RCGP Position Statement on Female Genital Mutilation

This statement relates to the whole of the UK

Introduction

1. Female Genital Mutilation (FGM) is a brutal crime that affects women and girls within the UK and worldwide. It is generally performed on pre-pubescent children and can lead to severe short and long term physical and psychological conditions. In some cases FGM can lead to the death of the child.

2. The RCGP views FGM as child abuse, as the child has been subjected to irreparable physical harm, and is committed to its eradication. If it is suspected by a GP that a child has undergone FGM then the parent(s) or guardian(s) should be referred to social services who should have the means to deal with the offence accordingly.

3. Adult victims of FGM should also be treated as victims of abuse and should have access to culturally sensitive support services. It is also important to note that and any children in their household or family could be at higher risk of also becoming victims of FGM.

Policy and political background

4. FGM is a crime. The prohibition of Female Circumcision Act (1985) was replaced by the Female Genital Mutilation Act (2003) in England, Wales and Northern Ireland and similar terms were ratified in the Prohibition of Female Genital Mutilation Act (2005) in Scotland. It is a crime to conduct FGM and to aid, abet, counsel or procure FGM either within or outside the UK, whether by a UK or non-UK national or the girl herself. In March 2014 the first prosecutions under the Acts(s) were announced, including one doctor.

5. FGM is a form of child abuse, as it usually affects girls under the age of 18 years. Multi-agency practice guidelines were produced by the DH in 2011, but “Working Together to Safeguard Children 2013” only mentions it once and this is in an appendix. FGM differs in signs and symptoms from other forms of abuse (although the signs one sees in terms of the consequence of emotional/psychological damage may overlap). Children subjected to FGM may be unknown to social services and concerns may be below current referral thresholds.

The role of the GP in combating FGM

6. GPs play a unique role within the community as not only the first point of contact for the vast majority of patients in the health service, but also as an expert medical generalist trained to see the whole patient. As such GPs have a very important role to play in combating FGM.

Identification

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1 Department of Health/HMG. Multi-agency practice guidelines: Female Genital Mutilation 2011

2 Department of Education. Working Together to Safeguard Children 2013
http://www.workingtogetheronline.co.uk/index.html
7. The most prominent role that GPs can play in tackling FGM is the identification of victims and potential victims.

8. There are a number of clinical situations when GPs and practice nurses may be able to identify patients who have been affected by FGM. These include:
   - The registration of new patients from affected communities.
   - At the start of pregnancy in women from affected communities. This can be achieved by asking a direct question.
   - Patients presenting with symptoms that may suggest they have been affected by FGM, such as UTIs or vaginal soreness.
   - Instances when patients from affected communities refuse cervical cytology or experience pain or distress during the test.
   - When immunisations are requested for an extended break overseas to countries where the procedure is practiced.

9. In France routine examinations of the genitalia of young girls has led to a higher rate of prosecution. While the RCGP appreciates that routine screening can have positive outcomes, we have concerns that a screening programme of this type could alienate hard to reach individuals and communities, and could in itself be a traumatic experience.

**Recording**

10. GP systems have a specific code to record FGM. This has the potential to be a valuable tool in combating FGM by increasing the level to which it is recorded and therefore understood. In addition, by gathering local prevalence data, it may be possible to make a better case to secure funding for additional resources such as specialist services and language services.

**Referring, Safeguarding and Child Protection**

11. FGM is a form of child abuse and if it is suspected that it has occurred or that there is a high risk that it is about to occur, GPs should refer the case to social services under Local Safeguarding Children Board (LSCB) procedures.

12. As the main point of entry into the health service for the majority of patients, GPs have a duty to refer patients to the relevant secondary bodies. However, in order to do this for patients affected by FGM there need to be clear pathways of care and thresholds for referral to police, social and other relevant services, including mental health. Local Safeguarding Boards (LSCB) need to be encouraged to develop their local multi-agency procedures to clarify these pathways and thresholds. The RCGP/NSPCC Safeguarding Children Toolkit contains further information.³

13. In addition some women and children will need specialist FGM support services, for the physical and/or psychological consequences of their trauma. The RCGP does not think adequate support services currently exist, except in small pockets within some large cities.

14. The RCGP opposes the introduction of mandatory reporting for FGM (the legal requirement to report all instances of FGM encountered) when the victim is an adult. Automatic disclosure in every instance of FGM would fail to take into account the unique circumstances of each patient and therefore may not be in their best interests. The College believes that GPs should be trusted to make the decision about when it is the right time to refer an adult victim to the relevant authorities and any move towards mandatory reporting

would undermine the safeguarding role of the GP. In addition, its use risks further isolating the communities which FGM affects.

**Raising awareness**

15. The RCGP has helped to produce a number of documents aimed at GPs which contain advice on how to address FGM (detailed in paragraph 29 below). In addition, GPs should feel free to display posters and have leaflets in their surgeries, especially if they are in an area with a high prevalence of FGM.

**Working with the wider health service**

16. In addition, GPs also have a role in supporting other health care professionals who may be closer to the victim or the mother of the victim, such as midwives or health workers, to identify and refer any cases of FGM they may encounter.

**Possible barriers to identification by GPs**

17. There are a number of possible barriers to identification by GPs, such as:

- A lack of awareness of the risk factors that suggest a patient may be affected by FGM. Unfortunately there is a lack of adequate data on communities and individuals who are affected by FGM within the UK. It is likely that this is impacting on the ability of GPs to judge which of their patients may be at risk.
- Cultural sensitivity issues. GPs may feel unable to raise the issue sensitively with members of affected communities.
- FGM may not be clinically apparent to a GP who does not often conduct intimate examinations, especially if it is Type 1 (clitorectomy) in a pre-pubertal girl. Less extensive surgery may still be as serious in terms of infection (including HIV and other blood borne viruses), pain and subsequent mental health problems.
- Difficulty asking questions sensitively, but directly. Particularly in the case of women and children who are accompanied by a family member.
- Difficulty obtaining consent to an examination.
- Language and communication problems. There has been less access to translation services in recent years due to cut-backs within the health service.

**What more can be done to tackle FGM in the UK**

18. The RCGP has concerns that the current medical and policy landscape does not provide the right tools for the reduction of the FGM within the UK. Of particular concern is the lack of adequate coverage for support services for victims, which currently only exist in small pockets within large cities. The available support and services can be improved by government by:

- Developing specific care pathways for FGM that involve health, education, and social services, with input from the medical royal colleges including the RCGP.
- Engaging with affected communities by identifying and supporting people to work in a culturally sensitive way within the affected communities.
- Making culturally sensitive specialist FGM services available, especially for long term psychological consequences, including PTSD.
- Increasing the availability of translation services.
- Publicising available support services such as the dedicated NSPCC helpline.
- Improving the evidence base through research into the epidemiology of FGM in the UK, its association with other forms of child abuse, long term outcomes for those affected, and the effectiveness of interventions.
- Publishing details of the kind of information needed from general practice to ensure a conviction of the perpetrator.
19. The RCGP has significant concerns over the lack of detailed data on the prevalence of FGM within the UK, as planning of services cannot be adequately undertaken without knowledge of the scale of the problem. All health workers who come into contact with those who have been affected by FGM should be encouraged to record this fact. This is particularly true of those who work in obstetrics, gynaecology, paediatrics and mental health. The Coalition Government announced in February 2014 that from September 2014, all hospitals in England will be required to record if a patient has had FGM, if there is a family history of the practice or whether deinfibulation has been carried out on a woman. This will include community midwives. The prevalence data will then be reported to the Department of Health every month.

Other health professionals (including GPs) may wish to support the standard and provide an FGM Prevalence Dataset. A national programme of education for communities affected and professionals is also taking place.

20. The College also has concerns around the lack of detailed research into the epidemiology of FGM in the UK which would provide significant support to GPs in their diagnosis, and the lack of a detailed guidelines about what information would be needed from general practice to ensure a conviction.

**RCGP work on FGM**

21. Readily available information on FGM and how it should be addressed is essential to support its diagnosis in general practice and the referral of the victim and perpetrator to the relevant services. The RCGP has helped to draw up a number of resources on FGM for use within primary care:

I. The Primary Care Child Safeguarding Forum (PCCSF) is a Primary Care Society affiliated to the RCGP and has recently produced a Statement on Female Genital Mutilation.

II. The RCGP has been involved in a major piece of work on FGM, led by our colleagues at the Royal Colleges of Midwives and Obstetricians and Gynaecologists, amongst others. This is focused on helping to raise clinician awareness of this problem, which affects some of the most vulnerable girls and women in our society. The report *Tackling FGM in the UK* looks at the role that all health and social care professionals - including GPs - have in identifying and reporting cases of FGM.

III. The RCGP, in conjunction with the NSPCC, had previously developed a toolkit for health professionals on safeguarding children and young people, including advice of relevance to cases of FGM.

IV. The RCGP 'Violence Against Women and Children' online course, developed in partnership with the Department of Health (England) VAWC team, which includes information on FGM and on identifying and responding to other forms of violence. As of April 2014, this course has been accessed by over 3600 practitioners: http://elearning.rcgp.org.uk/course/info.php?id=88

22. The RCGP is committed to working with government to tackle FGM, and will continue to provide information on identifying and tackling FGM aimed at medical practitioners within general practice.

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