Female Genital Mutilation (FGM) in Obstetrics and Gynaecology (V4)

Guideline Readership
This guideline applies to all women with FGM presenting within the Heart of England Foundation Trust and to attending clinicians; obstetricians, midwives and specialist midwives. All care is tailored to individual patient needs, with an in-depth discussion of the intended risks and benefits of either undergoing the deinfibulation procedure or declining intervention.

Guideline Objectives
To provide culturally aware clinical care for women who have undergone female genital mutilation.

Other Guidance

- World Health Organisation. 2014. *Female Genital Mutilation. Fact Sheet Number 241***.** www.who.int/mediacentre/factsheets/fs241/en/print.html
  - **RCOG recommendations (**Green Top Guideline No. 53 *Female Genital Mutilation and its Management*, RCOG 2009**)**

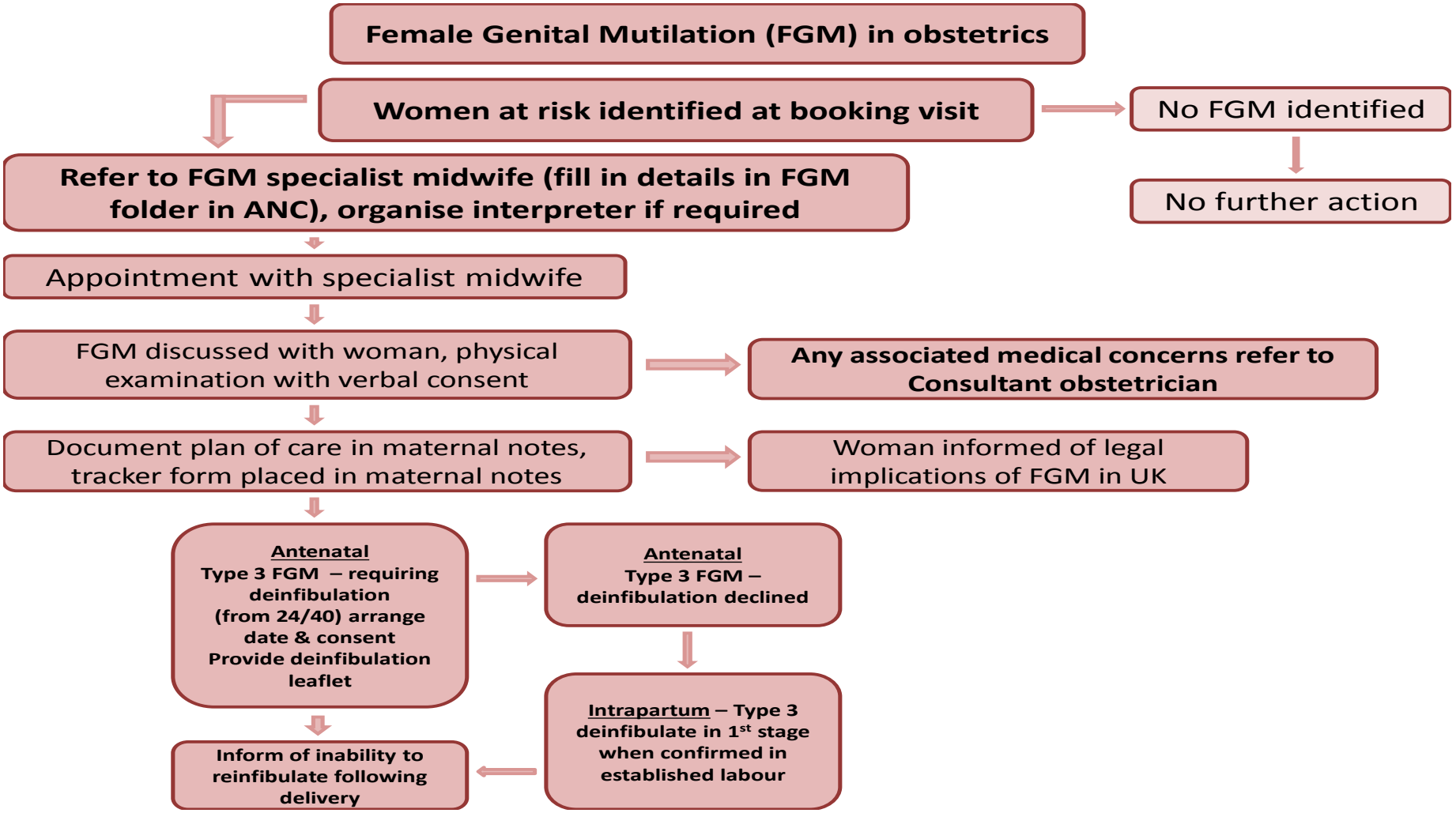
  Non-compliant:
  Partially compliant: Psychological assessment is undertaken through meeting with the woman, at time of writing, further referral is to psychosexual counsellor within HEFT. There is a Specialist Midwife for FGM within the Trust. There is not a named obstetrician attached to the midwifery led service, however, any can be approached for support and advice.

Ratified Date: 18th February 2016
Effective from: 16th March 2016
Review Date: 16th March 2019
Guideline Author(s) / Reviewer(s): A. Byrne – Specialist Midwives in FGM

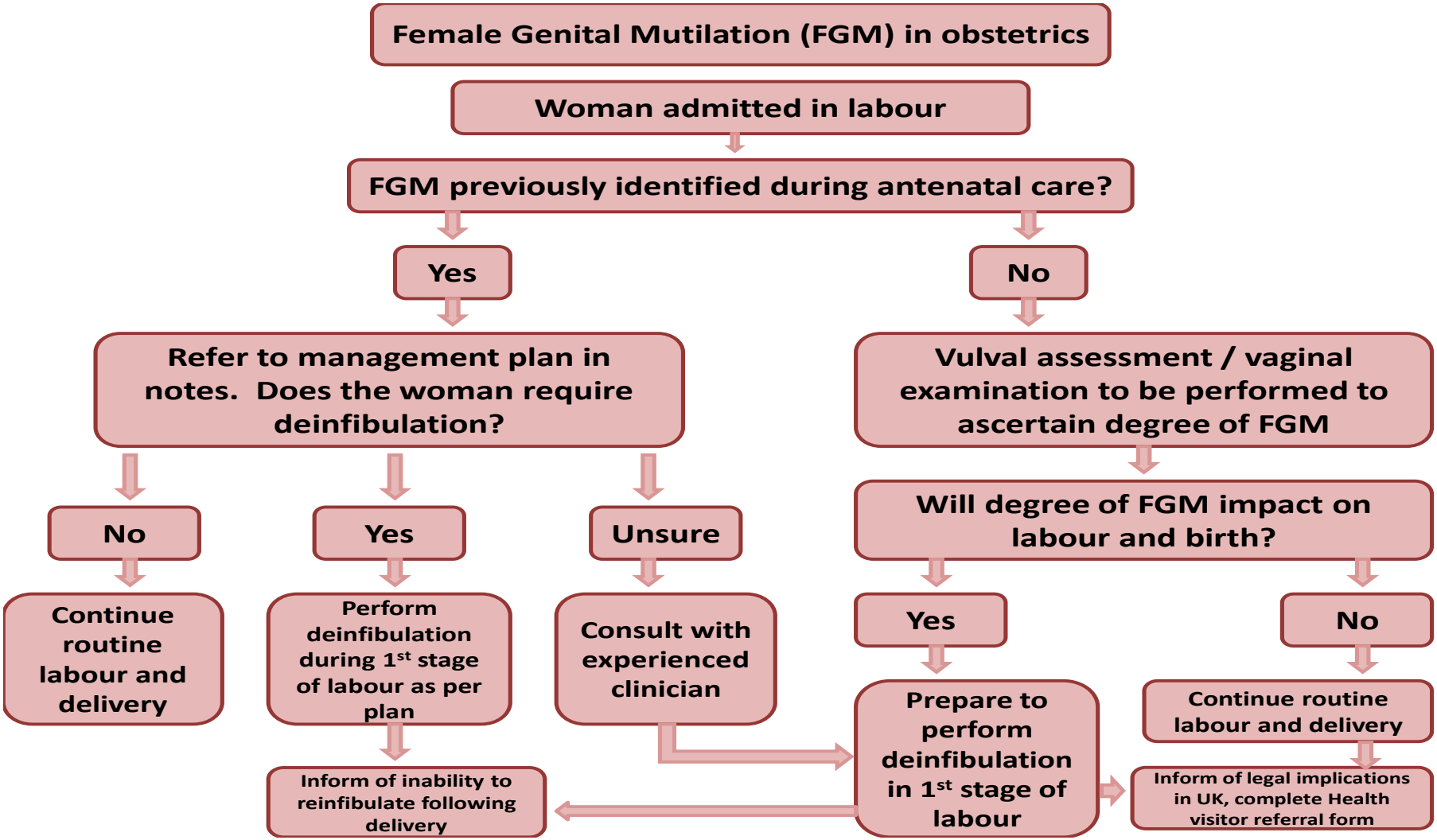
Contents & Page Numbers:

1. Flow Chart

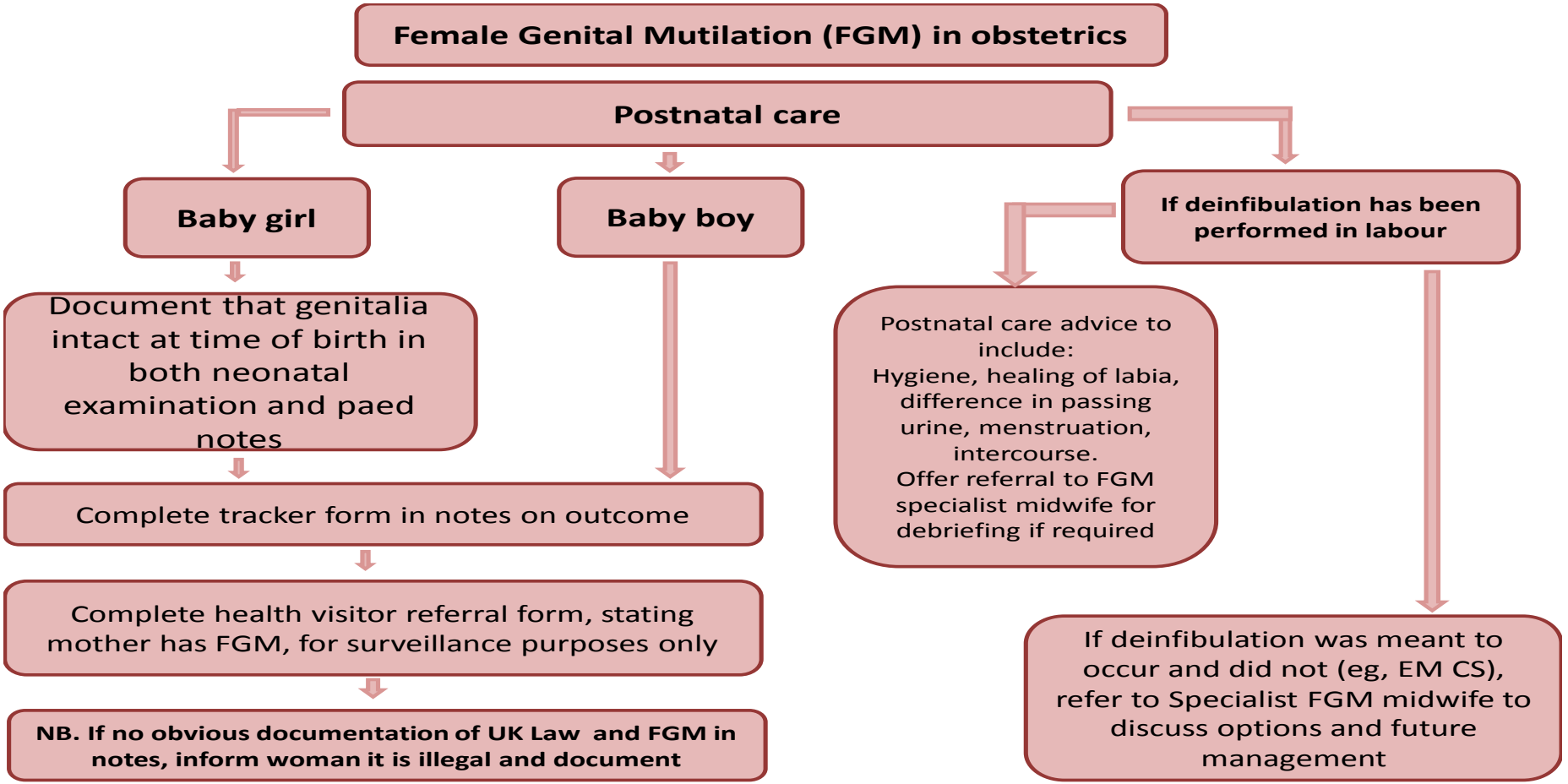
Flowchart 1 – Female Genital Mutilation (FGM) in obstetrics – women identified at Booking



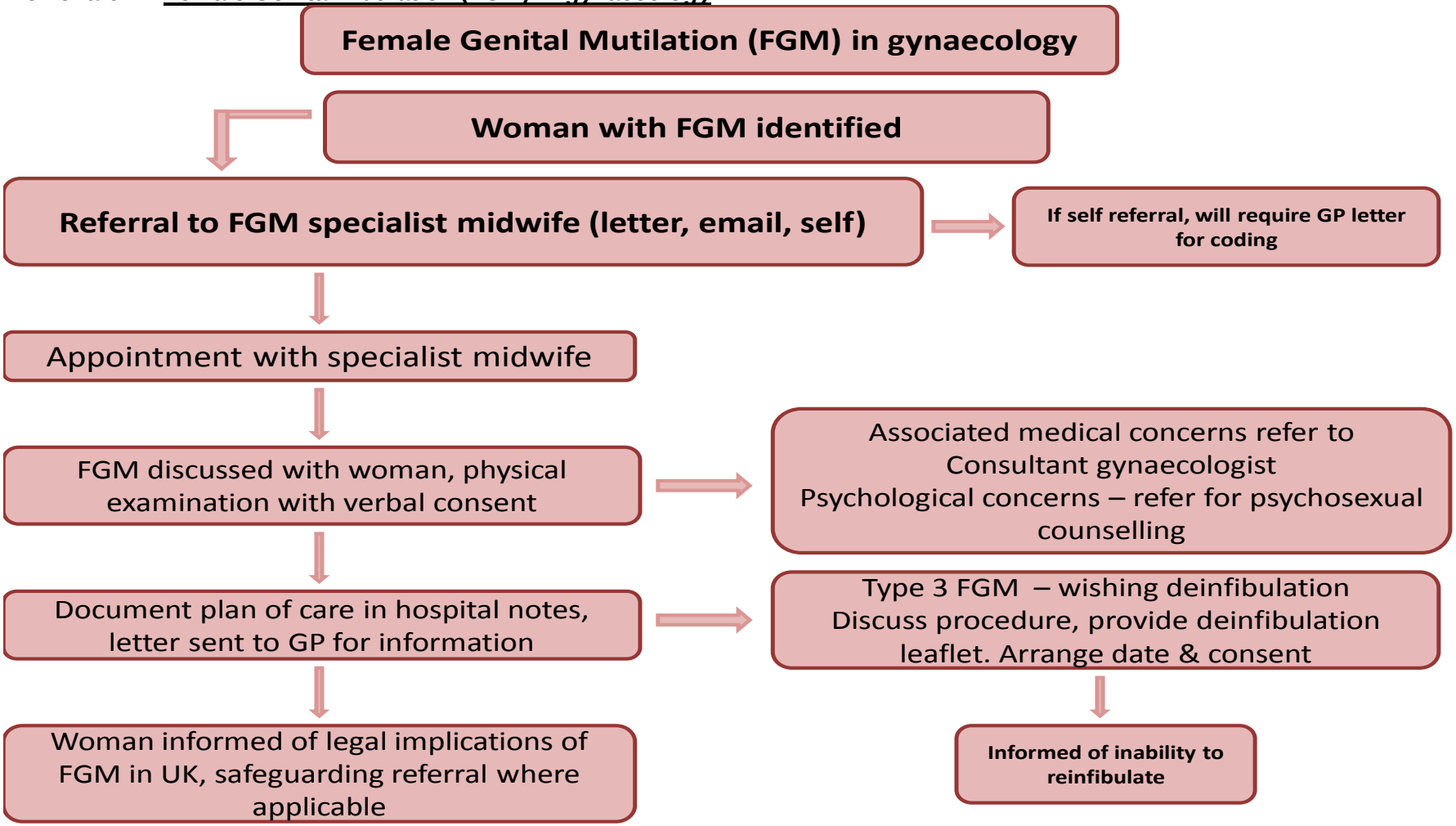
Flowchart 2 – Female Genital Mutilation (FGM) in obstetrics – women admitted in labour



Flowchart 3 – <u>Female Genital Mutilation (FGM) in obstetrics – postnatal care</u>



Flowchart 4 – Female Genital Mutilation (FGM) in gynaecology



2. Executive Summary & Overview

Definitions.

Female Genital Mutilation (FGM) is removal of part, or all of the female genitalia, or procedures that intentionally alter or cause injury to the female genital organs and has no health or medical benefit. (WHO, 2014)

The Law and FGM

The Female Genital Mutilation Act 2003 made it illegal for UK residents (in England and Wales) and permanent residents to practice FGM within or outside in the UK (there is different legislation for Scotland).

The act made also made it illegal for someone to take a British Citizen abroad to perform the operation whether or not it is against the law in that country. It is also illegal to assist in carrying out FGM abroad.

The Royal College of Midwives and the Royal college of Obstetricians and Gynaecologists interpret this to include re-suturing a previously infibulated women after vaginal delivery (RCM 1998). "Any repair carried out after birth, whether following spontaneous laceration or deliberate deinfibulation, should be sufficient to appose raw edges and control bleeding, but must not result in a vaginal opening that makes intercourse difficult or impossible" (RCOG 2009).

As from the 31st of October 2015 the Home office have stipulated that all known cases of FGM in the under 18s should be reported to the police, this is a mandatory requirement. Know cases are where either:

1. A girl under 18 informs the professional that she has been subject to FGM (including genital piercing), and/or
2. Where the professional observes that a girl under 18 has had FGM, or genital piercing

Professionals have a duty to report this to the police. This is achieved by documenting the meeting and the findings, then reporting by dialling 101 (Please also consider Trust Safeguarding Guidance).
Please note that this reporting mechanism is for UNDER 18s ONLY. For women over 18 with genital piercing, the professional must document the following: age when piercing took place, where this occurred and was informed consent given by the woman herself (Home Office and Department for Education, 2015).
Once the above has been undertaken the FGM specialist midwife must be informed and notified of the woman/girl involved, this is achieved either through switchboard or via Bleep 3019, this should be documented in the medical notes.

<u>Incidence</u>: international/ national / local

FGM is usually carried out sometime between birth and puberty although in some communities it is carried out before marriage or childbirth.

Most of the girls and women who have undergone genital mutilation live in African countries, although some live in Asia and the Middle East. They are also increasingly found in Europe, Australia, Canada and the USA, primarily among immigrants from these countries.

More than 125 million girls and women alive today have been cut in the 29 countries in Africa and Middle East where FGM is concentrated; another 30 million are at risk of being cut in the next decade (UNICEF, 2013). An estimated 137,000 women and girls with FGM, born in countries where FGM is practised, were permanently resident in England and Wales in 2011 (Macfarlane and Dorkenoo, 2014). See Appendix 1 for country prevalence.

From September 2014, the Department of Health (D.O.H) will be collecting data from all acute hospital Trusts for more up to date and accurate FGM figures.

3. Body of Guideline

The World Health Organisation state four classification types (WHO 1995);

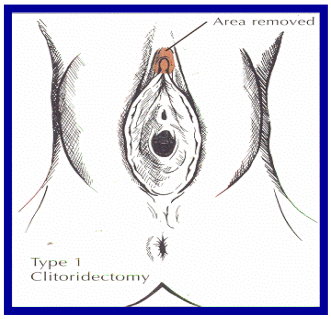
- Type I. (Clitoriodectomy) Excision of the prepuce, with or without excision of part or the entire clitoris.

- Type II. Excision of the clitoris with partial or total excision of the labia minora.

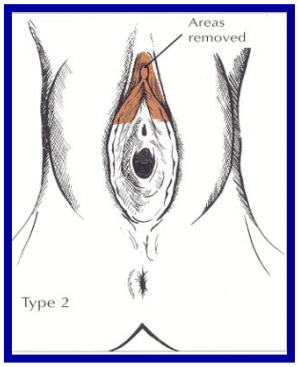
- Type III. (Infibulation) Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening.

- Type IV. Unclassified: Includes pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia, cauterisation by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice, or cutting of the vagina, introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purposes of tightening or narrowing it and any other procedure that falls under the definition of female circumcision given above.

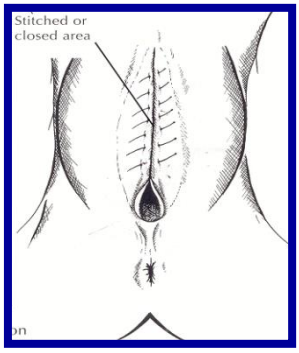
Type I



Type II



Type III



Type IV - Unclassified including pricking, piercing, burning, cutting to genitalia.

See Appendix 3 for Assessment and management plan and appendices 4 & 5 for visual representations of female genitalia with FGM

Associated health problems:

Immediate:

- Haemorrhage
- Pain
- Shock
- Infection (tetanus/sepsis)
- Urine infection
- Trauma to adjacent tissue
- Ulceration of genital region
- Death

Intermediate:

- Delayed wound healing
- Scarring/ keloid formation
- Pelvic infection
- Epidermoid cysts/abscess
- Neuroma

Long Term:

- Haematocolpos: vaginal closure by scarring can lead to the impaired flow of menstrual blood and dysmenorrhoea
- Recurrent urinary tract infections
- Trauma during delivery (See below)
- Painful intercourse
- Infertility
- Psychological trauma

Complications that may occur during pregnancy, labour and delivery:

- Fear of laceration and difficult birth or of the need for caesarean section
- Prolonged/ obstructed labour, usually in type 3 FGM due to tough unyielding scar tissue
- Perineal laceration and uterine inertia, due to prolonged labour
- Neonatal problems caused by fetal distress, brought about by obstructed or prolonged labour
- Post partum wound infections

- Difficulty performing examinations
- Need to perform reversal of infibulation during first or second stage with risk of blood loss
- Difficulty passing urine and catheterisation

Recommendations for care

Heart of England NHS Foundation Trust has a dedicated FGM Specialist Midwife who will act as a link person across the site for pregnant women who plan to deliver within the Trust who have undergone FGM, as well as for non-pregnant women identified with FGM. At the time of writing, she can be contacted Monday – Friday between 9am and 5pm on Bleep 3019 or via extension 43909.

Physical care

Antenatal

It is essential to classify the type and severity of FGM as this will influence maternity and obstetric care.

Women at risk should be identified during the antenatal period and referred to FGM Specialist Midwife for care planning during pregnancy. **All women** should be asked sensitively about FGM at booking. Complete Badgernet (Antenatal booking tab, in Medical Issues section under Confidential Data).

All maternity healthcare workers must be familiar with the nature and higher rates of complications related to FGM, and should take this into account when offering advice about antenatal and delivery care, including recommendations about the place of birth.

Women with FGM should usually be strongly recommended to deliver in a maternity unit with immediate access to facilities for emergency obstetric care. Following assessment by FGM Specialist Midwife, women who have Type 1 FGM or undergone successful deinfibulation and an uncomplicated vaginal birth (with no repeat procedure) can be considered for midwifery-led units.

Cultural aspects make discussion and communication difficult; therefore an interpreter should be involved in discussions of non-English speaking women. Appropriate language and cultural sensitivity should be used in discussion, for example the term FGM may not be understood, or may be offensive to these women and the use of the words ‘circumcision’ or cutting’ may be more appropriate. Some communities use local names for this practice, including the term “sunna”.

Common languages spoken are:

- Arabic
- Somalian
- French
- Tigrean
- Italian
- Dutch

Careful examination of the genitalia is recommended to ascertain what type of FGM has been performed as this will help with the planning of antenatal, intrapartum and postpartum care. Physical examination is also recommended to reassess women who have previously had deinfibulation as some may have undergone a further infibulation.

A plan of care will be made in collaboration with the woman and will be placed in the hospital notes. It is imperative that careful plans are made, documented and carried out for these women (see Appendix 3).

Where there are associated medical problems of FGM a referral must be made to a Consultant Obstetrician. There is also a lead consultant obstetrician for FGM available for complicated cases, contactable via switchboard.

Please refer to Flow chart for care pathway during the antenatal period.

Deinfibulation during pregnancy and labour

Women with Type III FGM will be offered de-infibulation either during the pregnancy at about 24 weeks gestation, or if this is not acceptable then it should be performed during the first stage of labour. Even if the labour ends with a Caesarean section the de-infibulation, if agreed to by the woman, should be performed.

De-infibulation in the antenatal period can be arranged by liaison with FGM Specialist Midwife. There is a patient information leaflet on the intranet available for women who are counselled regarding de-infibulation to explain the procedure and their options.

Benefits of antenatal deinfibulation:

- Avoids the need to cut scar tissue in labour
- Reduces excessive laceration
- Reduces the risk of fetal asphyxia due to delayed crowning at the point of delivery
- Reduces the incidence of bacterial vaginosis and associated preterm labour

Deinfibulation in labour

Some women would prefer to have the procedure performed during labour (so as to experience only one lot of pain and trauma). This may be normal practice in their country of origin.

When no antenatal deinfibulation (unbooked or elected for intrapartum deinfibulation):

- Birth should be in a unit with immediate access to facilities for emergency obstetric care
- The Labour Ward Coordinator must be informed. The woman should be allocated a Senior Midwife
- Aim for vaginal birth
- Send FBC and Group & Save (risk of PPH), & MSU to screen for bacteruria
- Provide adequate analgesia to prevent flashbacks to original procedure
- Inform experienced practitioner of deinfibulation procedure
- Epidural analgesia can be offered, adequate pain relief is essential as vaginal examinations may be poorly tolerated, for deinfibulation, and to psychologically reduce flashbacks
- Perform deinfibulation in the first stage of labour
- Informed consent is essential prior to deinfibulation is essential

Effects of FGM on Labour and Delivery

Decisions about delivery must take into account the psychological need of the woman.
FGM is not an absolute indication for caesarean birth unless the woman has such an extreme form of mutilation with anatomical distortion that makes deinfibulation impossible.

Type I This should not impede labour/ delivery but be aware that deep scaring may have occurred which could cause extensive bleeding.

Type II This should not impede labour/ delivery, but be aware that deep scaring may be present which could cause extensive bleeding.

Type III De-infibulation will be required; medio-lateral episiotomy may also be required.

Type IV This should not impede labour/ delivery but be aware that deep scaring may have occurred which could cause extensive bleeding.

After FGM, the surrounding tissues may be heavily scarred and less elastic. Episiotomy should be recommended if inelastic scar tissue appears to be preventing progress.

Psychological

The act of FGM is often carried out without explanation, analgesia, anaesthesia or qualified medical supervision, performed on young girls being held down by female relatives. Psychological effects can be life-long instilling fear, anxiety and depression. It is imperative that all birth attendants are aware of this, and act always in a sensitive manner. It is not uncommon for women to experience "flash backs" during birth.

Note that psychological trauma and physical morbidity associated with the original act may well lead to fear of childbirth (Tokophobia*) and discussion needs to be sensitive, with careful handling on the part of medical and midwifery clinicians.
* the term tokophobia is from the Greek *tokos*, meaning childbirth and *phobos*, meaning fear

Include a psychological assessment and referral to a psychologist (via perinatal mental health team) if deemed necessary and agreed upon by the woman.

NB in all cases be aware of need for psychological sensitivity. Good analgesia will be required to reduce the risk of psychological trauma or "flash backs", therefore the psychological needs of the woman should be taken into account when deciding the best form of pain relief.

Postnatal & Social care

NB Female infants of mothers affected by FGM are at risk.
You have a statutory responsibility to safeguard girls from being abused through FGM.

It is imperative that following the delivery of a females child that there is documentation that the "genitalia appear to be normal female" in the infant case notes. This evidence may be important on future child protection cases. Discuss with woman legal status of FGM in the UK (especially if baby girl or girls in the family)

A Health Visitor referral form is required. State: "this client has FGM- referral for surveillance purpose only"

If deinfibulation was carried out during labour then a debrief should take place to include advice / counselling in relation to passing urine, menstruation, sexual health needs, as well as contraception and cervical smear uptake discussions.
A 4-6 week postnatal follow up with FGM Specialist Midwife is also recommended to assess healing and address any issues or concerns that the woman may have.

Ensure that the yellow “FGM Tracker” form is completed so that follow up can be arranged (Appendix 2, to be completed on yellow tracker form NOT printed from appendix).

Procedure for deinfibulation:

- Pre-op: MSU, Group & Save
- Setting: suitable outpatient room, labour / delivery room, or operating theatre
- The professional undertaking the deinfibulation must have experience
- Ensure adequate analgesia (pre & post-op)
  usually local/ regional
  consider psychological needs (G.A. may be indicated)

I. The woman is placed in the lithotomy position and the vulva is washed with antiseptic solution. It may not be possible to clean inside the vagina as the opening can be just a few millimetres diameter.
II. A finger should be inserted under the anterior band or scar tissue. If the opening is too small to allow the finger to pass into, the closed point of artery forceps or a small Spencer-Wells forceps can be used.
III. Once the forceps is under the scar tissue they should be opened up so that the scar tissue can be infiltrated with local anaesthetic (e.g. 1% lidocaine). Initial infiltration may be painful and the woman should be informed of this, Entonox may be used if acceptable.
IV. Once the area is anaesthetised, a straight incision should be made anteriorly, with either a scalpel or scissors, through the scar tissue. The scar tissue may be thick and quite difficult to incise. In pregnancy it is adequate to excise the scar tissue until the urethra is visible.
V. A more extensive excision can be undertaken but should be discussed with the woman, such an excision is usual in non-pregnant women.
VI. The cut ends of the incised skin will usually retract outwards to reveal a normal vaginal introitus beneath. The raw edges should be sutured either with continuous or interrupted sutures (3.0 Vicryl Rapide). Suturing will decrease the chance of raw edges sticking together in the midline.

(Adapted from FGM National clinical group website www.fgmnationalgroup.org)

See Appendix 5 for deinfibulation procedure

4. Reason for Development of the Guideline

The guideline provides information to all clinicians on appropriate management of women with Female Genital Mutilation (FGM), as increasing number of these women are booking for maternity care within the Trust.

Locally the number of women who book for delivery at Heart of England Foundation Trust has grown significantly during recent years. There have been approx over 2000 women seen since the start of the local service and accounts for 10% of all bookings at HEFT.

Service for women receiving care at the Trust has been set up and recognised in the Royal College of Midwives (RCM) annual awards for innovative practise in socially excluded groups.

5. Methodology

Development of all guidelines adheres to a process of examining the best available evidence relevant to the topic, incorporating guidance and recommendations from national and international reports.

Finalised guidelines will ultimately be approved and ratified by the Obstetrics and Gynaecology Guideline Group and minuted at clinical Directorate as ratified.

6. Implementation in HEFT & Community

All members of the Women's Health Guideline group and the O&G Guideline group will be informed at meetings and via trust email of new/updated guidelines. This information will then be disseminated to all members of the multidisciplinary team, relevant to O&G, via trust email, audit meetings, team (ward) meetings, in-house training and any relevant workshops.

Electronic copies of the guideline will be available via the trust intranet and paper copies stored within designated clinical areas.

7. Monitoring & Suggested Quality Standards

Adherence and efficiency of clinical guideline will be monitored through regular clinical audit.

Following clinical audit of a guideline an addendum to change in clinical practice may be necessary. Any change to a clinical guideline requires that it must be ratified by the Obstetrics and Gynaecology Guideline Group locally and minuted at Directorate.

Review dates will be set at a period of three years; however this set period can be overridden in light of new clinical evidence.

All unused/previous guidelines will be logged and archived electronically, and in paper format within the trust.

8. References

- Macfarlane, A and Dorkenoo, E (2014) *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***.** City University London, London
- Royal College of Midwives. 1998. *Position paper no 21. Female Genital Mutilation.* RCM. London.
- Royal College of Obstetricians & Gynaecologists. 2009***.*** *RCOG Green Top Guideline No.53, Female Genital Mutilation and its Management****.*** RCOG London**.**
- UNICEF 2013. *Female Genital Mutilation/Cutting: a statistical overview and exploration of the dynamics of change*. New York, USA
- World Health Organisation. 1995. *A report of a Technical Working Group, Geneva.* 17-19 July 1995. Geneva: WHO.
- World Health Organisation 1997 *A report of a Technical Consultation Group, Geneva.* 15-17 October 1997. Geneva: WHO.
- World Health Organisation. 2014. *Female Genital Mutilation. Fact Sheet Number 241***.** www.who.int/mediacentre/factsheets/fs241/en/print.html
- World Health Organisation. 2001. *Estimated prevalence rate for FGM.* May 2001. www.who.int/frh-whd/FGM/FGM%20prev%20update.html
- www.middle-east-info.org/league/somalia/fmgpictures.htm

Appendices

Appendix 1. Countries where female genital mutilation has been documented

Listed below are countries in which female genital mutilation of Types I, II, III and "nicking". Type IV has been documented as a traditional practice. Prevalence is derived from national survey data (the Demographic and Health Surveys (DHS) published by Macro, or the Multiple Cluster Indicator Surveys (MICS), published by UNICEF).

Country	Year	Estimated prevalence of female genital mutilation in girls and women 15 – 49 years (%)
Benin	2006	12.9
Burkina Faso	2006	72.5
Cameroon	2004	1.4
Central African Republic	2008	25.7
Chad	2004	44.9
Côte d'Ivoire	2006	36.4
Djibouti	2006	93.1
Egypt	2008	91.1
Eritrea	2002	88.7
Ethiopia	2005	74.3
Gambia	2005/6	78.3
Ghana	2006	3.8
Guinea	2005	95.6
Guinea-Bissau	2006	44.5
Kenya	2008/9	27.1
Liberia	2007	58.2
Mali	2006	85.2
Mauritania	2007	72.2
Niger	2006	2.2
Nigeria	2008	29.6
Senegal	2005	28.2
Sierra Leone	2006	94
Somalia	2006	97.9
Sudan, northern (approximately 80% of total population in survey)	2000	90
Togo	2006	5.8
Uganda	2006	0.8
Uni **Appendix 2**	2004	14.6
Yemen	2003	38.2

Appendix 2 – FGM Clinic referral/tracker form

FGM CLINIC REFERRAL / TRACKER

Patient label or NAME ..... PID.....DOB..... Post code.....

Country of origin: .....

Region of origin: .....

Length of time in UK: .....

Partner country of origin: .....

Language(s) spoken: ..... Interpreter required? YES / NO

If yes, what language: .....

Has the woman been questioned regarding FGM? YES/ NO

Type of FGM? 1 ..... 2..... 3..... 4..... UNKNOWN.....

Has deinfibulation taken place? ..... When? .....

Has the woman been seen previously by specialist midwife for FGM in this Trust?
If yes, was it through:

Previous Pregnancy? ..... Gynae Referral? .....

Other:
.....
.....

IF NO – APPOINTMENT REQUIRED: Appt Date & Time .....

Interpreter Booked .....

If Pregnant: G.....P..... EDD: .....

DOES THIS WOMAN HAVE ANY FEMALE CHILDREN? YES/ NO

Name					
Date of birth					
Country of birth					
Circumcised?					

POSTNATAL ONLY

Please complete a Health Visitor referral form and forward to FGM specialist midwife.

Name & designation of professional completing form: .....

Version 1: AB/SHR 2016

Appendix 3 - FGM assessment and management plan

FEMALE GENITAL MUTILATION ASSESSMENT AND MANAGEMENT PLAN

Patient label or

NAME .....

PID..... DOB.....

Post code.....

Contact number: _____

Country / region of origin: _____

Languages spoken: _____

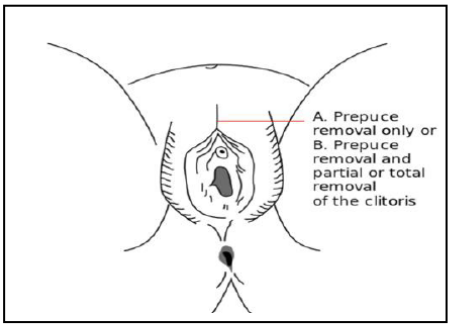
Interpreter required & in what language: _____

SYMPTOMS (please circle as appropriate)

Urinary :	Recurrent urinary tract infections	YES / NO
Menstrual:	Dysmenorrhoea	YES / NO
	Menorrhagia	YES / NO
Sexual:	Dyspareunia	YES / NO
	Loss of libido/lack of sexual pleasure.....	YES / NO
Psychological:	Flashbacks / depression/ other.....	YES / NO
Other:	Keloid scarring / recurrent abscess / cysts / chronic genital pain	

EXAMINATION FINDINGS ON INITIAL ASSESSMENT:

TYPE 1: Prepuce removal only or partial or total removal of the clitoris



Comments:

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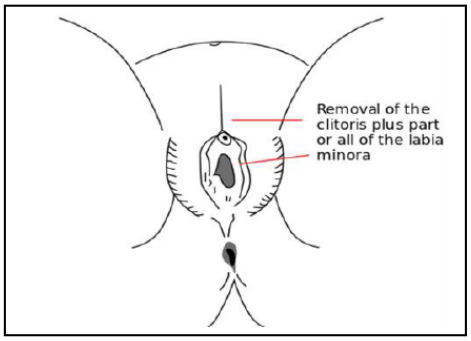
TYPE 2: Removal of the clitoris plus part or all of the labia minora



Comments:

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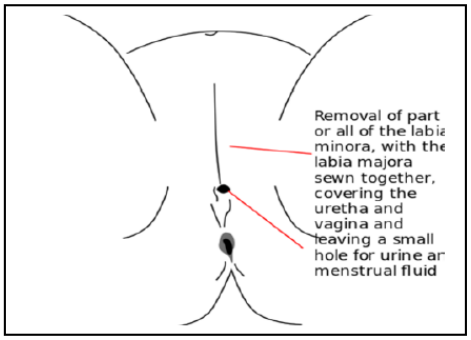
TYPE 3: Removal of part or all of the labia minora with the labia majora sewn together covering the urethra and vagina leaving only a small opening for urine and menstrual fluid



DEINFIBULATED: **YES** **NO**

If yes, when & where?

Comments:

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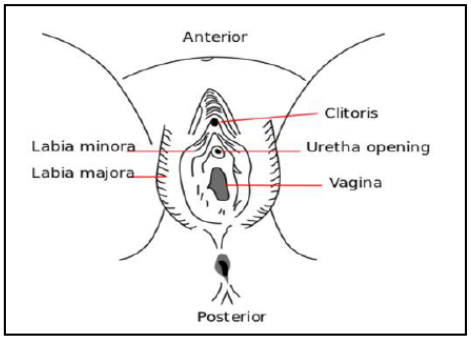
TYPE 4: Pricking, piercing or incising the clitoris and / or labia, stretching the clitoris and / or labia, cauterising the clitoris or surrounding tissues or any other procedure not classified as above



Comments:

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MANAGEMENT (circle as appropriate)

Counselled patient about type of FGM found:
YES / NO

For women with type 3 (who have not had deinfibulation previously):

Counselled patient about advantages and implications of deinfibulation: YES / NO

Informed about inability to re-infibulate following deinfibulation: YES / NO

Deinfibulation: not wished / gynae / antenatal / 1st stage labour

Date for deinfibulation if gynae / antenatal _____

Anaesthetic preference local / GA Where_____

Comments:

_____

Discussion with male partner, if present, regarding above: YES / NO

Pregnancy & Labour recommendations:

Suitable for Midwifery Led Care / delivery on Willow or Netherbrook YES / NO

Reason for decision: Type 1 / Type 3 & prev NVD after deinfibulation

Seen & agreed by: _____

Designation: ----------

Manage labour as normal	YES / NO
Counselled patient regarding childbirth & episiotomy if required	YES / NO
Medio- lateral episiotomy suggested	YES / NO
Deinfibulation in labour	YES / NO
Inform SpR when in labour	YES / NO

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SAFEGUARDING

Counselled regarding FGM Act 2003 YES / NO

Sign & Print: _____ Date: _____

Health visitor referral form completed YES /NO/ NA

Sign & Print:_____(required postnatally) Date: _____

Does this woman have any female children? YES/ NO

Name						
Date of birth						
Country of birth						
Circumcised? Y/N						
If yes, where & age						

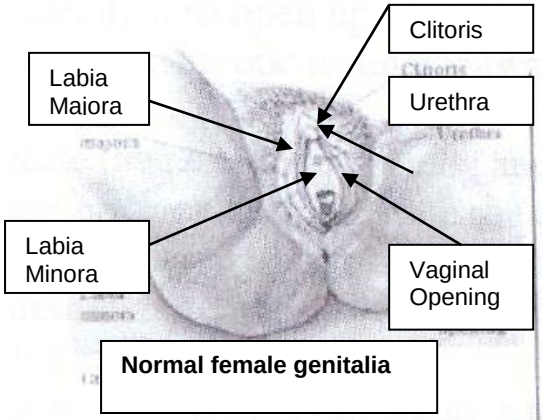
Any further referrals required at present time regarding information sharing / safeguarding concerns?

YES / NO (if yes please state)

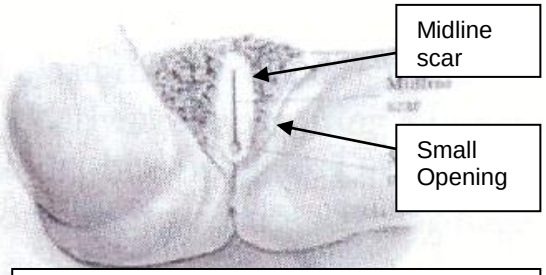
_____

_____

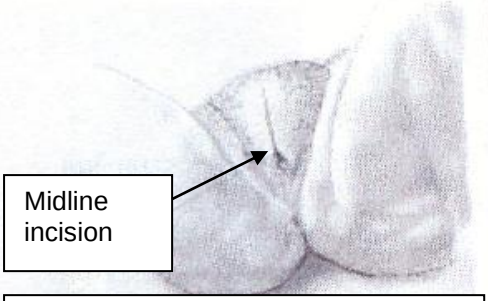
Appendix 4 - Visual representations of female genitalia



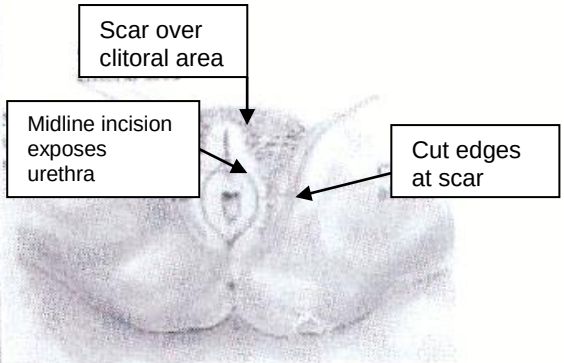
Normal female genitalia



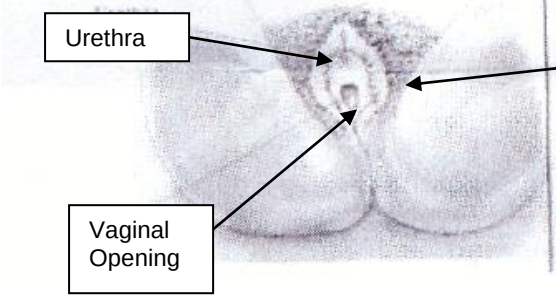
External female genitalia following type 3 FGM. The middle scar may be perforated in places owing to defective healing.



Position of incision to minimise bleeding,
keep strictly to the midline & continue only until the urethra has been exposed.

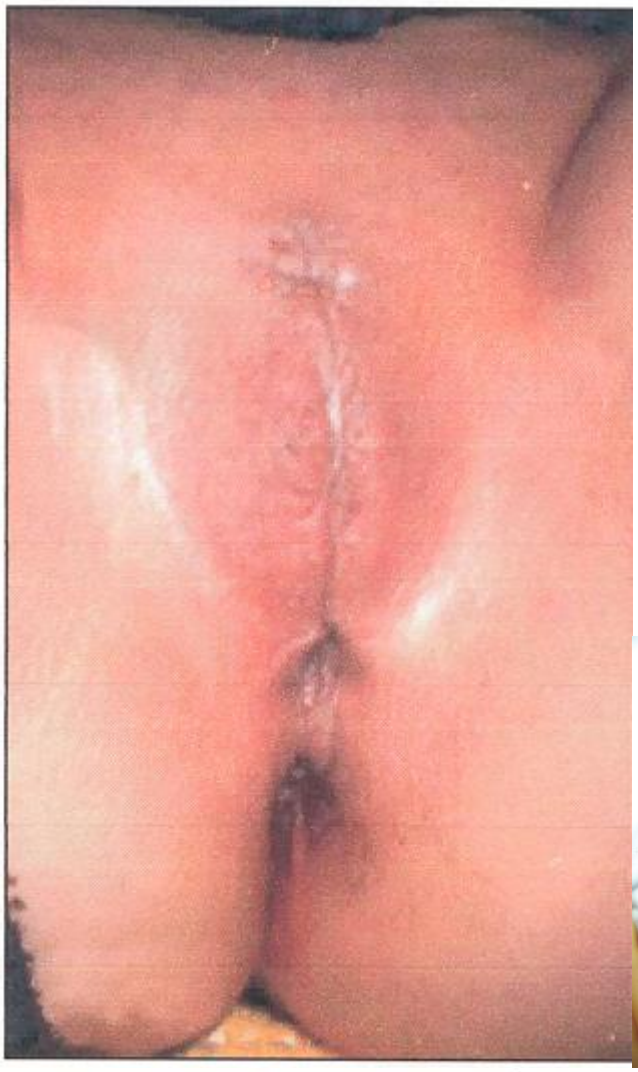


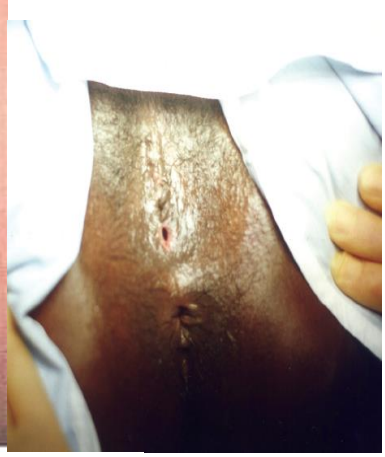
View following incision. Scar remains over clitoral area remains 2.5cm

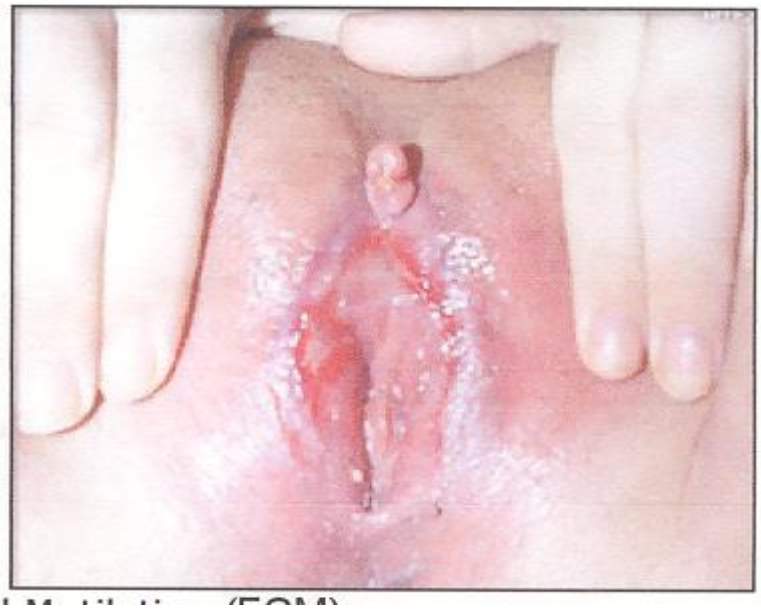


Position the sutures to prevent bleeding along the cut edges of labia.

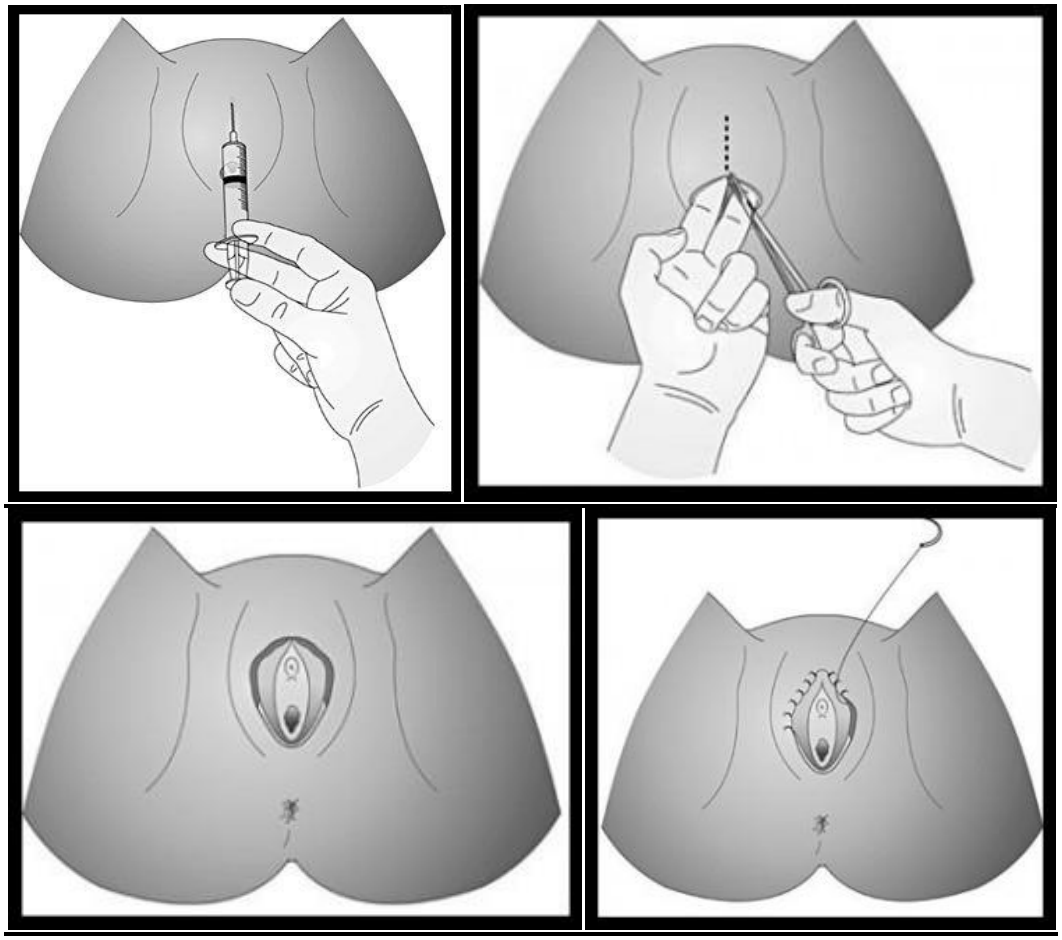
Appendix 5 – <u>Clinical photographs of FGM</u>







Appendix 5. Deinfibulation procedure



Meta Data

Guideline Title:	Female Genital Mutilation (FGM)
Guideline Sponsor:	Obstetric & Gynaecology Directorate
Date of Approval:	18th February 2016
Approved by:	Obstetric & Gynaecology Guideline Group
Date effective from:	16th March 2016
Review Date:	16th March 2016
Related Policies/Topic/Driver	• Perineal Trauma • Recovery • Women who decline blood and blood products

Revision History

Version No.	Date of Issue	Author(s) / Reviewer(s)	Reason for Issue
1	January 2008	A Hughes T Ball L McBride M Dobson	Merger
2	January 2011	A. Byrne (neé Hughes)	Review
3	May 2015	A. Byrne – Specialist RM S. Reynolds – Specialist RM secondment	Full review: • Updating of flowcharts, to include gynaecology referral system • Updating of incidence • Inclusion of assessment and management plan • Generating of deinfibulation leaflet (to be found on PAID system)
4	March 2016	A. Byrne – Specialist RM	Addendum to practice: • Mandatory reporting of girls under 18 with FGM, including genital piercing • To refer to lead named consultant in complicated cases Appendices: • FGM referral tracker • Inclusion of sexual relationship questions on referral proforma

Clinical Director: **Signed:** 

Name: Katherine Barber

Date: 16th March 2016