Royal Cornwall Hospitals NHS Trust

POLICY UNDER REVIEW

Please note that this policy is under review. It does, however, remain current Trust policy subject to any recent legislative changes, national policy instruction (NHS or Department of Health), or Trust Board decision. For guidance, please contact the Author/Owner.

Information Category	Detailed Information
Document Title:	Female Genital Mutilation/Cutting (FGM/C) Obstetric Clinical Guideline V3.0
This document replaces (exact title of previous version):	Female Genital Mutilation/Cutting (FGM/C) Obstetric Clinical Guideline V2.1
Date Issued / Approved:	February 2022
Date Valid From:	February 2025
Date Valid To:	September 2025
Author / Owner:	Karen Watkins, Consultant Obstetrics and Gynaecology and Suzie Williams, Named Midwife for Safeguarding.
Contact details:	01872 252729 / 01872 255741
Brief summary of contents:	This guideline gives guidance upon identification and management of FGM/C in the pregnant woman.
Suggested Keywords:	FGM/C, Female Genital Mutilation, sunna, cutting, circumcision, deinfibulation, FGM-IS
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** Yes
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Manager confirming approval processes:	Mary Baulch

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Related Documents:	• 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 • RCM (1998) Female Genital Mutilation (Female Circumcision). Position Paper No 21. RCM. London. Royal College of Nursing (2006) Female Genital Mutilation, An RCN educational resource for nursing and midwifery staff. • Royal College of Obstetricians and Gynaecologists (2009) Female Genital Mutilation. RCOG Green-Top Guideline No 53. London. • Sosa, G Clarke, J (2004) Female Genital Mutilation. The African Well Women Clinic at the Whittington Hospital NHS Trust. A Whittington Hospital Clinical Management Guideline. • Toubia, N (1999) Caring for women with circumcision: a technical manual for health care providers. • World Health Organisation (2001) Management of pregnancy, childbirth and the postpartum period in the presence of female genital mutilation. • London. 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-and-its-management-green-top-53
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Royal Cornwall Hospitals NHS Trust

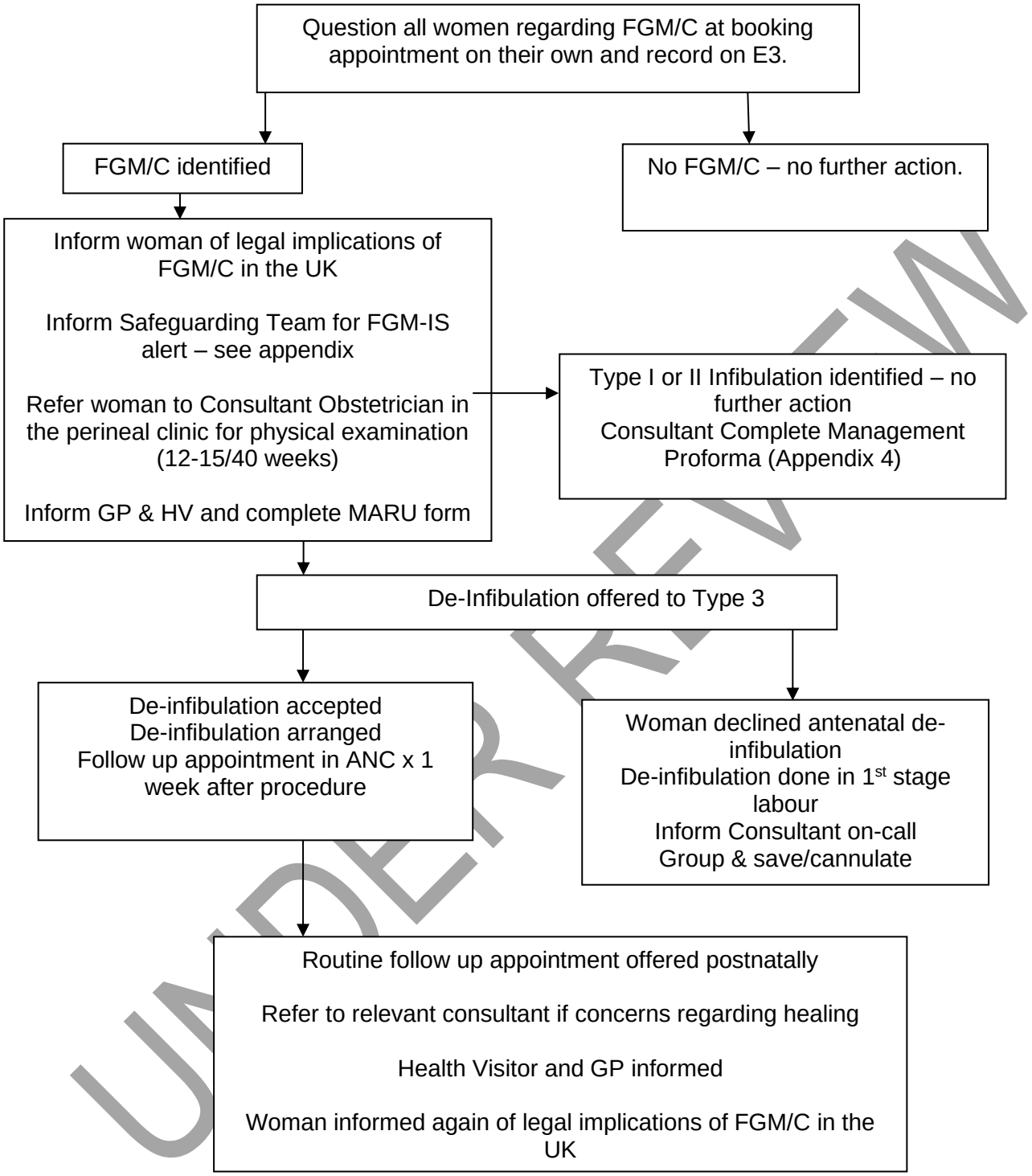
Female Genital Mutilation/Cutting (FGM/C) Obstetric Clinical Guideline

V3.0

March 2022

Summary

Obstetric FGM/C Pathway



1. Aim/Purpose of this Guideline

1.1. This guideline has been produced to inform all health professionals regarding FGM/C. It provides guidance on how to identify and address this issue with women, how to proceed when someone is identified as having FGM/C and how to safeguard girls from the practice of FGM/C 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 FGM/C.

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

- If a patient has had FGM/C
- If there is a family history of FGM/C
- If an FGM/C related procedure has been carried out on a women e.g. deinfibulation

1.3. FGM-IS is a national safeguarding system to share information, which enables a medical professional to record when a girl under 18 years has a family history of FGM, shares this information with other professionals who treat her as she grows up and prompts clinicians to consider if they need to take safeguarding or other action. As a NHS provider we have an obligation to add these alerts. (New 2019)

1.4. This version supersedes any previous versions of this document.

Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

2.1. Background

2.1.1. FGM/C 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/C is not a requirement of any religion.

2.1.2. According to the World Health Organisation (WHO) Female Genital Mutilation is practiced in approximately 30 countries in Africa, the Middle East, and now known to be practiced in many other countries worldwide, including the UK.

2.1.3. The WHO estimates that over 200 million girls and women worldwide have experienced FGM/C and around 3 million girls undergo some form of the procedure each year in Africa alone.

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

FGM/C is a traditional practice which can have serious health consequences.

2.2. 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? 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/C breaks it down into four types:

- **Type I:** Clitoridectomy: Partial or total removal of the clitoris and/ or the prepuce
- **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 III has most implications on childbirth.
- **Type IV:** All other harmful procedures to the female genitalia for non-medical purposes, e.g. nicking, pricking, piercing, incising, scraping and cauterising.

90% are Type I, II or IV, while Type III (infibulation) is only found in 10% of known cases.

2.4. **Short term consequences following FGM/C 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

2.5. **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

2.6. **The law and FGM/C:**

The Female Genital Mutilation Act 2003 made it illegal for UK residents (in England and Wales) and permanent residents to practice FGM/C 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/C 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). In 2015 the Serious Crimes Act amended the 2003 FGM Act to include mandatory reporting of all under 18's who have undergone FGM/C to the police on 101, including genital piercings and genital tattoos.

2.7. **Safeguarding and FGM/C:**

2.7.1. If you are worried about a child under 18 who is at risk of FGM/C or has had FGM/C you have a legal obligation to share this information with children's social care or and the police.

2.7.2. There is a duty for all professionals to act to safeguard girls at risk of FGM/C 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/C
- The risk to girls and young women where a relative has undergone FGM/C
- Situations where a girl may be removed from the country to
- undergo FGM/C

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/525405/FGM_mandatory_reporting_map_A.pdf

2.7.3. FGM/C 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 or suspected at risk of FGM/C this is a child protection concern and a referral to family and children's services (MARU) should be made.

2.7.4. Contact the police if you or someone you know is in immediate danger of FGM. You should also contact the Foreign and Commonwealth Office if you know a British national who's already been taken abroad.

2.7.5. All midwives should ask about FGM in the booking appointment, if a woman births a female child and there is a family history of FGM, the FGM –IS alert should be added to the neonatal and Maternal summary care record. This will be completed by the authorised users only, see Appendix 6. (New 2019)

2.8. FGM/C Leaflet

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/C through the booking appointment.

FGM/C Home Office Leaflet

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/482799/6_1587_HO_MT_Updates_to_the_FGM_The_Facts_WEB.pdf

Further information can be found for health professionals within the Department of Health, FGM and Safeguarding Risk Assessment guide (New 2021)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/585083/FGM_safeguarding_and_risk_assessment.pdf

2.9. Guidance for Midwives at booking

2.9.1. Antenatal Period, booking appointment and FGM/C 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 to the consultant obstetrician in the perineal clinic (New 2018)

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

2.9.3. **All women** should be asked sensitively about FGM/C 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?

2.9.4. 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

2.9.5. For women who come from outside the UK the question – Do you come from a country in which FGM/C or genital cutting is practiced? Will allow discussion about whether the woman has experienced FGM/C.

2.9.6. **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

2.10. **If FGM/C is disclosed to the CMW**

- Record FGM/C 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/C. If there are young female child in the family then we have a legal and moral obligation to protect them from
- Give a very clear explanation that FGM/C is illegal in the UK and that the law can be used to help the family avoid FGM/C 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 FGM/C
- Inform the woman that the FGM-IS alert will be added if she has a female child, and inform the Safeguarding Team , see Appendix 6 (New 2019)
- Refer the woman to the perineal clinic via e mail to the Consultant and report to DOH
- Assess the psychological impact and referral to a psychologist if deemed necessary and agreed upon by the woman

2.11. **If FGM/C is identified on examination or disclosed to an Obstetrician**

2.11.1. Use a diagram or medical photography (with consent). This aids communication with the patient and other clinicians, and limits repetitive examinations.

2.11.2. Classify the type of FGM/C using a preformatted sheet with pre-drawn diagram (See Appendix 4)

2.11.3. Assess the risk to female children in the family and inform the women of the legal implications (as above)

2.11.4. Following the assessment, if a woman is a primigravida with type III FGM/C or it is felt that vaginal examination or delivery will be difficult or impossible she should be referred to Obstetric Clinic for consideration for antenatal deinfibulation while remaining under the care of her original Midwife or Obstetrician.

2.12. Antenatal Deinfibulation (See Proforma Appendix 3)

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

2.12.2. 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/C services may be necessary to enable them to understand the benefits of antenatal de-infibulation and to support them to undergo the procedure.

2.12.3. **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

2.12.4. **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 (Vicryl Rapide) 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

2.13.1. When deinfibulation 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

2.13.2. 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
- 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 are 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.

https://www.rcog.org.uk/globalassets/documents/guidelines/gtg-53-fgm.pdf

2.14. Postnatal Care

2.14.1. 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

2.14.2. Debrief if deinfibulation was carried out during labour

2.14.3. Discuss with woman legal status of FGM/C in the UK (especially if baby girl or girls in the family)

2.14.4. Inform Health Visitor and safeguarding and inform the woman the referral has been made and write ‘Family history of FGM/C’ in the baby’s red book

2.14.5. Inform woman of the link between FGM/C, pain and health problems in later life

2.14.6. If deinfibulation was carried out in labour, 4-6 week postnatal follow up recommended to assess healing

2.14.7. If deinfibulation was carried out in labour , advise to avoid sexual intercourse until healing has occurred and to use lubrication if necessary

2.14.8. Advice / counselling may be required in relation to passing urine, menstruation, sexual health needs

2.14.9. Discuss contraception, IUCD will be a method not previously available

2.14.10. Cervical smear uptake should also be discussed

2.15. Guidance from Child Health

2.15.1. There are three circumstances relating to FGM/C which require identification and intervention:

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

2.15.2. The appropriate response to FGM/C is to follow usual child protection procedures to ensure:

- Immediate protection and support for the child or children
- That the practice is not perpetuated

2.15.3. **An appropriate response to a child suspected of having undergone FGM/C as well as a child at risk of undergoing FGM/C 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, e.g. 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

2.15.4. **An appropriate response by professionals who encounter a girl or woman who has undergone FGM/C 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/C is illegal and that the law can be used to help the family avoid FGM/C if/when they have daughters

2.15.5. **Identifying a child who has been subject to FGM/C or who is at risk of being abused through FGM/C** (See Appendix 4)

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/C. There are a range of potential indicators that a child may be at risk of FGM/C which individually may not indicate risk but if there are two or more present this could signal risk to the child.

Indications that FGM/C may be about to take place include:

- The family comes from a community that is known to practice FGM/C e.g. Somalia, Sudan and other African countries. It may be possible that they will practice FGM/C 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/C 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/C 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/C must be considered to be at risk, as must other female children in the extended family

2.15.6. **Indications that FGM/C 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 be/are suffering the adverse consequence of the practice, e.g. 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

2.16. Royal Cornwall Hospital NHS Trust Professionals' response

Any information or concern that a child is at immediate risk of, or has undergone, FGM/C should result in an immediate child protection referral to MARU (verbal and then written within 24 hours) in line with Section 47 enquiries. See Appendix 3 for referral pathway.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Female Genital Mutilation (FGM/C)
Lead	Karen Watkins Consultant Obstetrician
Tool	Compliance Monitoring Tool
Frequency	All cases of FGM/C
Reporting arrangements	Results will be reviewed by the Maternity Forum Integrated Safeguarding Adult/Children Operational Group Domestic Abuse and Sexual Violence Steering Group
Acting on recommendations and Lead(s)	If deficiencies or concerns identified an action plan will be produced and monitored by the Maternity Risk Management Forum
Change in practice and lessons to be shared	Patient Safety Newsletter Integrated Safeguarding Adult/Children's Operational Group Domestic Abuse and Sexual Violence Steering Group

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, Inclusion & 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.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Female Genital Mutilation/Cutting (FGM/C) Obstetric Clinical Guideline V3.0
This document replaces (exact title of previous version):	Female Genital Mutilation/Cutting (FGM/C) Obstetric Clinical Guideline V2.1
Date Issued/Approved:	February 2022
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Directorate / Department responsible (author/owner):	Karen Watkins, Consultant Obstetrics & Gynaecology & Suzie Williams, Named Midwife for Safeguarding
Contact details:	01872 252729 / 01872 255741
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Suggested Keywords:	FGM/C, Female Genital Mutilation, sunna, cutting, circumcision, deinfibulation, FGM-IS
Target Audience:	RCHT: Yes CFT: No KCCG: Yes
Executive Director responsible for Policy:	Medical Director
Approval route for consultation and ratification:	Maternity Guidelines Group Maternity Governance Obstetrics and Gynaecology Directorate
General Manager confirming approval processes:	Mary Baulch
Name of Governance Lead confirming approval by specialty and care group management meetings:	Caroline Amukusana
Links to key external standards:	None required

Information Category	Detailed Information
Related Documents:	• 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 • RCM (1998) Female Genital Mutilation (Female Circumcision). Position Paper No 21. RCM. London. • Royal College of Nursing (2006) Female Genital Mutilation, An RCN educational resource for nursing and midwifery staff Royal College of Obstetricians and Gynaecologists (2009) Female Genital Mutilation. RCOG Green-Top Guideline No 53. London. • Sosa, G Clarke, J (2004) Female Genital Mutilation. The African Well Women Clinic at the Whittington Hospital NHS Trust. A Whittington Hospital Clinical Management Guideline. • Toubia, N (1999) Caring for women with circumcision: a technical manual for health care providers. • World Health Organisation (2001) Management of pregnancy, childbirth and the postpartum period in the presence of female genital mutilation. London. • 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-and-its-management-green-top-53

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Training Need Identified?	No
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Date	Version No	Summary of Changes	Changes Made by *(Name and Job Title)*
19th May 2015	V1.0	Initial Document	Karen Watkins Consultant Obstetrician
5th July 2018	V2.0	Full review. FGM changed to FGM/C, Updated links and references. Amendments to references. MARU ref pathway deleted, obstetric management flowchart now	Bernie Dolan & Suzie Williams Named Midwife for Safeguarding
4th Sept 2019	V2.1	Addition of FGM-IS throughout. FGM-IS process, Appendix 6.	Suzie Williams Named Midwife for Safeguarding
February 2022	V3.0	Full review and update.	Karen Watkins Obstetric Consultant

Appendix 2. Initial Equality Impact Assessment Form

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity & Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Female Genital Mutilation/Cutting (FGM/C) Obstetric Guideline V3.0
Directorate and service area:	Obs and Gynae Directorate
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Suzie Williams Named Midwife for Safeguarding
Contact details:	01872 252729 / 01872 255741

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	To identify who has had FGM/C by 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 identify and manage FGM/C safely in the pregnant woman
3. Policy Intended Outcomes	Safe delivery of the baby and protection of other vulnerable girls and babies.
4. How will you measure each outcome?	Compliance Monitoring Tool
5. Who is intended to benefit from the policy?	Women & Children

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Maternity Guidelines Group Maternity Governance Obstetrics and Gynaecology Directorate
6c. What was the outcome of the consultation?	Guideline agreed.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys: No**

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	Yes	Any information provided should be in an accessible format for the patient/carer's needs- i.e. available in different languages if required/access to an interpreter if required

Protected Characteristic	(Yes or No)	Rationale
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	Those patients/carers with any identified additional needs will be referred for additional support as appropriate- i.e. to the Liaison team or for specialised equipment. Written information will be provided in a format to meet the family's needs e.g. easy read, audio etc.
Religion or belief	No	All staff should be aware of any beliefs that may impact on the decision to treat and should respond accordingly
Marriage and civil partnership	No	All staff should be aware of any marital arrangements that may have an impact on care (for example: separated parents, domestic abuse).
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Suzie Williams Named Midwife for Safeguarding

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3. FGM/C Management Proforma

MANAGEMENT (circle as appropriate)

Reversal (De-infibulation): Antenatal / Labour 1st Stage / Labour 2nd Stage:

Antenatal reversal booked: Yes/No Gest……..wks

Details of booking: Date: ____ / ____ / ____

Place: In room / Theatre
Preference: LA/Spinal

Labour recommendation:

1. Manage labour as normal Yes / No
2. Inform Registrar (with experience)/Consultant Yes / No
3. Reversal in labour (anterior midline) Yes / No
4. Cannulate Yes/ No
5. Group & Save Yes/ No

REVERSAL:

Operator (Name & Grade): _____(Cons / SpR / SHO/ Midwife)

Assistant (Name & Grade): _____(Cons / SpR / SHO/ Midwife)

Incision: Anterior midline / Other _____

Repair edges: Interrupted / Continuous / Other _____

Suture materials: Vicryl-rapide / Vicryl / Other_____

Anaesthesia/Analgesia: Local / Pudendal block / Regional / Entonox / None

Antibiotics Yes/No

TTA: Codydramol / Paracetamol / Other _____

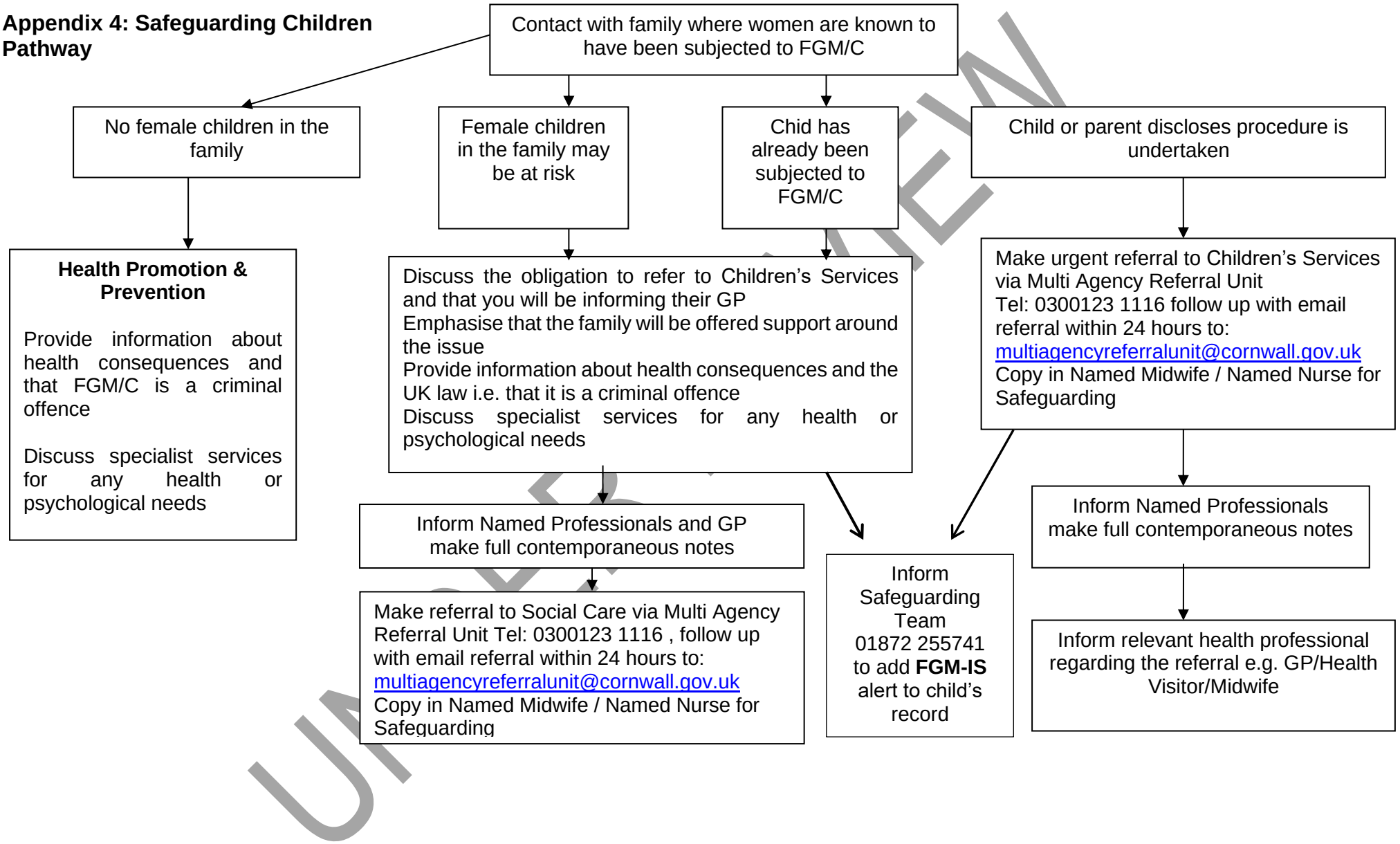
FOLLOW-UP: Yes / No

Antenatal clinic appointment: Date: ___ / ___ / ____

Other: _____

Sign & Print **Designation** **Date**

Appendix 4: Safeguarding Children Pathway



Appendix 5. Resources and Information

1) **Female Genital Mutilation Resources and Information:**

- Clinical guidelines -The Royal College of Obstetricians and Gynaecologist - 53
- Link to multi agency FGM/C guidelines

  www.fco.gov.uk/resources/en/pdf/travel-living-abroad/when-things-gowrong/multi-agency-FGM/C-guidelines.pdf
- FGM/C national clinical group www.FGM/Cnationalgroup.org/index.htm

2) **Sources of Support and Advice on FGM/C:**

NSPCC FGM Helpline
Email: fgmhelp@nspcc.org.uk
Telephone: 0800 028 3550

Foreign and Commonwealth Office Telephone: 020 7008 1500

Childline 0800 1111 www.childline.org.uk

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

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

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

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

Multi agency FGM/C guidelines (updated 2020),:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/333067/FGM/Cmulti-agencyPracticeGuidelines.pdf

3) Contact Details for Cornwall Support Services and Children and Adult Social Care Teams:

- First Light / Safer Futures – Cornwall Domestic Abuse and Sexual Violence Service 0300 777 4777

- Single Point of Contact for Independent Sexual Violence Advocates and Sexual Assault Referral Centre – 0300 303 4626

- MARU - Multi Agency Referral Unit (Child Protection Referrals and Advice line) 0300 123 1116 All Telephone referrals must be followed up in writing using the inter-agency referral form within 24 hours. Please refer to Our Safeguarding Children Partnership (OSCP) interagency link for appropriate referral form

- Adult Safeguarding - 0300 123 4131, or email accessteam.referral@cornwall.gov.uk

- To Contact the Named Professionals for Safeguarding for advice and support please telephone 01872 255741 and ask for the Named Nurse and/or Midwife or Doctor for the Integrated Safeguarding Team.

Appendix 6. FEMALE GENITAL MUTILATION – INFORMATION SYSTEM (FGM-IS)

BACKGROUND

The FGM-IS is a national safeguarding system to share information, which:

- Enables a medical professional to record when a girl under 18 years has a family history of FGM
- Shares that information with other professionals who treat her as she grows up
- Prompts the clinicians to consider if they need to take safeguarding/other action.

FGM-IS supports safeguarding by:

- Family history is known to be relevant when considering potential risk to a girl of undergoing FGM
- The user will record when a family history has been identified using the FGM-IS
- When a professional sees the FGM-IS indicator, they know a family history of FGM has been identified and they can treat the child accordingly

The FGM-IS tab is accessible on the Summary Care Record application (SCRa) (on the NHS Spine Portal) for girls under the age of 18.

Access to FGM-IS will be available to authorised staff within Royal Cornwall Hospital Trust (RCHT) using the Summary Care Record (SCR) Application. This allows authorised staff to trace the patient via the National Spine to view and input the FGM-IS indicator.

AUTHORISED USERS

Authorised users are limited to the Named Midwives for Safeguarding, Named Nurse Safeguarding Children, Specialist Safeguarding Midwife and Nurse.

PROCEDURE FOR ADDING AN ALERT

All midwives should ask about FGM in the booking appointment, if a woman births a female child and there is a family history of FGM, the FGM indicator should be added to the summary care record. It has been agreed that this will be completed by the authorised users only in the Safeguarding Team.

It is good practice for the delivering midwife to share with the parents that the FGM indicator will be added to the baby's record, however consent is not required. If parents object to the information share, discuss this with the Safeguarding Team.

If a child presents to Emergency (ED) / West Cornwall Urgent Care Centre (WCH-UCC) or any paediatric wards where there are concerns in relation to FGM, sensitive enquiry should be conducted (as per FGM guideline) and follow the procedure as described below.

To note:

- The indicator cannot be added on a child's record before she is born as a NHS number is required.

- If there are older female children identified within the family, RCHT staff do not add an indicator for these children.

Health professionals have the responsibility to:

- Update the Safeguarding Team of the birth of a female child by emailing the NHS number of the female baby who needs the indicator adding to the summary care record to rcht.maternitysafegarding@nhs.net

- Update the Safeguarding Team if a child discloses or presents with FGM by emailing the NHS number of the female baby who needs the indicator adding to the summary care record to rcht.sgchildren@nhs.net

- Inform the parents that an indicator will be added to the child's record.

- Document these actions in the child's records.

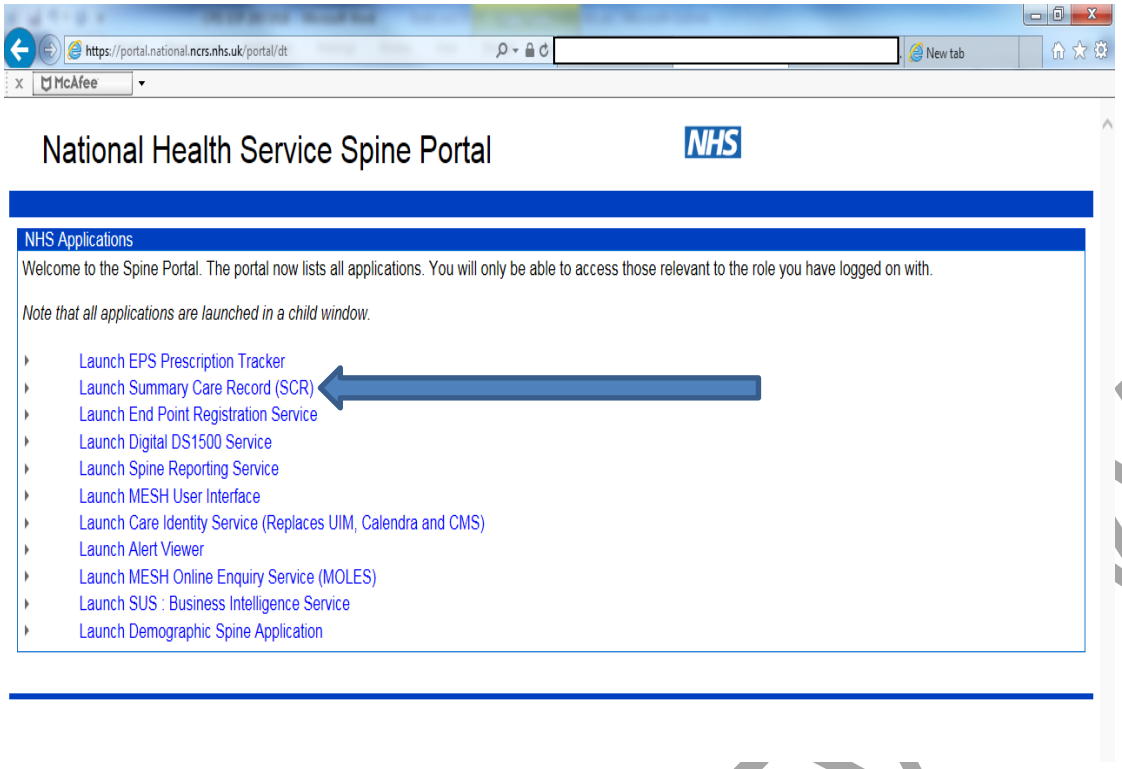
FGM-IS should be used alongside existing local and national safeguarding frameworks and processes, it does not change, replace or reduce professionals' safeguarding responsibilities

Step by step guide on how to add the indicator

Find and access a patient's record

To find the patient on the Summary Care Record, search for the patient using the NHS number.

Please note: the slides below have been shared by NHS England and contain a test patient.

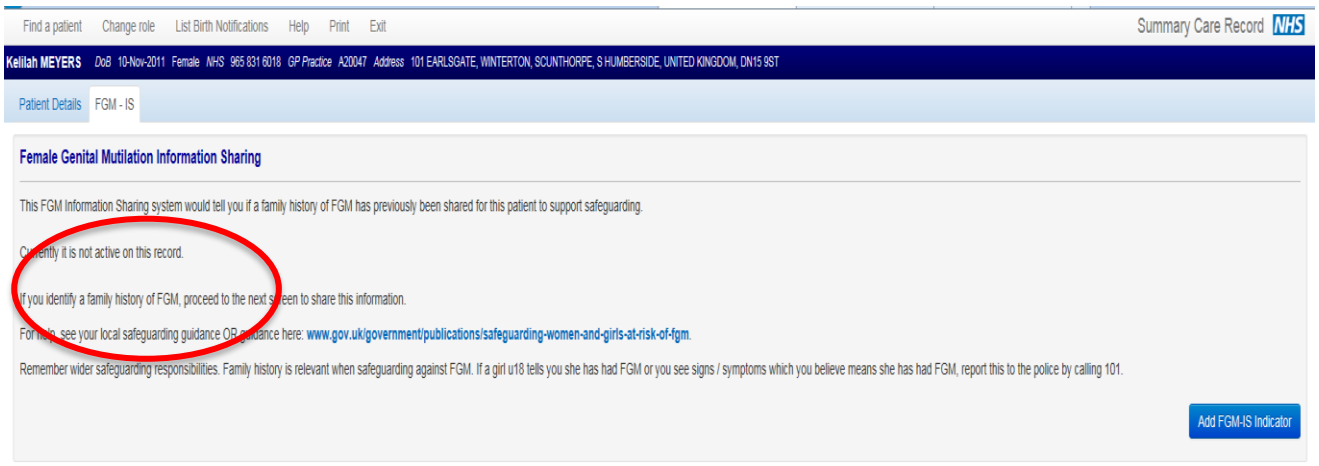


Finding the FGM-IS Indicator Tab in a patient record

When you have opened the patient's record, find the FGM-IS tab in the top left hand corner.

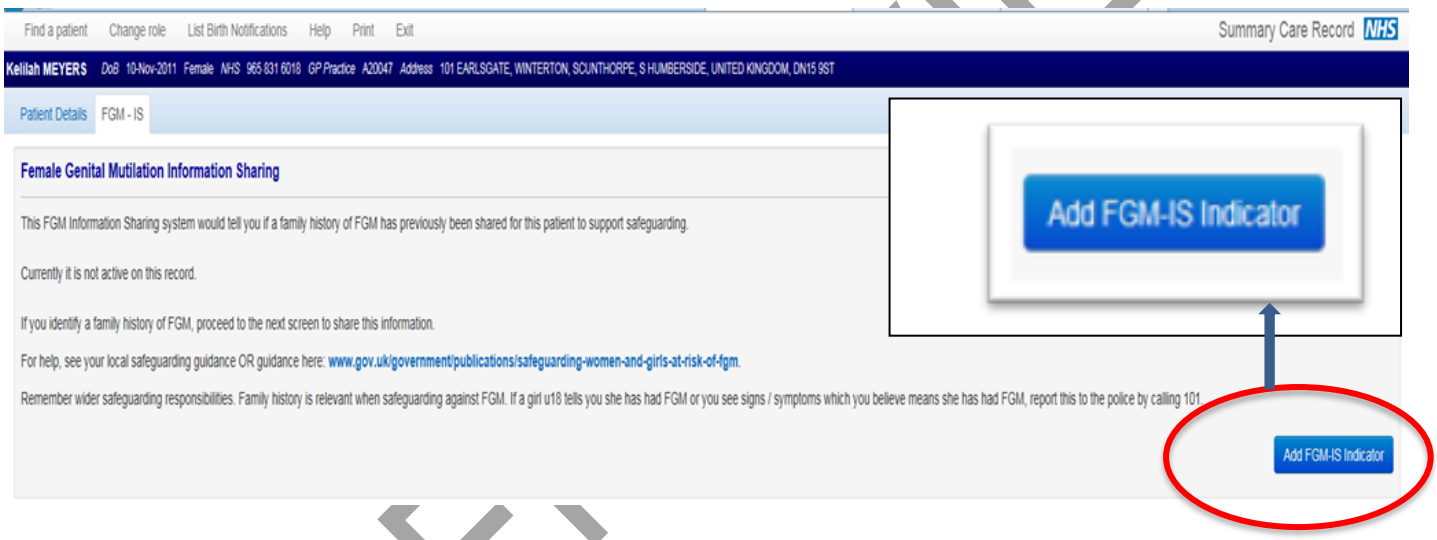
The FGM-IS Indicator Tab

For a new born female the following screen will be displayed:

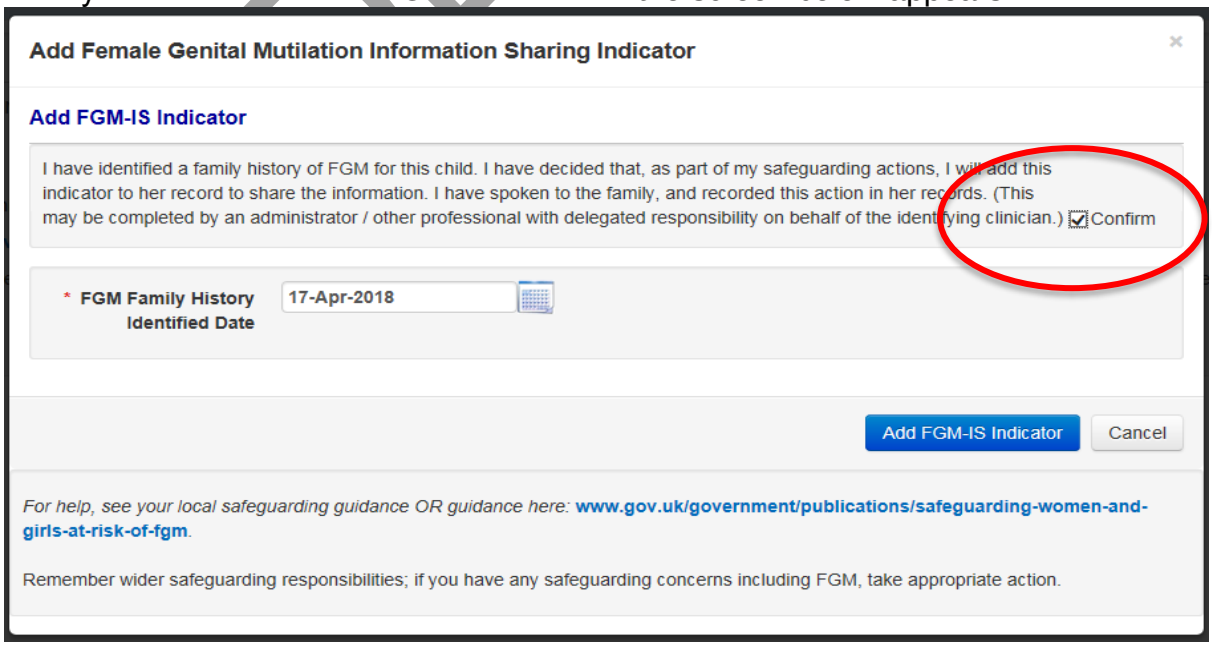


Adding the FGM-IS indicator (Safeguarding Team only)

Click on the 'add FGM-IS indicator'



After you click on the 'add FGM-IS indicator' the screen below appears:



1. Tick the box ‘Confirm’ to identify that the practitioner has:
    - Identified this girl has a family history of FGM
    - Information sharing has been discussed with her/her family
2. Add the date identified (or birth date if identified at birth)
3. Click the add FGM-IS indicator’ button, the following confirmation will be displayed:

PROCEDURE FOR VIEWING AN ALERT

- Find the patient’s record and open the FGM-IS tab (see section 2)
- Remember the FGM-IS Indicator tab is present on EVERY record for a female child under 18
- To know if the indicator is active / sharing important information, users need to click on the FGM-IS Indicator tab to ‘View’ the record

If the FGM-IS Indicator is active and sharing information, the Tab will display the following:

Removing FGM-IS Indicator

Standard practice is to keep the FGM-IS Indicator on a girl’s record until they are 18. When she turns 18, the system will automatically remove the indicator/information.
If the indicator is added by mistake, it needs to be removed. Please notify the safeguarding team of this by emailing rcht.maternitysafeguarding@nhs.net / rcht.sgchildren@nhs.net