Swindon LSCB

Female Genital Mutilation

Multi-agency Guidance relating to under 18s and pregnant women.

November 2017

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Introduction

FGM is considered child abuse in the UK and a grave violation of the human rights of girls and women. In all circumstances where FGM is practiced on a child it is a violation of the child's right to life, their right to their bodily integrity and their right to health. FGM is not an acceptable practice, it is illegal in the UK and it is a form of child abuse under UK law. These Swindon LSCB FGM guidelines will support the statutory guidance outlined in "Working Together 2015" and the FGM Guidance 2014.

There are three circumstances relating to FGM which require identification and intervention

- Where someone is at risk of FGM
- Where someone has undergone FGM
- Where a prospective Mother has undergone FGM

*This could include female children in the wider family (see appendix1)

Professionals in most agencies will have little or no experience of dealing with FGM. Encountering FGM for the first time can cause people to feel shocked and make them unsure how to respond.

Purpose

This Guidance is for all front line practitioners and volunteers who work with children and young people aged 0-18, and for groups who work with the parents of children.

Although FGM directly affects women and girls it can impact on the whole family and their communities. Practitioners and communities should be vigilant to the risks of FGM being practised.

This guidance is primarily for victims or potential victims of FGM who are under 18 years of age and women who have female children or are pregnant.

Women over 18 years of age without children should be reviewed under the Safeguarding Adults process or through the Care Management process, but any adult assessment must assess the potential risk to any other women or girls living in the same family. Professionals should contact Adult Safeguarding on 01793 463555.

This guidance takes account of the following documents:

- Multi-agency FGM Practice guidelines for professionals https://www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation
- London Safeguarding Children Board FGM Guidelines and toolkit 2017
- British Medical Association – FGM caring for patients and child protection 2011
- Royal College of Nursing – Female Genital Mutilation Resource 2016
- FGM Guidelines South West Child Protection Procedures http://www.proceduresonline.com/swcpp/swindon/p_fem_gen_mutil.html?zoom_highlight=FGM
- FGM Safeguarding and Risk Assessment Quick Guide for Health Professionals, DoH, January 2017 (http://ihv.org.uk/wp-content/uploads/2017/02/FGM_safeguarding_quickguide.pdf?wb48617274=3F578712)

Definition

The World Health Organisation (WHO-2010) has classified FGM as:
"all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organ for non-medical reasons"

FGM is classified into four major types:

1. **Type 1: Cliteroidectomy** which is the partial or total removal of the clitoris and, in rare cases, the prepuce (the fold of skin surrounding the clitoris);
2. **Type 2: Excision** which is the 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 I and II account for 75% of all worldwide procedures;
3. **Type 3: Infibulation** which is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, and sometimes outer, labia, with or without removal of the clitoris. Type III accounts for 25% of all worldwide procedure and is the most severe form of FGM;
4. **Type 4:** All other types of harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

Prevalence

FGM is practised around the world in various forms across all major faiths. Today it has been estimated that currently about three million girls, most of them under 15 years of age, undergo the procedure every year. The majority of FGM takes place in 29 African and Middle Eastern countries, and also includes other parts of the world; Middle East, Asia, and in industrialised nations through migration which includes; Europe, North America, Australia and New Zealand.

Globally, the WHO estimates that More than 200 million girls and women alive today have been cut in 30 countries in Africa, the Middle East and Asia where FGM is concentrated It is estimated that there are around 137,000 women & girls affected by FGM in the UK (NSPCC), and about 24,000 girls under 16 who are at risk of Type III procedure and a further 9,000 girls at risk of Type I and II. http://www.who.int/mediacentre/factsheets/fs241/en/

It should be noted that FGM is not purely an African issue, although there is greater prevalence there. In the UK, FGM has been found among Kurdish communities; Yeminis, Indonesians and among the Borah Muslims.

Cultural context

The procedure is often carried out by an older woman in the community, who may see conducting FGM as a prestigious act.

The procedure can involve the girl / woman being held down on the floor by several women. It is often carried out without medical expertise, attention to hygiene or an anaesthetic. Instruments used have been known to include un-sterilised household knives, razor blades, broken glass and stones. The girl / woman may undergo the procedure unexpectedly, or it may be planned in advance.

The practice is mostly carried out by traditional circumcisers, who often play other central roles in communities, such as attending childbirths. Increasingly, however, FGM is being performed by health care providers.

The WHO cites a number of reasons for the continuation of FGM, such as:

- Custom and tradition
- A mistaken belief that FGM is a religious requirement
- Preservation of virginity/chastity
- Social acceptance, especially for marriage
- A belief that it will increase marriageability
- Hygiene and cleanliness
- Increasing sexual pleasure for the male
- Family honour
- A sense of belonging to the group and conversely the fear of social exclusion
- Enhancing fertility

Religion and FGM

Muslim scholars and faith leaders, including the Muslim Council of Britain, have condemned the practice and are clear that FGM is an act of violence against women. Furthermore, scholars and clerics have stressed that Islam forbids people from inflicting harm on others and therefore most will teach that the practice of FGM is counter to the teachings of Islam. However, many communities continue to justify FGM on religious grounds. This is evident in the use of religious terms such as “Sunnah” that refer to some forms of FGM (usually Type I).

FGM is practised amongst some Christian groups, particularly some Coptic Christians of Egypt, Sudan, Eritrea and Ethiopia. The Bible does not support this practice nor is there any suggestion that FGM is a requirement or condoned by Christian teaching and beliefs.

FGM has also been practiced amongst some Bedouin Jews and Falashas (Ethiopian Jews) and again is not supported by Judaic teaching or custom.

Legislation

The momentum to end FGM has grown significantly in the last four years due to various campaigners raising awareness of the issue and the government strengthening its stance on FGM. The UK government is committed to eradicating this harmful practice within a generation and has strengthened the legal framework to help achieve this.

FGM has been a criminal offence in the UK since the Prohibition of Female Circumcision Act 1985 which was further amended by the Female Genital Mutilation Act of 2003. This makes it unlawful for UK nationals or residents of the UK to carry out FGM abroad, or to aid or abet, counsel or procure the carrying out of FGM abroad, even in countries where FGM is legal.

The penalty for FGM is up to 14 years’ imprisonment. The FGM Act 2003 also makes it a criminal offence to re-infibulate following an FGM procedure.
FGM constitutes child abuse and causes physical, psychological and sexual harm which can be severely disabling. A local authority may exercise its powers under Section 47 of the Children Act if it has reason to believe that a child has suffered or is likely to suffer significant harm. Local authorities can also apply to the courts to prevent a child being taken abroad for the purpose of mutilation.

Mandatory Reporting Duty (October 2015): Introduced under Section 5B of the 2003 Female Genital Mutilation Act, the duty requires regulated health and social care

professionals and teachers in England and Wales to report 'known' cases of FGM in under 18s to the police which they identify in the course of their professional work. See also p11. https://www.gov.uk/government/publications/mandatory-reporting-of-female-genital-mutilation-procedural-information

Links to forced marriage and domestic abuse

There can be a link between FGM and Forced Marriage, particularly in adults/teenagers when the woman may be mutilated shortly before the marriage. Professionals should be alert to this and consider a joint response to the Forced Marriage through local protocols alongside protection from FGM – see Forced Marriage and Honour Based Violence Procedure.

A woman/girl who has been subjected to FGM may have numerous gynaecological problems and this may make consummation of her marriage or sexual activity with her partner very uncomfortable/painful/impossible. In some communities it is expected that the man will 'open' the woman/girl before the wedding following Type III FGM. This may be with a sharp instrument. The female may be frightened, not consent to this, suffer re traumatisation and fear/be ostracised from her community as her husband may not stay with her if she does not consent to this.

Women and girls may be raped within their relationship and suffer pain and re-traumatisation every time a partner demands sex. Some men may be more understanding and the couple may seek support. It is important to consider the wider support needs that a woman may have including immigration, housing, debt, childcare and counselling support through community groups and domestic abuse specialist support. She may need to be referred to her local Multi Agency Risk Assessment Conference (MARAC) if the risk of forced marriage, serious injury or death is high.

Indicators

The following are some indications that FGM may be planned. These statements in isolation do not prove FGM will happen but they are indicators for further investigations to exclude the risks of FGM.

- Any female child born to a woman who has been subjected to FGM must be considered to be at risk, as must other female children in the extended family.
- Mother / family have limited contact with people outside of her family
- Parents have poor access to information about FGM and do know about the harmful effects of FGM or UK law
- Girl/family has limited level of integration within UK community
- Girl/women repeated fail to attend or engage with health and welfare services
- A family elder such a grandmother is very influential within the family and is / will be involved in the care of the girl
- Parents from practising communities state they or a relative will take the child out of the country for a prolonged period
- A child may talk about a long holiday to her country of origin or another country where the practice of FGM is prevalent, including African countries and the Middle East
- A child may confide to a professional that she is to have a special procedure or to attend a special occasion
- A professional hears reference to FGM in conversation, for example a child may tell another child about it.

Indicators that FGM may already have taken place:

- Girl is reluctant to undergo any medical examination
- Girl spends long periods of time in the bathroom / toilet / away from the classroom
- Girl has spoken about having been on a long holiday to her country of origin / another country where the practice is prevalent
- Increased emotional and psychological needs such as withdrawal, depression or significant changes in behaviour
- Girl presents to GP or A&E with frequent urine, menstrual or stomach problems
- Girl talks about pain or discomfort between her legs
- Girl has difficulty walking, sitting or standing and looks uncomfortable
- Girl finds it hard to sit still for long periods of time, which was not a problem previously
- Girl is avoiding physical exercise or requiring to be excused from PE lessons without a GP letter
- A child may ask for help or confides in a professional that FGM has taken place
- Mother of family member discloses that FGM has taken place

Health Implications of FGM

FGM has no health benefits, and it harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue, and interferes with the natural functions of girls' and women's bodies.

Short term consequences of FGM may include:

- Severe pain during the procedure and healing
- Shock, which may be caused by pain and / or haemorrhage
- Excessive bleeding
- Difficulty in passing urine and faeces due to swelling and pain
- Infections or septic shock are common, particularly as the procedure can be carried out in unhygienic conditions and/or with instruments that are not sterilised.
- Psychological consequences due to the pain, shock and use of physical force by those performing the procedure
- Death can be caused by haemorrhage or infections

Blood born viruses (for example Hepatitis B and C and HIV) and Tetanus are also a potential risk due to non-sterile equipment being used.

Long term consequences may include:

- Chronic pain
- Infections, particularly of the reproductive and urinary tracts
- Abscesses, painful cysts or keloids (excessive scar tissue formed at the site of the cutting)
- Menstrual problems
- Birth complications such as prolonged labour, recourse to caesarean section, postpartum haemorrhage and tearing
- Danger to the new-born, with high death rates and reduced Apgar scores
- Increased risk of HIV infection and transmission in adulthood due to an increased risk of bleeding during intercourse
- Psychological consequences such as fear of sexual intercourse, post-traumatic stress disorder, anxiety, depression and memory loss
- Loss of pleasure in sex and / or loss of ability to experience orgasm

Results from research in practicing African communities are that women who have undergone FGM have the same levels of Post-Traumatic Stress Disorder as adults who have been subject to early childhood abuse. Research also indicates that the majority of the women (80%) suffer from affective (mood) or anxiety disorders.

9. Practice guidance

a) Questions to consider when undertaking an assessment:

- Do I need to consider FGM here?
- Where do the family come from originally?
- Is there a risk of FGM to the individual or within the family?
- Are there any plans to travel to a country where FGM is present?

b) When talking about FGM remember these points:

- Get accurate information about the urgency of the situation if the individual is a risk of FGM
- Create an opportunity for the individual to disclose, SEEING THEM ON THEIR OWN
- Use simple language and ask straightforward questions
- Use terminology that the individual will understand, for example
  - have you ever been cut or had any form of surgery or piercings?
  - Have you been closed?
  - Were you circumcised?
  - Have you been cut down there?
- Be sensitive to the fact that the individual may be loyal to their relatives and parents
- If an interpreter is required they should be appropriately trained in FGM and must not be a family member or known to the individual. You must also know the interpreter's views on FGM so that they can advocate for the girl at risk.
- Give a clear explanation that FGM is illegal and that the law can be used to help the individual and family avoid FGM
- Give a clear message that the individual can come back and see you again.

Practitioners need to be sensitive to the fears that women and children may have that they will be deported or their children removed. The situation may be more complicated if there are immigration issues. Any investigation of immigration status should not impede police enquiries into an offence that may have been committed against the victim or their children.

Safeguarding Actions to be taken by agencies

There are three circumstances relating to FGM which require identification and intervention:

- Where a child is at risk of FGM
- Where a child has been abused through FGM
- Where a prospective mother has undergone FGM

In cases where it is known that a child has undergone FGM (if a professional has seen evidence of it or heard about it directly from the child) professionals must make a referral to Children's Social Care via MASH (See flow chart - Appendix 1).

Mandatory Reporting

On the 31st October 2015 a new duty was introduced that requires all regulated professionals working within health or social care, and teachers, to report 'known' cases of FGM in girls aged under 18 to the police. This is an individual rather than a corporate duty.

'Known' cases are those where either a girl discloses that FGM has been carried out on her, or where a professional observes physical signs on a girl appearing to show that FGM has been carried out. For example, if a doctor sees that a girl aged under 18 has had FGM they will need to make a report to the police. Similarly, if a girl tells her teacher that she has had FGM, the teacher will need to report this to the police.

To make a report you should call the Police on 101 and state you wish to make a report under the FGM mandatory reporting duty. Reports should be made as soon as possible after the FGM is discovered, and best practice is to complete the report by the close of the next working day.

All agencies should ensure relevant frontline staff understand this duty and how to make a report. The professional consequences for failing to report a known case of FGM in a child are very serious.

Professionals subject the duty and their employers should refer to the government guidance on mandatory reporting. This includes a list of those professionals covered by the report and more detail on how to make a report.

The government has also published additional information on the mandatory duty for health care professionals in England

Single agency guidelines

Health

Health professionals who encounter a girl or woman who has undergone FGM **must** be alert to the risk of FGM in relation to:

- The girl at risk
- Any younger siblings
- If it is a woman, consideration should be given for any daughter she may have now or in the future

If professionals come across a case and are unclear about reporting they should discuss with their safeguarding lead/advisor.

Health professionals in GP surgeries, sexual health clinics or maternity services are the most likely to encounter a girl of woman who has been subjected to FGM. All girls and women who have undergone FGM should be given information about the legal and health implications of practising FGM.

Department of Health (DH) guidance was published in January 2017 on helping health professionals identify and assess the risk of FGM and to support the discussion with patients and family members. In this document is a risk assessment (Part Two, Child/Young Adult, under 18 years Risk assessment) that you can use to assess the risks and what action to take next.

Staff within Great Western Hospital NHS Foundation Trust should also refer to their own FGM policy.

The FGM Enhanced Dataset

Some agencies will need to submit data on FGM to the FGM Enhanced Dataset. This dataset was set up to collect information on the prevalence of FGM from across the NHS in order to support a response to FGM that is based on an understanding of need. The Information Standard (SCC 12026 FGM Enhanced Dataset) requires clinicians across all NHS healthcare settings to record in clinical notes when patients with FGM are identified, and what type it is.

It became mandatory for all acute trusts to collect and submit the FGM Enhanced Dataset from 1st July 2015 and all mental health trusts and GPs from 1st October 2015. Community services within mental health trusts can participate. Sexual Health and GUM clinics do not need to submit FGM information but the legal obligation to appropriately share information for safeguarding purposes still applies. In Great Western Hospital Sexual Health do participate in the FGM Enhanced dataset reporting.

All relevant agencies should ensure their staff are familiar with these requirements. Further information on the dataset can be found at www.digital.nhs.fgm.

This guidance relates to children. If the concerns relate to an adult female and they are an adult in need of care and support, the adult safeguarding process should be initiated. Professionals should contact the Adult Safeguarding Team within Swindon Borough Council at 01793 463555.

Midwives

Before birth

Midwives must talk about FGM at initial booking to all women who come from countries that practice FGM or if they are married or have a partner who comes from practising communities.

A plan should be made for birth that takes account of their level of FGM.

It should be documented if the woman has had FGM and reported to the Safeguarding Midwife.

The woman should also be given written information about the risks of FGM, the law and local support services.

This information will be shared with the GP and Health Visitor.

The child protection lead must be consulted and a referral made to children's services via the Family Contact Point

After birth

After childbirth a woman who has been de-infibulated may request and continue to request re-infibulation. This is illegal and should be treated as a child protection concern. This is because whilst the request for re-infibulation is not in itself a child protection issue, the fact that the girl or woman is apparently not wanting to comply with UK law and/or consider that the process is harmful raises concerns in relation to daughters she may already have or may have in the future. Professionals should consult with their child protection adviser and make a referral to children's social care

Health Visitors

Health Visitors are in a good position to reinforce information about health consequences and the law relation to FGM.

Health visitors should discuss the risks of FGM with women from communities where this is practised. They should document the parents' response and any advice and leaflets given to explain the law relating to FGM.

Any concerns about a parent's attitude to FGM should be taken seriously and appropriate referrals made. Health Visitors should consult with their child protection adviser and inform their GP.

School Nurses

School nurses are in a good position to reinforce information about health consequences and the law relating to FGM. The school nurse should work closely with the child's school supporting them in any concerns. The school nurse should be vigilant to any health issue such as a recurrent UTI that may indicate the FGM has occurred. If the school nurse has contact with any child or family who come from a country where FGM is practised, they should discuss the risks of FGM and document the parent's response and any advice and leaflets given to explain the law relating to FGM. Any concerns about a parent's attitude to FGM should be taken seriously and appropriate referrals made, after discussion with their line manager. The child protection adviser should be consulted about any referral made.

Emergency Departments and Walk in Centres

Emergency Departments and Walk-in Centres need to be aware of the risks associated with FGM if girls/women from FGM practising countries attend, particularly with urinary tract infections (UTIs), menstrual pain, abdominal pain, or altered gait for example. Their assessment should include assessing the risks associated with FGM. This should be documented and professionals should consult with their child or adult safeguarding lead about making a referral to social care

Education – Schools and Colleges

Teachers, other school staff, volunteers and members of community groups may become aware that a female is at risk of FGM through a parent / other adult, a child or other children disclosing that:

- The procedure is being planned;
- An older child or adult in the family has already undergone FGM.
- See 'Indicators that FGM May Soon Take Place'.

If you suspect that a child may be going on a holiday that would place them at risk of FGM ask:

- Where is the holiday?
- Who is going on holiday with the child?
- How long do they plan to go for?
- Are they aware that FGM is illegal in the UK even if performed abroad?

If you have information or suspicions that a female is at risk of FGM, you should consult with your agency designated safeguarding adviser and should make an immediate Referral to the MASH and Public Protection Unit (Police).

The Referral should not be delayed in order to consult with the designated safeguarding adviser, a manager or group leader, as multi-agency safeguarding intervention needs to happen quickly.

Once concerns are raised about FGM there should also be consideration of possible risk to other females in the practising community.

Childcare Sector

Childcare practitioners may become aware that a female is:
1. At risk of FGM, or
2. That FGM has already taken place

The following procedures should apply:

1. **At risk of FGM**

If you become suspicious that a child is at risk of FGM through a parent/other adult, a child or other children disclosing that:

- The procedure is being planned;
- An older child or adult in the family has already undergone FGM.
- That the child may be going on a holiday that would place them at risk of FGM (See 'Indicators that FGM May Soon Take Place').

You should consult with your designated safeguarding lead and make an immediate referral to MASH. It is particularly important that there are no delays in this procedure as multi-agency safeguarding intervention needs to happen quickly.

2. **FGM has already taken place**

If you become aware or suspect that FGM has already taken place you should consult with your designated safeguarding lead and make an immediate referral to MASH

Children's Social Care

Key Principles

- FGM constitutes a significant risk of harm and should be fully and thoroughly investigated under Section 47 of the Children Act 1989 and 2004
- Every attempt should be made to work in partnership with the family

All referrals received which specify a risk of FGM will be considered at a strategy discussion in order to plan the Section 47 enquiry. Given the complexity of the issues involved it is not appropriate to hold the strategy discussion by phone but is should be held at the earliest opportunity.

In cases of possible and actual FGM the strategy discussion must be a meeting of the following:

- Children's social care assessment team manager and social worker
- Community specialist and a health specialist in FGM
- Police CAIT
- Education
- Legal advice
- The referring agency

The following issues should be part of the agenda in any strategy discussion:

- Use of an interpreter in all dealing with the family
- Provision of advice and information regarding the law and harmful consequences of FGM
- Where FGM has already occurred the strategy discussion should discuss how, where and when the procedure was performed and the implications of this
- Risk to siblings and other children in the community
- Any intelligence on who has or is to perform the mutilation
- The immediate health needs of the child
- The possibility for prosecution
- The need for any legal orders to protect the child
- The necessity for a medical examination

Police

There is a risk that the fear of prosecution of family members may prevent those concerned from seeking help and support from relevant agencies and in particular medical help as a result of long term complications caused by FGM.

In many communities where the practice of FGM is prevalent, children who may have undergone/be due to undergo FGM may accept it as part of their religious/cultural upbringing due to a lack of understanding of the potential criminal offence being committed and future health complications that may prevail.

Police should work with other agencies to obtain relevant support and guidance for the victim. Where relevant they can work with other professionals to prevent FGM by educating parents/carers about the legislation relating to FGM and possible consequences.

Police staff working with children - If a girl is at risk of undergoing or has already undergone FGM, the duty inspector must be made aware and support should be sought from the Public Protection Investigation Unit where the victim resides or in their absence the CID. Relevant safeguards should be put in place immediately in order to prevent any risk of harm to the child.

Risk to any other children should be considered and acted upon immediately. The investigation should be dealt with as a child safeguarding issue taking cognisance of any honour-based violence issues.

If any officer believes that the girl could be at immediate risk of Significant Harm, they should consider the use of Police Protection powers under Section 46 of the Children Act 1989.

The Public Protection Investigation Unit should commence Strategy Meetings with Children's Services and relevant agencies.

If it is believed or known that a girl has undergone FGM, a Strategy Meeting must be held as soon as practicable to discuss the implications for the child and the coordination of the criminal investigation.

Children and young people should be interviewed under the relevant procedure/guidelines (e.g. Achieving Best Evidence) to obtain the best possible evidence for use in any prosecution.

Any medical examination should be conducted by a qualified doctor trained in identifying FGM. In all cases involving children, an experienced paediatrician should be involved in setting up the medical examination. This is to ensure that a holistic assessment which explores any other medical, support and safeguarding needs of the girl or young woman is offered and that appropriate referrals are made as necessary.

When an Adult Female has Undergone/is about to Undergo FGM
These incidents should be dealt with by the Public Protection Investigation Unit as a form of Domestic Violence and Abuse/Honour Based Violence incident. Relevant risk assessments (such as the domestic abuse risk indicator checklist) and safeguards should be put in place and referrals to partner agencies made as appropriate in order to ensure the victim receives all relevant support.

Part of the investigation should entail identification of any UK based excisors, with a view to identifying further victims.

If the adult female is an adult in need of care and support, the adult safeguarding process should be initiated. Professionals should contact the Adult Safeguarding Team within Swindon Borough Council at 01793 463555.

Sources of information

Foundation for Women's Research and Development (FORWARD)
Tel: 0208 960 4000
Email: forward@forwarduk.org.uk

The NSPCC 24-hour helpline to protect children and young people affected by FGM
Tel: 0800 028 3550

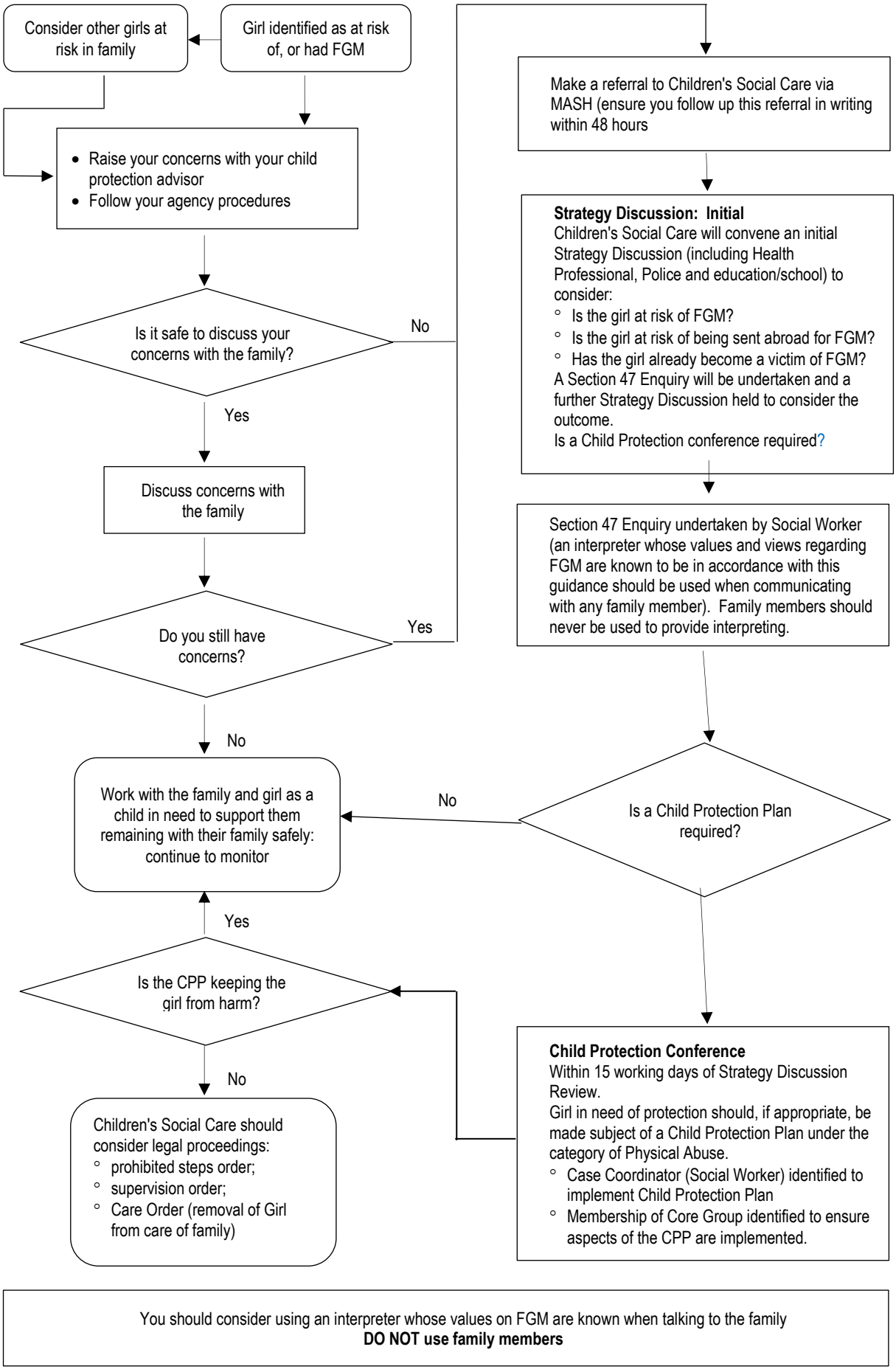
ChildLine
24 hour helpline for children: 0800 1111

Multi-agency FGM Practice guidelines for professionals
https://www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation

FGM Guidelines South West Child Protection Procedures
http://www.proceduresonline.com/swcpp/swindon/p_fem_gen_mutil.html?zoom_highlight=FGM

FGM Safeguarding and Risk Assessment Quick Guide for Health Professionals, DoH, January 2017 (http://ihv.org.uk/wp-content/uploads/2017/02/FGM_safeguarding_quickguide.pdf?wb48617274=3F578712

Appendix 1 – FGM Flowchart



Appendix 2

Health risks and complications of FGM

The complications that occur following FGM will depend on the types and extent of the procedure carried out. These are generally classified in 3 ways:

i. Immediate
Haemorrhage; pain; shock
Wound infection; septicaemia; tetanus
Urine retention
Injury to other tissues
Ulceration of the genital region
Bacterial or viral infections, such as Hepatitis and HIV
Death

ii. Intermediate
Delayed healing
Abscesses
Scarring/keloid formation, dysmenorrhoea and haematocolpos (obstruction to menstrual flow)
Obstruction to urinary flow
Urinary tract infection

iii. Long term complications
Psychosocial trauma and flashbacks, post-traumatic stress disorder
Lack of trust in carers
Vaginal closure due to scarring
Epidermal cyst formation
Neurotomy
Pain and chronic infection from obstruction to menstrual flow
Recurrent urinary tract infection and renal damage
Painful intercourse
Lack of sensation, marital conflict
Risk of HIV and traumatic intercourse
Childbirth trauma- perennial tears and vaginal fistulae
Postnatal wound infection
Prolonged or obstructed labour from tough scarred perineum, uterine inertia or rupture, death of infant and mother
Vaginal fistulae

Type 3 FGM inevitable causes more health problems and deaths

Appendix 3 - Glossary & Further Information

Glossary of terms used in practising and affected communities

The term “closed” refers to type 3 FGM where there is a long scar covering the vaginal opening. This term is particularly understood by the Somali and Sudanese communities

Infibulation is derived from the name given to the Roman practice of fastening a ‘fibular’ or ‘clasp’ through the large lips of a female genitalia (usually within marriage) in order to prevent illicit sexual intercourse.

Re-infibulation (sometimes known as or referred to as re-infibulation or re-suturing): The re-stitching of FGM type 3 to re-close the vagina again after childbirth (illegal in the UK as it constitutes FGM).

Sunnah: the traditional name for a form of FGM that involves the removal of the prepuce of the clitoris only. The word 'Sunnah' refers to the 'ways or customs' of the prophet Muhammad considered to be religious obligations (wrongly in the case of FGM). Studies show, however, that the term 'Sunnah' is often used in FGM practising communities to refer to all forms of FGM, not just FGM that involves only the removal of the hood of the clitoris

When talking to women a suitable form of words should be used, ‘circumcised’ is medically correct and although ‘mutilation’ is the most appropriate term, it may not be understood or may be offensive to a woman from a practising community who does not view FGM in that way. Different terminology will be culturally appropriate to different cultures; ‘Thara’ & ‘Khitan’ (Egypt), ‘Kutairi’ (Kenya), ‘Gudnin’ (Somalia) and ‘Khifad’ (Sudan)

There is a 30-minute training programme from e-learning from health care (see below) which will enhance health employees’ knowledge of FGM. Whilst this video clip is primarily for health care, other professionals may find this useful.

http://www.e-lfh.org.uk/programmes/female-genital-mutilation/presentation/