


Maternity care provision for women living with female genital mutilation/cutting: A qualitative study from a high asylum-seeking dispersal context in the UK

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Abstract

Objective: To explore the perspectives of midwives and obstetrician/gynaecologists providing maternity care to women living with female genital mutilation/cutting (FGM/C) in a high asylum-seeker dispersal area in the North West of England.

Methods: We carried out a qualitative study in four hospitals providing maternal health services within the North West of England, with the highest population of asylum-seeking individuals (many from high-prevalence FGM/C countries) in the UK. Participants included 13 practicing midwives and an obstetrician/gynaecologist. In-depth interviews were conducted with study participants. Data collection and analysis were carried out concurrently until theoretical saturation was reached. Data were analysed thematically to generate three key overarching themes.

Results: There is a disconnect between Home Office dispersal policy and healthcare policy. Participants indicated that there was inconsistent identification or disclosure of FGM/C, constraining appropriate follow-up and care prior to labour and childbirth. All participants noted existing safeguarding policies and protocols, which were seen by most as being important to protect female dependants, but

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potentially detrimental to the patient-provider relationship and to the woman's care. Unique challenges around accessing and maintaining continuity of care for asylum-seeking women due to dispersal schemes were indicated. All participants highlighted a lack of specialised training for FGM/C to support provision of clinically appropriate and culturally sensitive care.

Conclusions: There is a clear need for harmony between health and social policy as well as specialised training that centres holistic wellbeing for the woman living with FGM/C, particularly where there are increased numbers of asylum-seeking women from high-prevalence FGM/C countries.

KEYWORDS

female genital mutilation/cutting, healthcare provision, maternity care, qualitative research, safeguarding, United Kingdom

Highlights

- Training gaps
- Holistic care need
- Safeguarding weaknesses
- Policy limitations

1 | INTRODUCTION

Female genital mutilation/cutting (FGM/C) is defined by the World Health Organization (WHO) 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'.¹ There are four globally recognised classifications of FGM/C (typically referred to as Types 1–4), which the National Health Service (NHS) definitions are based upon.² Type I is the partial or total removal of the externally visible parts of the clitoris. Type II involves Type I in addition to the removal of some or all of the labia minora, and possibly the labia majora. Type III involves excision of the external genitalia and stitching and narrowing of the vaginal opening (infibulation). Type IV includes all other harmful non-medical procedures involving the female genitalia (e.g., piercing or cauterising).¹ Dependent on what classification of FGM/C has been performed, there are different interventions required prior to or during the intrapartum period to facilitate childbirth.³ FGM/C occurs for socio-cultural reasons, and women in high-prevalence FGM/C settings who do not undergo the practice may face social ostracisation and stigmatisation.^{4–6} Unfortunately, there are a myriad of physical complications that accompany FGM/C, including infections, heavy bleeding, menstrual difficulties, and sexual impairment.^{7–12} The practice can also have pronounced psychological impacts, including post-traumatic stress disorder and other affective disorders.^{5,13–15} Many of these negative outcomes begin at the time that FGM/C is performed, affecting girls in childhood and throughout adolescence.^{3,4,14}

Women and girls living with FGM/C have greater risk of poor obstetric outcomes,^{12,16} which increase in correlation to the extent and severity of FGM/C, with the highest risks to women with Type III FGM/C.^{17,18} It may be difficult or impossible to carry out a vaginal exam to assess the progress of labour in an infibulated woman. Infibulation

TABLE 1 Total number of asylum seekers in UK regions at the end of Quarter 1 in years 2018–2022.²⁹

Region	Q1 2018	Q1 2019	Q1 2020	Q1 2021	Q1 2022
East Midlands	3016	2985	2743	2801	3071
East of England	823	901	969	1206	1834
London	5610	6165	6855	7995	10,129
North East	4316	5393	4443	4953	5381
North West	10,952	11,346	10,508	10,246	11,576
Northern Ireland	814	940	923	912	1404
Scotland	4370	4576	4395	4736	4667
South East	725	756	834	1178	1846
South West	1085	1063	1068	1182	1370
Wales	3205	3099	3204	3014	2603
West Midlands	6055	6116	5941	6503	7005
Yorkshire and the Humber	5714	6137	6365	6081	7003

may create a line of skin that obscures the urinary opening, obscuring catheter insertion, necessitating defibulation (opening of the stitches), even in women scheduled for a caesarean section. Vaginal childbirth without defibulation will necessarily lead to severe tearing, likely involving the anal canal. Bleeding from such tears may be severe. Labour is usually prolonged, and may contribute to the development of obstetric fistula.¹⁸ The risk of these outcomes is increased if FGM/C is not disclosed or identified during antenatal care.⁹ For example, with planning, defibulation can occur during pregnancy or intra-partum, leading to better obstetric outcomes.¹⁹

Disclosure of FGM/C in maternity care requires cultural sensitivity, particularly in an environment where, as in the UK, FGM/C is illegal and can trigger safeguarding concerns and initiate child protection and safeguarding protocols for a woman's female children. FGM/C becomes significant at the intersections between health and social services.²⁰ In the UK, research with women living with FGM/C has found that, due to reporting and safeguarding requirements, questioning during maternity services can feel insensitive and relentless, leaving the impression that gaining information about FGM/C takes precedence over clinical care.^{21–23} Research on the experiences of care among women living with FGM/C suggests that 'cultural sensitivity' may translate into care that is 'culturally safe'—care that is respectful, safe, and empowering. That is, care that respects the cultural and bodily integrity of the woman, seeking to understand rather than judge, and ensuring their involvement in decision-making. Further, for care to be 'culturally safe' women need access to information about care, providers need to be confident and competent to reassure their patient, and existing systems, services, and care pathways need to be appropriate and aligned.^{24,25} Clinical experiences in which the woman is not listened to, treated with negative attitudes, judged, stereotyped, or where clinical management is poor may leave women re-traumatised and voiceless.²⁴

Asylum-seekers in the UK are awaiting legal recognition from the Home Office as refugees. Once granted refugee status, individuals are protected under international law.²⁶ Although data on whether refugees stay in the area that they were dispersed to as an asylum-seeker is not available, participants referred to patients as both refugees and asylum-seekers. Therefore, the term refugee and asylum-seeking (RAS) is used throughout, aside from explicit reference to dispersal policy, which only impacts asylum-seeking women. As per the Home Office's Allocation of Accommodation Policy,^{27,28} asylum-seeking women enter a 'no choice basis' accommodation system. Due to this dispersal system, the North West of England receives the largest number of asylum-seeking individuals in the UK (Table 1).²⁹ This includes individuals from countries with a high prevalence of FGM/C among women and girls aged between 15 and 49 years, such as Eritrea (83%), Sudan (87%) and Somalia (99%) (Table 2).^{27,30,31} In addition to the longstanding physical and psychosocial implications of FGM/C that affect all women, there are specific vulnerabilities of RAS women affected by FGM/C.³² For example, they are more likely (than migrants or British-born women

TABLE 2 Female genital mutilation/cutting (FGM/C) prevalence and attitudes within high-FGM/C prevalence settings.³⁰

	FGM/C prevalence among girls and women aged 15–49 years (%)	FGM/C prevalence among girls aged 0–14 years (%)	Girls and women aged 15–49 years opposing the continuation of FGM/C (%)	Boys and men aged 15–49 years opposing the continuation of FGM/C (%)
Somalia	99	26	19	-
Guinea	95	39	26	33
Djibouti	94	43	51	-
Sierra Leone	83	8	34	40
Mali	89	73	18	13
Egypt	87	14	38	28
Sudan	87	30	53	64
Eritrea	83	33	82	85
Burkina Faso	76	13	90	87
Gambia	73	46	46	42
Mauritania	67	51	44	26
Ethiopia	65	16	79	87
Guinea-Bissau	52	30	76	-

living with FGM/C) to have lower literacy and to face linguistic and sociocultural barriers that impede uptake of care and effective communication about sensitive health topics like FGM/C.^{33,34} They are also less likely to have familial support and are affected by dispersal schemes, which can interrupt their development of social support networks and any continuity of care they may have.³⁴ Critically, the practice of FGM/C in the UK, and across Europe, is primarily associated with RAS communities.^{32,35}

As the number of asylum-seeking individuals from countries with high prevalence increases, so do the numbers of women living with FGM/C in the UK. A supplementary policy document, the UK Visas and Immigration's (UKVI) 'Healthcare Needs and Pregnancy Dispersal Policy', confirms that engagement with maternity services is insufficient to prevent multiple instances of dispersal, despite reference to increased risk of mortality in asylum-seeking women. Guidance on the maternity healthcare needs of asylum-seeking women is provided predominantly by medical associations and NHS Trusts (see, for example: Refs.^{36–39}).

Despite the seriousness of identifying and caring for a woman according to whatever needs she may have based on the type of FGM/C she is living with, there is minimal dedicated training for midwives to provide appropriate maternity care. The UK has more women living with FGM/C than any other country in Europe.⁴⁰ In England, there are approximately 6000–7000 women identified with FGM/C each year. However, the existence of FGM/C, and the type, is only known for about 60% of women living with FGM/C in England.⁴¹ Training of healthcare providers is through an online programme, e-FGM,⁴² which features five 20–30 min e-learning sessions. There is also published guidance largely focussing on identifying FGM/C, and the safeguarding and legal responsibilities of staff—including mandatory reporting—rather than providing person-centred and culturally appropriate care. Though the need for 'sensitive' communication is emphasised, the time and content dedicated to fostering meaningful communication skills with women living with FGM/C is limited.⁴³ Engagement with maternity care is usually the first and possibly only instance in which a woman will discuss FGM/C with a healthcare provider in the UK, at which point they should be referred to a specified consultant obstetrician/gynaecologist.³⁶

There is minimal literature from the healthcare provider perspective about providing maternity care to women living with FGM/C, particularly within the UK. Healthcare providers are often the sole point of access to health and social services, particularly for RAS women, and their work is guided by social and child protection legislation

(including safeguarding protocols). As such, given their unique position at the interface between healthcare provision and social policy, we felt that gaining their insights would be of particular value. In an increasingly diversifying country with growing RAS communities, and within the context of the dispersal policies discussed above, this paper will share midwife and obstetrician/gynaecologist experiences providing maternity care to women with FGM/C in the North West of England.

2 | METHODS

This was a qualitative study that aimed to explore healthcare provider perspectives around maternal health care for women with FGM/C, within the context of a high asylum-seeker dispersal context in the UK.

2.1 | Sampling and recruitment

To access healthcare providers with relevant experience, two-stage sampling took place. We purposively sampled any maternity staff in the North West of England, employed by the NHS for any length of time, with experience providing maternity care to women with FGM/C. In the first phase, we shared study recruitment materials with a large hospital that provides a weekly antenatal service for non-English speaking women that is locally regarded as an access and referral point for women with FGM/C requiring maternity care. Three participants were identified through this approach. Concurrently, we searched on hospital websites for 'specialist FGM midwives' at other health facilities throughout urban centres in the North West—to increase the likelihood of maternity staff exposure to women living with FGM/C through greater ethnic diversity of populations in urban settings—whilst maternity services and community midwife teams were contacted. Four participants were identified through this approach. In phase two, we deployed snowball sampling, as participants identified in the initial phase were then asked to identify other colleagues with similar experiences. We identified seven participants through this approach.

2.2 | Data collection

Semi-structured in-depth interviews were carried out with participants. This interview guide was developed from Robertshaw et al.'s systematic review of challenges and facilitators of providing healthcare to women living with FGM/C, from which we identified key topics to discuss with participants.⁴⁴ Specific questions around the different needs of women arose from the WHO's detailed information about FGM/C.^{1,3} The interview questions centred: experiences and challenges providing maternity care to women living with FGM/C; specific needs of women living with FGM/C; availability of FGM/C-specific training; and knowledge of protocols, guidelines, and local experts on FGM/C in maternity care. It was piloted before use with one midwife, resulting in only one minor wording change in the tool. As a result, that transcript was included in the analysis, as the tool used was not sufficiently different to warrant its exclusion.

Interviews were mostly carried out in private spaces within NHS buildings, however, due to the large geographic area covered, six interviews were carried out over the telephone. They were all conducted in English, audio-recorded, and transcribed verbatim.

2.3 | Data analysis

Interview data were analysed thematically. Transcripts were read and re-read for familiarisation, and then coded line-by-line using NVivo software to generate an overall coding framework. These codes arose inductively from the interview data. Both JT and TT coded transcripts and agreed to a coding framework. This coding framework was

revised throughout data analysis and was used to identify key emerging themes. Data collection and analysis were done concurrently, with participants sampled in groups of three-to-four and transcripts analysed to determine which themes emerged, with further data collection occurring if it appeared new insights were obtained from each participant. Theoretical saturation was reached after 12 participants (all midwives), however, one additional interview was carried out with an obstetrician/gynaecologist, whose views resonated wholly with the previous participants. As above, the participant from the pilot was included for a total of 14 participants.

2.4 | Ethics statement

Ethical approval was granted by the Liverpool School of Tropical Medicine Research Ethics Committee (reference M18-025). This study did not require approvals from the NHS Health Research Authority or an NHS Research Ethics Committee as it did not involve patients, nor did it use biological data. All participants provided written informed consent prior to any data collection. For telephone participants, the information sheet and consent form were sent ahead of the interview, discussed at the start of the interview to ensure all questions were resolved, and verbal consent was taken. Signed consent forms were encrypted and confidentially emailed thereafter. Relevant safeguarding contacts (internal and external to the NHS) were identified and communicated to participants, however, no safeguarding concerns were raised.

3 | RESULTS

Fourteen interviews were conducted. The participants were located across four NHS hospitals with maternal health services. Of the 14 participants, 13 were midwives and one was a consultant obstetrician. The midwives were variously located in the community, antenatal clinics, delivery suites, and university teaching and research positions. Several midwives held roles of specialism in relation to FGM/C, RAS women or safeguarding.

All participants were female and self-identified as White British or White European. Participants were aged between 26 and 58 years old, with between four and 36 years of work experience as maternity staff.

From our analysis, three key themes emerged, all resonating within an overarching narrative around there being disconnect between asylum-seeker dispersal policy, safeguarding policies, and healthcare policies: there are significant limitations in providing appropriate maternity care for women living with FGM/C; there are specific challenges faced by RAS women living with FGM/C in particular; and there is inadequate provision of FGM/C-specific training to maternal health care providers. These themes and their subthemes are presented below.

3.1 | Limitations in providing appropriate maternity care for women living with FGM/C

Participants identified a number of individual (e.g., within the confines of the patient-provider interaction) and institutional barriers impacting upon the provision of appropriate maternity care for women living with FGM/C.

3.1.1 | Difficulty identifying FGM/C

Participants recognised the difficulty in identifying different types of FGM/C, as well as whether FGM/C had occurred. This was particularly the case with Type 1 (clitoridectomy). For most participants, FGM/C identification remained a challenge due to being outside of their usual practice.

Our core role is based around normality, and FGM, for us at least, isn't normal.

(Participant 9)

Most participants agreed that, as part of mandatory reporting, women are routinely asked at their booking appointment (or first antenatal appointment) whether they have had FGM/C, regardless of their nationality or ethnicity. However, due to lack of knowledge by a woman herself—especially as, most often, FGM/C occurs in childhood—the experience of FGM/C being traumatic and difficult to discuss, or the perception by women that it will not affect care, it was seen as a challenge for women to disclose their experience of FGM/C. Trust and comfort with the provider was essential to facilitate this process, which could not always be built. Further, it was commonly expressed that maternity staff may also lack the confidence to discuss the topic of FGM/C in detail through lack of exposure to the practice, meaning that disclosure is not facilitated when it is most essential.

Unless the midwife has cause to believe the practice has occurred and conducts a physical examination, FGM/C will be missed at the booking appointment, potentially until much later in the pregnancy, or at the time of labour and childbirth. Appropriate interventions, for example, defibulation, may not be possible at this time.

The girls with severe FGM, they typically do mention it because they know they're going to need a caesarean. But there are lots that don't mention it. And you just don't know until they come into delivery suite.

(Participant 1)

Traumatic experiences are a reality if FGM/C is not identified or disclosed before delivery. One participant described a particularly distressing memory of a woman with undisclosed FGM/C at the time of childbirth, resulting in substantial tearing and pelvic floor damage to the woman. She acknowledged that colleagues may not be as thorough in facilitating disclosure at booking because, 'they haven't had that experience that I've had' (Participant 5).

3.1.2 | Providers find safeguarding focus challenging

All participants discussed the mandatory reporting of FGM/C following legislative changes by the Department of Health and Social Care,⁴⁵ in booking appointments, which prompts an internal safeguarding protocol. This protocol usually combines a safeguarding referral, the involvement of an obstetric consultant to diagnose the type of FGM/C, a conversation on the illegality of FGM/C in the UK, and the possibility of Social Services inclusion if the woman is expecting, or already has, a female dependent. Knowledge of the seriousness of the approach taken as a result of this protocol also constrained disclosure of FGM/C and compromised trust and confidentiality within the patient-provider relationship.

I found the social worker side of things so brutal, like raiding the house for passports and I found that quite difficult to deal with as a midwife. To give her that support and [build] trust, but also, there was obviously child protection issues, but I never really felt like there was any support for a woman and four children. It was just very severe.

(Participant 13)

Many participants acknowledged that this preoccupation with safeguarding, although valuable for child protection, can lead to a skewed focus on the female neonate, not the mother, and does not allow for holistic and empathetic care. This need for care—which participants widely recognised should encompass comprehensive sexual and reproductive health care, as well as mental health care—was perceived as basically ending after the baby's birth.

They're just kind of lost once the baby's born.

(Participant 13)

3.2 | Challenges faced by RAS women with FGM/C

Almost all participants acknowledged that the populations of women living with FGM/C in the North West and RAS women are largely synonymous.

Honestly, it's only through working with asylum-seekers in Liverpool that I've gained this experience...I have colleagues who predominantly work with white British women and have never seen FGM.

(Participant 7)

RAS women living with FGM/C were described by participants as being particularly 'vulnerable' (participants 2, 10, 12) in the context of all women with FGM/C, evidencing the concerns of maternity staff for this specific population.

3.2.1 | Acknowledgement of cultural barrier in patient-provider relationship

Most participants were aware that a cultural barrier exists between themselves and women living with FGM/C, given the nature of the practice being potentially normalised in other communities or countries of origin, yet being illegal in the UK. This barrier was perceived to work both ways, with midwives sometimes being very uncomfortable with the topic, and patients being wary of discussing it.

[...] they're just coming in for care and they're already on the defensive [...] you don't want them to think you're attacking them because it's not their fault it's happened to them.

(Participant 8)

3.2.2 | Dispersal and insecure immigration status interrupts healthcare service continuity

The ability of asylum-seeking women to fully participate in the patient-provider relationship is made complex by the disruptive nature of the Home Office dispersal policy, whereby individuals and families are moved around the UK at various points in the asylum process. Reference was repeatedly made to the impact dispersal has for asylum-seeking women living with FGM/C in accessing care, and also on their continuity of care.

Getting them to engage with the services [is difficult]...[and is] the challenge of supporting any migrant community.

(Participant 12)

My biggest thing is keep them in one place. Build trust... Seeing the same person all the time...They can be in Liverpool for a few weeks, they can be shipped off to Manchester, so it's hard for them to get continuity of care, which I think is awful.

(Participant 2)

As a result, some asylum-seeking women 'come in the latter stages of their pregnancy [...] quite late on in the third trimester, or they can just turn up in labour' without previously accessing maternity care, and due to 'fear of things like being sent back home, the immigration side of things' (Participant 9). Fear of deportation both constrains uptake of care and ability to provide appropriate care post-partum.

After giving birth, she was being deported back out. So, with regards to the NHS and care we could offer her, it was very limited.

(Participant 6)

- Two participants had not attended or been offered training
- One participant teaches the FGM/C topic of a midwifery undergraduate degree. The topic involves half a day of teaching in a three-year degree.
- One participant attended training during midwifery undergraduate degree
- Two participants attended training sessions by external FGM/C charities (one of which was in a specialist midwifery role with vulnerable families)
- One participant thought FGM/C was included on previous NHS study days but wasn't sure, and hadn't attended any other training
- Three participants attended NHS study days. Two of those also undertake a lot of self-study to maintain their competence and knowledge.
- One participant has attended NHS study days and safeguarding training
- Two participants attend annual safeguarding training which includes FGM/C (comprising of different types of FGM/C, what action to take after identification or disclosure of FGM/C, and the pathway to internally refer)
- One participant has attended multiple external training events and Public Health England conferences, but stated of own accord this was due to her specialist area of work (as midwife with RAS women)

FIGURE 1 Participant experience with female genital mutilation/cutting (FGM/C)-specific training.

3.3 | Inadequate provision of FGM/C-specific training

Participants recognised that training for FGM/C was often piecemeal or totally absent. Most training was informal through learning by doing. Unfortunately, this approach concentrates specific knowledge and skills in individuals rather than intuitions, leaving little likelihood of institutional memory. Figure 1 highlights the specific ways in which training around FGM/C was obtained. Much was driven by participants' own personal interest in improving their clinical competence.

Three participants who did have prior experience working with RAS women were able to increase their clinical competence on providing care to women with FGM/C.

I think my training on FGM really in my early career was more that I worked in a Somali community and an Eritrean community [...] and most of them had it [...] It wasn't really through anyone giving me any formal training.

(Participant 13)

Most participants were insistent on the need for more training for maternity staff on the management of FGM/C in maternity care. Not only around clinical aspects of FGM/C care, but around delivering culturally-sensitive maternity care and improving comfort in working with interpreters.

I feel like healthcare providers are just embarrassingly under-skilled to manage it. And I'm talking all levels. Maybe not consultant levels. Some of the consultants have done lots of work overseas, they're really good... But some of the more junior doctors and the midwives, everyone just seems so frightened of it. And it's just a clear lack of training, a lack of understanding, a fear of doing or saying the wrong thing.

(Participant 1)

3.3.1 | Providers recognise the need for FGM/C specialists

All participants discussed the need to refer any women living with FGM/C to a consultant obstetrician for her delivery options to be assessed. All but one participant were able to name a midwife or consultant obstetrician who was

recognised as a point of advice or information for managing FGM/C in maternity care. Several participants reflected on previous experiences, also in the North West, where there were no focal persons for FGM/C, or where there previously were, but then these roles were ended, often when the focal person retired. There was clear suggestion in the need for obstetricians and midwives to have increased training around FGM/C to establish a critical mass of specialists in the North West.

I think they need specialist midwives who know a lot about FGM who have a lot of experience, a lot of knowledge, a lot of training. I think we need obstetric consultants who have an interest or a specialist in FGM. We're lucky at the [health facility] because we have one of those. And it really helps because they've got that specialist knowledge. They can offer women deinfibulation antenatally, they can do it in labour. They know all the risks, all the benefits to be able to discuss it with women.

(Participant 9)

Specialist resources need to be concentrated in areas or cities or regions where you've got high concentrations of multiple ethnicities and asylum-seekers and refugees.

(Participant 4)

4 | DISCUSSION AND RECOMMENDATIONS

Though of course not all RAS women will be living with FGM/C, previous research throughout the UK and across Europe—and the clear shared experience of our participants—has suggested that women living with FGM/C predominantly hail from RAS communities. Therefore, against the context of a concentrated population of RAS women in the North West of England, there is a clear gap in the ability to provide appropriate maternity care. Key emerging issues centred around inability to identify FGM/C, limited disclosures from women, and the sometimes counter-productive safeguarding protocols in place. Participants clearly recognised the unique and additional needs that RAS women have in terms of accessing and having continuity of care, and the need for much more FGM/C-specific training for providers. Despite UKVI's acknowledgement of these needs (described as 'possible FGM issues'), pregnancy dispersal policy includes no reference to experienced or specialist providers of maternity care for women living with FGM/C. Reference is made to housing pregnant asylum-seeking women 'where they will be able to access services throughout their pregnancy and into new motherhood', without any suggestion as to what these services should include.²⁸ Whilst the policy does state that pregnant asylum-seeking women should be housed 'as close to the maternity unit where they are currently accessing care',²⁸ this is not exhaustive and does not prevent dispersal.

Literature on care for FGM/C in the UK predominantly centres women's experiences (see examples: Refs. 15,46–50). These highlight often poor experiences of care, feelings of stigma and discrimination, and distrust of healthcare providers. Across these studies there is suggestion of a resounding need for more knowledgeable, culturally sensitive care from healthcare providers, ideally through formalised training efforts.

Research from the midwife or obstetrician perspective around providing maternity care to women living with FGM/C within the NHS in the UK is limited. However, literature from other European countries renders similar findings to our own. For example, studies from Belgium, Spain, and Sweden also recognised that increasing migration from high-prevalence FGM/C countries was presenting an emerging challenge, particularly around provision of clinically appropriate and culturally respectful and ethical care.^{51–53} Bottlenecks of high quality care were reiterated in a large review of care provision for women living with FGM/C, which found 30 studies from across Europe—most prominently from Scandinavia (12/30)—the United States, and Australia.²⁵ This review identified consistent challenges in identifying FGM/C, poor communication between providers and women, cultural misunderstandings, and an absence of training and clinical management practices/protocols across countries.²⁵ Very much inline with our findings, a recent study within the UK exploring general practitioners' responses to patients with FGM/C emphasised

the need for training, particularly around having sensitive conversations. This study also found that safeguarding and reporting requirements impeded such conversations.⁵⁴ Such findings suggests that the recommendation around training may not just be restricted to healthcare professionals offering maternity services, but more broadly.

It is clear that literature centring patient and provider perspectives from across contexts, and indeed, findings from this study reiterate the need for better training of healthcare providers, particularly around the sociocultural aspects of FGM/C and having effective, sensitive communication. To seek understanding does not mean to condone, and respectful, dignified care can, and should, still occur, regardless of the context in which care is taking place. Though much research points out the need for this,^{15,20,44,47,49,52,53,55,56} there is limited evidence of effective training curricula to this end, which is an important area of future research. Further, increasing clinical competency would likely be of value, especially in the absence of specialist care. For example, some participants in this study referred to the use of caesarean section when a woman presented with Type III FGM/C almost as a guarantee, though defibulation and vaginal birth are possible and widely carried out amongst women living with FGM/C.^{19,57} Additionally, redirecting women living with FGM/C to 'National FGM Support Clinics',⁵⁸ where possible, may enable appropriate care within a supportive environment. At these clinics, care is intentionally 'sensitive and non-judgemental' and encompasses clinical care, including referral to specialist consultants, as well as emotional support and counselling and access to FGM Health Advocates. Unfortunately, these services are concentrated in London, which may preclude women living in other parts of the country like the North West where there is only one such clinic as of 2022.

Somewhat uniquely in the UK, clinical protocols are overshadowed by an emphasis on safeguarding. Safeguarding is extremely important, but seems to, when applied to FGM/C, ignore the woman living with FGM/C as a vulnerable person. This is particularly true of women who have additional precarity around immigration status. There is a need for sensitivity to the trauma and violence that people have suffered, as well as sensitivity to the implications of those people seeking or being offered care. For example, a UK-based qualitative study in Bristol investigated the impact of FGM/C-safeguarding protocols in healthcare settings and described it as 'putting salt on the wound', prompting providers to ignore the health needs and lived experience—often as victims—of women with FGM/C, leading them to feel stigmatised and traumatised.^{21,23} An extensive study centring women's experiences with such safeguarding protocols in Scotland likewise described these as 'heavy-handed and insensitive',⁵⁹ reinforcing stigma and precluding uptake of care. Preventing the practice of FGM/C from occurring further is an important goal, but upholding existing safeguarding protocols seems to come at the cost of the welfare and physical and psychosocial wellbeing of women living with FGM/C.

4.1 | Strengths and limitations

A strength of this study is that it is contextualised to maternity care provision in an area of the UK with a high number of RAS women likely to be living with FGM/C. Though this study had a small sample size (14), theoretical saturation was reached. However, it would be useful to explore these experiences with male participants, more obstetrician/gynaecologists who may have specialised clinical knowledge, and across different NHS Trusts in the UK to strengthen transferability of findings, and further studies to this end would be an asset. It would also be enormously useful for future research to identify and learn from FGM/C-practicing communities to best understand appropriate communication and harm reduction strategies to, ideally, support culturally competent and ethically sensitive care.²⁰ Further, there is need for more research to better understand the lived experiences of women who have had safeguarding concerns raised about them and their families, which we were unable to explore here.

Maternity care in the UK is currently under scrutiny, given recurrent findings of confidential enquiries into maternal deaths and the recent MBRRACE report, which highlighted enormous disparities in maternal health outcomes for Black and Asian women when compared to white women.⁶⁰ Though these disparities are not necessarily due to FGM/C, this report has led to calls to understand and respond to the maternal health needs of Black and Minority Ethnic (BAME) women in the UK. A strength of this study is that it highlights recommended policy and practice

changes in maternity services that will better serve women living with FGM/C, who are predominantly from BAME communities, at a time when such insights are of critical importance.

4.2 | Recommendations

We have four overarching recommendations across levels:

1. At the midwife/healthcare provider level:
 - Consistent FGM/C-specific training for all student and qualified midwives that goes beyond the safeguarding protocol of FGM/C disclosure or identification. It should include cultural awareness training to develop and improve confidence in openly discussing FGM/C with patients. This training should be accessed by all midwives, regardless of specialism, as recommended by participants.
2. At the health facility level:
 - There should be named FGM/C-specialist maternity staff, ideally female, as points of information and advice in health facilities with maternity services.
3. At the health service/national level:
 - Improvement and development of internal care pathways and external referral mechanisms to FGM/C-relevant services. This should happen alongside increasing the awareness of maternity staff of these support options.
 - There should be a concentration of FGM/C resources and specialists with specific attention to locations of Home Office accommodation of asylum-seeking women.
 - Increase National FGM Clinic availability, particularly in areas with large RAS communities.
 - The current UK dispersal policy makes no allowance for the specific healthcare needs of women living with FGM/C. Whilst disclosure of FGM/C to an asylum caseworker in a screening interview is not expected of women, the Home Office should and could prioritise the accommodation of pregnant women from high-prevalence FGM/C countries in relation to the availability of specialised FGM/C maternity care.
 - Review of safeguarding protocols to consider the wellbeing of women affected by FGM/C and the importance of preserving trust within the provider-patient relationship.
4. At the international level:
 - Challenges providing appropriate care to women living with FGM/C are, evidently, shared and widespread. Consolidated efforts at a global level to learn from one another and to advocate for holistic support for women living with FGM/C are needed.

5 | CONCLUSION

Whilst working with the NHS to build a critical mass of providers with training in specialised FGM/C clinical and culturally-sensitive care in each institution offering maternity services within the UK would be ideal, ensuring maternity services are equipped to support RAS women living with FGM/C in dispersal areas should be the minimum required by the Home Office in the current context of concerns surrounding maternal care for BAME women in the UK. Reconsideration of safeguarding protocols such that the mental, physical, and psychosocial wellbeing of women living with FGM/C is promoted is a necessary step in the UK.

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CONFLICT OF INTEREST STATEMENT

We declare we have no competing interests to disclose.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

ETHICS STATEMENT

Ethical approval was granted by the Liverpool School of Tropical Medicine Research Ethics Committee (reference M18-025). This study did not require approvals from the NHS Health Research Authority or an NHS Research Ethics Committee as it did not involve patients, nor did it use biological data. All participants provided written informed consent prior to any data collection. For telephone participants, the information sheet and consent form were sent ahead of the interview, discussed at the start of the interview to ensure all questions were resolved, and verbal consent was taken. Signed consent forms were encrypted and confidentially emailed thereafter. Relevant safeguarding contacts (internal and external to the NHS) were identified and communicated to participants, however, no safeguarding concerns were raised.

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