FEMALE GENITAL MUTILATION (FGM) CLINICAL GUIDELINE

1. Aim/Purpose of this Guideline

1.1 This guideline has been produced to inform all health professionals regarding FGM. It provides guidance on how to identify and address this issue with women, how to proceed when someone is identified as having suffered FGM and how to safeguard girls from the practice of FGM within RCHT. Within the maternity setting it also supports the policy of asking all women whether they have experienced any form of surgery to their genitals including female genital mutilation.

1.2 RCHT is required to record and report this data centrally to the Department of Health on a monthly basis:

- If a patient has had FGM
- If there is a family history of FGM
- If an FGM related procedure has been carried out on a woman - (deinfibulation)

2. The Guidance

2.1 Background
FGM is a form of violence against women and girls and is an abuse of human rights and is a form of child abuse. It is sometimes inappropriately referred to as Female Circumcision or Female Genital Cutting. Some communities use local names for this practice, including the term “sunna”. FGM is not a requirement of any religion.

According to the World Health Organisation (WHO) Female Genital Mutilation (FGM) is practiced in approximately 30 countries in Africa and the Middle East.

In the Unite Kingdom it is often seen among immigrants from:

**Somalia, Guinea, Mali, Sudan, Ethiopia, Sierra Leone, Egypt**

FGM has also been documented in communities in **Yemen, Iraq, Israel, Oman, the United Arab Emirates, the Occupied Palestinian Territories, India, Indonesia, Malaysia and Pakistan**.

The World Health Organization 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.

FGM is usually carried out on girls between the age of 2 and 12 years, but occasionally later before marriage. The communities which practice FGM see it as a rite of passage to womanhood. It is a deeply rooted tradition.

FGM is a traditional practice which can have serious health consequences.
2.2 The World Health Organisation (WHO) defines female genital mutilation as: “all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons – (WHO 2010)

The practice causes severe pain and can have several immediate and long-term health consequences, including difficulties in childbirth also causing dangers to the child.

2.3 The WHO classification of FGM breaks it down into four types:

**Type I**: Partial or total removal of the clitoris and/ or the prepuce (clitoridectomy).

**Type II**: Partial or total removal of the clitoris and labia minora, with or without excision of the labia majora.

**Type III**: (Infibulation). Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/ or labia majora, with or without excision of the clitoris. Type 111 has most implications on childbirth. (WHO 2007)

**Type IV**: All other harmful procedures to the female genitalia for non-medical purposes, e.g. nicking, pricking, piercing, incising, scraping and cauterising.

Ninety percent are either Type I, II or IV, while Type III (infibulation) is only found in 10% of known cases.
Diagram 1: Normal Female Genitalia

- Prepuce or hood of clitoris
- Glans penis
- Labia majora
- External urethral orifice
- Perineum
- Anus
- Labia minora
- Clitoris
- External genitalia
Diagram 2: Types of FGM
2.4 The short term consequences following 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.

The Long term health implications 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.
- Death of mother and child during childbirth.

2.5 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 also made it illegal for someone to take a British Citizen aboard 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 law however appears to allow surgery to the external genitalia for comfort, sexual confidence, body image and self esteem (e.g. labial reduction surgery).

2.6 Safeguarding and FGM:

If you are worried about a child under 18 who is at risk of FGM or has had FGM you have a legal obligation to share this information with social care or the police (HM Government 2014). See Appendix 3

There is a duty for all professionals to act to safeguard girls at risk of FGM with four key issues to consider:

An illegal act being performed on a female regardless of her age
The need to safeguard girls and young women at risk of FGM
The risk to girls and young women where a relative has undergone FGM
Situations where a girl may be removed from the country to undergo FGM


The legal and safeguarding implications should be sensitively explained to woman. The leaflet below should be provided to all women identified as having some form of FGM through the booking appointment.

FGM education information
SWCPP.co.uk

2.7 Guidance from Sexual Health

Women seen in Sexual Health are routinely asked questions that may lead the clinician to have concerns about FGM affecting the patient in front of them. We are aware FGM is a complex and sensitive issue that requires professionals to approach the subject carefully.

Routine sexual health questions that may lead a clinician to be concerned include questions such as:

- “Do you experience any pains or difficulty during intercourse?”
- “Do you have any problems passing urine?”
- “Do you have any pelvic pain or menstrual difficulties?”

All women are also asked about obstetric history and gynaecological procedures Questions include:

- Have you had any difficulties in childbirth?”
• Have you had any genital piercings or genital procedures?

All patients attending sexual health services can request a clinician of the same gender, ensure the woman is aware of this and if needed, interpreting services are available.

FGM in a child or adult raises significant safeguarding concerns for both the individual and other family members. All patients under 18 years of age are routinely assessed for child protection concerns and a departmental policy is in place for onward management of these young people identified to be at risk. If a young person under the age of 18 years attends and has been a victim of FGM this is abuse and the child protection protocol needs to be implemented immediately. If a child is suspected to be at risk of FGM, referral to safeguarding should also be made.

Clinicians in Sexual Health who suspect or identify FGM have a duty to report to the Safeguarding lead for discussion and referral.

Examination of the patient who has disclosed FGM should be by a senior clinician and following departmental examination and chaperone policy, but at the clinician’s discretion to adapt the examination to suit the individual woman. It is mandatory for health professionals to record in their healthcare record if a patient has FGM whenever it is identified in the course of NHS treatment. Injuries should be carefully documented. Examination of a child or young person should be in strict accordance with safeguarding children procedures and a consultant paediatrician may need to be present.

Patients should be signposted onto appropriate counselling and support, and offered referral in gynaecological services for discussion of reversal/ de-infibulation if appropriate.

Patients should be informed that FGM is an illegal act performed on a female, regardless of her age. 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 the UK (there is different legislation for Scotland).

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 a disclosure may be the first time that a woman has 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 wishes of the woman must be respected at all times. If the woman is pregnant, the welfare of her unborn child or others in her immediate or extended family must also be considered at this point as they are potentially at risk and action must be taken accordingly. (Female Genital Mutilation Prevention Programme: Requirements for NHS staff. Statement by the Department of Health and NHS England)

Revised HMG FGM multi agency guidelines:
The Sexual Health Service will report numbers of patients identified with FGM to the RCHT for mandatory reporting.

Women affected, who would like further support, can be referred onto a specialist FGM service – see www.nhs.uk/fgm

The FGM helpline is a free 24-hour service. Call 0800 028 3550 for further advice. As previously discussed – consider onward referral into gynaecology services and ask permission to involve the GP where appropriate.

Guidance from Child Health

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

The appropriate response to FGM is to follow usual child protection procedures to ensure:

- Immediate protection and support for the child/ren; and
- That the practice is not perpetuated

An appropriate response to a child suspected of having undergone FGM as well as a child at risk of undergoing FGM could include:

- Arranging for an interpreter if this is necessary and appropriate;
- Creating an opportunity for the child to disclose, seeing the child on their own;
- Using simple language and asking straightforward questions;
- Using terminology that the child will understand, eg. the child is unlikely to view the procedure as abusive;
- Being sensitive to the fact that the child will be loyal to their parents;
- Giving the child time to talk;
- Getting accurate information about the urgency of the situation, if the child is at risk of being subjected to the procedure;
- Giving the message that the child can come back to you again.

An appropriate response by professionals who encounter a girl or woman who has undergone FGM includes:

- Arranging for a professional interpreter and not agreeing to friends/family members interpreting on their behalf;
- Being sensitive to the intimate nature of the subject;
- Making no assumptions;
- Asking straightforward questions;
- Being willing to listen;
- Being non-judgemental (condemning the practice but not blaming the girl/woman);
- Understanding how she may feel in terms of language barriers, culture shock, that she, her partner, her family are being judged;
- Give a clear explanation that FGM is illegal and that the law can be used to help the family avoid FGM if/when they have daughters.
Identifying a child who has been subject to FGM or who is at risk of being abused through FGM

Professionals in all agencies, and individuals and groups in the community, need to be alert to the possibility of a child being at risk of or having experienced FGM. There are a range of potential indicators that a child may be at risk of FGM which individually may not indicate risk but if there are two or more present this could signal risk to the child.

Indications that FGM may be about to take place include:

- The family comes from a community that is known to practice FGM eg. Somalia, Sudan and other African countries. It may be possible that they will practice FGM if a female family elder is around;
- Parents state that 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 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 other children about it;
- A child may request help from a teacher or another adult;
- Unaccompanied asylum seeking children, refugee families;
- 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;
- Any female child who has a sister who has already undergone FGM must be considered to be at risk, as must other female children in the extended family.

Indications that FGM may have already taken place include:

- A child may spend long periods of time away from the classroom during the day with bladder or menstrual problems;
- There may be prolonged absences from school;
- A prolonged absence from school with noticeable behaviour changes on the girl’s return;
- Professionals also need to be vigilant to the emotional and psychological needs of children who may/are suffering the adverse consequence of the practice, eg. withdrawal, depression etc;
- A child may confide in a professional;
- A child requiring to be excused from physical exercise lessons without the support of her GP;
- A child may ask for help.

Royal Cornwall Hospital NHS Trust Professionals’ response

Any information or concern that a child is at immediate risk of, or has undergone, female genital mutilation should result in an immediate child protection referral to MARU (verbal and then written within 24 hours) in line with Section 47 enquiries.

Information required by MARU. See Appendix 2
- Full details of index child – name, date of birth, address, school, GP
- Full details of parents – name, date of birth, address
• Full details of siblings – name, date of birth, school, address, GP
• Description of concern
• Any background health information available to referrer
• Any additional social information regarding the family ie. mental health, learning difficulties, domestic violence, drug and alcohol issues, family circumstances if known

2.8 Guidance from maternity

Antenatal Period, booking appointment and FGM enquiry:

All clinical staff should be aware of a nominated obstetrician (link-person) in the Trust or community with whom cases may be discussed or referred. At the Royal Cornwall NHS Trust (RCHT) Karen Watkins is the nominated obstetrician.

Hospitals and clinics in the UK offering specialist FGM services can be found at:

• http://www.nhs.uk/NHSEngland/AboutNHSservices/sexual-health-services/Pages/fgm-healthservices-for-women.aspx
• www.forwarduk.org.uk/resources/support/well-woman-clinics

It is RCHT’s maternity guidance that sensitive enquiry at the booking appointment should be made to determine the FGM status of all women. In addition, it is essential to classify the type and severity of FGM as this will influence maternity and obstetric care.

All women should be asked sensitively about FGM using the following question: Have you ever had any surgery to your genitals such as: genital piercings, operations or have you been cut or circumcised?

If the answer to this is yes the health professional will ask the question:

What type of genital surgery have you had?

• Episiotomy repair
• Episiotomy refashioning
• Repair of 3rd or 4th degree tear?
• Female circumcision/cut/closed?
• Other.

For women who come from outside the UK the question –‘do you come from an country in which FGM or gential cutting is practiced’ will allow discussion about whether the woman has experienced FGM.

Factors to remember for the booking appointment:

• The woman may be asked at booking if she is on her own or at the woman only appointment at 16 weeks gestation.
• Where a woman has a hearing impairment, or her first language is not English, arrangements should be made for an interpreter to be present.

• Wherever possible it should be ascertained from the woman whether the interpreter is suitable. Family members and friends should never be used to interpret interviews of this kind.

2.9 If FGM is disclosed:

• Record FGM in the patient’s healthcare record, as well as details of any conversations.
• Ascertain whether there are any daughters within the family and whether they have also had FGM. If there are young female child in the family then we have an legal and moral obligation to protect them from FGM (see appendix 2)
• Give a very clear explanation that FGM is illegal and that the law can be used to help the family avoid FGM if/when they have daughters
• Inform the woman that you will need to make a referral to MARU and you will need to inform the woman GP if there are female children in the family or if the baby is female
• Assess the psychological impact and referral to a psychologist (via perinatal mental health team) if deemed necessary and agreed upon by the woman
• If the disclosure is to the community midwife then she should refer the woman to the Designated Obstetric Lead for FGM to be seen in clinic and who will arrange to see and examine the woman and report

2.10 If FGM is identified on examination or disclosed to an Obstetrician (in addition to 2.9 above):

• Use a diagram or medical photography (with consent). This aids communication with the patient and other clinicians, and limits repetitive examinations
• Classify the type of FGM
• Assess the risk to female children in the family and inform the women of the legal implications (as above)
• Inform the Obstetric Lead for FGM

Following the assessment, if a woman is a primigravida with type III FGM or it is felt that vaginal examination or delivery will be difficult or impossible she should be referred to the Designated Obstetric Lead for FGM antenatal clinic for consideration for antenatal deinfibulation while remaining under the care of her original midwife or obstetrician.

2.11 Antenatal deinfibulation
De-infibulation (reversal) should be offered if vaginal access is inadequate and to all women with type III FGM. Ideally this is performed antenatally around 20 weeks gestation (reduces risk of miscarriage and allows time for healing before birth).

Often the woman has not been identified antenatally and she presents in labour (see below for intrapartum de-infibulation). In addition, 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. Counselling by specialist FGM services may be necessary to enable them to understand the benefits of antenatal de-infibulation and to support them to undergo the procedure.

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

2.12 Procedure for antenatal deinfibulation:

- Pre-op: MSU, Group & Save
- Setting: Minor-op Out-Patient 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 rarely be indicated)
- Use a blade or scissors for the procedure
- The incision should be made along the vulval excision scar until reaching the point where the urethral meatus is clearly visualised
- Closure of the newly opened edges should be brought together with fine absorbable material to reduce the likelihood of infection and bleeding and to keep the opposed edges separated
- Women should be advised that the flow of urine will change as they will pass urine much quicker and with greater volume. A perceived 'lack of control' when emptying the bladder is common
- Women should drink plenty of water after the procedure to help dilute the urine and reduce stinging sensation to the area. They should not use soap or detergent (only plain water) to keep the area clean for the first 3-4 days following the procedure
- Consider prophylactic antibiotics
- Antenatal care continues as for any other woman

2.13 Intrapartum care

**When defibulation has been performed antenatally:**

- Aim for vaginal birth
- Aim for intact perineum
- Episiotomy is recommended if inelastic scar tissue prevents progress
- Episiotomy when indicated should be medio-lateral

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

- 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
• Place IV Access; send FBC and Group & Save (risk of PPH)
• Provide adequate analgesia to prevent flashbacks to original procedure
• Inform Consultant Obstetrician
• Epidural should be offered, adequate pain relief is essential as vaginal examinations re poorly tolerated, for anterior episiotomy and deinfibulation, and to psychologically reduce flashbacks
• Perform deinfibulation in the first stage of labour
• Informed consent is essential prior to deinfibulation is essential
• Infiltrate with local anaesthetic or top up epidural for adequate pain relief
• Perform an anterior midline incision to expose the urethra and clitoris that are beneath the scar tissue. (If uncertain, stop when the urethral meatus is visible)
• If woman presents in the 2nd stage of labour perform the incision at the time of the fetal head crowning
• Stretching the fused labia allows a good view of the fusion line and minimises blood loss
• Care must be taken to protect the fetal head from laceration
WHO recommends suturing raw edges to prevent re-infibulation. It is illegal to re-infibulate i.e. resew or to resuture the incised skin edges and close the scar tissue and to do so would risk a criminal prosecution.
• Routine care, inform women that if there were no complications, she is otherwise low risk and the deinfibulation was successful she would be suitable for a community birth in a future pregnancy.
• Debrief if deinfibulation was carried out during labour
• Discuss with woman legal status of FGM in the UK (especially if baby girl or girls in the family)
• Inform Health Visitor and Named Safeguarding Nurse for RCHT and make a MARU referral. Inform Health Visitor and safeguarding and inform the woman the referral has been made and write ‘Family history of FGM’ in the baby’s red book
• Inform woman of the link between FGM, pain and health problems in later life
• If deinfibulation was carried out in labour, 4-6 week postnatal follow up recommended to assess healing (Designated Obstetric Lead for FGM clinic)
• If deinfibulation was carried out in labour, advise to avoid sexual intercourse until healing has occurred and to use lubrication if necessary
• Advice / counselling may be required in relation to passing urine, menstruation, sexual health needs
• Discuss contraception, IUCD will be a method not previously available
• Cervical smear uptake should also be discussed

3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>FEMALE GENITAL MUTILATION (FGM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Karen Watkins Consultant Obstetrician</td>
</tr>
<tr>
<td>Tool</td>
<td>Data collection</td>
</tr>
<tr>
<td>Frequency</td>
<td>As an FGM case is diagnosed.</td>
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<tr>
<td>Reporting arrangements</td>
<td>Numbers reported on a monthly basis to Department of Health via the data quality department.</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>Monitored by the Divisional Board or the Domestic Abuse &amp; Sexual Violence Forum, Safeguarding. Any FGM cases will be discussed at audit meeting.</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Guideline will be distributed widely and any learning from cases detected.</td>
</tr>
</tbody>
</table>

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the ‘Equality, Diversity & Human Rights Policy’ or the Equality and Diversity website.

4.2. Equality Impact Assessment
The Initial Equality Impact Assessment Screening Form is at Appendix 2.
<table>
<thead>
<tr>
<th>Appendix 1. Governance Information</th>
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<td><strong>Date Valid From:</strong></td>
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<td><strong>Date Valid To:</strong></td>
</tr>
<tr>
<td><strong>Directorate / Department responsible (author/owner):</strong></td>
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<tr>
<td><strong>Contact details:</strong></td>
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<tr>
<td><strong>Brief summary of contents</strong></td>
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<tr>
<td><strong>Suggested Keywords:</strong></td>
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<tr>
<td><strong>Target Audience</strong></td>
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<tr>
<td><strong>Executive Director responsible for Policy:</strong></td>
</tr>
<tr>
<td><strong>Date revised:</strong></td>
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<tr>
<td><strong>This document replaces (exact title of previous version):</strong></td>
</tr>
<tr>
<td><strong>Approval route (names of committees)/consultation:</strong></td>
</tr>
<tr>
<td><strong>Divisional Manager confirming approval processes</strong></td>
</tr>
<tr>
<td><strong>Name and Post Title of additional signatories</strong></td>
</tr>
<tr>
<td><strong>Signature of Executive Director giving approval</strong></td>
</tr>
<tr>
<td><strong>Publication Location (refer to Policy on Policies – Approvals and Ratification):</strong></td>
</tr>
<tr>
<td><strong>Document Library Folder/Sub Folder</strong></td>
</tr>
<tr>
<td><strong>Links to key external standards</strong></td>
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</table>
Complications. 
WHO Fact sheet on Female Genital Mutilation 
RCM position paper 
RCOG position paper 
RCN position paper 

References: 
Momoh, C. (2003) Female Genital Mutilation also known as Female Circumcision. Information for Health Professionals. The African Well Women’s Clinic at Guys and St Thomas Hospital Trust


Toubia, N (1999) Caring for women with circumcision: a technical manual for health care providers. RAINBO.


Department of Health Taskforce on the Health Aspects of Violence Against Women and Children set up a sub group on Harmful Traditional Practices and Human Trafficking.

The Royal College of Obstetricians and Gynaecologist - Female Genital Mutilation and its management: www.rcog.org.uk/female-genital-mutilation-
Multi-Agency Practice Guidelines: Female Genital Mutilation
South West Child Protection Procedures
RCHT Child Protection Procedures

Training Need Identified? Yes

Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
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</thead>
<tbody>
<tr>
<td>October 15</td>
<td>1.0</td>
<td>New document</td>
<td>Lorraine Sole Matron Gynaeocology Services &amp; Karen Watkins Obstetric Lead</td>
</tr>
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</table>

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

Controlled Document
This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
## Appendix 2. Initial Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as <em>policy</em>) (Provide brief description):</th>
<th>Clinical Guideline for Female Genital Mutilation (FGM)</th>
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<tbody>
<tr>
<td>Directorate and service area:</td>
<td>Obstetrics &amp; Gynaecology</td>
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<tr>
<td>Is this a new or existing Policy?</td>
<td>New</td>
</tr>
<tr>
<td>Name of individual completing assessment:</td>
<td>Karen Watkins/Lorraine Sole</td>
</tr>
<tr>
<td>Telephone:</td>
<td>01872 253120</td>
</tr>
</tbody>
</table>

### 1. Policy Aim*
**Who is the strategy / policy / proposal / service function aimed at?**
- Asking all women at their booking appointment whether they have experienced any form of surgery to their genitals including female genital mutilation.

### 2. Policy Objectives*
**To inform Healthcare workers of the issues of FGM and to raise awareness**

### 3. Policy – intended Outcomes*
- As above

### 4. *How will you measure the outcome?*
- Monitoring of the numbers of FGM reported

### 5. Who is intended to benefit from the policy?
- Women & Children

### 6a) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?

#### b) If yes, have these *groups been consulted?*
- YES

#### C). Please list any groups who have been consulted about this procedure.
- Fully consulted with key Divisional representatives from ED, Sexual Health, Paediatrics, Gynaecology.
- Jenny Bourne – Lead Nurse for FGM – Department of Health
- Michelle Davis

As above
7. The Impact
Please complete the following table.

Are there concerns that the policy could have differential impact on:

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
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<tr>
<td>Age</td>
<td>X</td>
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</tr>
<tr>
<td>Sex (male, female, trans-gender / gender reassignment)</td>
<td>X</td>
<td></td>
<td>Does not apply to male</td>
</tr>
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<td>Race / Ethnic communities /groups</td>
<td>X</td>
<td></td>
<td>Aim is to ask all women regarding FGM. This policy is relevant for particular ethnic origins.</td>
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<td>Disability - learning disability, physical disability, sensory impairment and mental health problems</td>
<td>X</td>
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<td>Religion / other beliefs</td>
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<td>Marriage and civil partnership</td>
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<td>Pregnancy and maternity</td>
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<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended. No

9. If you are not recommending a Full Impact assessment please explain why.

Signature of policy developer / lead manager / director Date of completion and submission

Names and signatures of members carrying out the Screening Assessment 1. 2.

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead,
A summary of the results will be published on the Trust's web site.

Signed ........................

Date .............................
Obstetric FGM Pathway

Identify women with FGM at booking appointment. Question all women identified at risk.

FGM identified

Woman informed of legal implications of FGM in the UK

Inform Designated Obstetric Lead for FGM and arrange referral to her Antenatal Clinic for physical examination (if not already done)

You must make a MARU referral and inform the GP.

Obstetric Lead for FGM will complete the NHS England Database

No FGM – no further action. Document in notes

Type I or II Infibulation identified – no further action

De-Infibulation offered

De-infibulation accepted
De-infibulation arranged
Follow up appointment in ANC x 1 week after procedure

Woman declined antenatal de-infibulation
De-infibulation done in 1st stage labour
Group & save/cannulate

Routine follow up appointment offered postnatally
Refer to relevant consultant if concerns regarding healing
Health Visitor and GP informed, and record in red book
Woman informed again of legal implications of FGM in the UK
Safeguarding Children

Contact with family where women are known to have been subjected to FGM

- No female children in the family

- Female children in the family may be at risk

- Child has already been subjected to FGM

Health Promotion & Prevention

- Provide information about health consequences and that FGM is a criminal offence
- Discuss specialist services for any health or psychological needs

Discuss the obligation to refer to Social Services and that you will be informing their GP
- Emphasise that the family will be offered support around the issue
- Provide information about health consequences and the UK law i.e. that it is a criminal offence
- Discuss specialist services for any health or psychological needs

Inform Named Professionals and GP make full contemporaneous notes

Make referral to Social Care via Multi Agency Referral Centre Tel: 0300123 116
- Encrypt and copy your email within 48 hours to: MultiAgencyReferralUnit@cornwall.gcsx.gov.uk
- Confirm that written referral has been received by telephoning above number

Child or parent discloses procedure is undertaken

- Make urgent referral to Social Care via Multi Agency Referral Centre
- Tel: 0300123 116
- Encrypt and copy your email within 48 hours to: MultiAgencyReferralUnit@cornwall.gcsx.gov.uk

Inform Named Professionals make full contemporaneous notes

Inform relevant health professional regarding the referral e.g. GP/Health Visitor/Midwife
Female Genital Mutilation resources and information:

- Clinical guidelines - The Royal College of Obstetricians and Gynaecologists - 53
- FGM national clinical group www.fgmnationalgroup.org/index.htm
- Contact details for specialist FGM support services www.forwarduk.org.uk/resources/support
- http://www.online-procedures.co.uk/swcpp/

Sources of support and advice on FGM:

If you have a concern about FGM happening to someone contact the police as FGM is a crime www.met.police.uk/local/ or contact Metropolitan Police Child Abuse Investigation Command/Project Azure 0207 161 2888, who deal with FGM involving children as this against the law and is a form of child abuse www.met.police.uk/scd/specialist-units/fgm_reward.htm

Advice and Brief Intervention Team (ABIT) 0844 600 1018 provide a range of therapies to people over 18 (you don’t have to go through your GP) abit@nelft.nhs.uk

Black Women’s Health and Family Support 020 8980 3503, provides information and support to women and communities affected by FGM www.bwhafs.com

FORWARD 020 8960 4000, work to improve the health, wellbeing and rights of African women and girls www.forwarduk.org.uk

FGM Foreign and Commonwealth Office 0207 008 1500 www.fco.gov.uk/en/travel-and-living-abroad/when-things-go-wrong/fgm/fgm@fco.gov.uk

Childline 0800 1111 www.childline.org.uk

The NSPCC Child Protection Helpline 0808 800 5000, text 88858 (24 hours a day, 7 days a week, 365 days a year it’s free and you don’t have to say who you are), a service for adults who are concerned about the safety or welfare of a child. They provide advice and support, and can take action on your behalf www.nspcc.org.uk/helpline

Africa: Africans unite against Child Abuse 020 7704 2261 info@afruka.org
www.afruka.org

Karma Nirvana - National Help line for advice and guidance in relation to forced marriage and 'honour' based crimes - 0800 5999247

IKWRO - Iranian and Kurdish Women's Rights Organisation - offers support to Middle Eastern Women and girls in relation to 'honour' based violence, domestic abuse and female genital mutilation - 0207 920 6460

Local Resources

Cornwall Rape and Sexual Abuse Centre (CRASAC) Specialist counselling organisation. All counsellors have received training to enable them to offer support to girls and women who have undergone or are at risk of FGM.
CRASAC, Truro Health Park, Infirmary Hill Truro, TR1 2JA
Office Number: 01872 262100
Website: www.visioncornwall.com

Multi agency FGM guidelines (July 2014):

CRSAC - Cornwall Rape and Sexual Abuse Centre - 01872 262100
WRSAC - Women's Rape and Sexual Abuse Centre - 01208 76466
REACH - Risk Evaluation and Co-Ordination Hub ( Independent Domestic Violence Advocates) - 0300 777 4 777
SARC - Sexual Assault Referral Centre - 01872 272059
MARU - Multi Agency Referral Unit (Child Protection Referrals and Advice line) 0300 123 1116
Adult Safeguarding - 0300 123 4131

Contact details for children and adult social care teams:

Children’s Safeguarding referrals: Go to Intranet-Services- follow child protection- How to make a referral and complete the interagency referral form by clicking the link.
http://intra.cornwall.nhs.uk/Intranet/AZServices/C/ChildProtection/HowToMakeAReferral.aspx

To make a telephone child protection referral phone the Multi-Agency Referral Unit (MARU) Telephone 03001231116.

All Telephone referrals must be followed up in writing using the inter-agency referral form within 48 hours.

To Contact the Named Professionals for advice ring switch and ask for the Named Nurse/Doctor or Midwife.