase in the number of patients accessing the services on offer as awareness rises.

Cultural underpinnings and motives of FGM

FGM is a complex issue, with a variety of explanations and motives given by individuals and families who support the practice. More information about the reasons can be found in the FGM Multi-Agency Practice Guidelines (see Chapter 4).

Need for FGM Services

The benefits of dedicated services for the health and well-being of women with female genital mutilation are considerable. Such services will provide patients with the opportunity for high quality health care, and the opportunity to consider the need for safeguarding any women and girls in the family unit, and to initiate a suitable multi-agency response. In addition, where an adult patient consents, service should offer support to report the crime to the police.

Service models

Currently many FGM services are based within or linked to maternity services, with some services being delivered through community settings, within GP Practices.

Within the different models providing the services, the expectation is that as a minimum the service should cover three main elements:

- How to meet the physical health needs of a patient with FGM.
- How to meet the mental health needs of a patient with FGM.
- Safeguarding assessment for the woman/girl, and children of the patient, and consideration to other children within the family unit.

Service data, audit and governance

FGM services are required to complete the mandatory DH FGM Enhanced Dataset return which is being introduced in April 2015,[7] which replaces the FGM Prevalence Dataset.

[7] www.hscic.gov.uk/isce/publication/scci2026

FGM services should record data on de-infibulation procedures including how and where performed and subsequent operative complications.

In the case of a pregnant woman who has given birth to a daughter, family history of FGM should be documented in the Personal Child Health Record (or red book). This information must also be passed on to the GP and health visitor on discharge from hospital.

For more details about the standards and requirements to share information to support the provision of care, see the FGM Enhanced Dataset specification and implementation guidance.

Chapter 3. Scope of service

Aims and objectives of service

NHS England is expected to commission a patient centred healthcare response to support women and girls who have had or are suspected to have had FGM. NHS England should work with the local safeguarding children board and the health and well-being board to ensure that local strategies and multi-agency processes and policies are reflected in the provision of healthcare services. Care will optimise future reproductive and sexual function, psychological health and quality of life in survivors of FGM and will also protect girls at risk of FGM. The services must also provide an effective safeguarding response, ensuring that all healthcare provision to women and girls with FGM considers whether they or others in their family unit require safeguarding.

The primary aims are to provide a safe and effective care pathway for women and girls who have had or are at risk of FGM.

In the Public Health Outcomes Framework,[8] commissioners are advised to consider the following indicators on improving the wider determinant of health. A specific indicator relating to female genital mutilation is not yet possible given the lack of data currently.

Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing quality of life for people with long-term conditions
Domain 3	Helping people to recover from episodes of ill-health or following injury
Domain 4	Ensuring people have a positive experience of care
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm

Outcome Measures

The NHS England FGM Health Subgroup will consider a set of outcome measures to monitor on an annual basis. Commissioners should plan to consider the following outcome measures as the starting basis upon which the group can monitor outcomes:

- Named FGM lead in all Trusts.

[8] http://www.phoutcomes.info/

- Numbers of referrals to dedicated FGM services.
- Numbers of de-infibulation procedures and whether performed as in or out patient.
- Compliance with FGM HSCIC enhanced data collection requirements.
- Children with FGM seen within dedicated paediatric surroundings.
- Staff compliance with completion of appropriate HEE FGM e-learning modules.
- Availability and uptake of psychological and psychosexual services.

Service description and use

Services should provide as minimum the defined activities outlined below as part of a multidisciplinary team approach associated with interdependent services. Patients will follow a care pathway as described below and in the appendix.

The patient journey should include:

- Self Referral.
- Referral from GP, midwifery or other services (e.g. A+E, sexual health services, urology, social services).
- Initial outpatient assessment.
- Inpatient or outpatient treatment in designated settings with appropriate health professionals. Treatment could include de-infibulation or referral to linked specialist services e.g. psychology, urogynaecology.
- A safeguarding needs assessment and appropriate follow up actions and pathway put in place.
- Outpatient follow up.
- Discharge where appropriate.

The type and number of health professionals working within an FGM service will vary depending on local prevalence of FGM and nature of services.

Areas of low prevalence are unlikely to hold a regular clinic with published opening times. In these circumstances it may be more appropriate to have a named FGM lead who can advise on FGM issues including safeguarding and can refer via well defined clinical pathways to other regional FGM services. It is important that appropriate trained cover for leave, training and sickness is made for the FGM Lead. The named FGM lead and associated management team will have a responsibility to maintain their training and knowledge on FGM and work within local FGM networks. Commissioners may wish to consider hub and spoke commissioning arrangements between CCGs and/or area teams, or associate commissioning arrangements, however such a provision will not replace the need to have a named FGM lead in the organisation.

The service provision should also be put in place taking account of the cultural mix of the population. All areas, whether with high or low FGM prevalence should undertake appropriate consultation with patient groups to ensure that the service will best serve the need of the population.

The hospital-based clinics have often been linked with maternity services, as very often FGM has been identified through delivery of antenatal care. With a move to earlier identification of patients with FGM, commissioners should be aware of this and review existing services where appropriate. There is recognition that, if services were on offer and known to exist, many women may seek support and care in advance of marriage and/or having sex. Consideration must be given to an effective and sustainable structure for the future.

It is unlikely that co-location of an FGM within a sexual assault referral centre (SARC) or any sexual health services is appropriate. Stakeholder and patient engagement across England undertaken as part of the FGM Prevention programme has determined that the vast majority of patient groups feel that co-location of FGM services with either SARC or sexual health services is not appropriate and will not help support patients to access the services.

Local commissioners are to review the best location for FGM services in their area, based on the needs of the patient, the clinical requirement and other commissioning priorities.

Roles within a service/provision

A commissioned service should consider how to meet all of the following roles within an FGM services:

- Named FGM lead in all trusts across England.

In dedicated clinics (likely to be in areas of high prevalence)

- Named FGM lead.
- Named consultant obstetrician and gynaecologist for FGM (who may or may not be the same person as the named FGM lead).

Any commissioned service must also consider provision of or links to:

- Appropriate interpretation services.
- Psychology and Psychosexual services.
- Maternity services (if not based in maternity).
- Gynaecology services including general gynaecology and urogynaecology.
- Advocacy/patient support.
- Paediatric safeguarding services.
- Access to de-infibulation as in-patient and out-patient.
- Local community FGM support groups/advocates – may be available in high prevalence areas.

FGM Appointment

Patients may be referred with confirmed FGM or with suspected but unconfirmed FGM. They may be children (under 18) or adult.

In all cases the first appointment should be with a health worker with experience in FGM. A standard first appointment should aim to cover the following:

- Take a detailed clinical history.
- Perform a genital assessment to confirm the presence or absence of FGM.

- If FGM is confirmed, an assessment of the type of FGM should be made and documented.
- Consider the physical and mental health needs of the patient to put in place appropriate care plans.
- Undertake a safeguarding assessment to identify if the patient, her children or other girls within or close to the family unit are at risk of FGM. See safeguarding sub-chapter.

However at all times the needs of the patient will need to drive the delivery of care.

Children under 16 years should be seen within a paediatric setting and this should be within safeguarding services. However some girls aged 16 to 18 years will be pregnant and will need joint management with maternity services.

This may be a sibling in the case of a child found to have FGM or in the case of an adult woman it may be the unborn child or already born children. If a child is thought to have had or be at risk of FGM, a referral to social services must be made.

Investigations

The diagnosis of FGM can be made on clinical history and genital inspection. No clinical investigations are required to reach this diagnosis.

However basic gynaecological investigations may be performed depending on other presenting symptoms and these may include:

(i) Pelvic ultrasound scan (for pain or menstrual problems).

(ii) Vaginal swab.

(iii) Mid-stream urine culture.

Treatment Strategy

The appropriate treatment will depend on the symptoms, type of FGM and whether the woman is pregnant or not.

Most women with Type 3 FGM where the vagina is narrowed should be offered de-infibulation. This is a minor surgical procedure to divide the scar tissue sealing the vaginal opening. If the woman is pregnant this is best performed in the second trimester. However, some women prefer to undergo de-infibulation in labour and this should be documented in the medical notes. Most de-infibulation procedures can be performed under local anaesthetic in an outpatient setting with an appropriate healthcare professional. The presence of extensive scarring, clitoral cysts or psychological trauma such as flashbacks may mean that some women require de-infibulation under general anaesthetic usually as a day case procedure. In pregnant women a spinal anaesthetic is usually preferred to a general anaesthetic.

Some women and girls will require psychological intervention. It is unlikely that this will be a core component offered at the same location/clinic at most FGM services but clear referral pathways must exist. Mental health input may be provided by various health professionals at different levels depending on the need:

1. Psychosexual – usually a counsellor.
2. Psychological – qualified clinical psychologist.
3. Trauma e.g. Post-traumatic Stress Disorder – psychiatrist.

4. Family issues (children referred with FGM) – child psychologist/psychotherapist.
5. Support from third sector organisations with specialist experience of supporting women who have undergone FGM.

Women with gynaecological symptoms such as pelvic or genital pain, incontinence or prolapse and menstrual dysfunction may need referral on to gynaecological services such as general gynaecology and urogynaecology. Clear local referral pathways should exist into established services.

Follow-up

Commissioners should consider whether this would be best carried out in a hospital/maternity setting or a community setting, taking into account that this would usually performed at a second appointment. It should also be considered if a service wishes to offer a "one stop" service at the initial appointment, depending on the wishes of the woman.

When a de-infibulation procedure is performed, a further follow up examination is required 2-4 weeks later. This appointment lends itself to taking place in a community setting.

After this follow up examination, a patient may be discharged back to GP care after evaluation. Women referred on for specific services e.g. psychology will continue follow-up within those services as part of the usual pathway. Pregnant women who have undergone de-infibulation will be referred back to maternity services for management as specified by professional guidelines.

Pregnancy

Pregnant women with FGM are at increased risk of post-partum haemorrhage, perineal trauma (including episiotomy and 3rd degree tear), caesarean section and perinatal death. These risks are present in all types of FGM and are thought to remain even after de-infibulation of type 3 FGM. The Health Education England elearning includes a session with guidance on pregnancy management in women with FGM (see Chapter 5).

Access to antenatal de-infibulation should be available to all pregnant women with Type 3 FGM. This is usually performed under local anaesthetic as an outpatient procedure but may occasionally require spinal anaesthetic and a day case hospital admission.

All pregnant women receiving care for FGM must be made aware of the health implications of FGM. The legalities around FGM must also be discussed with the pregnant woman as part of the informed discussion about ensuring future generations are not subjected to FGM. It is best practice that the date of this discussion be documented in the notes. As with all FGM appointments, safeguarding needs must be considered.

Interpreter services

Commissioning arrangement must ensure that an interpreter is available, as this will be required in many appointments relating to FGM.

The interpreter should be an authorised accredited interpreter and should not be a family member, not be known to the individual, and not be an individual with influence in the individual's community.

Referral processes and sources

The service should accept referrals from primary or secondary care clinicians in adult or paediatric services as well from social services.

The service will accept referrals from other providers particularly where the referring service is not accredited to undertake the clinical role the patient requires.

Many patient groups request access via self-referral for FGM, as many patients find it difficult to ask for help in relation to FGM.

There are two main types of presentation:

- FGM detected or suspected in an adult woman.
- FGM detected or suspected in a child (under 18).

The Provider will be expected to use evidence based approaches and to demonstrate efficiencies whenever possible.

Eligible patients will be referred using a defined referral system that can be audited for waiting times.

Appropriate referrals to specialist colleagues will be documented and GP informed of any transfer of care.

Discharge criteria and planning

A discharge plan will be prepared offering support and facilities required for providing care at home.

Patient-centred services

In development, commissioners should always consult with local patient groups, local community groups, and should consider how to incorporate the help and support of patient, community and third sector groups at all stages, as well as whether there can be an ongoing role once the service is established.

In all centres there will be a focus on patient centred services which consider the health and well-being needs of the patient.

Services should include:

- Direct access (phone and e mail) to FGM specialist midwife or nurse.
- Appropriate interpreting services – usually via language line. A family member should not be asked to interpret.
- Close links should be established with national and local community support groups.
- Provision of health advocacy support for women on FGM care pathway.

Care Pathway

A high-level FGM care pathway diagram is set out in annex three. The elements therein refer to the expectations for delivery of an FGM service as set out in this document.

Safeguarding

FGM is not an issue that can be decided on by personal preference – it is an illegal, extremely harmful practice and a form of child abuse and violence against women and girls.

Each NHS organisation will have local safeguarding protocols and procedures for helping children and young people who are at risk of or facing abuse. These should include multiagency policies and procedures, consistent with those developed by their Local Safeguarding Children Board. If organisations have not already done so, these should be reviewed to include handling cases where FGM is alleged or known about, or where there is a potential risk of FGM identified. As FGM is a form of child abuse, professionals have a statutory obligation under national safeguarding protocols (e.g. Working Together to Safeguard Children 2013) to protect girls and women at risk of FGM. These policies and procedures should consider the characteristics around FGM, ensuring that the response to FGM includes the sharing of information with multi-agency partners throughout the girl's childhood, and that if, or when, the risk facing the girl changes (which may mean it escalates or even becomes less immediate), this is identified and consideration is given as to whether or not a change in subsequent safeguarding actions are required. It must always be remembered that fears of being branded 'racist' or 'discriminatory' must never weaken the protection that professionals are obliged to provide to protect vulnerable girls and women.

Commissioners and Trusts may wish to review the Department of Health 'Female Genital Mutilation Risk and Safeguarding: Guidance for professionals', published March 15, which provide guidance around what issues need to be considered, and support to establish ongoing and effective safeguarding measures.

All FGM services must have a clear policy around safeguarding, agreed with multi-agency partners.

Children and vulnerable adults: If any child (under-18) or vulnerable adult in your care has symptoms or signs of FGM, or if you have good reason to suspect they are at risk of FGM having considered their family history or other relevant factors, they must be referred using standard existing safeguarding procedures, as is the procedure with all other instances of child abuse. This referral is initially often to the local Children's Services or the Multi-Agency Safeguarding Hub, though other arrangements may be in place locally. Additionally, when a patient is identified as being at risk of FGM, this information must be shared with the GP and health visitor as part of safeguarding actions (See section 47 of the 1989 Children Act). Please note, this will change with the introduction of the mandatory reporting duty (see Chapter 5).

Adults: There is no requirement for automatic referral of adult women with FGM to adult social services or the police. Healthcare professionals should be aware that any disclosure may be the first time that a woman has ever discussed her FGM with anyone. Referral to the police must not be introduced as an automatic response when identifying adult women with FGM, and each case must continue to be individually assessed. The healthcare professional should seek to support women by offering referral to community groups who can provide support, and clinical intervention or other services as appropriate, for example through an NHS FGM clinic. The wishes of the woman must be respected at all times. If she is pregnant, the welfare of her unborn child or others in her extended family must be considered at this point, as these children are potentially at risk and safeguarding action must be taken accordingly.

Multi-Agency Practice Guidelines: Female Genital Mutilation

In 2011, the government launched multi-agency practice guidelines for front-line professionals such as teachers, GPs, nurses and police.[9] The guidelines aims to provide advice and support to frontline professionals who have responsibilities to safeguard children and protect and support adults from the abuses associated with FGM. No single agency can adequately

[9] https://www.gov.uk/government/publications/female-genital-mutilation-guidelines

meet the multiple needs of someone affected by FGM, so these guidelines set out a multiagency response and strategies to encourage agencies to cooperate and work together.

The guidelines provide information on: identifying when a girl (including an unborn girl) or young woman may be at risk of FGM and responding appropriately to protect them; identifying when a girl or young woman has had FGM and responding appropriately to support them; and measures that can be implemented to prevent and ultimately eradicate the practice of FGM.

The guidelines make clear that FGM is child abuse and a form of violence against women and girls, and therefore should be dealt with as part of existing child and adult safeguarding/ protection structures, policies and procedures.

A recent Home Office review of the guidelines found that whilst the guidelines are largely deemed to be very useful, there is a lack of awareness of their existence.

Population covered

The service outlined in this specification is for patients ordinarily resident in England; or otherwise the commissioning responsibility of the NHS in England (as defined in Who Pays?: Establishing the responsible commissioner and other Department of Health guidance relating to patients entitled to NHS care or exempt from charges).[10]

Specifically this service is for girls and adult women with confirmed or suspected FGM.

Any acceptance and exclusion criteria and thresholds

There are none expected at present.

Interdependencies with other services/providers

Commissioning arrangements should consider interdependencies with the following:

- Psychology and Psychosexual services.
- Maternity services (if not based in maternity).
- Gynaecology services include urogynaecology.
- Advocacy/patient support.
- Paediatric safeguarding services.
- Access to de-infibulation as in-patient and out-patient.
- Local community FGM support groups/advocates – may be available in high prevalence areas.

Related Services will include:

- Primary Care.
- Local Mental Health Services (Paediatric, Adolescent and Adult).

[10] http://www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf

- Social services.
- Police.

Whilst co-location with SARCs is unlikely to be appropriate, it may be required to investigate if the forensic services element of the SARCs could be accessed if required in cases relating to FGM.

Chapter 4. Service standards

Commissioners may wish to consider the following sample standards within their service specification.

- All patients must be under the care of a clinician experienced in FGM.
- Independent interpreting services should be available for all women if required. It is not acceptable to use a friend or family member or someone of influence in the patient's community. Interpreting services may be face to face or via Language Line.
- 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 de-infibulation should be available for women undergoing this procedure. Diagrams of the types of FGM should be available as they may assist in explanation.
- The majority of girls and women will require a genital assessment. The reason for this should be explained in a sensitive manner. The process should be explained before the woman undresses including who will be doing the examination and who will be present. A chaperone is required.
- All clinics should have access to a de-infibulation service. If not provided by the clinic, then a clear referral pathway for de-infibulation should be in place.
- The majority of de-infibulations should be performed under local anaesthetic in an outpatient setting. Some women with extensive genital scarring or psychological distress during examination will require de-infibulation under a general or spinal anaesthetic. This will usually require a day case hospital admission.
- 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.
- All clinical staff should be familiar with the implications for safeguarding and FGM.
- All staff should be familiar with the Multiagency Practice Guidelines.
- All staff working in the clinic (including clerical and support staff) should have completed the Health Education England introductory module on FGM. Clinical staff

including midwives obstetricians and gynaecologists are expected to work towards completion of all 5 HEE FGM e learning modules.[11]

- All consultations must include a discussion about the legal status of FGM and this must be documented in the notes.
- All services should be designed following consultation with patient groups and local community groups. Where possible, ongoing involvement should be built into the service assurance model to ensure it remains fit for purpose.
- All Trusts/organisations must have an agreed multi-agency response to cases of FGM. This may be within the wider safeguarding processes.
- Contact details for the Trust safeguarding lead must 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, and a multi-agency response following.
- Peer support is of benefit and contact details should be offered of any local community groups as well as national groups such as FORWARD and Daughters of Eve.

Applicable National Standards

6. Female genital mutilation: multi-agency practice guidelines, Her Majesties Government, July 2014 https://www.gov.uk/government/publications/female-genital-mutilation-guidelines
7. Working together to safeguardin children: A guide to inter-agency working to safeguarde and promote the welfare of children, Department for Education March 2013 http://www.workingtogetheronline.co.uk/index.html
8. Tackling FGM in the UK Intercollegiate recommendations for identifying, recording and reporting. Intercollegiate Report 2013 https://www.rcm.org.uk/sites/default/files/FGM_Report.pdf
9. Royal College of Obstetricians and Gynaecologists (RCOG). Female Genital Mutilation and its Management. Green-top Guideline No. 53, May 2009 https://www.rcog.org.uk/globalassets/documents/guidelines/greentop53femalegenitalmutilation.pdf
10. Female Genital Mutilation An RCN educational resource for nursing and midwifery staff (second edition) http://www.rcn.org.uk/__data/assets/pdf_file/0010/608914/RCNguidance_FGM_WEB.pdf
11. FGM National Clinical Group Clinical Standsard for FGM services www.fgmnationalgroup.org

Applicable local standards

Variations to local standards are permissible where these are above national or international standards.

[11] Health Education elearning for Healthcare FGM Programme www.e-lfh.org.uk

Chapter 5. Existing services and support materials

A list of FGM services is maintained on the NHS Choices website, www.nhs.uk/fgm, although it is recognised that this does not cover all services in England.

The following resources are available and may be considered for use either in service development or built into the contracting arrangements by commissioners.

Training for healthcare professionals

NHS organisations and professionals can access an FGM e-learning programme on the eLearning for Healthcare website, www.e-lfh.org.uk, consisting of 5 sessions providing training on all aspects of FGM and standard care provision principles.

Patient Information leaflet

A standard patient information leaflet is available to provide information about FGM to patients. Using this leaflet is an important part of the FGM Enhanced Dataset process to information patients about how we are using their information.

Copies can be obtained from the Department of Health orderline, https://www.orderline.dh.gov.uk.

Health passport – Statement opposing female genital mutilation

The Government publish a 'Statement Opposing Female Genital Mutilation' leaflet, commonly referred to as the Health Passport. This pocket-sized document sets out the law and the potential criminal penalties that can be used against those allowing FGM to take place. It is designed to be discreetly carried in a purse, wallet or passport.

It can be used by families who have immigrated to the UK and do not want their children to be subjected to FGM, but still feel compelled by cultural and social norms when visiting family abroad. It has been supported and signed by Ministers from the Home Office, Department of Health, Ministry of Justice, Department for Education and the Director of Public Prosecutions (DPP). In Holland a similar document is used, where it has supported families and has sent a strong signal that FGM is unacceptable.

Organisations should consider routinely offering this leaflet to patients when discussing FGM.

Copies can be obtained from the Department of Health orderline in June 2015, https://www.orderline.dh.gov.uk. Until then, copies can be requested from the Home Office by emailing FGMenquiries@homeoffice.gsi.gov.uk.

NHS Choices resources

There are a number of useful materials available on the FGM pages of the NHS Choices website. This includes a video of women talking about their personal experiences of FGM. This video may be used by organisations as part of efforts to raise awareness around FGM. The video is also available on YouTube.

NSPCC Helpline

Organisations should also ensure that professionals are aware of the NSPCC FGM helpline, 0800 028 3550. This is helpline can support both professionals or family members concerned that a child is at risk of, or has had FGM.

Chapter 6. Commissioning

The NHS has a responsibility to provide services for survivors of FGM, and through this, to recognise girls and women at risk of further harm.

Issues for Commissioners

Given the developing nature of commissioning for FGM services, commissioners are likely to find the following issues challenging:

- **Provision/development of clinical experts**
  How will clinical expertise be developed and maintained given the relatively low numbers of patients who may be seen and treated.
- **Security and sensitivity**
- **Tariff payments**
  FGM services do not have specific tariff payments associated.
- **Hub and spoke model**
  In areas of low prevalence, it may be possible to consider arrangements across CCGs and/or area teams, with one commissioner taking a lead role.

Chapter 7. Future work of FGM Prevention programme

FGM Prevention – Information Sharing System

From summer 2015 we will introduce a system that allows a clinician to record on a child's healthcare record that she is potentially at risk of FGM at some point in her childhood/lifetime. This information will be accessible to all healthcare professionals throughout childhood, highlighting that they need to consider the potential risk of FGM as and when they provide care, as well as whether they need to take any action in this regard. The system will be available via the NHS Summary Care Record application.

First use of this system is scheduled for summer 2015. Successful implementation will be dependent upon the user understanding of risk of FGM, and ongoing awareness and consideration through the early years of a girl's life.

Further information will be released in due course.

Mandatory Reporting duty

A new mandatory duty is being introduced through the Serious Crime Act to report cases of FGM.

The move follows a public consultation which sought views from a wide range of professionals, community groups, survivors and law enforcement on how a mandatory reporting duty could work and who it should apply to. A summary of responses to the consultation has also been published today.

The mandatory duty will:

- Apply in cases of 'known' FGM – i.e. instances which are disclosed by the victim and/or are visually confirmed. This is in line with the majority of the consultation responses.
- Be limited to girls under 18 – those responding to the consultation held differing views on whether the duty should be limited to under 18s, but a number highlighted concerns regarding extending the duty to adults, including the risk that this could deter women from seeking medical advice and assistance.
- Apply to all regulated healthcare and social care professionals, and teachers.
- Require reports to be made to the police within one month of initial disclosure/identification – depending on the circumstances of the case, this will not necessarily

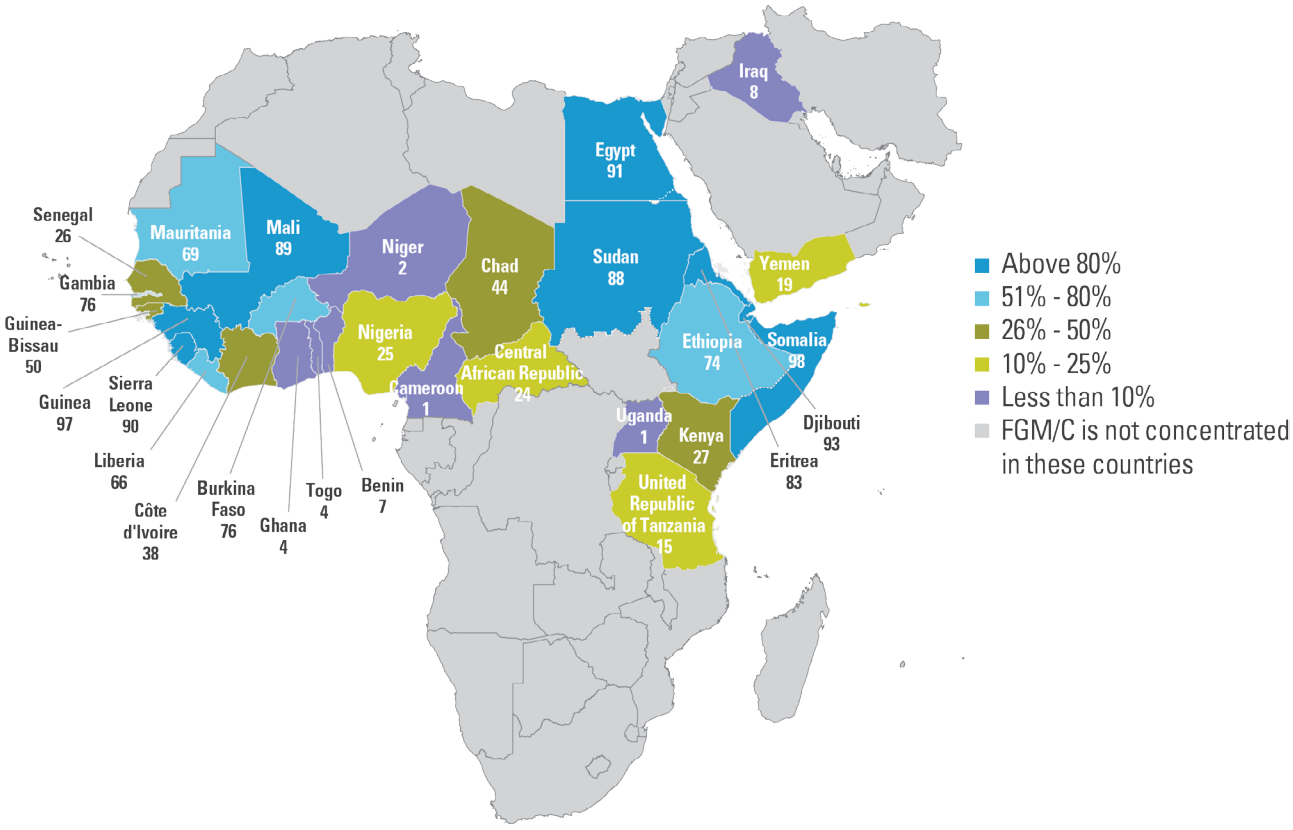
trigger automatic arrests; the police will then work with the relevant agencies to ensure an appropriate safeguarding response is put in place which places the interests of the child front and centre.

- Failure to comply with the duty will be dealt with via existing disciplinary measures, which may include referral to the professional regulator as appropriate – this will ensure that all breaches are dealt with appropriately and in accordance with the specifics of the individual case and is in line with the approach favoured by the majority of respondents to the consultation.

The new duty does not yet apply as of March 2015 and we will work with NHS England and partner organisations including the professional bodies to widely communicate this new duty as and when it is implemented.

Annex 1. Map of FGM prevalence

FGM/C is concentrated in a swathe of countries from the Atlantic coast to the Horn of Africa.



Percentage of girls and women aged 15 to 49 years who have undergone FGM/C

Note: In Liberia, girls and women who have heard of the Sande society were asked whether they were members; this provides indirect information on FGM/C since it is performed during initiation into the society.

Source: UNICEF global databases, 2014, based on DHS, MICS and other nationally representative surveys, 2004-2013.
http://www.data.unicef.org/child-protection/fgmc

Annex 2. Names for FGM

FGM is known by a number of names, including 'female genital cutting', 'circumcision' or 'initiation'. The term 'female circumcision' is unfortunate because it is anatomically incorrect and gives a misleading analogy to male circumcision. The names 'FGM' or 'cut' are increasingly used at the community level, although they are still not always understood by individuals in practising communities, largely because they are English terms.

Country	Term used for FGM	Language	Meaning
EGYPT	Thara	Arabic	Deriving from the Arabic word 'tahar' meaning to clean/purify
	Khitan	Arabic	Circumcision – used for both FGM and male circumcision
	Khifad	Arabic	Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)
ETHIOPIA	Megrez	Amharic	Circumcision/cutting
	Absum	Harrari	Name giving ritual
ERITREA	Mekhnishab	Tigregna	Circumcision/cutting
KENYA	Kutairi	Swahili	Circumcision – used for both FGM and male circumcision
	Kutairi was ichana	Swahili	Circumcision of girls
NIGERIA	Ibi/Ugwu	Igbo	The act of cutting – used for both FGM and male circumcision
	Sunna	Mandingo	Religious tradition/obligation – for Muslims

Country	Term used for FGM	Language	Meaning
SIERRA LEONE	Sunna	Soussou	Religious tradition/obligation – for Muslims
	Bondo	Temenee/ Mandingo/ Limba	Integral part of an initiation rite into adulthood – for non-Muslims
	Bondo/Sonde	Mendee	Integral part of an initiation rite into adulthood – for non-Muslims
SOMALIA	Gudniin	Somali	Circumcision used for both FGM and male circumcision
	Halalays	Somali	Deriving from the Arabic word 'halal' ie. 'sanctioned' – implies purity. Used by Northern & Arabic speaking Somalis.
	Qodiin	Somali	Stitching/tightening/sewing refers to infibulation
SUDAN	Khifad	Arabic	Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)
	Tahoor	Arabic	Deriving from the Arabic word 'tahar' meaning to purify
CHAD – the Ngama	Bagne		Used by the Sara Madjingaye
Sara subgroup	Gadja		Adapted from 'ganza' used in the Central African Republic
GUINEA-BISSAU	Fanadu di Mindjer	Kriolu	'Circumcision of girls'
GAMBIA	Niaka	Mandinka	Literally to 'cut/weed clean'
	Kuyango	Mandinka	Meaning 'the affair' but also the name for the shed built for initiates
	Musolula Karoola	Mandinka	Meaning 'the women's side'/'that which concerns women'

Annex 3. High level sample Care Pathway

Patient identified as needing care/support around FGM

May be identified through:

- Self referral.
- GP referral.
- Referral from maternity services.
- Other.

Women and girls may present with the following symptoms or be identified as needing support relating to the following:

- Pre Marriage Support.
- Mental Health.
- Sex.
- UTI.
- Cervical cytology screening.
- Pregnancy.
- Through A&E.
- At family planning/genito urinary medicine clinics.
- Pain.
- Referral via safeguarding.

FGM Appointment

This may be within a dedicated FGM clinic or part of an existing service.

Must include as a minimum three core elements:

- Physcial health needs assessment.
- Mental health needs assessment.
- Safeguarding assessment.

Care plan/onward referral

Following the assessment, care plans agreed which will either include the delivery of healthcare services or onwards referral to other services. There may be a number of referrals required.

Referral back to GP

Annex 4. Sample quality standards template

Quality standards specific to the service using the following template:

Quality Requirement	Threshold	Method of Measurement	Consequence of breach
Domain 1: Preventing people dying prematurely			
1. De-infibulation performed in all pregnant women with Type 3 FGM.	0% (All pregnant women with Type 3 FGM require de-infibulation.	Number of de-infibulations as percentage of pregnant women with Type 3 from DH figures.	Audit to evaluate reasons why de-infibulation not performed.
Domain 2: Enhancing the quality of life of people with long-term conditions			
1. Referral to uro-gynaecology for women with FGM and symptoms of incontinence and prolapse.	80%	Percentage of women with incontinence or prolapse seen in urogynaecology service.	Audit of referral and reasons not seen e.g. not referred, patient declined etc.
Domain 3: Helping people to recover from episodes of ill-health or following injury			
1. Psychological support for all aspects of FGM including psychosexual.	100% All girls and women with FGM must be offered psychology session.	Proportion of patients seeing psychologist.	Audit to evaluate why patients are not seeing psychologist.
Domain 4: Ensuring that people have a positive experience of care			
1. Patient satisfaction with service – annual survey.	100% of patients offered survey.	Patient satisfaction score.	Audit proportion of patients surveyed and reasons for dissatisfaction.
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm			
1. All girl under 18 with confirmed FGM seen in appropriate safeguarding clinic with social services input.	100% girls under 18 with FGM.	Numbers of under 18s referred.	Audit of under 18's referred.

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