Female Genital Mutilation (FGM) Strategy[1]

A Partnership Approach

2020 – 2023

[1] Update from the Hampshire 2017-2019 strategy

Contents

1. Introduction

This FGM strategy aims to provide a coordinated and uniform approach to tackling FGM. The strategy is based on these principles:

- the safety and welfare of the child is paramount;
- all agencies should act in the interests of the rights of the child, as stated in the United Nations Convention on the Rights of the Child (1989);
- FGM is illegal in the UK;
- FGM is an extremely harmful practice - responding to it cannot be left to personal choice;
- accessible, high quality and sensitive health, education, police, social care and voluntary sector services must underpin all interventions;
- as FGM is often an embedded social norm, engagement with families and communities plays an important role in contributing to ending it; and
- all decisions or plans should be based on high quality assessments (in accordance with 'Working Together to Safeguard Children' (2018) statutory guidance in England, and the 'Social Services and Wellbeing (Wales) Act Part Code of Practice – assessing the needs of individuals' (2015)

(HM Government , 2020)

It provides multi-agency frontline staff with guidance on safeguarding women, children and young girls who have undergone or at risk of undergoing FGM. It should be considered in conjunction with other relevant safeguarding adults and Childrens guidance. Specific summary guidance identified below are included on page 22 to page 28.

- Flowcharts for those aged under 18 years
- Flow chart for adults aged over 18 years
- Risk assessment tool for use in practice
- Guidance on mandatory reporting and recording of FGM

Partners (commissioners & providers) within the Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) are encouraged to raise awareness of FGM and share this strategy with professionals within the services they commission and provide.

This strategy offers a practical, evidence based set of recommendations to address the many issues relating to FGM in order to prevent and tackle the

damage such practice can cause on the health, wellbeing and quality of life of some of our residents (such as physical, psychological and emotional long term impact).

A series of fact sheets have been included at the end of the strategy to act as a short guide to key FGM issues and signpost agencies and individuals to local, national and international resources (Home Office , 2016).

The HIPS safeguarding adult's boards and children safeguarding partnerships are jointly responsible for the review of this strategy on a three-yearly basis. It is crucial that the document and the fact sheets remain current.

1.1 Aims and objectives

The aim of this strategy is to eliminate the risk of girls and women experiencing FGM in the HIPS areas. In order to achieve this, the objectives of this strategy are:

- To strengthen the HIPS response to FGM in line with current guidance, policy and good practice
- To adapt rather than duplicate existing guidance, policies or procedures to tackle FGM.
- To improve the safeguarding response of all relevant agencies concerning girls and women at risk of and already affected by FGM.

1.2 Strategic Recommendations

All Partners agree the following recommendations to achieve the aims and objectives of this strategy:

- To oversee the delivery of the strategy through the Safeguarding Adult Board and Safeguarding Children Partnership within the HIPS areas
- To engage with the HIPS Harmful Practices Strategic and Operational Groups
- To monitor the evolution of the FGM agenda at a national and regional level and translate into a co-ordinated, appropriate local response

- To effectively address FGM related issues at all levels of universal and targeted services ensuring that commissioners, managers and frontline professionals (such as GPs, social workers, paediatricians, mental health workers, teachers, health visitors, school nurses, mid wives and police officers) have the necessary knowledge, skills and resources to identify and appropriately manage suspected and actual cases of FGM

- To empower communities to take action to prevent FGM by raising awareness of FGM across the HIPS areas as appropriate, maximising opportunities for individuals throughout HIPS to seek help and ensuring that the voice of the child is heard when discussing issues surrounding FGM with girls and their families

- To describe effective arrangements for data recording, analysis and sharing among partners

2. What is FGM?

FGM comprises of 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.

Traditional circumcisers, who often play other central roles in communities, such as attending childbirth, mostly carry out the practice. However, health care providers (not within their professional capacity) perform more than 18% of all FGM, and the trend towards medicalisation is increasing.[2]

FGM is recognised internationally as a violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes and constitutes an extreme form of discrimination against women. It is nearly always carried out on minors and is a violation of the rights of children. The practice also violates a person's rights to health, security and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment and the right to life when the procedure results in death (WHO, 2016).

Note: See Fact sheet 01 for more information about the cultural, religious and social causes of FGM.

[2] https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation

2.1 Types of FGM

The WHO classifies FGM into four types:

- Type 1- Clitoridectomy: partial or total removal of the clitoris (a small, sensitive, and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).

- Type 2 – Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are the 'lips' that surround the vagina);

- 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, or outer, labia, with or without removal of the clitoris; and

- Type 4 - Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterising the genital area.

2.2 Consequences of FGM

The impact of FGM is devastating and hugely detrimental to the physical, psychological, emotional and social wellbeing of the women at risk or survivors of FGM.

Immediate physical complications can include severe pain, shock, haemorrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores in the genital region and injury to nearby genital tissue.

Long-term consequences can include recurrent bladder and urinary tract infections, cysts, infertility, an increased risk of childbirth complications, new-born deaths and the need for later plastic and corrective surgeries specific to FGM.

Immediate and long-term mental health consequences are also frequent and can include Post Traumatic Stress Disorder, Affective Mood Disorder, Anxiety Disorders and depression.

Note: See fact sheet 02 for more information on the physical and mental consequences of FGM.

3. Overview of FGM

Efforts to counteract FGM, through research, work within communities, and changes in public policy continues. Progress at both international and local levels includes:

- In most countries, the prevalence of FGM has decreased, and an increasing number of women and men in practising communities support ending its practice.

- Wider international involvement to stop FGM[3]

- International monitoring bodies and resolutions that condemn the practice

- Revised legal frameworks and growing political support to end FGM (this includes a law against FGM in 24 African countries, and in several states in two other countries, as well as 12 industrialised countries with migrant populations from FGM practicing countries)

Research shows that, if practicing communities themselves decide to abandon FGM, the practice can be eliminated very rapidly.

Note: See fact sheet 03 for Statement Opposing Female Genital Mutilation

4. Legal Framework

The law in England and Wales includes this key national guidance:

- Multi-agency statutory guidance on female genital mutilation, HM 2020
- Keeping children safe in education statutory guidance for schools and colleges (2020)
- Working Together to Safeguard Children (2018)
- Multi-agency statutory guidance on FGM published by HM Government. (April 2016)
- Female Genital Mutilation risk and safeguarding: Guidance for Professionals. Department of Health (2015)
- Serious Crime Act 2015
- Female genital mutilation prevention programme. Department of Health, September 2015.

[3] World Health Organisation, United Nations and UNICEF

- Female Genital Mutilation: multi-agency practice guidance (2014).
- Protecting Children and young people: the responsibilities of all doctors (2012)
- Multi-Agency Practice Guidelines: Female Genital Mutilation (2011)
- Female Genital Mutilation: Caring for patients and safeguarding children (2011)

- Safeguarding Children and Young People: A Toolkit for General Practice (2011)
  https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/child-safeguarding-toolkit.aspx

- Female Genital Mutilation and its Management (2009)
- Royal College of Nursing Female genital mutilation (2006)
- Female Genital Mutilation Act 2003
- Prohibition of the Female Circumcision Act 1985

4.1 Legislation on FGM

4.1.1 Prohibition of Female Circumcision Act 1985

Female Genital Mutilation (FGM) has been a specific criminal offence since 1985, with the introduction of the Prohibition of Female Circumcision Act 1985. However, a 'loophole' was identified in the legislation, in that taking girls who were settled in the UK abroad for FGM was not a criminal offence. It is this 'loophole' that the Female Genital Mutilation Act 2003 intended to close.

4.1.2 Female Genital Mutilation Act 2003

The Act was brought into force on 3 March 2004 by the Female Genital Mutilation Act 2003 (Commencement) Order 2004. The provisions of the Act only apply to offences committed on or after the date of commencement.

For offences committed before 3 March 2004 the Prohibition of Female Circumcision 1985, as re-enacted in the Female Genital Mutilation Act 2003 (“The Act”), continues to apply.

The Act affirms that it is illegal for FGM to be performed, and that it is also an offence for UK nationals or permanent UK residents to carry out, or aid, abet, counsel or procure the carrying out of FGM abroad on a UK national or permanent UK resident, even in countries where the practice is legal.

4.1.3 Children Act 2004

The Act amended the Children Act 1989.

This Act's ultimate purpose is to make the UK better and safer for children of all ages. The purpose of the Act is to promote (co-ordination) between multiple official entities to improve the overall well-being of children. The 2004 Act also specifically provided for including and affecting disabled children.

4.1.4 Care Act 2015

The Care Act 2014, which came into effect from 1st April 2015, represents the most significant reform of care and support in more than 60 years, putting people and their carer's in control of their care and support.

Where a person involved in a Safeguarding Enquiry or Review needs help to understand and take part in the process, and to express their views, councils will now need to ensure that there is someone involved who can speak on the person's behalf.

4.1.5 Serious Crime Act 2015 and FGM Protection Orders

This legislation introduces mandatory reporting requirements for healthcare professionals, teachers and social care workers regarding FGM (see page 16 of this strategy for further detail).

Section 73 of this Act provides for FGM Protection Orders (FGMPO), to protect a girl who may be at risk of FGM or has had the procedure performed. A breach of an FGMPO is a criminal offense which carries up to five years imprisonment.

The court may make an FGMPO on application by the girl who is protected or a third party.

Under the new provisions an FGMPO might contain such prohibitions, restrictions or other requirements for the purposes of protecting a victim or potential victim of FGM. This could include, for example, provisions to surrender a person's passport or any other travel document; and not to enter into any arrangements, in the UK or abroad, for FGM to be performed on the person to be protected.

4.1.6 Offence of FGM[4]

[4] https://www.legislation.gov.uk/ukpga/2003/31/body/2015-05-03/data.xht?view=snippet&wrap=true

The Act refers to "girls", though it also applies to women. The Act contains the following offences, including an offence of performing the act of FGM on a UK national or permanent UK resident overseas. The offences are:

Section 1 - it is a criminal offence to excise, infibulate, or otherwise mutilate the whole or any part of a girl's labia majora, labia minora or clitoris;

Section 2 - a person is guilty of an offence if he aids, abets, counsels or procures a girl to excise, infibulate or otherwise mutilate the whole or any part of her own labia majora, labia minora or clitoris;

Section 3 - it is an offence for a person to aid, abets, counsel or procures the performance outside the UK of a relevant FGM operation;

Section 4 - extends the offences outlined in sections 1-3 to any act done outside the UK by a UK national or permanent UK resident, and where an offence is committed outside the UK, even in countries where the practice is legal, treats the offence as having been committed anywhere in England, Wales or Northern Ireland.

4.1.7 Defence

No offence is committed by an approved person who performs:

- a surgical operation on a girl which is necessary for her physical or mental health, or
- a surgical operation on a girl who is in any stage of labour, or has just given birth, for purposes connected with the labour or birth.

Nor is an offence committed by a registered midwife or a person undergoing a course of training with a view to becoming a registered medical practitioner or registered midwife, but only if the operation is on a girl who is in any stage of labour, or has just given birth, and is for purposes connected with the labour or birth.

This applies if the surgical operation is carried out in the UK or outside the UK, by persons exercising functions corresponding to those of a UK approved person.

Since FGM Act 2003, female genital piercing has been considered Type 4 mutilation and as such illegal. The 2003 Act allows for prosecution where piercing salon or parlours are used as venues to legitimise FGM. Additionally,

the law does not require consent for an offence of FGM to be committed so there is no relevance to "consensual piercing".

It does not follow that a vaginal piercing will automatically lead to a prosecution. The issue of consent and self-election for clitoris piercing will pose a challenge when determining whether it is in the public interest to prosecute such a case in accordance with the Code for Crown Prosecutors. In addition to this, as a matter of basic criminal law, a woman may consent to a trivial injury (like vaginal piercing)

4.2 FGM Prevention Programme

The FGM prevention programme backed by £1.4million is funded through the largest domestic funding package for FGM and is designed to improve the way in which the NHS tackles FGM and clarifies the role of health professionals, which is to care, protect and prevent.

The range of measures launched by the Department of Health in 2014 at the Girl Summit to tackle FGM includes[5]:

- £1.4m funding to launch the FGM prevention programme
- introduction of improved data collection across the NHS to help understand the prevalence of FGM in England
- improved training packages to enable frontline health workers to respond appropriately when treating or identifying FGM
- work to clarify the safeguarding role of health professionals

The programme of work focuses on prevention and care, with the ultimate aim to get an improved response to FGM from the health services.

5. Who is at risk?

5.1 International context

It is very difficult to know the full extent of the impact of the practice of FGM. The most recent statistics highlights the fact the FGM is a well-established practice and carried out mainly amongst specific populations in Africa, parts of

[5] https://www.gov.uk/government/news/new-fgm-measures-launched-to-care-protect-prevent

the Middle East and Asia (HM, 2020). The numbers of girls and women affected by FGM is unknown, but figures from UNICEF estimates that over 200 million girls and women worldwide have undergone FGM. Evidence suggests that this practice can be seen in other communities such as Colombia, India, and Saudi Arabia.

Most females affected live in 28 African countries, while some are from parts of the Middle East and Asia, with national FGM prevalence rates varying from as low as 1% to 90% or more.

The highest prevalence rates, of 90% or more, is found in Somalia, Djibouti, Guinea and Sierra Leone, where the age group finds little difference in trends in prevalence.

In the UNICEF Survey, FGM was conducted on girls under the age of five years of age in half of the countries surveyed. In the rest of the countries, FGM was performed on girls between the ages of 5 to 14 years.

Note: See appendix 01 for map of countries where FGM is practiced

5.2 Prevalence at a National Level

Due to an increase in international migration, the practice of FGM has spread too many other countries including the UK and other parts of Europe, which host migrants from countries with high FGM prevalence. Consequently, some of those affected by FGM may be British citizens born to parents from FGM practising communities or girls resident in the UK who were born in countries that practice FGM and may include immigrants, refugees, asylum seekers, overseas students or the wives of overseas students.

An estimated 103,000 women aged 15-49 who have suffered/undergone FGM born in practising countries were living in England and Wales in 2011, compared with the estimated 66,000 in 2001. In addition, there were an estimated 24,000 women aged 50 and over with FGM born in FGM practising countries and nearly 10,000 girls aged 0-14 born in FGM practising countries who have undergone or are likely to undergo FGM. Combining the figures for the three age groups, an estimated 137,000 women and girls with FGM, born in countries where FGM is practised, were permanently resident in England and Wales in 2011.

The Female Genital Mutilation Prevalence Dataset (ISB 1610) reported a total of 578 girls were treated for female genital mutilation in England in March 2015 and the latest figures, from the Health and Social Care Information Centre, bring

the total of identified cases to 3,963 since data began to be collected on FGM in September 2014. This represents an average of 566 per month.

5.3 Prevalence at a Local Level

It is crucial to understand the dataset for the HIPS area, as this will help to understand the needs of the population affected by FGM. NHS Digital reports on a quarterly basis on patients treated in the NHS who are highlighted as having undergone FGM. This dataset is broken down by regions, which can be accessed via the link below:

https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/january-to-march-2019

6. Local guiding principles

This HIPS FGM guidance updates the FGM 2016/19 guidance. Whilst there are differences in the demographic makeup of the HIPS area, the development of this FGM strategy aims to ensure a strategy that is proportionate and adapted to the specific criteria of FGM related issues in each area:

There is a risk of stigmatising whole communities. This could be counterproductive and scare women away from services. For example, whilst there is a recognised prevalence of FGM in Somalia the picture varies greatly across the country with villages often only a few miles apart practising or not practising FGM.

Professionals will need to understand the difference between originating from a country and being part of a specific community within that country which practices FGM.

Partners have decided to place an emphasis on using and building on already existing Safeguarding frameworks and pathways rather than setting up new procedures. Partners also agree accurate data is essential in understanding, then planning for effective FGM prevention, interventions and support modalities.

Note: The Home Office has launched free online training for frontline professionals in identifying and helping girls at risk of FGM: www.fgmelearning.co.uk/.

7. The Role of the HIPS Safeguarding Children's Partnership and Adults Safeguarding Boards

FGM is abuse and a form of violence against women and girls, and therefore should be dealt with as part of existing child and adult safeguarding/protection structures, policies and procedures.

Professionals and volunteers in most agencies across England have little or no experience of dealing with FGM. Coming across FGM for the first time can leave practitioners feeling shocked, upset, helpless and unsure of how to respond appropriately to ensure that a child, and/or a mother, is protected from harm or further harm.

HIPS Safeguarding Children Partnership's duties and responsibilities include promoting activity amongst local agencies and in the community to:

- Identify and prevent maltreatment or impairment of health or development, and ensure children are growing up in circumstances consistent with safe and effective care

- Safeguard and promote the welfare of groups of children who are potentially more vulnerable than the general population

- Increase understanding of safeguarding children issues in the professional and wider community, promoting the message that safeguarding is everybody's responsibility

The role of the safeguarding children partnerships and adults board will be central in leading the changes needed to ensure the HIPS response to the challenge of FGM is effective, timely and appropriate. This will include integrating FGM as part of existing safeguarding procedures, developing and implementing training to all relevant staff (in partnership with Public Health) and regularly reviewing the effectiveness of its procedures.

Partners will need to agree evaluation criteria for the success of the strategy. Whilst the overall outcome will be the eradication of FGM for the HIPS areas a series of measurable outputs leading to this outcome should be clearly set out. These could include (but not be restricted to):

- An increase in numbers of FGM cases identified by relevant agencies

- An increase in successful prosecutions for perpetrators of FGM

- A measurable increase in awareness of FGM related issues and of the procedures, pathways, mandatory reporting and resources available to tackle it.

- Improved data collection and data sharing leading to increased knowledge of the local picture

Note: See flow charts and risk assessment tools in section 6

8. The role of the local law enforcement agencies

FGM has been illegal in the UK since 1985, with the law being strengthened in 2003 to prevent children travelling from the UK to undergo FGM abroad. In February 2019, a 37-year old woman was found guilty of performing FGM on her 3-year-old daughter and was sentenced in March to 13 years in prison.

"Working Together to Safeguard Children (DFE, 2018) states that a local authority may exercise its powers under section 47 of the Children Act 1989 if it has reason to believe that a child is likely to suffer or has suffered FGM. Professionals working with children can apply for a "Protection Order".

https://www.gov.uk/female-genital-mutilation-protection-order

The Serious Crime Act 2015 received Royal Assent on 3 March 2015. This legislation introduces mandatory reporting requirements for health professionals and others regarding FGM. Persons working in "regulated professions" (healthcare professionals, teachers and social care workers) will now be required to notify the police if they discover in the course of their work that an act of FGM appears to have been carried out on a girl less than 18 years of age.

This mandatory duty must be completed by the professional who has identified that FGM has taken place within 30 days of identification and cannot be delegated to another professional. Failure to comply with this duty may lead to action by the professional's regulatory body.

To report an act of FGM in a girl under 18 to the police under the Serious Crime Act call 101

In 2015 a risk assessment was developed by the task and finish group established by the HIPS FGM task and finish group. This document is likely to

be used mainly by Health but is also be appropriate for schools[6] or colleges and any other community workers who may have responsibility for safeguarding or come across this in their line of work.

Girls and women identified as high risk will be referred to Children's Services using this tool. Those identified as low risk may not require input currently, but this risk could fluctuate with time. It is important that a low risk assessment is shared as a concern with Children's Services, under section 10 of the Children Act. This will require discussion with the parents and their consent.

Please see the flowcharts and risk assessment tool in section 6 of this strategy

Identification and Interventions

No single agency can adequately meet the multiple needs of someone affected by FGM. In 2011, the government launched multi-agency practice guidelines for front-line professionals such as teachers, GPs, nurses and police. These guidelines set out multi-agency responses and strategies to encourage agencies to cooperate and work together.

The guidelines aim to provide advice and support to frontline professionals who have responsibilities to safeguard children and protect and support adults from the abuses associated with FGM. The guidelines provide information on:

- Identifying when a girl (including an unborn girl) or woman may be at risk of FGM and responding appropriately to protect them.

- Identifying when a girl or woman has experienced FGM and responding appropriately to support them

9. Where a child is suspected to be at risk of FGM

Under section 47 of the Children Act 1989, anyone who has information that a child is potentially or actually at risk of significant harm is required to inform Children Social Care or the police.

Professionals must always respond by informing Children Social Services or the Police. As such professionals in all agencies, and individuals and groups in relevant communities, need to be alert to the possibility of a girl being at risk of FGM, or already having suffered FGM.

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6 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/912592/Keeping_children_safe_in_education_Sep_2020.pdf

The Multi Agency Safeguarding Hub (MASH) provides triage and multi-agency assessment of safeguarding concerns in respect of vulnerable children and adults. It brings together professionals from a range of agencies into a multi-agency team. The MASH team makes assessments and decisions depending on statutory need, child protection or early help. Quicker response times, a co-ordinated approach and better-informed decision making ensures that vulnerable children and adults are protected.

There are a range of potential indicators that a child or young person may be at risk of FGM, which individually may not indicate risk but if there are two or more indicators present this could signal a risk to the child or young person. As described in section 2 of this strategy, victims of FGM are likely to come from a community that is known to practise FGM.

Professionals should note that girls at risk of FGM may not yet be aware of the practice or that it may be conducted on them, so sensitivity should always be shown when approaching the subject.

Staff should activate local safeguarding procedures, using existing national and local protocols for multi-agency liaison with police and children's social care.

See fact sheet 04 for warning signs that FGM may be about to take place.

See fact sheet 05 for guidance in talking about FGM

10. Where a child or a woman has been abused through FGM

It is important that professionals remain vigilant for signs that FGM has already taken place so that:

- The girl or woman affected can be supported to deal with the consequences of FGM.
- Enquiries can be made about other female family members who may need to be safeguarded from harm.
- Education should be provided to inform families that FGM is illegal in the UK.
- Criminal investigations into the perpetrators, including those who carry out the procedure, can be considered to prosecute those breaking the law and to protect others from harm.

It is important to make the distinction between adults and children when considering reporting FGM. In regard to children, FGM is child abuse and should be dealt with as such as detailed in the HIPS Child Protection procedure.

The General Medical Council (GMC) has issued guidance[7] on child protection examinations. Consent or other legal authorisation is required to carry out any child protection examination, including a psychiatric or psychological assessment. The GMC guidance also outlines the steps to take when consent to examination is not given.

In cases of FGM abuse in women it is important to note that, as with domestic violence and rape, if an adult woman has had FGM and this is identified through the delivery of NHS healthcare, the patient's right to patient confidentiality MUST be respected if they do not wish any action to be taken.

However safeguarding needs of other women and children need to be considered and education that the practice of FGM is illegal in this country should be provided.

The guidance within the HIPS unborn baby protocol should be followed for unborn babies at risk of FGM[8].

See fact sheet 06: Indications that FGM may have already taken place.

See Fact sheet 07: Appropriate professional responses to FGM.

See Fact sheet 08: Current requirements on NHS staff in reporting FGM.

See Fact sheet 09: Procedure for reporting FGM concerns to social services or the police

11. Where a prospective mother has undergone FGM

Health professionals in GP surgeries, sexual health clinics and maternity services are the most likely to encounter a girl or woman who has been subjected to FGM.

Where FGM is identified in NHS patients, it is now mandatory to record this in the patient's health record. Since September 2014, all acute trusts are required to provide a monthly report to the Department of Health on the number of patients who have undergone FGM or who have a family history of FGM.

[7]See: http://www.gmc-uk.org/news/13578.asp

[8] https://hipsprocedures.org.uk/qkyyoh/children-in-specific-circumstances/unborn-baby-safeguarding-protocol

A risk assessment should be completed to assess the need for safeguarding procedures for the mother and her children. A record of FGM needs to be included in the mother's antenatal notes, discharge summary and new-borns red book.

At the antenatal booking appointment, the holistic assessment may identify women who have undergone FGM. The plan should be an extension of NICE guidelines[9] that midwives are already familiar with including history taking, offering individual care and being culturally sensitive.

12. Data reporting and information management

Female Genital Mutilation D*ataset*

The Female Genital Mutilation Enhanced Dataset began collecting data on 1 April 2015. The Dataset builds on the Female Genital Mutilation Prevalence Dataset, which finished collecting data on 10 April 2015[10].

The FGM Enhanced Dataset contains more data items than the Prevalence Dataset, including some patient identifiable demographic data, and is extending the collection to include mental health trusts and GP practices[11].

Health and Social Care Information Centre (HSCIC) is collecting data on FGM within England on behalf of the Department of Health (DH) and NHS England (NHSE). This is to support the DH and NHSE FGM Prevention Programme. The data is collected to improve the NHS response to FGM and to help commission the services to support women who have experienced FGM as well as safeguarding women and girls at risk of FGM.

What does it measure?

The FGM Enhanced Information Standard (SCCI2026) instructs all clinicians to record into clinical notes when a patient with FGM is identified, and what type it is.

Whenever FGM is identified, not just the first time, and however FGM is identified, whether through clinical examination or self-reported by the woman

[9] See https://www.nice.org.uk/guidance/cg62/chapter/guidance
[10] To read more about the FGM Prevalence Dataset Information Standard, visit the archived Information Standards Board website: http://webarchive.nationalarchives.gov.uk/+/http://www.isb.nhs.uk/documents/isb-1610
[11] To read the Implementation Guidance and Specification visit the SCCI website: http://www.hscic.gov.uk/isce/publication/scci2026

or girl, it should be recorded on the clinical notes and submitted to the data collection. There is a system in place that prevents duplication.

The dataset includes patient demographic data, specific FGM information, referral, and treatment information[12]. The FGM Datasets use the World Health Organisation's (WHO) definitions for the four types of FGM described in section 01 of this strategy.

See factsheet 10 for more information about the FGM Enhanced Dataset

13. Information sharing

Professionals in all agencies need to be confident and competent in sharing information appropriately both to safeguard children from being abused through FGM and to enable children and women who have been abused through FGM to receive physical and emotional and psychological help.

Guidance regarding information sharing for practitioners making decisions about sharing personal information can be found on the following web link:

- Information Sharing – Advice for practitioners providing safeguarding services to children, young people, parents and carers (HM GOV)
- https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice
- https://hipsprocedures.org.uk/skyytq/safeguarding-partnerships-and-organisational-responsibilities/information-sharing/#s3827

14. Female Genital Mutilation – Information Sharing (FGM-IS)

The FGM-IS[13] is a national IT system that helps frontline staff to ensure early intervention and continuous safeguard of girls that are under the age of 18

[12] To see the full dataset visit: http://www.hscic.gov.uk/media/16753/FGM-Enhanced-Dataset/xls/FGM_Enhanced_Dataset_v1.0.xls

[13] https://digital.nhs.uk/services/female-genital-mutilation-information-sharing

years. All the maternity services within the HIPS area have this system implemented.

PROCEDURES FOR FRONTLINE STAFF

Please follow the safeguarding children and adults' processes within the HIPS area. For additional information, please see flow charts and risk assessment below. The link below can be used to access the NHS England flowchart for under 18-year olds.

FGM Mandatory reporting


FGM <18 years

- FGM mandatory reporting flowchart for <18 years


FGM ≥ 18 years.docx

- FGM reporting flowchart for ≥ 18 years


RISK_ASSESSMENT_ FOR_FGM

- FGM risk assessment tool

ASSESSMENT FOR FEMALE GENITAL MUTILATION/CUTTING

This checklist includes factors/indicators that can suggest an increased risk of FGM being performed. This checklist is not exhaustive and **professional judgement** is needed to fully assess the risk to the individual child. Consideration should be given to the suitability of completing this form with the parents and not just the mother/ Female carer.

Please explain that the purpose of asking these questions is for the safety and protection of the individual concerned. **Tick if the factor is present, comments can be added below.** **If the information is provided by a third party, please indicate source in right hand column.**		**Yes**	**Suspected**	**No**	Third party Source (clarify)
Score as HIGH RISK if answering 'YES' to any questions 1- 10 **Submit this risk assessment with a child protection (s47) referral to Children's Services**					
1.	Has the child disclosed that she has had FGM? Comments:				
2.	Has the child got symptoms which appear to show that she has had FGM? (do not examine genitalia if this is out of your professional remit)				
3.	Has the child disclosed that they are afraid of FGM/C or made a non-specific request for help due to concerns regarding personal safety, shame, or dishonour to the family?				
4.	Has the child disclosed that they are having a special occasion, such as where they are going to 'become a woman'?				
5.	Has the child or family member informed someone that FGM/C is to be performed soon?				
6.	Is a family member/friend expressing concern that FGM/C may be performed when the child is born?				
7.	Have the child's siblings or close female minor relatives had FGM/C performed? How is this known and when was it performed? Comment:				
8.	Has deinfibulation/reinfibulation been performed or requested?				
9.	Does the mother or father have strong familial ties to a community where FGM/C is practised and are feeling pressurised by the family or community for FGM/C to be performed?				
10.	Have arrangements been made for the child to travel to a high-risk country where FGM/C is performed? (When, where, flight booked, any other details) Comment:				

	Score as MEDIUM RISK if answering 'YES' to any questions 11-14	**Yes**	**Suspected**	**No**	Third party Source (clarify)
11.	Has the mother or other significant female adult been subject to FGM/C? How is this known? (Who, when & what age?) Comment:				
12.	Is an older female relative visiting from a country or community when FGM/C is commonly practised?				
13.	Have other family members been forced to marry or reported missing? (Name, relationship, age, when & where?) Comment:				
14.	Has the child had behaviour change (anxious, withdrawn, depressed mood) at school prior to a school holiday or known travel?				
	Score as STANDARD RISK if answering 'YES' to any questions 15-25	**Yes**	**Suspected**	**No**	Third party Source (clarify)
15.	Has the mother cancelled/not attended her own visits/appointments with a health professional on more than one occasion?				
16.	Has the child not been brought to visits/ appointments with a health professional on more than one occasion?				
17.	Is the mother or father originally from a high-risk country where FGM/C is performed?				
18.	Do the parents avoid removing nappies etc. during health appointments/visits? (when appropriate to do so)				
19.	Has the child been presented to primary care with vague non-specific symptoms, obvious symptoms or anxiety?				
20.	Has the child attempted to run away from home?				
21.	Has the child been missing or reported missing?				
22.	Has the child self- harmed or attempted suicide?				
23.	Has the child been withdrawn from PSHE or PSE lessons?				
24.	Does the mother/female carer feel safe and empowered to make decisions regarding the children?				

25.	Are there any other risks or vulnerabilities that need addressing? Comment:				

Comments, professional judgement/family views

(For example does the mother understand/speak English, do the family socialise outside their own community or access non-essential services in the mainstream community)

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RISK ASSESSMENT - OVERALL ASSESSMENT OF RISK OF FGM

When assessing the risk answers from the checklist should be considered alongside your professional judgement as this checklist is not exhaustive and may not cover the individual indicators of risk for the individual.

HIGH ☐ **Immediate child protection (s47) referral**

MEDIUM ☐ **Referral to children's services for multi-professional safeguarding care planning**

STANDARD ☐ **Routine health checks and monitoring as per NICE Guidance. Request consent to share information with Children's Services.**

Remember - FGM Mandatory reporting duty

You must phone the police on 101 if a girl under 18:

a) Tells you she has had FGM

b) Has signs which appear to show she has had FGM

The professional who identifies FGM must report it as soon as possible. **This is your personal legal duty**.

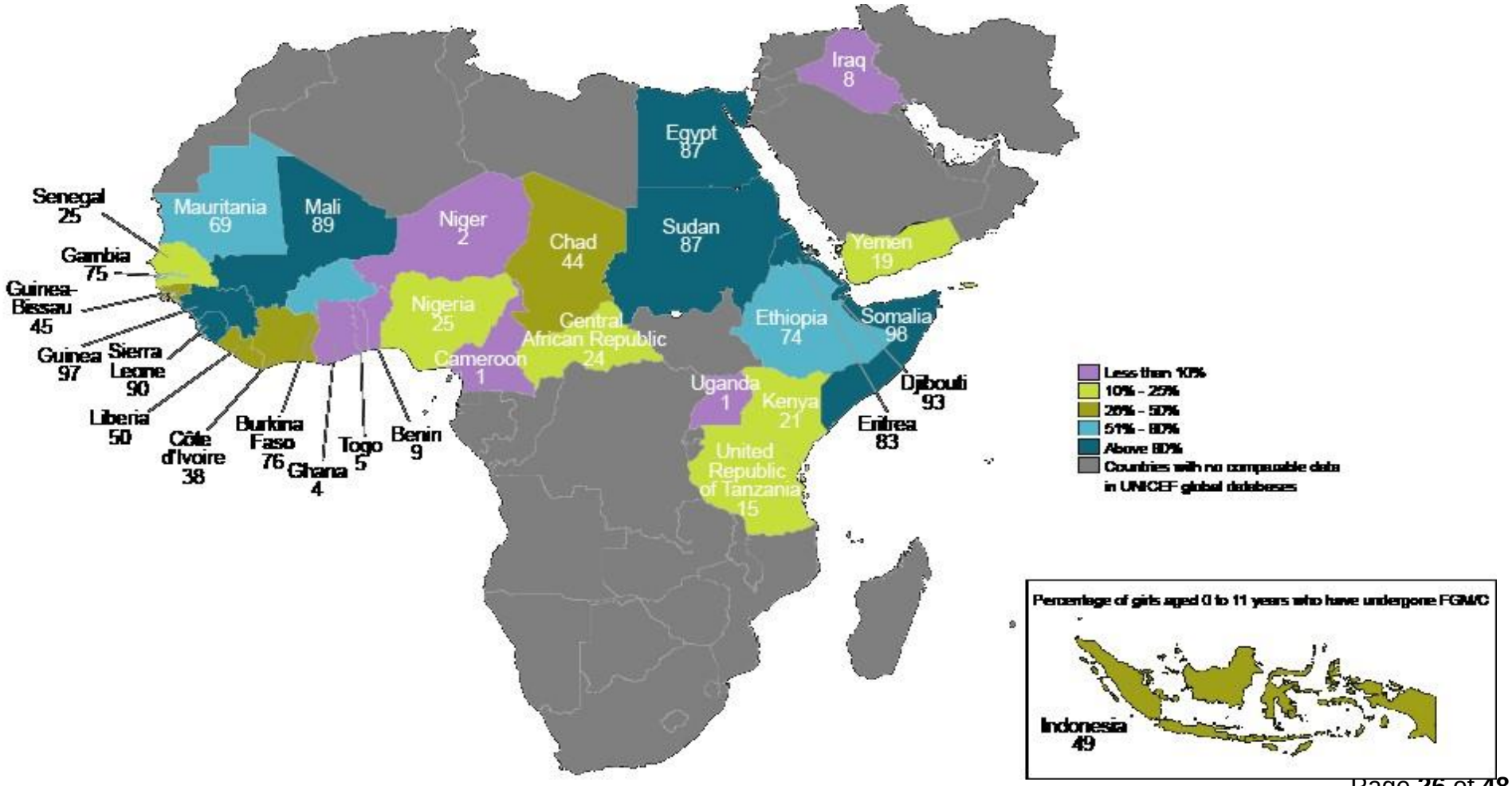
NEXT STEPS FOR ALL PROFESSIONALS

Please tick to indicate that you have provided the following information to the children & parent/carer

Informed that FGM is illegal in the UK	
Informed about the health consequences of FGM	
Advised where to access community support services	
Informed the GP or other relevant health care professionals such as HV or School Nurse	

Name of Professional	
Date	
Agency address & telephone number	
Discussed concerns with	
Date & time of discussion	

Figure 1: Percentage of girls and women aged 15-49 who have undergone FGM in Africa, the Middle East, and Indonesia



Notes: In Liberia, girls and women who have heard of the Sande society were asked whether they were members; this provides indirect information on FGM since it is performed during initiation into the society. Data for Indonesia refer to girls aged 0 to 11 years since prevalence data on FGM among girls and women aged 15 to 49 years is not available. **Source:** UNICEF global databases, 2016, based on DHS, MICS and other nationally representative surveys,
2004-2015. Map disclaimer

14

Percentage of girls and women aged 15-49 who have undergone FGM in Africa, the Middle East, and Indonesia

Africa

Benin – 9%

Burkina Faso – 76%

Cameroon – 1%

Central African Republic – 24%

Chad – 44%

Côte d'Ivoire – 38%

Djibouti – 93%

Egypt – 87%

Eritrea – 83%

Ethiopia – 74%

Gambia – 75%

Ghana – 4 %

Guinea – 97%

Guinea-Bissau – 45%

Kenya – 21%

Liberia – 50%

Mali – 89%

Mauritania – 69%

[14] https://www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation

Niger – 2%

Nigeria – 25%

Senegal – 25%

Sierra Leone – 90%

Somalia – 98%

Sudan – 87%

Togo – 5%

Uganda – 1%

United Republic of Tanzania – 15%

Middle East

Iraq – 8%

Yemen – 19%

Asia

Indonesia – 49%

(Source of data- https://www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation)

FACT SHEETS

Fact sheet 01: Cultural, religious and social causes of FGM
Fact sheet 02: Physical and mental consequences of FGM
Fact sheet 03: Statement Opposing Female Genital Mutilation
Fact sheet 04: Warning signs that FGM may be about to take place
Fact sheet 05: Guidance in talking about FGM
Fact sheet 06: Indication that FGM may have already taken place
Fact sheet 07: Appropriate professional responses to FGM
Fact sheet 08: Current requirements on NHS staff in reporting FGM
Fact sheet 09: Reporting FGM concerns to social services or the police
Fact sheet 10: FGM Enhanced Dataset

Fact sheet 01: Cultural, religious and social causes of FGM

The causes of female genital mutilation include a mix of cultural, religious and social factors within families and communities.

- Where FGM is a social convention, the social pressure to conform to what others do and have been doing is a strong motivation to perpetuate the practice.

- FGM is often considered a necessary part of raising a girl properly, and a way to prepare her for adulthood and marriage.

- FGM is often motivated by beliefs about what is considered proper sexual behaviour, linking procedures to premarital virginity and marital fidelity. FGM is in many communities believed to reduce a woman's libido and therefore believed to help her resist "illicit" sexual acts. When a vaginal opening is covered or narrowed (type 3 above), the fear of the pain of opening it, and the fear that this will be found out, is expected to further discourage "illicit" sexual intercourse among women with this type of FGM.

- FGM is associated with cultural ideals of femininity and modesty, which include the notion that girls are “clean” and "beautiful" after removal of body parts that are considered "male" or "unclean".

- Though no religious scripts prescribe the practice, practitioners often believe the practice has religious support.

- Religious leaders take varying positions regarding FGM: some promote it, some consider it irrelevant to religion, and others contribute to its elimination.

- Local structures of power and authority, such as community leaders, religious leaders, circumcisers, and even some medical personnel can contribute to upholding the practice.

- In most societies, FGM is considered a cultural tradition, which is often used as an argument for its continuation.

- In some societies, recent adoption of the practice is linked to copying the traditions of neighbouring groups. Sometimes it has started as part of a wider religious or traditional revival movement.

- In some societies, FGM is practised by new groups when they move into areas where the local population practice FGM.

Fact sheet 02: Physical and Mental Consequences of FGM

A. Physical consequences

Immediate consequences of FGM include severe pain and bleeding, shock, difficulty in passing urine, infections, injury to nearby genital tissue and sometimes death. The procedure can result in death through severe bleeding leading to haemorrhagic shock, neurogenic shock as a result of pain and trauma, and overwhelming infection and septicaemia, according to Manfred Nowak, UN Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.

Almost all women who have undergone FGM experience pain and bleeding as a consequence of the procedure. The event itself is traumatic as girls are held down during the procedure. Risk and complications increase with the type of FGM and are more severe and prevalent with infibulations.

“The pain inflicted by FGM does not stop with the initial procedure, but often continues as ongoing torture throughout a woman’s life”, says Manfred Nowak, UN Special Rapporteur on Torture.

In addition to the severe pain during and in the weeks following the cutting, women who have undergone FGM experience various long-term effects - physical, sexual and psychological.

Women may experience chronic pain, chronic pelvic infections, development of cysts, abscesses and genital ulcers, excessive scar tissue formation, infection of the reproductive system, decreased sexual enjoyment and psychological consequences, such as post-traumatic stress disorder.

Additional risks for complications from infibulations include urinary and menstrual problems, infertility, later surgery (defibulation and reinfibulation) and painful sexual intercourse. Sexual intercourse can only take place after opening the infibulation, through surgery or penetrative sexual intercourse. Consequently, sexual intercourse is frequently painful during the first weeks after sexual initiation and the male partner can also experience pain and complications.

When giving birth, the scar tissue might tear, or the opening needs to be cut to allow the baby to come out. After childbirth, women from some ethnic communities are often sewn up again to make them “tight” for their husband (reinfibulation). Such cutting and re-stitching of a woman’s genitalia results in painful scar tissue.

A multi-country study by WHO in six African countries, showed that women who had undergone FGM, had significantly increased risks for adverse events

during childbirth, and that genital mutilation in mothers has negative effects on their newborn babies. According to the study, an additional one to two babies per 100 deliveries die as a result of FGM.

B. Mental health consequences

Of all aspects of FGM, the psychological or the emotional aspect is a less known area. Toubia (1993) cites three psychological cases: “anxiety state” originating from lack of sleep and hallucinations; “reaction depression” from delayed healing, and “psychotic excitement” from childlessness and divorce. Other problems include traumatic experience, sense of being betrayed by family members, elders, and joining peer groups by force through the FGM operation[15].

For many girls and women, undergoing FGM is a traumatic experience that has been found to have lasting psychological consequences. Women who have been subjected to FGM suffer emotional disorders, such as anxiety, somatisation, and low self-esteem, and are at greater risk of a mental illness[16].

C. Social consequences

While there are few rigorous studies on the social impact of FGM, some research has identified the potential negative consequences for families, girls and women of refraining from FGM. The practice is performed in response to strong social conventions and supported by key social norms; thus, failure to conform often results in harassment and, exclusion from important communal events and support networks, as well as discrimination by peers. Unless there is a joint agreement within a larger group, individuals and families are likely to consider the social risks to be greater than the physical and mental health risks to girls of FGM. Even legal restrictions against FGM may be seen as less important than the restrictions that can be imposed by the community for non-compliance with the practice[17].

D. Economic costs

[15] African Women : Consequences of FGM (2009) Accessed on 05/06/2015 via: http://www.african-women.org/FGM/consequences.php

[16] **The psychological impact of Female Genital Mutilation/Cutting (FGM/C) on girls/women’s mental health: a narrative literature review (2014). Accessed on 05/06/2015 via: http://www.researchgate.net/publication/267641373_The_psychological_impact_of_Female_Genital_MutilationCutting_%28FGMC%29_on_girlswomens_mental_health_a_narrative_literature_review**
https://www.researchgate.net/publication/267641373

[17] WHO (2012) *Understanding and Addressing Violence Against Women* Accessed on 05 June 2015 via: http://apps.who.int/iris/bitstream/10665/77428/1/WHO_RHR_12.41_eng.pdf

FGM is a potential financial burden to health systems. A study based on data from six African countries found that costs associated with the medical management of obstetric complications resulting from FGM were equivalent to 0.1–1% of total government spending on women of reproductive age. The cost to families is largely unknown; a study from Nigeria estimated the cost of treating post-FGM complications in a paediatric clinic to be US$120 per girl. A recent study from the Gambia found that one out of three gynaecological complications women sought help for was the direct result of FGM. In many cases, surgery was required, indicating that FGM complications are a significant cost for gynaecology services.

Additional Resources:

Health complications of female genital mutilation

http://www.who.int/reproductivehealth/topics/fgm/health_consequences_fgm/en/

Female genital mutilation: an injury, physical and mental harm

http://www.fertilitycenterberlin.de/images/PDF/publikationen/Female%20genital%20mutilation.pdf

An alternative cannot be found for this

Female genital mutilation and obstetric outcome

http://www.who.int/reproductivehealth/publications/fgm/fgm-obstetric-study-en.pdf?ua=1

Mental Health consequences of female genital mutilation

http://www.who.int/reproductivehealth/topics/fgm/mental_problems_and_fg

Fact sheet 03: Statement Opposing Female Genital Mutilation

In 2012 the Government published a 'Statement Opposing Female Genital Mutilation' leaflet, commonly referred to as the "Health Passport". This pocket-sized document sets out the law and the potential criminal penalties that can be used against those allowing FGM to take place.

It is designed to be discreetly carried in a purse, wallet or passport. It can be used by families who have immigrated to the UK and do not want their children to be subjected to FGM, but still feel compelled by cultural and social norms when visiting family abroad.

It has been supported and signed by Ministers from the Home Office, Department of Health, Ministry of Justice, Department for Education and the Director of Public Prosecutions (DPP).

Organisations should consider routinely offering this leaflet to patients when discussing FGM.

From June 2015 copies can be obtained from the Department of Health order line: www.orderline.dh.gov.uk. Until then, copies can be requested from the Home Office by emailing FGMEnquiries@homeoffice.gsi.gov.uk.

Additional resources

Information about the government's strategy to eradicate violence against women and girls can be found at www.gov.uk/government/policies/ending-violence-against-women-andgirls-in-the-uk

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/783596/VAWG_Strategy_Refresh_Web_Accessible.pdf

To view some examples of effective practice in tackling FGM, please visit: https://www.gov.uk/government/publications/female-genital-mutilation-resource-pack

Fact Sheet 04: Warning signs that FGM may be about to take place[18]

The age at which girls undergo FGM varies enormously according to the community. The procedure may be carried out when the girl is new-born, during childhood or adolescence, at marriage or during the first pregnancy. However, most cases of FGM are thought to take place between the ages of 5 and 8 and therefore girls within that age bracket are at a higher risk.

It is believed that FGM happens to British girls in the UK as well as overseas (often in the family's country of origin). Girls of school age who are subjected to FGM overseas are thought to be taken abroad at the start of the school holidays, particularly in the summer holidays, in order for there to be sufficient time for her to recover before returning to her studies.

There can also be clearer signs when FGM is imminent:

It may be possible that families will practise FGM in the UK when a female family elder is around, particularly when she is visiting from a country of origin.

A professional may hear reference to FGM in conversation, for example a girl may tell other children about it.

A girl may confide that she is to have a 'special procedure' or to attend a special occasion to 'become a woman'.

A girl may request help from a teacher or another adult if she is aware or suspects that she is at immediate risk.

Parents state that they or a relative will take the child out of the country for a prolonged period.

A girl may talk about a long holiday to her country of origin or another country where the practice is prevalent

Parents seeking to withdraw their children from learning about FGM.

Organisations should also ensure that professionals are aware of the NSPCC FGM helpline, **0800 028 3550**. This is helpline can support both professionals or family members concerned that a child is at risk of or has had FGM.

[18] See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/380125/MultiAgencyPracticeGuidelinesNov14.pdf

Fact sheet 05: Guidance in talking about FGM

1. Generic guidance in case of Safeguarding concerns about an adult[19]

Try to speak to the person about what you have noticed, being as open and honest as possible. Give the person the opportunity to talk and listen carefully to what they tell you, offering to seek help if that is appropriate.

Some people may want to talk but may be worried about how you might react, so it is important to stay calm if they begin telling you that they have been abused. Some people may ask you to promise not to tell anyone else about the abuse. Whether you are a practitioner, friend or relative, you should always be honest and never make false promises sometimes the abuse might affect more than one person and you will have a responsibility to other people too.

You must remember that the person is an adult, and should never be treated like a child; even if they appear confused and disoriented (he or she can still react to what you are saying and how you say it). Try not to take over or be over-protective and remember that you should not lead someone into saying something. Try to balance the need of the person to be heard with the need to ensure you do not prejudice future action, such as a police or disciplinary investigation.

If it is appropriate, try to explain simply who might be able to help e.g. health or social care professionals (such as a GP), police, home carers, care-home employees, volunteers and advocates, etc. Perhaps offer to approach one of these on the person's behalf. Ask what they want you to do.

Remember that in some minority communities there is great stigma associated with abuse by family members and it is not always true that the person would prefer to talk to someone from their own community. This may in fact be the last thing that they want, so never seek to use a family friend, neighbour or similar as an interpreter instead seek such services from an organisation unknown to the person.

2. Specific guidance in talking about FGM[20]

Asking the right questions in a simple, straightforward and sensitive way is key to establishing the understanding, information exchange and relationship needed to plan for the girl/woman's wellbeing and the welfare and wellbeing of any daughters she may have, or girl children she may have access to.

If the girl/woman is from a community which traditionally practices FGM, information gathering should be approached sensitively. A question about FGM should be incorporated when the routine patient history is being taken. A female interpreter may be required. The interpreter should be appropriately trained in relation to FGM and must not be a family member.

A suitable form of words should be used, 'circumcised' is not medically correct and although 'mutilation' is the most appropriate term, it might not be understood or it may be offensive to a

[19] Adult Social Care: Keeping Adults Safe; Isle of Wight Council, Accessed on 22 July 2015 via: https://www.iwight.com/Residents/Care-and-Support/Adults-Services/Keeping-Adults-Safe/Concerned-about-an-Adult

[20] Extract from: Multi-Agency Practice Guidelines: Female Genital Mutilation (2011) Accessed on 7 may 2015 via: (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/380125/MultiAgencyPracticeGuidelinesNov14.pdf)

woman from a practising community who does not view FGM in that way. Different terminology will be culturally appropriate to the different cultures.

FGM is a complex and sensitive issue that requires professionals to approach the subject carefully.

A health professional may make an initial approach by asking a woman whether she has undergone FGM saying: 'I'm aware that in some communities women undergo some traditional operation in their genital area. Have you had FGM or have you been cut?'

To ask about infibulation health professionals can use the question: 'are you closed or open?' This may lead to the woman providing the terminology appropriate to her language/culture.

When talking about FGM, professionals should:

- ensure that a female professional is available to speak to if the girl or woman would prefer this.
- make no assumptions and give the individual time to talk and be willing to listen.
- create an opportunity for the individual to disclose, seeing the individual on their own in private.
- be sensitive to the intimate nature of the subject.
- be sensitive to the fact that the individual may be loyal to their parents.
- be non-judgemental (pointing out the illegality and health risks of the practice, but not blaming the girl or woman).
- get accurate information about the urgency of the situation if the individual is at risk of being subjected to the procedure.
- take detailed notes and record FGM in the patient's healthcare record, as well as details of any conversations.
- use simple language and ask straight forward questions such as:
    - "Have you been closed?"
    - "Were you circumcised?"
    - "Have you been cut down there?"
- be direct, as indirect questions can be confusing and may only serve to compound any underlying embarrassment or discomfort that you or the patient may have.
- If any confusion remains, ask leading questions such as:

    - "Do you experience any pains or difficulties during intercourse?"
    - "Do you have any problems passing urine?"
    - "How long does it take to pass urine?"
    - "Do you have any pelvic pain or menstrual difficulties?"
    - "Have you had any difficulties in childbirth?"

- give the message that the individual can come back to you at another time if they wish.
- give a very clear explanation that FGM is illegal and that the law can be used to help the family avoid FGM if/when they have daughters.
- offer support for example counselling, NHS FGM specialist clinics or literature such as "Statement Opposing FGM

If a woman or child is accompanied by a partner or parent/relative/guardian respectively, the health and social care professional must be vigilant and aware of the signs coercion and control as detailed by the Crown Prosecution Service in the Serious Crime Act 2015.

http://www.cps.gov.uk/publications/equality/domestic_violence.html
https://www.cps.gov.uk/publication/violence-against-women-and-girls

Safeguarding women and girls at risk of FGM

https://www.gov.uk/government/publications/safeguarding-women-and-girls-at-risk-of-fgm

This document provides practical help to support NHS organisations developing new safeguarding policies and procedures for female genital mutilation (FGM).

Fact Sheet 06: Indication that FGM may have already taken place[21]

- A child may spend long periods of time away from the classroom during the day with bladder or menstrual problems if she has undergone Type 3 FGM
- Noticeable behaviour changes on the girl's return could be an indication that a girl has recently undergone FGM
- Professionals also need to be vigilant to the emotional and psychological needs of children who may/are suffering the adverse consequence of the practice such as withdrawal, depression or distress
- A child may confide in a professional / ask for help
- A child requiring to be excused from physical exercise lessons without the support of her GP
- A girl or woman may have difficulty walking, sitting or standing and may even look uncomfortable.
- A girl or woman may spend longer than normal in the bathroom or toilet due to difficulties urinating. A girl may spend long periods of time away from a classroom during the day with bladder or menstrual problems.
- A girl or woman may have frequent urinary, menstrual or stomach problems.
- There may be prolonged or repeated absences from school or college.
- A prolonged absence from school or college with noticeable behaviour changes (e.g. withdrawal or depression) on the girl's return could be an indication that a girl has recently undergone FGM.
- A girl or woman may be particularly reluctant to undergo normal medical examinations.
- A girl or woman may confide in a professional.
- A girl or woman may ask for help but may not be explicit about the problem due to embarrassment or fear.
- A girl may talk about pain or discomfort between her legs.

[21] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/380125/MultiAgencyPracticeGuidelinesNov14.pdf

Fact sheet 07: Appropriate professional responses to FGM

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

- Arranging for an interpreter if this is necessary and appropriate
- Creating an opportunity for the child to disclose, seeing the child on their own
- Using simple language and asking straightforward questions
- Using terminology that the child will understand 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

Coventry University has designed a new app to educate young people about female genital mutilation. It is endorsed by the NSPCC: http://petals.coventry.ac.uk/

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

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

C. Appropriate response by professionals who encounter a prospective mother who has undergone FGM includes:

Health professionals in acute trusts should always update a patient record with whatever discussions or actions have been taken. If the patient has undergone FGM, referral to a specialist FGM clinic should always be considered. If you refer a patient to social services or the police, then this should also be recorded in the patient's health record. If a patient is identified as being at risk of FGM, then this information must be shared with the GP and health visitor, as part of safeguarding actions[22].

Women with FGM Type 3 require special care during pregnancy and childbirth, especially if it is first pregnancy or the woman has had a previous caesarean section or re-infibulation took place in the past. Early antenatal registration is important in providing midwives with the opportunity to plan for this. Women may not know which type of FGM they have undergone, it is therefore best practice to examine the woman during the booking. Unfortunately, many women only access services very late in their pregnancy.

Counselling

All girls/women who have undergone FGM (and their boyfriends/partners or husbands) must be told that re-infibulation is against the law and will not be done under any circumstances. Each woman should be offered counselling to address how things will be different for her afterwards.

Counselling sessions should be offered and arranged, taking into account that the woman may not want to make the arrangements about it when her boyfriend/partner or husband or other family members are present. Professionals should be aware that there may be coercion and control involved which may have repercussions for the girl/ woman. Boyfriends/partners and husbands should also be offered counselling, they are usually supportive when the reality is explained to them.

Health professionals should communicate equally the disadvantages of infibulation and the benefits of remaining open after childbirth. It:

- Is more hygienic.
- Means that sex will be much more comfortable and better once both partners get used to it.
- Will make future births much easier and less risky
- Increases the likelihood of conception
- Reduces the chances of neonatal death

Once women know all the facts and the benefits of remaining open most of them are happy to remain so. Health professionals should not, however assume that this means that the woman will be more able to resist the pressure from the community to subject any daughter/s she may have to FGM.

Additional resources

Information from the Department for Education about safeguarding children can be found at https://www.gov.uk/childrens-services/safeguarding-children

[22] Ibid 15

A Department of Health DVD about FGM can be also ordered by emailing fgm@dh.gsi.gov.uk

The FGM National Clinical Group has produced an educational DVD which clearly instructs and shows doctors, midwives and nurses how to undertake de-infibulation. This can be ordered from the group's website: www.fgmnationalgroup.org

An NHS Choices FGM page containing information and support for frontline professionals and members of the public who are concerned about the practice and are seeking advice. www.nhs.uk/fgm

NHS organisations and professionals can access an FGM e-learning programme on the eLearning for Healthcare website, www.e-lfh.org.uk, consisting of 5 sessions providing training on all aspects of FGM and standard care provision principles.

Professionals, civil society partners and members of the public can request copies of the government's leaflets, posters and latest DVD about FGM from: FGMEnquiries@homeoffice.gsi.gov.uk

The government's FGM unit can offer advice and support to local areas who would like to strengthen or develop their work on tackling FGM. To contact the FGM unit, please email: FGMEnquiries@homeoffice.gsi.gov.uk

More information on the role of the FGM unit can be found at: https://www.gov.uk/government/collections/female-genital-mutilation

Fact sheet 08: Current requirements on NHS staff in reporting FGM.

It is now mandatory to record FGM in a patient's healthcare record:

Following publication of the Data Standard on 2nd April 2014, it became mandatory for any NHS healthcare professional to record (write down) within a patient's clinical record if they identify through the delivery of healthcare services that a woman or girl has had FGM.

For Acute Trusts from September 2014, it became mandatory to collate and submit basic anonymised details about the number of patients treated who have had FGM to the Department of Health every month. The first report of this anonymised data, reporting on the data from September, was published on 16th October and is available on the Health and Social Care Information Centre website.

There is no requirement to ask every girl and woman whether they have had FGM. The requirement is to record FGM in a patient's healthcare record only if and when it is identified during the delivery of any NHS healthcare. Professionals are reminded to be aware of the risk factors, including country of origin (see multi-agency guidelines for list of countries), and to use their professional judgement to decide when to ask the patient if they have had FGM.

It remains best practice to share information between healthcare professionals to support the ongoing provision of care and efforts to safeguard women and girls against FGM. For example, after a woman has given birth, it is best practice to include information about her FGM status in the discharge summary record sent to the GP and Health Visitor, and to include that there is a family history of FGM within the Personal Child Health Record (PCHR), often called the 'red book'.

Fact sheet 09: Procedure for reporting FGM concerns to social services or the police

There has been confusion around when health professionals should refer girls and women with FGM to other agencies.

Children:

> FGM is child abuse. If any child (under-18s) or vulnerable adult in your care has symptoms or signs of FGM, or if you have good reason to suspect they are at risk of FGM having considered their family history or other relevant factors, they must be referred using standard existing safeguarding procedures, as with all other instances of child abuse.

This is initially often to the local Children's Services or the Multi-Agency Safeguarding Hub, though local arrangements may be in place. Additionally, when a patient is identified as being at risk of FGM, this information must be shared with the GP and health visitor as part of safeguarding actions (See section 47 of the 1989 Children Act).

Adults:

There is no requirement for automatic referral of adult women with FGM to adult social services or the police. Healthcare professionals should be aware that a disclosure may be the first time that a woman has discussed her FGM with anyone. Referral to the police must not be introduced as an automatic response when identifying adult women with FGM, and each case must continue to be individually assessed.

In case of a vulnerable adult with symptoms or signs of FGM or there is good reason to suspect they are at Risk of FGM being carried out, it is important to consider at the outset the persons capacity to give their consent to have information shared about them or for any intervention to be made. It is important to consider coercion and control when assessing mental capacity.

The wishes of a vulnerable adult with the mental capacity MUST be respected and information, advice or support offered. If however, there is concern that the adult may lack the mental capacity to make such decisions, then a safeguarding adult's referral should be made to:

Adult Services on 0300 555 1386

The healthcare professional should seek to support women by offering referral to community groups for support, clinical intervention or other services as appropriate, for example through an NHS FGM clinic. The wishes of the woman must be respected at all times. If she is pregnant, the welfare of her unborn child or others in her extended family must also be considered at this point as they are potentially at risk and action must be taken accordingly.

In both scenarios above, please follow the revised HMG FGM multi-agency guidelines.

Factsheet 10: FGM Enhanced Dataset [23]

Patient identifiable data

The FGM Enhanced Dataset is being undertaken under Directions for the Department of Health (DH). This provides the legal basis for collecting patient identifiable data without explicit patient consent. To read the Directions visit the DH website (Opens in a new window).

HSCIC complies with all national standards regarding data security and confidentiality. Full details are available at: http://systems.hscic.gov.uk/infogov/confidentiality.

No patient identifiable data will be published, and to further prevent individual patient identification small numbers of aggregate numbers will be suppressed. De-identified aggregate data will be published as an official statistic, complying with UK Statistics Authority rules.

De-identified data will also be used to support the DH and NHSE programme of FGM prevention. The data will be collected to improve the NHS response to FGM and to help commission the services to support women who have experienced FGM and safeguarding for girls at risk of FGM.

Patient objections

Explicit patient consent is not required (see above) but women and girls should be advised that information about their FGM will be submitted to the FGM Enhanced Dataset. DH has provided a patient leaflet for this purpose which can be ordered from the DH website (add link? Add page reference?)

Women and girls wishing to object to their FGM information being used in the FGM Enhanced Dataset should email: enquiries@hscic.gov.uk

How is the data collected?

All data for the FGM Enhanced Dataset is submitted via the HSCIC Clinical Audit Platform http://www.hscic.gov.uk/clinicalauditplatform (CAP). Data can be submitted directly into CAP or via CSV file upload. The CSV specification can be found within Excel Dataset file.

GPs and trusts can register to access CAP by completing the User Registration Form found under User Documents to the right of this page. Once registered, users can access CAP by clicking on this link: https://clinicalaudit.hscic.gov.uk/fgm

How to Participate

Mental health trusts and GPs within areas identified by the Prevalence Dataset as having a prevalence of FGM are required to collect and submit data from 1 June 2015.

[23] Source: Female Genital Mutilation Datasets; Health and Social Care Information Centre, (2015) accessed on 23/07/15 via: http://www.hscic.gov.uk/fgm

Reporting is quarterly and organisations have a month to submit their data before the extract for the report is taken.

Publications

For the FGM Enhanced Dataset, the HSCIC is publishing quarterly reports based on quarterly extractions from the data collection system, which will be published as an official statistic.

Additional resources

For further information or if you have a query please contact the Health and Social Care Information Centre's Contact Centre on 0300 303 5678 or alternatively email enquiries@hscic.gov.uk (please include 'FGM' in the subject line)

Appendix

Appendix 1: Materials available about FGM guidance and guidelines for professionals.

Appendix 2: Map to show countries where FGM is practiced.

ADD summary clinic information

https://www.nhs.uk/conditions/female-genital-mutilation-fgm/national-fgm-support-clinics/

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