Frimley Health
NHS Foundation Trust

Female Genital Mutilation

Key Points

- Clinicians should be aware of the short- and long-term complications of FGM and UK Law (Female Genital Mutilation Act 2003) and the legal and regulatory responsibilities of health professionals which provide that:
- Re-infibulation is illegal; there is no clinical justification for re-infibulation and it should not be undertaken under any circumstances (HMIC 2015).
- When a girl, or child/young female under 18 or woman with FGM is identified:
- A Child identified to have undergone FGM requires checks with Social Services to check they are aware. If not, then the case is reportable to the Police.
- A DOH risk assessment form must be completed by the Midwife/Clinician
- If the unborn child, or any related child, is considered at risk then a safeguarding report should be made (HMIC/RCOG 2015). See Safeguarding pathway (Appendix 4).
- Staff should familiarise themselves with Trust and national reporting systems and should ensure mandatory training in FGM is completed.
- Accurate documentation plus enhanced data reporting systems are important and staff should use Appendix 1 and 2 to ensure consistency.
- For pregnant women with history of FGM, use Appendix 3 as pathway for care.

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Abbreviations

CMiS and Euroking	Internal data collection and reporting systems
CMW	Community Midwife/midwives
Dermoid cyst	A type of tumour that contains a cyst filled with tissues that are normally found in the outer layers of the skin, including sweat and oil glands.
DoH	Department of Health
FGC/M	Female Genital Cutting/Mutilation
FGM-IS	Female Genital Mutilation Information System, part of NHS spine
HMIC	His Majesty's Inspectorate of Constabulary
HSCIC	Health and Social Care Information Centre
RBAC	Role Based Access Codes
RCOG	Royal College of Obstetrics and Gynaecology
SCRa	Summary Care Record Application
UNFPA	United Nations Population Fund for Population Activities

Contents

1. Purpose of this Guideline 4
2. Definitions 4
3. Prevalence 5
4. Health implications of FGM 5
5. Obstetric complications and implications of FGM 5
6. Law and Human Rights 6
7. Professional Responsibilities 7
8. Principles of Multidisciplinary Antenatal Care 7
9. Classifications of FGM 8
10. Management in Labour 9
11. Postnatal Management 10
12. Conclusion 10
13. Implementation Plan 10
14. Audit and Monitoring Compliance with this Guideline 11
15. References 11
16. Resources 12
Appendix 1: Examination Findings on Initial Assessment 13
Appendix 2: Booking Midwife / clinician in ANC to complete 14
Appendix 3: FGM Pathway for Pregnant Women 15
Appendix 4: FGM Safeguarding Pathway 16
Full version control record 17

1. PURPOSE OF THIS GUIDELINE

While the terminology for this centuries-old practice varies across regions, ideological perspectives, and research frames, the preferred expression by UNICEF and UNFPA is the hybrid term “female genital mutilation/cutting” or FGM/C (UNICEF 2013). FGC/M is a violation of girls and women’s rights and her entitlement to her bodily integrity (Dike 2014). However recent debate suggests that FGM conveys the violation of the women more forcibly than using other terms such as FGC but can also appear judgemental rather than factual. We appreciate that both terms can be used but FGM will be used in this guideline.

The aim of this document is to provide all grades of the multidisciplinary team with a structured and systematic way of caring for women who have FGM in order to provide safe and effective care and to safeguard the female child and/or women at risk of FGM.

National Data Collection by DOH for FGM and prevalence of FGM
The FGM Enhanced Dataset was opened five in 2015. Since the collection began, information has been reported by NHS trusts and GP practices about 24,420 individual women and girls, who have (between April 2015 and March 2020) had a total of 52,050 attendances where FGM was identified.

Total Attendances refers to all attendances in the reporting period where FGM was identified or a history of FGM having been undertaken. Women and girls may have one or more attendances in the reporting period. This category includes both newly recorded and previously identified women and girls.

2. DEFINITIONS

FGM "female genital mutilation" refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons (WHO 2008).

- **Infibulation**
  - refers to all procedures involving partial or total removal of the clitoris, labia minora, labia majora and stitching together of the labia majora thereby narrowing /closing the vaginal opening, this is seen in Type 3 FGM.

- **De-infibulation**
  - FGM type 3 / infibulation may cause a physical barrier to sexual intercourse and childbirth
    - an infibulated girl and woman therefore may have to undergo dilation of the vaginal opening before sexual intercourse can take place; this may be on the first night of marriage (by the husband, or a circumciser)
    - at childbirth, many women with type 3 have to undergo opening up of the vagina by anterior episiotomy because the vaginal opening is too small to allow for the passage of a baby. This can be a planned procedure at 20 weeks antenatally if needed.

- **Re-infibulation**
  - in some communities, the raw edges of the wound (opened up type 3 FGM) are sutured again after childbirth, recreating a small vaginal opening. This is referred to as re-infibulation. **This is Illegal in the UK.**

3. PREVALENCE

More than 125 million girls have been cut worldwide (UNICEF, 2013).

Why is FGM practised?

- social acceptance and cultural identity
- control of women
- female beauty or 'de-masculinisation'
- coming of age/pre-marriage
- enforcement of virginity/fidelity
- enhancing sexual pleasure for the male
- medicalisation

4. HEALTH IMPLICATIONS OF FGM

General complications are more common with infibulation and include:

- problems associated with micturition, retention of urine, recurrent urinary tract infections and chronic renal failure
- keloid scars
- implantation dermoid cysts
- vaginal infections, chronic pelvic inflammatory disease, dysmenorrhoea and infertility
- sexual dysfunction and psychosexual problems
- psychological problems

5. OBSTETRIC COMPLICATIONS AND IMPLICATIONS OF FGM

Potential maternal consequences of FGM, especially type 3 FGM, include:

- Problems associated with labour, including, prolonged labour
- Obstructed labour leading to Caesarean section
- Extended/unnecessary perineal tears/trauma and/or episiotomy
- Haemorrhage.
- Difficult Delivery/Instrumental Delivery (Berg et al 2014).
- Fear of childbirth
- Difficult intrapartum vaginal examinations, FSE/FBS and urinary catheterisation
- Need for anterior episiotomy
- Increased risk of haemorrhage and infection
- Risk of poor healing
- Increased risk of maternal and neonatal morbidity and mortality
- Increased Caesarean section rate.

6. LAW AND HUMAN RIGHTS

FGM is an abuse of human rights and a child protection issue (RCOG 2015)

UK Law and Safeguarding

- The Prohibition of Female Circumcision Act 1985 states that it is an offence for any person:
  (a) to excise, infibulate or otherwise mutilate the whole or any part of the labia majora or clitoris of another person; or
  (b) to aid, abet, counsel or procure the performance by another person of any of those acts on that other person's own body.
  - FGM is illegal in the UK and for all UK citizens even when abroad (HMIC 2015). It is illegal to arrange, or assist in arranging, for a UK national or UK resident to be taken overseas for the purpose of FGM
  - It is an offence for those with parental responsibility to fail to protect a girl from the risk of FGM.
  - according to the Female Genital Mutilation Act (2003) the penalty for a person found in contravention of the Act is a prison sentence of up to 14 years
  - it is not an offence to cut a woman at the time of delivery, provided that the purpose is to aid delivery
  - as of 31 October 2015, Health and Social Care professionals and teachers are required to report known cases of FGM (either on examination or because the patient or parent says it has been done), in girls less than 18 years of age, to the police. This must be reported within 1 month of confirmation (HMIC 2015). See Appendix 4.
  - An individual risk assessment should be made by a member of the clinical team (midwife or obstetrician) using an FGM safeguarding risk assessment tool (see appendix 2).
  - FGM Information System was launched by the Department of Health (DH) and NHS England at the Girl Summit in July 2014. The FGM-IS provides a national IT system for healthcare professionals and administrative staff to record that a girl has a family history of FGM. The FGM-IS supports the early intervention and ongoing safeguarding of girls, under the age of 18, who have a family history of Female Genital Mutilation (FGM).
  - The FGM-IS is part of the NHS Spine. Healthcare professionals and administrative staff can view, add and remove the FGM indicator, and it can be accessed via the Summary Care Record Application (SCRa), or with a local clinical system integrated with FGM-IS
  - Access is controlled via NHS smartcards and the appropriate (RBAC), so only authorised healthcare professionals and administrative staff with the relevant security permissions can access the FGM information. Frimley Health Foundation Trust has systems in place from April 2019 for staff to report on to the FGM is https://www.england.nhs.uk/safeguarding/workstreams/fgm-information-sharing/

7. PROFESSIONAL RESPONSIBILITIES

- non-judgement and respect
- knowledge of immediate and long-term complications and how to manage them
- Children's Social Care. Awareness of mandatory reporting of children at risk and timely referral to child protection
- awareness of the law
- provision of specialist clinics/services in areas with high risk populations and appointed specialist midwives/obstetricians for maternity services in such areas
- appropriate provision of psychological and psychosexual support and counselling.

8. PRINCIPLES OF MULTIDISCIPLINARY ANTENATAL CARE

- Careful antenatal questioning of all women. The family origin questioning (FOQ) used for Haemoglobinopathy can be used as a basis for this.
- Aim to identify women at booking by asking all women about FGM, ensuring to include family members from both sides of the family.
- Diagrams may be used to avoid repeated examinations (appendix 1). The diagrams can be found on EPIC as a smart text.
- Be aware that this may be a culturally sensitive issue. Remember that some women had this performed when they could not give consent as children and they should not be blamed. Show respect and understanding to them.
- Offer counseling if psychological distress evident. This can be through the Women's Health Counselling Service at Wexham or Frimley Park Hospital or through the GP if more convenient. Local Psychosexual counselling referral may also be needed.
- Offer local support group to women if available. Signpost to national support groups.
- Ask "have you been closed?" or "did you have the operation when you were a child?"
- Use appropriate interpreting services if necessary.
- All disclosures of FGM must be entered onto EPIC as a safeguarding issue. Female infants born to these women are at risk of having this procedure performed on them.
- The Named Midwife for Safeguarding employed by the Trust must be informed of any disclosure of FGM by completing a safeguarding assessment form.
- If a woman has had FGM, please refer to Miss Lamia Zafrani if woman booked at Wexham or to Miss Maud Van de Venne if booked at Frimley Park Hospital to their respective antenatal clinics.
- Examination by an obstetrician/trained midwife is required for those with confirmed FGM even if multiparous. The relevant information is gathered using Appendix 1, 2 and 3 by the Consultant at the ANC and used to define type of FGM and data for reporting to DOH.

    a. De-infibulation (Reversal) will be discussed as needed on clinical grounds, which should ideally be performed at around 20 weeks' gestation under spinal or local anaesthesia. General anaesthesia maybe offered if the woman suffers from flashbacks due to childhood trauma.

    b. Performing reversal in the second trimester minimizes risk of surgery in the first trimester when there may be a slightly increased risk of miscarriage (not from

the surgery of reversal but any surgery and anaesthetic) and will ensure that complete healing is achieved prior to labour.

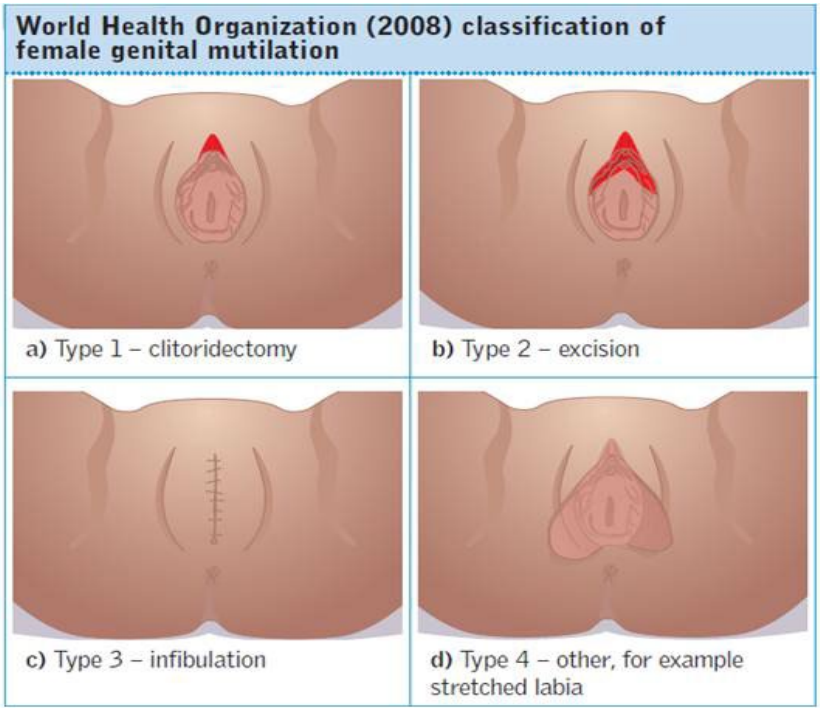
c. It can however be performed at any stage of the pregnancy if the woman books late. Many women choose to have reversal at time of vaginal delivery (see Appendix 1), which clinician should complete for a plan.

d. Post-reversal care should include adequate pain relief and promotion of personal hygiene. Some re-education maybe necessary as some women would have forgotten or may never have known what normal micturition or menstruation is like.

9. CLASSIFICATIONS OF FGM

(WHO, 2008 *)

- Type 1 – **Clitoridectomy**: partial or total removal of the clitoris and, rarely, the prepuce as well (Figure a)
- Type 2 – **excision**: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (Figure b)
- Type 3 – **infibulation**: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, and sometimes outer, labia, with or without removal of the clitoris (Figure c)
- Type 4 – **other**: all other procedures to the female genitalia for non-medical purposes, for example pricking, piercing, incising, scraping or stretching the labia (Figure d)



Documentation

- Complete the FGM enhanced dataset collection form in flowsheets (by the doctors).
- documentation of the FGM on the pre-formatted diagrams (see Appendix 1) by a trained clinician or midwife.
- documentation of risk assessment in the flowsheets (see Appendix 2). This should be completed by the CMW at booking and an email sent to the Named Midwife for Safeguarding.
- The health professional must explain the UK law on FGM (HMIC/RCOG 2015).
- The health professional must understand the difference between recording (documenting FGM in the medical records for data collection) and reporting (making a referral to police and/or social services) and their responsibilities with regards to these (HMIC/RCOG 2015).
- The health professional must be familiar with the requirements of the Health and Social Care Information Centre (HSCIC) FGM Enhanced Dataset and explain its purpose to the woman (in flowsheets).
- The requirement for her personal data to be submitted without anonymisation to the HSCIC, in order to prevent duplication of data, should be explained. However, she should also be told that all personal data are anonymised at the point of statistical analysis and publication (HMIC/RCOG 2015).
- The Trust is responsible for submitting quarterly reports to the Department of Health of FGM enhanced datasets. The Integrated Digital Midwife in conjunction with the Named Safeguarding Midwife sends the in-house data stored on the maternity information system which is derived from the hard copy FGM submissions to one of the Health Information Specialists in our Trust. The Safeguarding Midwives at Frimley and Wexham Park updates the National Spine Risk Indicator with this information. The link to the FGM collection information is https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/female-genital-mutilation-datasets/health-professionals-and-nhs-organisations and all the supporting documents are at the bottom of the webpage.

10. MANAGEMENT IN LABOUR

The aim is for a normal delivery with Caesarean section only for the usual childbirth indications.

If reversal is performed antenatally, then treat as per normal.

If reversal has not been performed, the midwife should discuss with consultant on call. (Refer to RCOG guidelines for further details re detailed management, outlined below).

Aim to de-infibulate in the first stage of labour under epidural, if vaginal opening is extremely small. This will reduce the increased risk of bleeding, shock and infection.

Alternatively, de-infibulate in the second stage of labour: infiltrate the fused labia with lignocaine and cut anteriorly as the fetal head stretches both labia. Identify and protect the urethra to avoid unintentional injury.

Delivery will then usually proceed normally but sometimes a right medio-lateral episiotomy may also be required.

Re-infibulation is an illegal practice in the United Kingdom and MUST NOT be carried out. FGM is a criminal offence under the "Prohibition of Female Circumcision Act 1985".

Therefore, the raw edges should only entail "over sewing" (but not closing) of the edges of the labia using 2/0 Vicryl by a consultant or an experienced registrar.

11. POSTNATAL MANAGEMENT

Normal postnatal care with particular attention paid to vulval hygiene and micturition.

Provide adequate pain relief for the woman.

The woman may require additional psychological help, as she will feel physically different and may feel guilty about being 'opened'. Health visitor to be updated by CMW.

No routine postnatal follow up for FGM by Consultant clinic as the only indication.

Named Midwife for Safeguarding to be informed of female babies born to families with a history of FGM so they can update National Spine Risk indicator for female infants. FGM risk information to be stored on the national Spine for all Female infants born to mothers who have undergone FGM or born into high-risk families for FGM.

12. CONCLUSION

FGM affects millions of girls and women worldwide and in this increasingly multicultural British society we, as health care professionals, have a duty of care to be aware of it and the potentially devastating effects it can have both physically and emotionally on these patients so that we can manage it effectively.

13. IMPLEMENTATION PLAN

This guideline will be implemented as follows:

- guidelines are approved locally by the Obstetric Clinical Governance Group (OCGG).
- after approval by OCGG, the guideline will be placed on the Trust intranet for viewing by any member of staff and a notice will be placed on the intranet homepage informing all staff of the guideline.
- all Community Midwives will have access to this guideline via the intranet which can be accessed in each GP surgery.
- new members of Maternity staff will be signposted as to how to find and access this guidance at the Mandatory Update day and the Maternity Safeguarding Level 2 & 3 Safeguarding training, both facilitated by the Named Midwife for Safeguarding.

14. AUDIT AND MONITORING COMPLIANCE WITH THIS GUIDELINE

- The number of mothers giving birth with FGM in the Trust will be collected each month by the Named Safeguarding Midwife and fed back to the Local Safeguarding Children's Boards via the Annual Child Protection Safeguarding report.
- Maternity records will be audited for:
    - documentation of enquiry into FGM at booking for high risk women (this is in a separate box)
    - proportion of women with FGM where the Safeguarding midwife has been involved at least once
    - proportion of women with FGM cared for by a Specialist Obstetrician
    - assessment for antenatal reversal procedures
    - evidence in notes of senior Obstetrician input

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16. RESOURCES

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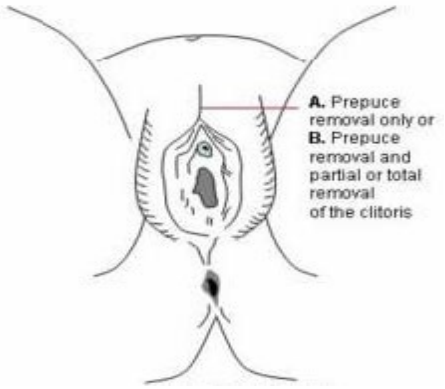
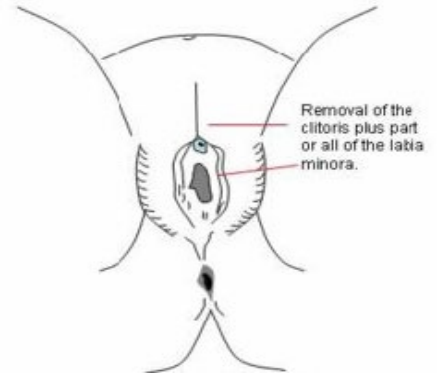
APPENDIX 1: EXAMINATION FINDINGS ON INITIAL ASSESSMENT

Type 1: Prepuce removed only / partial or total removal of the clitoris



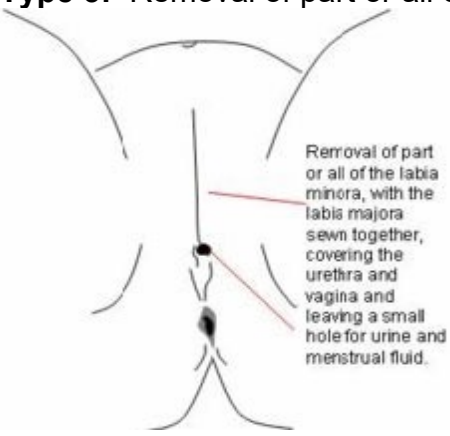
Comments:

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



Comments:

Type 3: Removal of part or all of the labia minora with the labia majora



Comments:

APPENDIX 2: BOOKING MIDWIFE / CLINICIAN IN ANC TO COMPLETE

PREGNANT WOMEN

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This is to help you make a decision as to whether the unborn child (or other female children in the family) are at risk of FGM or whether the woman herself is at risk of further harm in relation to her FGM.

Name:	**Plan:** Low risk - No requirement for Social Care referral High Risk (HIGHLIGHTED TEXT) - CONSIDER if Social Care referral is necessary if any of the answers are "YES". [DELETE AS APPROPRIATE]
DOB:	**Completed form:** 1 x hand held Maternity notes/Discharge Park 1 x Named Midwife for Safeguarding
Hospital No:	
EDD:	
Del:	

Date:	Completed by:
Initial/On-going Assessment	

Indicator	Yes	No	Details
CONSIDER RISK			
Country of birth			
Woman has undergone FGM herself			
Husband/partner comes from a community known to practice FGM			
Woman/family has limited integration in UK community			
Woman and/or husband/partner have limited/ no understanding of harm of FGM or UK law			
Woman's nieces of siblings and/or in-laws have undergone FGM			
Woman has failed to attend follow-up appointment with an FGM clinic/FGM related appointment.			
Woman's husband/partner/other family member are very dominant in the family and have not been present during consultations with the woman			
Woman is reluctant to undergo genital examination			
SIGNIFICANT OR IMMEDIATE RISK			
Woman already has daughters have undergone FGM			
Woman requesting reinfibulation following childbirth			
Woman is considered to be a vulnerable adult and therefore issues of mental capacity and consent should be considered if she is found to have FGM			
Woman says that FGM is integral to cultural or religious identity			
A female family elder is involved/will be involved in care of children/unborn child or is influential in the family			
Family are already known to social care services – if known, and you have identified FGM within a family, you must share this information with social services			

Please remember: any child under 18 who has undergone FGM should be referred to social services.

Adapted from: Department of Health - Female Genital Mutilation Risk and Safeguarding Guidance for professionals

ACTION

Ask more questions – if one indicator leads to a potential area of concern, continue the discussion in this area.

Consider risk – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/designated safeguarding lead.

Significant or immediate risk – if you identify one or more serious or immediate risk, or the other risks are, by your judgement, sufficient to be considered serious, you should look to refer to Social Services/CAIT team/ Police/MASH, in accordance with your local safeguarding procedures.

If the risk of harm is imminent, emergency measures may be required and any action taken must reflect the required urgency.

In all cases:–

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

APPENDIX 3: FGM PATHWAY FOR PREGNANT WOMEN

ANTENATAL

6-10 weeks gestation:
- FGM disclosed at pregnancy booking with midwife.
- Booking midwife to advise the mother/parents that the practise of FGM in the UK is illegal.
- Booking to advise that FGM will be addressed further at her clinic appointment with the consultant obstetrician.
- Booking midwife completes FGM risk assessment (see Appendix 2). Files a copy in the blue handheld records and the medical records.
- Low risk = no referral to children's social care required.
- High risk = referral to children's social care.
- Booking midwife refers the woman to the obstetric consultant clinic for examination and assessment.
- Booking midwife completes a cause for concern form. Files a copy in the medical records and emails a copy to the named midwife for safeguarding, HV & GP.

↓

12-13 weeks' gestation:
Woman attends routine dating ultrasound scan

↓

14-16 weeks' gestation:
- Obstetric consultant classifies FGM type and whether de-infibulation is required
- Obstetric consultant informs GP via letter that patient seen re FGM and plan.

↓

20 weeks gestation:
Routine anomaly ultrasound scan (sex of baby can be identified upon maternal request)

↓

20 weeks gestation:

De-infibulation performed → 21-24 weeks gestation: Obstetric consultant appointment for post-operative review → 25 weeks gestation onwards: Routine antenatal care with normal labour and delivery anticipated unless there are other clinical indications

De-infibulation not required → 25 weeks gestation onwards: Routine antenatal care with normal labour and delivery anticipated unless there are other clinical indications

INTRAPARTUM

Attending midwife reviews FGM assessment notes from ANC documentation and is aware of plan. If woman not previously assessed senior midwife or Obstetric registrar/consultant to classify FGM type and make delivery plan and document. Safeguarding team to be informed re risk assessment.

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If required, de-infibulate in 2nd stage when head is distending the vulva and anterior episiotomy can be performed using local anaesthetic or under epidural block. This can be done by any HCP who is confident to do so.

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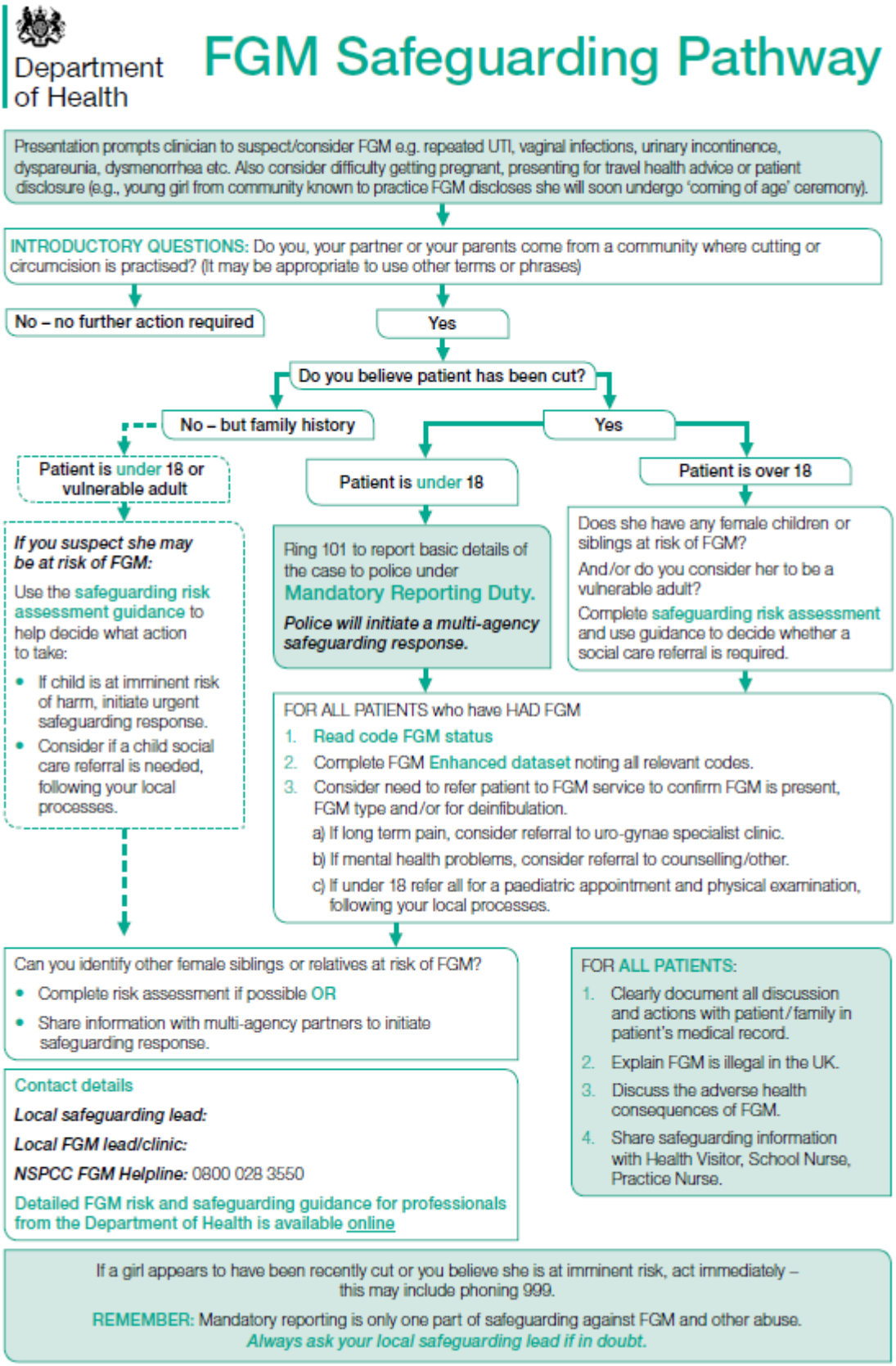
- Healthcare professional (Midwife) to complete FGM risk assessment (see Appendix 2)
- Ascertain whether high or low risk. Refer to children's social care **only** if high risk threshold is met.
- Copy of FGM risk assessment to be sent to named midwife for safeguarding. Data re FGM to be submitted as usual.
- Named midwife for safeguarding to make GP & HV aware of woman, FGM type/de-infibulation (if performed) and risk assessment outcome.

POSTNATAL

- Delivering midwife to inform named midwife for safeguarding of the sex of baby
- If Female, named midwife for safeguarding to update the SCRa FGM- IS system

APPENDIX 4: FGM SAFEGUARDING PATHWAY



FULL VERSION CONTROL RECORD

Version:	2.0
Guidelines Lead(s):	Lamia Zafrani, Consultant Obstetrician and Gynaecologist, WPH
Contributor(s):	
Lead Director / Chief of Service:	Anne Deans
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This guideline has been registered with the Trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Caution is advised when using guidelines after the review date.

This guideline is for use in Frimley Health NHS Foundation Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version History

Version	Date	Guideline Lead(s)	Status	Comment
1.0	April 2021	Miss Fatima Husain, Priscilla Dike	Final	First cross site version
2.0	May 2024	Lamia Zafrani, O&G consultant WPH	Final	Scheduled review. Ratified at Cross site Obstetric Clinical Governance meeting 21.05.2024

Related Documents

Document Type	Document Name
Guideline	Antenatal Care and Booking
Guideline	Care of Women in Labour