Responding to FGM for Women In Pregnancy in the Highlands: A Trauma Informed Pathway of Care

Maternity Services
NHS North Highland/Highland Council

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Language Use Statement

Please note, within this guideline when discussing 'women' we are referring to all birthing people inclusively of their pronouns or gender identity.

Date	Author	Change

Introduction

NHS Highland and Highland Council recognise the increasing prevalence of women with Female Genital Mutilation being supported by maternity services in our area.

This guidance is in place to provide evidence-based practice in the support of women with Female Genital Mutilation (FGM) in pregnancy and in identifying FGM as early as possible as it is critical to effective maternity care and to preventative strategies in protecting women and girls.

The aim of this guideline is to reduce the impact of FGM on women's' health by:

- Detailing the health professional's duty of care when FGM is identified in pregnancy and in labour.
- Assessing the safeguarding risk of the unborn child and any other child in the family.
- Referral of women to specialist services if there have been any health impacts from FGM for example referral to psychological services or gynaecological services.

Scope

This document has been produced to support midwifery and obstetric staff in NHS Highland along with health staff employed by Highland council such as family nurses and health visitors. It will also be relevant to clinical staff that have contact with women during the antenatal, intrapartum and postnatal period.

Background

FGM is a form of child abuse and violence against women. It is a deeply harmful practice which violates the human rights of women and girls. It can significantly affect their physical, sexual and mental health.

Female Genital Mutilation (FGM) refers to 'all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons. It is estimated that more than 125 million women and girls in 29 countries around the world, are affected by FGM today. The hidden nature of FGM makes it particularly challenging to build a true picture of how often it happens in Scotland. A Scottish Refugee Council Report (2014) estimated that more than 30,000 people in Scotland come from countries known to practice FGM.

When considering FGM, there is a strongly held belief in many communities that women are representatives of and carry with them their entire family's honour, and therefore it is the responsibility of men to ensure that they do not transgress family or community boundaries of acceptable behaviour. Such transgression can lead to dishonour, shame, and can result in violence. (National FGM Centre 2024). Therefore, it is important for health professionals caring for women with FGM to approach conversations sensitively and using a trauma informed approach.

Key Facts:

- FGM includes procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons.
- The procedure has no health benefits for girls and women.
- Procedures can cause severe bleeding and problems urinating, and later cysts, infections, infertility as well as complications in childbirth and increased risk of newborn deaths.
- FGM is mostly carried out on young girls sometime between infancy and age 15.
- FGM is a violation of the human rights of girls and women.

All health professionals must be aware of the Prohibition of Female Genital Mutilation (Scotland) Act 2005 and Female Genital Mutilation (Protection and Guidance) (Scotland) Bill: equality impact assessment - gov.scot (www.gov.scot).

- It is a criminal offence:
  i. To have FGM carried out in Scotland and the UK.
  ii. To arrange, or assist in arranging, for a UK national or UK resident to be taken overseas for the purpose of FGM.
  iii. For those with parental responsibility to fail to protect a girl from the risk of FGM.
- Re-infibulation is illegal; there is no clinical justification for re-infibulation and it should not be undertaken under any circumstances.

ANY child under 18 years of age, where FGM is confirmed or suspected (because the patient or parent reports it has been done) should be referred to Social Work and Police.

The incidence of FGM is underestimated due to secrecy amongst the affected communities. Custom and tradition are the main reasons given in the justification of FGM. However, professionals should be supported to challenge FGM as an extremely harmful practice. It should not be left to personal preference or cultural custom (NSPCC, 2019).

Definition & Classification

FGM is also known as 'female genital cutting', 'female circumcision' or 'cutting' (staff need to be aware that the term 'mutilation' can cause offence to women affected).

FGM is classified into four major types:

- Type 1 – clitoroidectomy – removing part or the entire clitoris.
- Type 2 – excision – removing part or all of the clitoris and the inner labia (lips that surround the vagina), with or without removal of the labia majora (larger outer lips).
- Type 3 – infibulation – narrowing of the vaginal opening by creating a seal, formed by cutting and repositioning the labia.
- Type 4 - Other harmful procedures to the female genitals, which include pricking, piercing, cutting, scraping and burning the area.

Ante-Natal Booking Appointment (Screening for FGM):

- All women, irrespective of country of origin, must be asked for a history of FGM at their midwife booking appointment so that FGM can be identified early in pregnancy. It is good practice, if possible, to ask the woman sensitively without her partner or other family members present.
- FGM may be described in many terms by the women who experience it e.g., sunna, gudniin, halalays, tahur, megrez, khitan. **Please be aware that the term mutilation may cause offence**. Staff discussing FGM should be aware of these different terminologies
- Women with FGM may have obstetric complications and consultant-led care is recommended. However, most women with previous uncomplicated vaginal births or type 1 or type 2 FGM may be suitable for midwife-led care in labour.
- FGM must be documented in BadgerNet and it's the midwife's responsibility to ensure that the GP is notified so that the FGM can be documented on Vision (GP electronic system).
- If FGM is disclosed, or the woman's parents or partner come from a community where cutting or circumcision is practised, the risk assessment for FGM should be completed on BadgerNet. (If no concerns, this should be clearly recorded in the risk assessment in BadgerNet)
- Any woman who comes from / or has a partner who comes from a community known to practice FGM and has one or more additional indicator, should be discussed with the Child Protection Nurse Advisor (01463 705828) and a Child Concern Form (CCF) should be submitted.
- Red flag indicators should be considered as significant or immediate risks. If any of these are identified then in addition to contacting the CPNA and completing a CCF, a telephone referral to social work (relevant Practice Lead for Care and Protection) should be made to share your concerns +/- request an Interagency Referral Discussion (IRD).
- In addition, a referral to a Consultant Antenatal Clinic must then be made so that care can be planned. A physical examination is not required at the midwife booking appointment; however, the suspected type of FGM should be documented from the description offered by the woman.
- Referrals should be made for an **in-person** antenatal clinic appointment at Raigmore. Women can be seen by any of the Obstetric Consultants. Staff should contact the Child Protection Advisor (Health) for advice and commence **Child Protection Risk Assessment (Appendix 1)**
- The Scottish Law on FGM must be explained to the woman with an emphasis being placed on an

approach that is centred on supporting the woman and ensuring the rights and best interests of the child.
- The Scottish Government Statement on FGM leaflet should also be given to the woman at this time. This is available on the Highland Information Trail and can be allocated to the woman's Badgernotes app.

Antenatal Care:

At the initial consultant appointment:

- The Consultant Obstetrician will offer a vaginal examination to inspect the vulva to determine the type of FGM and whether de-infibulation is indicated. If the introitus is sufficiently open to permit vaginal examination and if the urethral meatus is visible, then de-infibulation is unlikely to be necessary.
- Screening for hepatitis C should be offered in addition to the routine antenatal screening tests.
- De-infibulation may be performed antenatally, in the first stage of labour or at the time of delivery and can usually be performed under local anaesthetic. It can also be performed perioperatively after a caesarean section.
- It should be discussed sensitively with the woman that, in Scotland, re-infibulation is illegal and can not be undertaken. It is important to remember that women may be distressed by this.
- In partnership with the woman, the obstetrician will discuss, agree and document a plan of care on BadgerNet in the management plan.
- The obstetrician should re-visit the risk assessment on BadgerNet that the community midwife has commenced and consider the risk of FGM to the unborn baby. Any woman who comes from / or has a partner who comes from a community known to practice FGM and has one or more additional indicator, should be discussed with the Child Protection Nurse Advisor (01463 705828) and a Child Concern Form (CCF) should be submitted.
- Red flag indicators should be considered as significant or immediate risks. If any of these are identified then in addition to contacting the CPNA and completing a CCF, a telephone referral to social work (relevant Practice Lead for Care and Protection) should be made to share your concerns +/- request an Interagency Referral Discussion (IRD).
- If not already given, please provide the leaflet "FGM – A Statement Opposing Female Genital Mutilation" Available in various translations . The NHS Highland leaflet on Deinfibulation should be given. Both leaflets are available as a download on the Highland Information Trail and can also be allocated on Badgernet.
- Obstetrician will notify community midwife/HV and GP regarding referral outcome.

Intrapartum Care:

- Women with FGM giving birth in Highland (particularly type 3) should be advised to give birth in Raigmore Maternity Unit where immediate access to emergency obstetric care is available. Intravenous access should be established in labour and blood taken for full blood count and group and save.
- Please check the Management Plan on BadgerNet for any specific intrapartum instructions that need to be followed.
- **In certain circumstances women with FGM, such as a previous uncomplicated vaginal birth, may be considered low risk and midwifery-led care may be appropriate.**
- If the woman presents in labour with type 3 FGM the impact of this must be sensitively discussed and a plan of care agreed and documented. If a vaginal examination, Intrapartum procedures or urinary catheterisation are not feasible, then de-infibulation in the first or second stage of labour is recommended. An epidural should be offered to ensure comfort and manage pain effectively during the procedure, as well as for subsequent examinations and during the birth.
- The technique of de-infibulation at delivery is similar in principle to de-infibulation performed at other times. However, in contrast, to de-infibulation in pregnancy or in the first stage of labour, when either a scalpel or scissors may be used, at delivery the incision should be made just before

crowning of the fetal head(using scissors). Lidocaine without adrenaline (epinephrine) should be used if no epidural is in-situ or if there is inadequate pain relief. Once the procedure has been performed, the need for episiotomy should be assessed; this is commonly required (irrespective of FGM type) due to scarring and reduced skin elasticity at the introitus. This procedure will be carried out by a senior obstetric clinician.

- If discussion with the woman (and other parent if appropriate) indicates that there is imminent risk of FGM following the birth or if any new/additional safeguarding indicators are identified, the child protection risk assessment (Appendix 1) and actions taken should be reviewed. Any woman who comes from / or has a partner who comes from a community known to practice FGM and has one or more additional indicator, should be discussed with the Child Protection Nurse Advisor (01463 705828) and a Child Concern Form (CCF) should be submitted.
- Red flag indicators should be considered as significant or immediate risks. If any of these are identified then in addition to contacting the CPNA and completing a CCF, a telephone referral to social work (relevant Practice Lead for Care and Protection) should be made to share your concerns +/- request an Interagency Referral Discussion (IRD).

Postnatal Care:

- Whilst de-infibulation is possible peri-operatively as part of a caesarean section, if it is not performed referral to gynaecology clinic should be done. De-infibulation can then be offered before a subsequent pregnancy.
- The named consultant or midwife should consider a postnatal debrief with the woman and her partner, regardless of whether Intrapartum procedures were undertaken or not.
- Discussion should include:
    - Information on the legal and regulatory aspects of FGM,
    - who has been informed of FGM (GP and Health Visitor/FNP)
    - where the information is documented.
- Postnatal ward staff will ensure that the child protection risk assessment (Appendix 1) for any woman with FGM has been completed. Any woman who comes from / or has a partner who comes from a community known to practice FGM and has one or more additional indicator, should be discussed with the Child Protection Nurse Advisor (01463 705828) and a Child Concern Form (CCF) should be submitted.
- Red flag indicators should be considered as significant or immediate risks. If any of these are identified then in addition to contacting the CPNA and completing a CCF, a telephone referral to social work (relevant Practice Lead for Care and Protection) should be made to share your concerns +/- request an Interagency Referral Discussion (IRD).Community Midwives must ensure clear handover to Health Visitors regarding risk to newborn baby.

Education & Training

All Health Professionals should access training to develop their knowledge and skills around the management of FGM. Some resources can be found below. Please note that the legal position on mandatory reporting in England, Wales and Northern Ireland is NOT applicable in Scotland

- This FGM e-learning resource from the Royal College of Obstetricians & Gynaecologist is designed to raise greater awareness and help support healthcare professionals when working with women and girls who are victims of female genital mutilation (FGM). Female genital mutilation (rcog.org.uk) All NHS staff in the UK with a valid NHS email account, e.g. @nhs.scot, are eligible for free access to the resource

- This **RCM** i-learn module therefore looks at how to identify FGM, communicate effectively and sensitively whilst caring for women and girls who have had FGM and also considers how to prevent FGM being practised in the future. Accessible to RCM members. Female genital mutilation | Royal College of Midwives (rcm.org.uk)

- This e-leaning module from The National FGM Centre is estimated to take 1-2 hours. This tool enables you to think holistically about FGM, and takes you through key information about the practice, context, and will test you throughout. FGM E-Learning Course – National FGM Centre

- This video resource from the FGM National Clinical Group is targeted at specialists, practitioners and educators, with the intention to provide overall context of FGM and current standing within healthcare and political arenas: This video last approx. 25 minutes. FGM Resource – An initiative by the FGM National Clinical Group

REFERENCES

NSPCC(2019), Female Genital Mutilation Policy, Procedure & Guidance [Online]. Available from: Female genital mutilation guidance (nspcc.org.uk) (Accessed 19/11/2024)

RCOG(2015) Green Top Guideline 53: Female Genital Mutilation and it's Management; [online]. Available from: Female Genital Mutilation and its Management (Green-top Guideline No. 53) | RCOG (Accessed 19/11/2024)

Smith J (2022) Staff Guidance on Female Genital Mutilation and its Management in Pregnancy. Aberdeen: NHS Grampian

The Scottish Government(2019) Female Genital Mutilation(Protection and Guidance) (Scotland) Bill: equality impact assessment[online]. Available from Female Genital Mutilation (Protection and Guidance) (Scotland) Bill: equality impact assessment - gov.scot (www.gov.scot) (Accessed 19/11/2024)

The Scottish Government(2016) Scotland's National Action Plan to Prevent and Eradicate FGM [online]. Available from Scotland's national action plan to prevent and eradicate FGM - gov.scot (www.gov.scot) (Accessed 19/11/2024)

The Scottish Government(2023) Equally Safe: Scotland's Strategy for Preventing and Eradicating Violence Against Women and Girls [online]. Available from Equally Safe: Scotland's Strategy for Preventing and Eradicating Violence Against Women and GirlsScotland's Strategy for Preventing and Eradicating Violence Against Women and Girls (Accessed 19/11/2024)

World Health Organisation(2024) Female Genital Mutilation [online]. Available from Female genital mutilation (who.int) (Accessed 19/11/2024)

FGM Child Protection Risk Assessment for Pregnant Women – Appendix 1

This risk assessment tool should be used to support decision making around FGM and the risks to the woman, unborn child and other female children in the family.

	Indicator	Yes	No	Details
	Woman comes from a community known to practice FGM			
	Husband/Partner comes from a community known to practice FGM			
	Woman has undergone FGM			
	A female family elder in involved/will be involved in the care of the children/unborn child or is influential in the family			
	Woman/family has limited integration into the UK community			
	Woman and/or husband/partner have limited/no understanding of harm of FGM or UK law			
	Woman's family members have undergone FGM			
	Woman has failed to attend FGM clinic/related follow-up appointments			
	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			
	Woman has a daughter who has already undergone FGM			
	Woman is requesting reinfibulation after childbirth			
	Woman is considered a vulnerable adult - issues of mental capacity and consent should be considered if she is found to have FGM			
	Woman says FGM is integral to cultural or religious identity			

Actions

Ask more questions - If one indicator leads to a potential area of concern, it is important to continue the discussion and explore further potential indicators.
Any woman who comes from / or has a partner who comes from a community known to practice FGM **and** has one or more additional indicator, should be discussed with the Child Protection Nurse Advisor (01463 705828) and a Child Concern Form (CCF) should be submitted. Red flag indicators should be considered as significant or immediate risks. If any of these are identified then in addition to contacting the CPNA and completing a CCF, a telephone referral to social work (relevant Practice Lead for Care and Protection) should be made to share your concerns +/- request an Interagency Referral Discussion (IRD).

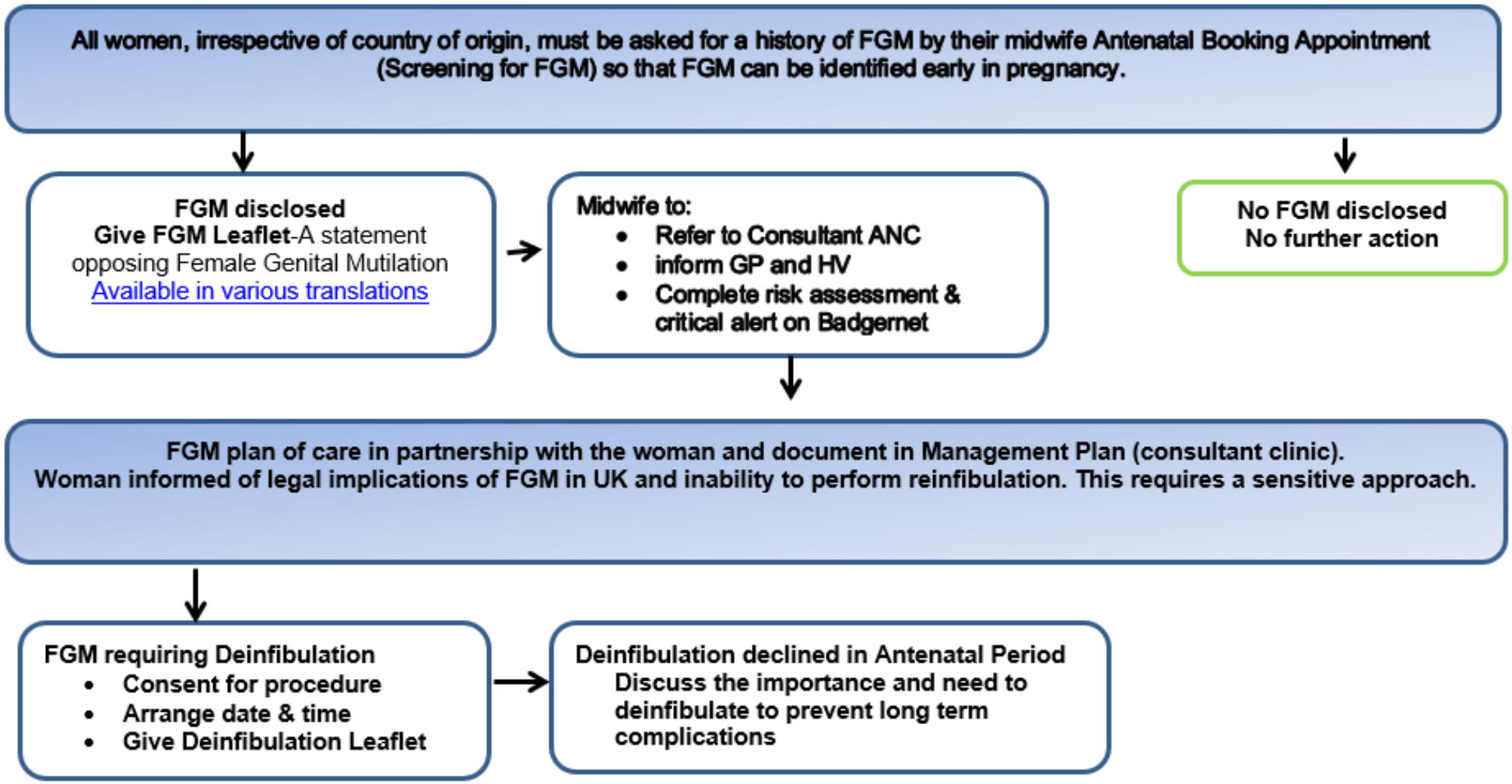
FGM Child Protection Risk Assessment for Pregnant Women - ACTIONS TAKEN

Risk Assessment Completed in Badger	Y/N	Date:
Genital Exam Carried out?	Y/N/NA	Date:
Discussed with Child Protection Advisor? Y/N Date: Outcome:		
Child Concern Form Completed?	Y/N	Date:
Social Work Contacted?	Y/N	Date: Name: Contact number:
Interagency Referral Discussion Requested?	Y/N	
GP Notified?	Y/N	Date:
Health Visitor Notified?	Y/N	Date:
Referred to Antenatal Clinic?	Y/N	Date:

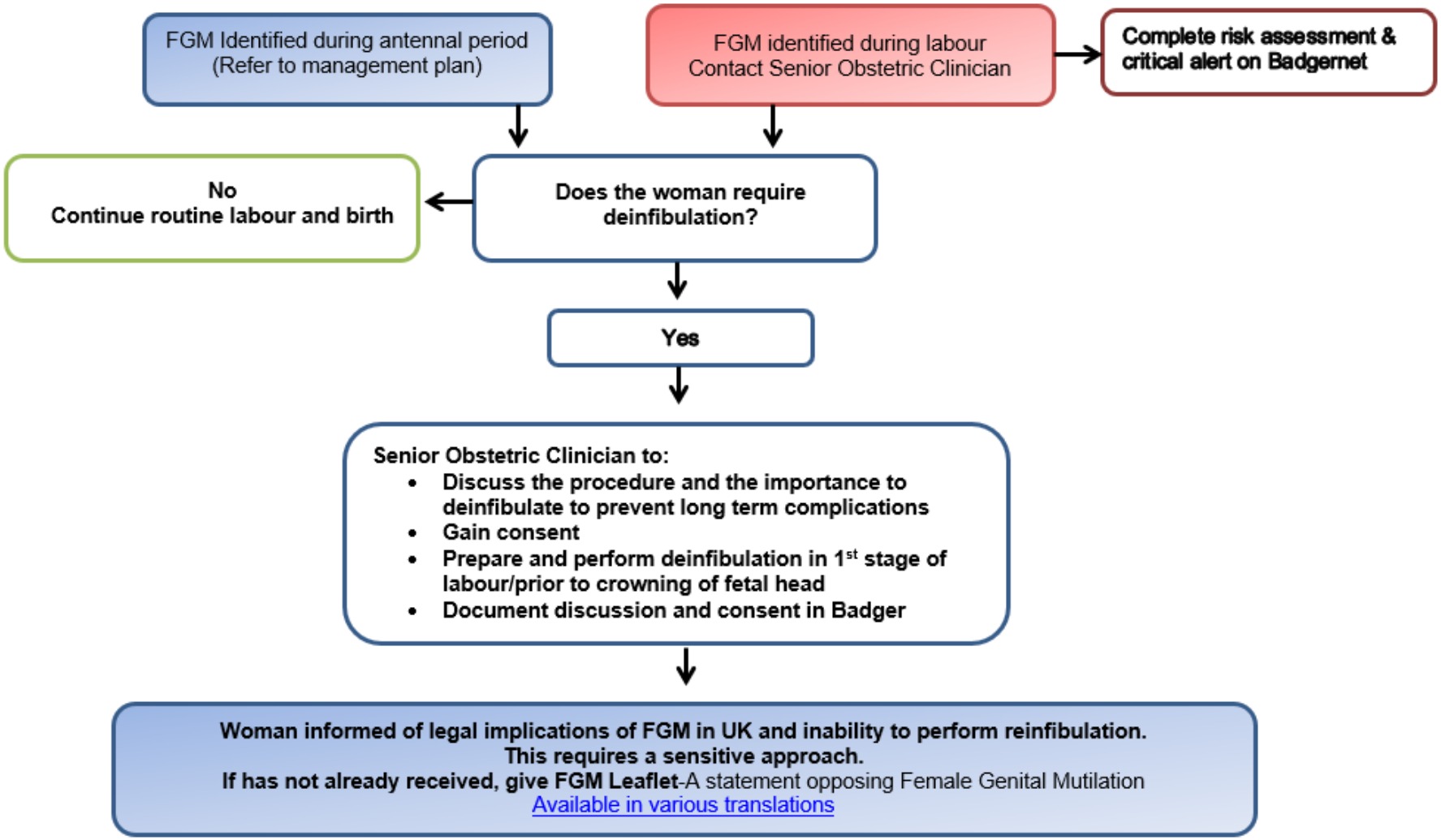
Notes related to risk assessment or actions carried out.

Please remember to document fully in Badger notes and upload this assessment as a scanned document to the maternity record. A Critical Alert note should also be completed.

Appendix 2- Flow Chart for antenatal women identified with FGM at booking- Obstetric Care



Appendix 3- Flow Chart for women identified with FGM in Labour- Obstetric Care



Appendix 4- Flow Chart Postnatal care for women identified with FGM- Obstetric Care