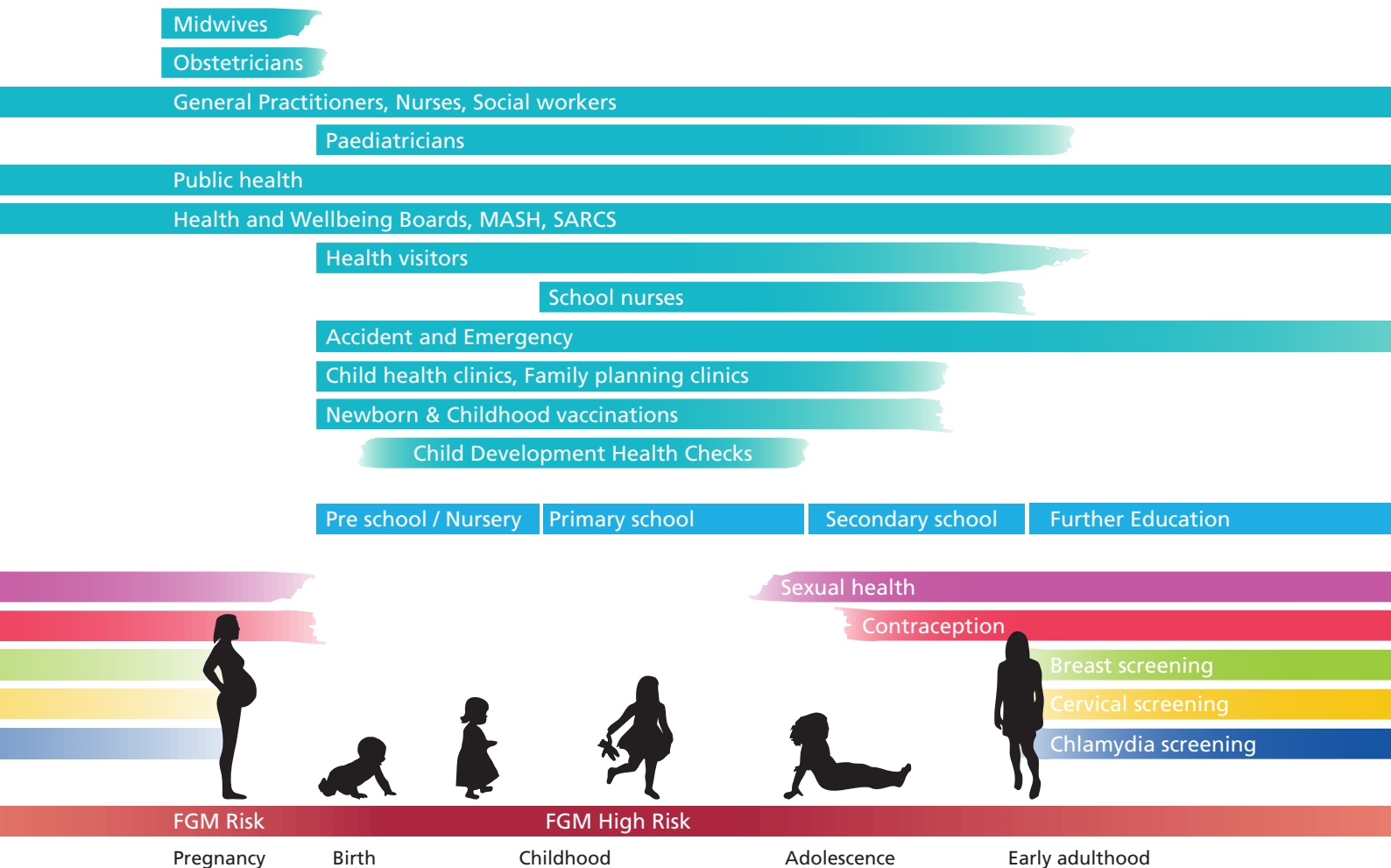


Tackling FGM in the UK

Intercollegiate recommendations for identifying, recording and reporting



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Tackling FGM in the UK – Intercollegiate recommendations for identifying, recording and reporting

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Foreword

During my time as Director of Public Prosecutions, I have sought to improve how we respond to and support victims of crime.

Female Genital Mutilation (FGM) is a crime that affects some of the most vulnerable girls and women in our society. Through working together closely with the police, health and social care professionals and the third sector, we are now in a much better place to have a successful prosecution against those who perpetrate this practice. It is only a matter of time before this happens and this will send a very powerful message that FGM is a crime that will not be tolerated in a modern multicultural society.

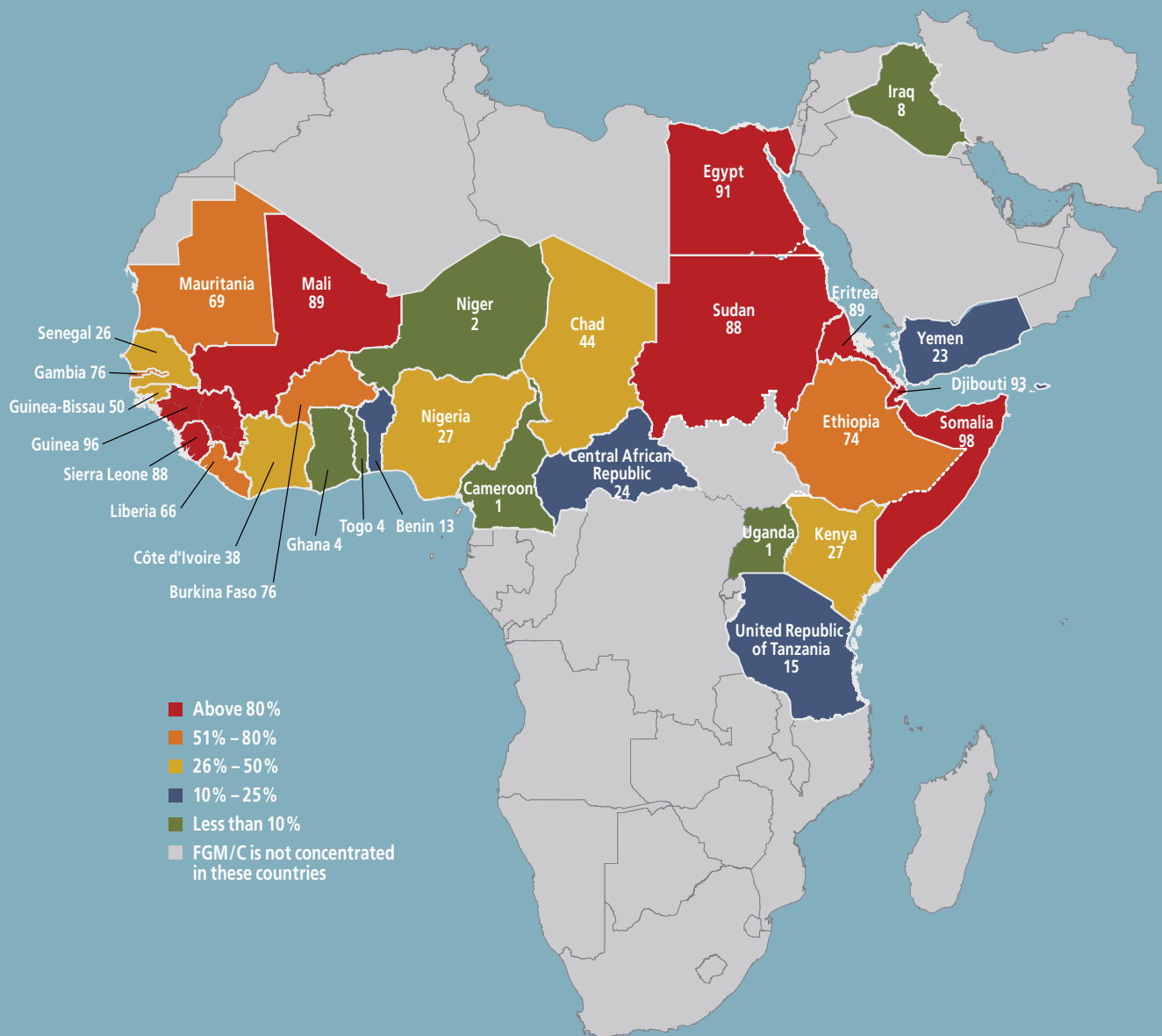
Health and social care professionals have a pivotal role to play in identifying, sharing information and reporting cases of FGM. It is through identifying women who have already gone through this barbaric and painful procedure that we can better help to prevent potential victims in the future – their female babies – from having to undergo the same practice. By reporting and sharing information, the necessary safeguarding strategies can be put in place and, when there are concerns that a child is at risk, the right action can be taken.

This important publication sets out recommendations aimed at those professionals who are key to bringing about the changes needed in the UK to help eradicate FGM.

A handwritten signature in black ink that reads "Keir Starmer". The signature is written in a cursive style and is positioned above a horizontal line.

Keir Starmer QC Director of Public Prosecutions

Prevalence of FGM in Africa and the Middle East



Source: UNICEF (2013)

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Summary

Female Genital Mutilation (FGM) is a violation of a girl's rights as a child and her entitlement to her bodily integrity. It is a cruel act perpetrated by parents and extended family members upon young girls who are entrusted to their care. FGM is not simply an exotic or 'cultural' ritual that girls need to undergo, but a practice which has intolerable long-term physical and emotional consequences for the victims. FGM causes death, disability, physical and psychological harm for millions of women every year. There is strong evidence of a correlation between FGM and psychiatric disorders – with young girls and women presenting with psychological distress and post-traumatic stress disorder¹.

It is estimated that 66,000 women resident in England and Wales in 2001 had undergone FGM and over 23,000 under the age of 15, from African communities, were at risk of – or may have undergone – FGM². The United Kingdom is a signatory to two key international Conventions: the UN Convention on the Rights of the Child (CRC) and the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)³. Article 24 of the CRC calls for the prohibition of all traditional practices that are prejudicial to the health and wellbeing of children across the globe.

The UN has recognised FGM as torture and calls for its elimination as a form of cruel, inhumane and degrading treatment of girls and women. Efforts to eliminate FGM have been gathering pace globally, reflected in the UN General Assembly's call for intensifying global efforts for the elimination of female genital mutilations issued in 2012⁴.

There is a growing consensus that the system is failing to protect girls from FGM and more needs to be done in the UK to intervene early in a child's life, and to safeguard those girls at risk. This cannot solely rely on isolated activities by civil society groups and the actions of individual professionals within an uncoordinated system, rather, we need to make systems work to support frontline professionals to identify and intervene to protect girls at risk of FGM. This requires leadership across the relevant agencies – health and social care, education and the police – and the development and implementation of comprehensive and integrated strategies for tackling FGM.

It is known that the number of communities affected by FGM is growing and with increased migration from the countries where FGM is widely practised (see page 4), more girls in the UK are at risk of undergoing FGM. Yet at the local level, FGM is still not fully integrated into the child protection system and girls at risk of FGM are not receiving adequate protection from harm. Our data systems do not consistently record

information on FGM to make the identification of girls at risk of FGM easier; nor is information on FGM shared formally and systematically between those professionals and organisations best placed to protect at risk girls, when they are least able to ask for help.

This is despite the fact that the UK has specific legislation, which has outlawed FGM since 1985 (updated in 2003 to address FGM performed on UK citizens and permanent residents outside the UK). Provisions under The Children Act 1989, 2002, and subsequent statutory guidance have also been designed to enable and support professionals and institutions to intervene to safeguard the health and wellbeing of children who are suffering or likely to suffer significant harm.

There have been no prosecutions to date in the UK on FGM. A recent report of the Director for Public Prosecution (DPP) Action Plan to address barriers to prosecutions on FGM has highlighted a major gap in the existing reporting duties for medical professionals, social care professionals and teachers in referring possible FGM cases to the police⁵. A key recommendation from the DPP Action Plan is that consideration should be given to how existing mechanisms for reporting on FGM can be strengthened, for example through links between midwives and General Practitioners, in addition to assurances to the medical profession that information will be used sensitively. There is also a need for wider awareness of FGM as a crime among health professionals and identification of what is required by the police and prosecutors from health professionals to enable effective reporting of FGM crime. Implementation of the recommendations emanating from the DPP action plan will require strong leadership nationally and locally, collaboration among the various agencies, a willingness to share information as well as to change the culture and attitudes of frontline staff. Critical to this is an understanding that systems must be designed in ways that prioritise every child at risk of harm from FGM and ensure reporting of FGM. This means that all professionals must know their roles and responsibilities in eliminating FGM.

The recommendations contained in this report from the Intercollegiate Group and its partners demonstrate solidarity to raise awareness of the need to intervene early to prevent FGM. They call for health and social care agencies, the Department for Education and the police to integrate FGM prevention into national and local strategies for safeguarding children from FGM abuse. By acting together, we can work towards the elimination of this illegal and abhorrent practice.

Recommendations

Top Intercollegiate recommendations for Tackling FGM in the UK

1. **Treat it as Child Abuse:** FGM is a severe form of violence against women and girls. It is child abuse and must be integrated into all UK child safeguarding procedures in a systematic way.
2. **Document and collect information:** The NHS should document and collect information on FGM and its associated complications in a consistent and rigorous way.
3. **Share that information systematically:** The NHS should develop protocols for sharing information about girls at risk of – or girls who have already undergone – FGM with other health and social care agencies, the Department for Education and the police.
4. **Empower frontline professionals:** Develop the competence, knowledge and awareness of frontline health professionals to ensure prevention and protection of girls at risk of FGM. Also ensure that health professionals know how to provide quality care for girls and women who suffer complications of FGM.
5. **Identify girls at risk and refer them as part of child safeguarding obligation:** Health professionals should identify girls at risk of FGM as early as possible. All suspected cases should be referred as part of existing child safeguarding obligations. Sustained information and support should be given to families to protect girls at risk.
6. **Report cases of FGM:** All girls and women presenting with FGM within the NHS must be considered as potential victims of crime, and should be referred to the police and support services.
7. **Hold frontline professionals accountable:** The NHS and local authorities should systematically measure the performance of frontline health professionals against agreed standards for addressing FGM and publish outcomes to monitor the progress of implementing these recommendations.
8. **Empower and support affected girls and young women (both those at risk and survivors):** This should be a priority public health consideration; health and education professionals should work together to integrate FGM into prevention messages (especially those focused on avoiding harm, e.g. NSPCC 'Pants' Campaign, Personal, Social and Health Education, extracurricular activities for young people).
9. **Implement awareness campaign:** The government should implement a national public health and legal awareness publicity campaign on FGM, similar to previous domestic abuse and HIV campaigns.

The full recommendations, including recommendations for government, lead health, social care and education agencies, are presented in Section 3.

1. Background

1.1 Definition

The term 'Female Genital Mutilation' (FGM) comprises all procedures involving partial or total removal of the external genitalia or other injury to the female genital organs for non-medical reasons. The WHO classifies FGM into four types (see Box 1), the most extreme of which (Type III) involves narrowing of the vaginal orifice.

World Health Organisation (WHO) classification of female genital mutilation:

Type I: Clitoridectomy: partial or total removal of the clitoris (clitoridectomy).

Type II: Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.

Type III: Infibulation: narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or labia majora with or without excision of the clitoris (infibulation).

Type IV: All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterisation.

Female genital mutilation is medically unnecessary as it interferes with the normal functioning of the external female genitalia and can give rise to a range of physical health complications. The immediate complications include severe pain (as FGM is frequently performed without anaesthetics), bleeding, shock, urine retention, infections, injury to neighbouring organs and death. The immediate complications may be fewer when the procedure is undertaken by a skilled health professional, although cases of death from uncontrolled bleeding from the clitoral artery have occurred even when performed by a trained physician. The long term complications of Type I and II include failure of the wound to heal, abscess formation, urinary tract infection, dermoid cysts, vulval adhesions, keloids, neuromas, painful sexual intercourse and sexual dysfunction. The long-term complications of Type III include those mentioned in Type I and Type II and in addition, the following – reproductive tract infections which may lead to pelvic inflammatory disease, dysmenorrhoea, chronic urinary tract obstruction, urinary incontinence, haematocolpos (retained menstrual blood) and stenosis of the artificial opening to the vagina. A study conducted by WHO in 2006 on FGM and obstetric outcomes noted that women with FGM are

significantly more likely than those without FGM to have adverse obstetric outcomes⁶. Risks seem to be greater with more extensive FGM. FGM is estimated to lead to an extra one to two perinatal deaths per 100 deliveries. Psychological effects are less documented but there is increasing evidence that girls and women who have had FGM may suffer from post-traumatic stress disorders (PTSD) or other mental health problems (such as depression)⁷.

Reasons why FGM is practised

The World Health Organisation (WHO) has described FGM as a practice that *"reflects a deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women"*.

FGM is related to the **control of women's sexuality** and gender-based social norms relating to 'marriageability'. FGM is 'culturally-embedded', as it is viewed as a form of cultural expression among those who support it. FGM may be upheld **as a religious obligation** by some Muslim populations, even though the practice predates Islam and it is practised by Muslims, Christians and followers of traditional African religions.

In the UK, reasons for practising FGM may have adapted to their context, for instance, the use of FGM to curb sexuality and to preserve girls' cultural identity, even as prevention of FGM in the country of origin gains ground. Parents may also come under pressure from family and community members in the UK or abroad to have FGM performed on their girls, and need support to avert this.

1.2 The scale of the problem

Globally, 100 to 140 million women and girls have undergone FGM, and a further 3 million girls undergo FGM every year in Africa⁸. Most females affected live in 28 African countries, and also parts of the Middle East and Asia. National FGM prevalence rates in the African region and Yemen vary from as low as 1% to 90% or more. The highest prevalence rates, of 90% or more, are found in Somalia, Sudan, Djibouti, Egypt, Guinea and Sierra Leone, where little difference in trends in prevalence is found by age group. In countries which have lower prevalence, the younger age groups consistently show lower prevalence figures, suggesting that prevalence is decreasing. Due to the increase in international migration, FGM is also practised among migrant communities in many countries, including in the UK and in other parts of Europe.

Except for a few cases where FGM is performed on adult women, FGM is usually performed on girls under the age of 18 years. There is some evidence that FGM is being performed at a younger age in some settings in response to preventive agendas. In 2005, UNICEF reported that the median age of FGM had reduced in five countries (Burkina Faso, Cote D'Ivoire, Egypt, Kenya and Mali), arguably to better avoid detection⁹. Amongst groups who practise Type III FGM (infibulation), it may be repeatedly performed during the course of a woman's life, for instance, in cases of re-infibulation after birth.

In UNICEF's (2013) Statistical Survey, FGM was conducted on girls under 5 years of age in half of the countries surveyed. In the rest of the countries, it was done between the ages of 5 to 14 years.

Increased knowledge and awareness of FGM has not always resulted in abandonment of the practice, as community-based surveys have shown that people can be aware of the illegality of FGM and its health impacts, but continue to support the practice. Furthermore, education and prevention has widely focused on the health impacts of FGM, but in recent times this has resulted in a medicalisation of FGM: WHO surveys found that globally up to 18% of FGM procedures on girls were conducted by medical staff¹⁰.

The United Nations Convention on the Rights of the Child (UNCRC) states that children have the right to:

- Protection from all forms of violence, including abuse committed by parents (Article 19).
- The right to health (Article 24).
- Non-discrimination: no child should be treated unfairly, including being unable to access protective measures.

The Committee for the Convention of the Elimination of Discrimination against Women (CEDAW) states that women have the right to:

- Protection from all forms of violence, including FGM.
- The right to re-dress for the harm caused by FGM.

1.3 Global policy frameworks

Female genital mutilation in all its types violates a number of human rights principles, including the principle of equality and non-discrimination on the basis of sex. It is important to note that the right to participate in cultural life and freedom of religion are protected by international law. However, international law also stipulates that freedom to manifest one's religion or beliefs might be subject to limitations necessary to protect the fundamental rights and freedoms of others. Therefore, social and cultural claims cannot be evoked to justify female genital mutilation¹¹.

As signatories to international human rights treaties (see Box on the left), governments have a legal duty to protect women and children from harm, including violence, abuse, degrading and inhumane treatment. FGM has also been pronounced as a form of torture¹².

The UN has called for the elimination of FGM in all girls under 18 years of age, and that all states which accede to CEDAW should take urgent steps to eliminate FGM¹³.

There is now a global consensus that prevention agendas to eliminate FGM need to be framed within not only health but human rights, gender and violence against women and girls frameworks¹⁴.

1.3.1 Global responses to the elimination of FGM

Efforts to eliminate FGM have been gathering pace globally, reflected in the UN General Assembly's call for *intensifying global efforts for the elimination of female genital mutilations* issued in 2012.

Evidence reviews on the effectiveness of prevention programmes have found that comprehensive and integrated strategies – comprising community education, widespread mainstreaming of prevention into government systems, legislation and prosecution – have worked best to eliminate FGM¹⁵. There are still concerns in many countries about weaknesses in efforts to prevent FGM¹⁶:

- Community mobilisation and education efforts to prevent FGM are piecemeal, under-funded and are often not sustained.
- Prevention efforts are not co-ordinated.
- FGM is not mainstreamed into government services – health, education and social care.
- Low legal awareness among both communities affected and professionals.
- Laws banning FGM are inconsistently enforced.
- Cases of FGM are under-reported.
- Perpetrators operate with impunity.

A UN Special Rapporteur on prevention of violence against children noted in his 2010 report that **by not acting with due diligence to protect victims of female genital mutilation, states may commit torture or cruel, inhuman or degrading treatment or punishment.**

The UN has recommended to countries where FGM is practised to put in place comprehensive educational and legal measures. Simply put, prevention programmes which solely focus on community awareness alone are less effective, resulting in little change in people's support for FGM¹⁷. Prosecutions are a vitally important part of FGM prevention and of women and girls' rights to redress for the harm they have suffered¹⁸.

1.4 Measuring the scale of the problem in the UK

It is known that FGM is practised in the UK. With increased migration of people from countries where prevalence of FGM is high, and without comprehensive preventative responses, this is likely to be an on-going problem.

Child Protection Policies across the Four Countries of the UK

- Working Together (2013) (England).
- Co-operating to Safeguard Children (2003) (Northern Ireland).
- Child Protection in Scotland (2010) (Scotland).
- All Wales Child Protection Procedures (2008) (Wales).

Estimates of the prevalence of FGM in the UK are alarming. A study conducted by FORWARD (2007) with the London School of Hygiene and Tropical Medicine and City University Midwifery Department using modelled estimates (based on census figures of the number of women from countries where FGM is practised, residing in the UK in 2001) found that 66,000 women resident in England and Wales had undergone female genital mutilation and 23,000 girls under the age of 15 were at risk of it¹⁹. This number is now likely to be higher, as births to women affected by FGM have increased from 1.04% in 2001 to 1.67% in 2008²⁰. A more recent study on women accessing care from six specialist FGM clinics across the UK found that over 1,700 women had sought care for FGM within the past 2 years²¹. The NSPCC also runs a national FGM helpline, and over the course of three months in 2013, there were 102 calls relating to girls at risk of FGM – 38 of these were referred to the police for further investigation.

FGM has been described as a 'hidden phenomenon', referring to the strong taboo associated with the practice and the cultural sensitivities involved in speaking out against it. It is also to a large extent hidden in the sense that it is under-reported in health and other information systems. A recent European Union report on FGM indicated that this is an EU-wide phenomenon, reflecting under-investment in comprehensive responses to prevention²².

While access to specialist FGM health services (especially in maternity services) has been increasing, data on women accessing care, or girls who are at risk of FGM, are not systematically collected in health or in social care settings. For instance, FGM is not coded in Hospital Episode Statistics, and there is no routine sharing of information between maternity services and child health teams²³.

Professionals – such as primary school teachers, doctors, midwives and nurses – who are well placed to safeguard girls are often unaware that girls are at risk of FGM. For those under-18 years of age, FGM is often not viewed as a safeguarding issue, and is therefore not aligned with professionals' current duties to identify, report and refer child maltreatment²⁴.

Local agencies need better data to plan prevention strategies and ensure services meet the needs of women and girls affected by FGM. In one stakeholder analysis, service providers reported that commissioners were unwilling to plan for services where there was no data to support a public health need²⁵. A rapid policy review also found that embedded policy responses to FGM prevention and caring for women and girls affected by FGM were often lacking, even in areas with dense populations of people from affected communities²⁶.

In the absence of local prevalence data on FGM, local strategic plans, including Joint Strategic Needs Assessments (JSNAs), should make better use of socio-demographic data to locate areas with higher proportions of people from affected communities. Socio-demographic data should be able to indicate areas where Black and Minority Ethnic Refugee groups (BMER) reside, and where an enhanced response to FGM should be considered²⁷.

1.5 What do people in communities affected by FGM in the UK say?

A number of small scale qualitative studies across the UK have highlighted the views of people affected by FGM on its prevention²⁸. These have shown that:

- There is strong support for a more interventionist stance by the UK government, particularly among young women from affected communities, who want to see the practice stopped.
- Women and mothers living in the UK may come under pressure from family members to practice FGM, either in the UK or abroad.
- Those who want to end FGM say that civil society community-based education initiatives, while important, are not enough to stop FGM.
- There is mixed evidence about the effectiveness of the law against FGM and the extent to which it deters the practice; those who support FGM in some cases also view their risk of being detected as low. The lack of prosecutions has undermined the impact of legal awareness programmes in the UK.

Evaluations of community-based studies have also shown that access to specialist FGM services (for instance, for de-infibulation) are vital for addressing continuing support for FGM. Women with FGM may not always recognise that subsequent health problems are caused by FGM; this realisation often lessens their support for this practice although some midwives in FGM specialist clinics report that some women who have undergone reversals (de-infibulations) during previous pregnancy care, return to the maternity clinics during subsequent pregnancies, having undergone re-infibulation. In other instances, British girls who have escaped the practice when they were young, were forced by husbands and family members to undergo FGM at marriage. These examples underline the strong pressures within families to continue with the practice and the need for strengthened government intervention to support breaking down the cycle of abuse.

2. Legal and policy responses to FGM in the UK

2.1 The UK law on FGM

FGM has been a specific criminal offence since 1985, under the Prohibition of Female Circumcision Act (1985), which was replaced by the Female Genital Mutilation Act (2003) (in England, Wales and Northern Ireland) with similar terms ratified in the Prohibition of Female Genital Mutilation Act (2005) in Scotland. Both Acts carry a maximum penalty of 14 years imprisonment.

Under the terms of these acts, it is criminal to:

- Excise, infibulate or otherwise mutilate the whole or any part of the labia majora or labia minora or clitoris of another person.
- Aid, abet, counsel or procure a girl to mutilate her own genitalia.
- Aid, abet, counsel or procure another person who is not a UK national to mutilate a girl's genitalia outside the UK.

The FGM Act (2003) (and the 2005 Act in Scotland) extended the offence to enable prosecution of those who assist a non-UK person to mutilate a girl's genitalia overseas. For instance, parents who procured FGM for their daughters outside of the UK would be committing a criminal offence, even if they have not carried out the procedure themselves, but have made the relevant arrangements.

For the purposes of the FGM Act, re-infibulation is not covered. The offence of FGM requires proof that the defendant has excised, infibulated or otherwise mutilated the whole or any part of a girl's labia majora, labia minora or clitoris. "Excise" and "Infibulation" refer to "the removal" (by cutting) of the clitoris and partial or total removal of the labia minora and stitching of the labia majora. Therefore the re-infibulation which occurs at some stage between the time the woman leaves hospital after giving birth and returning to give birth to another child would not be considered as FGM. It is the re-suturing of a woman rather than the cutting and removal of her genitalia which are the vital elements required to prove FGM. If a victim of FGM was forced to be re-infibulated after giving birth and made a complaint to the police, there might be consideration of other criminal offences depending on what is disclosed in the evidence obtained but would not satisfy any of the offences under the FGM Act (2003). However, the WHO has recommended that re-infibulation should not be undertaken under any circumstances and has provided guidance on how to re-suture women after giving birth.

2.2 Prosecutions

The Crown Prosecution Service (CPS), when making the decision to prosecute, will review each case received from the police, to be satisfied that there is sufficient evidence to provide a realistic prospect of conviction. Evidence for a prosecution will include proof that FGM has taken place, including medical evidence. There is also some reliance on the victim to provide details of when and where the procedure took place and who was responsible to enable an investigation to commence. Police and prosecutors may consider whether any other offences are disclosed, for example a conspiracy to commit the FGM procedure where there is evidence of an agreement to commit the offence of FGM, even though the substantive offence may or may not have been carried out. In some instances, the police will apply for an emergency protection order, under the terms of The Children Act (1989) to ensure the safety of the child.

Under the terms of these acts, FGM is to be considered as child abuse, and anyone (girls or women) who presents with FGM and who has been a UK resident since 3rd of March 2004 (when the FGM Act was enacted) should be considered the victim of a crime, even if this was committed abroad.

2.3 Prosecutions to date

Since the 1985 Act on the Prohibition of Female Circumcision, there have been no prosecutions for FGM in the UK, though three doctors found to have committed serious professional misconduct by the General and the Dental Medical Council in relation to FGM were subsequently struck off. The link between prosecutions and prevention has been increasingly recognised, and concerted action is needed to directly address the barriers to prosecution²⁹.

It is a strong possibility that there will be a cohort of young British women who will have had FGM illegally performed on them under the FGM Act (2003). These young women may be about to be identified through mainstream maternity and sexual health services, as they reach sexual maturity. Robust referral pathways, access to support services, and information sharing protocols (including with police, when a crime is identified) need to be in place to meet this demand.

2.4 Current initiatives

There has been concerted activity recently to: a) mainstream FGM into existing strategic plans, including VAWG strategies, b) focus on the barriers to prosecution for FGM, and work to close gaps in the identification, recording and sharing of that information.

Recent initiatives have included:

- The Director of Public Prosecutions (DPP) Action Plan on FGM recommends a focus on information sharing pathways and better evidence gathering to support prosecutions.
- The government multi-agency guidelines, released in 2011, outline the responsibilities of frontline professionals in cases where they suspect FGM may occur or where it has already happened (see below).
- An FGM toolkit for local areas, highlighting effective practice and signposting services, is in development by the Home Office. The Home Office has also produced a booklet on the law on FGM, targeted at affected communities.
- The Home Office disburses fifty thousand pounds in grants to civil society groups to support community actions in affected communities. The ceiling for each group application is five thousand pounds.
- The Home Office and Trust for London have funded an update of the 2007 prevalence estimates on FGM for England and Wales.
- The Department of Health has funded a feasibility study on inclusion of FGM data in the Hospital Episode Statistics.
- The All Party Parliamentary Group on FGM has successfully advocated for the inclusion of FGM in OFSTED inspections of schools in areas with high BMER populations.
- The London Metropolitan Police Force has set up a strategy group on FGM and is proactively engaged in creating prosecution opportunities. 'Project Azure' works with partners to raise awareness of the implementation of the FGM Act (2003).
- The Mayor of London's Taskforce on 'Harmful Practices' includes a focus on FGM and will pilot interventions to enhance responses.
- The NSPCC, with the collaboration of the Metropolitan Police and partners, has launched a national FGM helpline, 0800 028 3550, for children at risk and as a reference point for advice for the public and professionals to report their concerns on FGM: 102 enquiries have been received over 3 months, resulting in 38 referrals to the police so far.
- The FGM Initiative: a third sector-funded community-based empowerment programme, gathering evidence on 'what works' for prevention of FGM. The initiative funds civil society groups for community action.
- The Department for International Development (DFID) has launched an ambitious programme toward ending FGM in Africa. This is a comprehensive programme, with a budget of up to £35 million over 5 years, which will combine targeted action with communities with support for legislative and policy change, and effective implementation of laws and policies, in at least 15 countries. This programme aims to see a reduction of FGM by 30% in 10 countries over 5 years and has a vision to see an end to the practice in one generation.

Local Safeguarding Children's Boards (LSCBs) have responsibility for developing inter-agency policies and procedures for safeguarding and promoting the welfare of children. An LSCB's policy should focus on a preventive strategy involving community education and be alert to the fact that the practice may also take place in the UK. *Working Together (2010)*

2.5 Barriers to preventing FGM

2.5.1 Safeguarding girls at risk of FGM

FGM is a form of child abuse, and an act of violence against women. There is some evidence that child protection guidelines are not being followed when girls affected by FGM are identified³⁰. This may be due to:

- Professional lack of awareness of FGM (when to consider a child at risk).
- Concerns that they risk offending or stigmatising people from BME communities.
- Concerns that referrals of at-risk girls will overwhelm services.
- Unclear referral thresholds, particularly within health, education and children's social services.
- Lack of robust monitoring and surveillance systems.
- Lack of accountability in relation to local performance.

Professionals have a legal duty to protect girls from FGM. In the UK, Section 31 of The Children Act (1989) sets out the thresholds for intervention if a child is likely to suffer or is suffering from 'significant harm'. When there is a suspicion or concern that significant harm will be experienced, professionals have a legal duty to report and refer cases, document responses, and share information between agencies³¹. This includes where there are concerns about FGM. According to *Working Together* (2013), local authorities have a legal duty to make enquiries to decide whether they will take action to safeguard or promote the welfare of the child.

2.5.2 Comprehensive responses to prevention in the UK

The UK experience reflects the global evidence: a 'whole systems' approach to the prevention of FGM works best to enhance the identification, reporting and referral of girls at risk. Best practice focus on: building professional competence and confidence to intervene; investing in multi-agency forums to operationalise professional responses; and co-ordination of wider stakeholders including those working in community-based prevention, in schools for example³². However, the scale of response varies widely across the UK, and appears to bear little relationship to the size of the population affected by FGM.

Arguably, eliminating FGM in the UK demands a more rigorous approach to applying models of best practice to where it is needed most – in health, education and social care settings. Co-ordination between national and local level agencies is needed to achieve this.

2.5.3 Barriers to identification, risk and referral

There are numerous pieces of guidance for frontline professionals – doctors, nurses, teachers, social workers and others – about what they should do to prevent and care for girls affected by FGM. However, the lack of prosecutions for FGM highlights the fact that FGM remains under-reported in the UK, by those who have undergone the procedure, as well as those encountering FGM cases professionally.

Guidance for Health Professionals on Prevention and Care of FGM

Her Majesty's Government (2011) Government Multi-Agency Guidelines.

Royal College of Nursing (2006) Female Genital Mutilation: An RCN Educational Resource for Nurses and Midwives.

Royal College of GPs (2011) Safeguarding Children and Young People: A Toolkit for General Practice.

Royal College of Obstetricians & Gynaecologists (2009) Female Genital Mutilation and its Management, Green Top Guideline No. 53.

BMA Ethics Guidance (2011) Female Genital Mutilation: Caring for patients and safeguarding children.

General Medical Council (2012) Protecting Children and young people: the responsibilities of all doctors.

The Mayor of London's Office noted that: "FGM and other harmful practices are not systematically integrated within local authority and local NHS policies, strategic plans, child protection policies and procedures which leads to inconsistent approaches and responses across London". *The Missing Link* (2011) report noted that current guidance has tended to focus on the care and treatment of women presenting with FGM, but that there was a need for a clearer focus on earlier intervention and prevention³³.

2.5.4 Barriers to applying indicators of risk

There was a wide consensus among those consulted for this report that a key barrier to FGM prevention is the failure of professionals to respond when presented with a child who may be at risk of FGM. The DPP has noted that FGM may significantly differ in the 'signs and symptoms' of risk from the four other forms of child abuse (physical, emotional, sexual and neglect). Children at risk of FGM may not be known to social services. When there are concerns, potential referrals may not meet current referral thresholds.

"Anyone working with children should see and speak to the child; listen to what they say; take their views seriously; and work with them collaboratively when deciding how to support their needs".

Working Together (2013) on Child-Centred Safeguarding Systems

Comprehensive approaches to prevent FGM could better support professionals who need to intervene. The risk of FGM for a girl requires professionals to know the FGM status of her mother, siblings, and possibly other females within her household. By implication, practitioners need to have access to this information to establish if and when a girl is likely to be at risk of FGM, until she reaches adulthood and beyond. This would enable professionals to be alert at the right times (often between the ages of 5 to 8 years of age), and when girls are least able to report their risk³⁴.

Other child protection systems in the EU have responded with systematic screening of girls under 6 years of age through annual physical examinations (as is the case in France)³⁵. Although the UK may not want to take this position as it is viewed as too intrusive, it is important to underline the principal that in specific situations where there is a suspicion that girls have undergone FGM, FGM assessments and medical examinations are helpful and it should not be seen as abusive to undertake such examinations. Where there is a suspicion that a girl has undergone FGM and that siblings may also have undergone FGM, a doctor, specialist midwife or nurse trained to recognise the types of FGM should examine girls so that there is a base line in case the suspicion arises later. There needs to be understanding by all agencies that an examination is part of a whole health assessment. In the experience of the Royal College of Paediatricians and Child Health (RCPCH) Child Protection Standing Committee, children and their parents do not find such examination traumatic.

Professionals need to be aware of best practice in talking with children when maltreatment is suspected, including making space for private discussions and the child having a chaperone during the examination³⁶.

2.6 Identifying girls affected by FGM

Commissioning agencies, Local Safeguarding Children Boards (LSCBs), and regulatory authorities need to ensure that frontline professionals are adequately supported to identify girls affected by FGM.

Three main groups affected by FGM may be identified by frontline professionals:

- A girl at risk of having FGM.
- A girl who has undergone FGM.
- A baby girl born to a mother who has undergone FGM.

Risk to the child must be considered if:

- Any female child born to a woman who has undergone FGM.
- Any female child whose older sibling has undergone FGM must be considered at immediate risk.
- Risk to other children in the woman's or child's household must also be considered.

2.6.1 Identifying girls at risk of FGM

Some professionals will have greater opportunities to identify girls at risk of FGM, and they should be alert to the risk of FGM. These include general practitioners, paediatricians, midwives, health visitors, school nurses, accident and emergency professionals, teachers and nursery staff. These may also include specific health settings, such as sexual health clinics, sexual assault referral centres or community contraception services.

The London safeguarding board's FGM procedures note that "school nurses are in a particularly good position to identify FGM or receive a disclosure about it". The government's *Multi-Agency Guidelines (2011)* also highlight specific opportunities for identifying girls at risk, including vaccination clinics and patient history taking (for doctors).

There is a strong consensus within current guidelines about FGM risk factors. However, these rely on selective enquiry and self-disclosure on the part of the girl to professionals that she may trust and have contact with.

There is also agreement among stakeholders that more could be done to integrate FGM into prevention messages (especially those focused on avoiding harm, such as the NSPCC's "Pants" Campaign) in the places where children can be found, and where professionals may have the opportunity to support disclosures, such as in schools.

2.6.2 Girls who have undergone FGM

In cases where girls are identified as having undergone FGM, a referral to children's services and the police must be made³⁷. All health, education and social care professionals have a statutory duty to report any suspected case of child maltreatment, including FGM. Risk assessments must include a consideration of the risk to other female children within the household, and sharing of information to safeguard these children, who should be deemed 'children in need of protection'.

Current guidance also notes that professionals must be competent and confident to enquire about FGM, including being sensitive to the child's on-going relationship with her parents. Once an assessment by children's social services has been conducted, the child may or may not be placed on the child protection register, if risk of further harm has not been identified. The child should also be assessed for further needs, including access to counselling services. In cases where a health assessment is needed (for instance, to confirm suspicions that FGM has been conducted already), a referral to a paediatrician, gynaecologist, general practitioner, specialist midwife or nurse specialising in FGM should be made.

If any child was a UK resident at the time of the FGM procedure taking place and after the FGM Act (2003) was enacted (in March 2004), this would be considered an illegal act. Professionals need to be alert to the legal status of women and girls identified as having had FGM, and report and share information appropriately.

2.6.3 Women who have undergone FGM

There are numerous pieces of guidance on the care and treatment of women who have undergone FGM³⁸. This section considers current policy on how these women link into a preventative agenda, with the aim of protecting children at risk of FGM.

Women who have undergone FGM are most likely to be identified through maternity services. At booking, maternity health professionals have an opportunity to sensitively enquire about FGM, and once identified, to respond to the woman's complex needs, and refer appropriately. Other settings where women who have undergone FGM can be identified are GP clinics, genitourinary medicine clinics (GUM), Sexual Assault Referral Centres (SARCs) and family planning clinics.

The Royal College of Nursing issues specific guidance on FGM and notes that certain health and teaching practitioners are well placed to enhance early intervention, including legal education and health promotion to women who have had FGM, who may also have daughters of their own. Potential professionals include health visitors, community midwives, school nurses and children's centre staff, general practitioners and teachers. Women who are identified as having had FGM should receive information on the health impacts of the procedure, and its legal status in the UK.

Women who have undergone FGM are victims of crime, with complex needs. A referral to the police, or directly to Project Azure, should be considered, with the woman's consent. Health staff should not consider that the FGM case is historical, and should be able to establish through direct questioning the circumstances under which FGM has taken place. Health staff should also enquire about the presence of female children in the woman's household. Further enquiries to other professionals who may be in contact with these children may be necessary. There is currently no systematic means of sharing information between maternity and child health teams, even if the woman is identified as having had FGM herself (thus increasing the likelihood that her female children could be at risk).

2.7 Sharing information

The reporting and sharing of information between professionals about FGM is not sufficiently robust and is not protecting girls and women at risk of FGM³⁹.

Professionals' concerns about patients' rights to confidentiality may be acting as a barrier to effective information sharing between agencies. Current guidance already states that referrals must be made to children's social services and Multi-Agency Safeguarding Hubs (MASHs)⁴⁰. Information needs to be shared across agencies during a girl's young life-course, specifically during the ages when girls are at highest risk of FGM.

In most countries in the EU, including in the UK, the duty to share information where there is a concern or risk to a person or child's welfare, is more important than the patient's right to confidentiality. In the UK, this is a statutory duty laid under The Children Act (1989 & 2005), and *Working Together to Safeguard Children (2013)*. Additional guidance is also laid out for practitioners specifying that they must record their concerns, refer and share information where there is a significant 'public interest' to do so^{41, 42}.

Midwives, nurses, doctors, teachers and others are bound by professional standards to work to make the care of children their first concern. Information sharing is a crucial part of early intervention and prevention. In the case of FGM, the focus should be on information sharing between health services, primary care and schools, to ensure a comprehensive preventative response at times when girls are at higher risk of FGM.

Types of information which is useful to collect when FGM is identified in a girl or woman

- What type of FGM has been conducted (for relevant health staff, using WHO ICD codes).
- Country of origin.
- On-going cultural links to the country of origin.
- When was FGM performed.
- Where was FGM performed.
- Any brief interventions undertaken (for instance, information given).
- Referrals to appropriate services.

A robust data system should be developed for surveillance, auditing and monitoring of FGM by those who are charged with leading a preventative response. By implication, this system should also consider the mobility of populations, particularly where there may be a large refugee cohort. Other child protection mechanisms allow for a records audit, so that practitioners can identify what previous interventions to prevent abuse have been taken.

3. Joint Statement by the Intercollegiate Group on Tackling FGM in the UK

The Intercollegiate Group believes that much more can be done to prevent FGM with a view to eliminating the practice in the UK. However, several challenges, as detailed in this report, stand in the way of progress.

Based on our work with stakeholders, we present nine key principles and further detailed recommendations for action that we believe are urgently needed to bring about change to better safeguard girls and young women at risk of FGM.

Top Intercollegiate recommendations for Tackling FGM in the UK

1. **Treat it as Child Abuse:** FGM is a severe form of violence against women and girls. It is child abuse and must be integrated into all UK child safeguarding procedures in a systematic way.
2. **Document and collect information:** The NHS should document and collect information on FGM and its associated complications in a consistent and rigorous way.
3. **Share that information systematically:** The NHS should develop protocols for sharing information about girls at risk of – or girls who have already undergone – FGM with other health and social care agencies, the Department for Education and the police.
4. **Empower frontline professionals:** Develop the competence, knowledge and awareness of frontline health professionals to ensure prevention and protection of girls at risk of FGM. Also ensure that health professionals know how to provide quality care for girls and women who suffer complications of FGM.
5. **Identify girls at risk and refer them as part of child safeguarding obligation:** Health professionals should identify girls at risk of FGM as early as possible. All suspected cases should be referred as part of existing child safeguarding obligations. Sustained information and support should be given to families to protect girls at risk.
6. **Report cases of FGM:** All girls and women presenting with FGM within the NHS must be considered as potential victims of crime, and should be referred to the police and support services.
7. **Hold frontline professionals accountable:** The NHS and local authorities should systematically measure the performance of frontline health professionals against agreed standards for addressing FGM and publish outcomes to monitor the progress of implementing these recommendations.
8. **Empower and support affected girls and young women (both those at risk and survivors):** This should be a priority public health consideration; health and education professionals should work together to integrate FGM into prevention messages (especially those focused on avoiding harm, e.g. NSPCC 'Pants' Campaign, Personal, Social and Health Education, extracurricular activities for young people).
9. **Implement awareness campaign:** The government should implement a national public health and legal awareness publicity campaign on FGM, similar to previous domestic abuse and HIV campaigns.

Key Policy Recommendations

Target audience	Policy recommendations/ rationale	Expectations of action to carry out this recommendation
All agencies	<p>Treat FGM as Child Abuse and integrate it into all safeguarding procedures across the four countries of the UK (England, Northern Ireland, Scotland and Wales) outlined in <i>Working Together to Safeguard Children</i> (2013) (England), <i>Co-operating to Safeguard Children</i> (2010) (Northern Ireland), <i>Child Protection in Scotland</i> (2010) (Scotland), and <i>All Wales Child Protection Procedures</i> (2008).</p>	<ul style="list-style-type: none"> • NICE should revise their guidance on “<i>When to Suspect Child Maltreatment</i>” (Clinical Guideline CG89) to include FGM. • Girls born to mothers who have had FGM should be considered at risk of significant harm. They require monitoring through the child protection system until they are at an age when they can speak about FGM and are able to seek protection for themselves. • Lead social work agencies should urgently work to revise and clarify referral thresholds when risk of FGM is a concern or suspicion, including conducting assessments and monitoring of the child at risk. • Referral pathways must be developed so that all health and social care agencies are aware of their respective roles and responsibilities.
NHS	<p>Document and collect information on FGM and its associated complications in a consistent and rigorous way.</p> <p>Good documentation is important for planning and commissioning services on FGM, providing quality care for girls and women affected, for research and for monitoring trends of FGM in the UK.</p>	<ul style="list-style-type: none"> • The Health and Social Care Information Centre should develop specifications to code FGM in Hospital Episode Statistics and in Maternity and Child Health datasets. • Every woman from a practising community who books for maternity care should be asked in a sensitive manner about FGM and the discussion recorded in paper-based and electronic records, to include action taken or referral to the appropriate professional. • All new patient registrations in primary and secondary care, including A&E of young girls/women, should include detailed enquiry about country of origin. If the family is from FGM practising community, document any presence of FGM to establish a baseline for monitoring and sharing information with the relevant agencies. • This information should be captured at all pregnancy bookings. • The Royal College of Paediatrics and Child Health (RCPCH) should update the specifications for the ‘Personal Child Health Record’ (the Red Book) to include a code for the child’s mother having FGM. This should include recording FGM in the electronic ‘Red Book’ (Personal Child Health Record). • Health practitioners in maternity services should ensure that FGM is coded in electronic records and information shared with child health teams. • Adequate language translation services are required in areas of high prevalence.

Target audience	Policy recommendations/ rationale	Expectations of action to carry out this recommendation
Health, Social Care, Education and the Police	<p>Share information on FGM systematically.</p> <p>There is a need to develop information sharing protocols between health, the police and other relevant agencies such as social care and education.</p>	<ul style="list-style-type: none"> • The NHS should develop protocols for sharing information about girls at risk – or girls who have already undergone – FGM with other health and social care agencies, the Department for Education and the police. • These protocols should be based on national guidance and should regularly be reviewed for their effectiveness by public health directors and GP commissioners.
Healthcare professionals	<p>Develop the competence, knowledge and awareness of frontline health professionals to ensure prevention and protection of girls at risk of FGM.</p> <p>Ensure that health professionals know how to provide quality care for girls who suffer complications of FGM.</p>	<ul style="list-style-type: none"> • Health and social care staff must work to the WHO guidelines for nurses and midwives, the UK multi-agency practice guidelines and CPS legal guidance. www.who.int/reproductivehealth/publications/fgm/en/index.html • On the opening and re-suturing of women with Type III FGM, WHO guidelines should be followed. Guidelines can be accessed from the WHO website as follows: www.who.int/reproductivehealth/publications/maternal_perinatal_health/RHR_01_13_/en/index.html • Refer all women identified with FGM for support and further medical and psychological assessment as appropriate. This must be done very sensitively. • A multi-agency and multi-professional approach should include the Medical Royal Colleges, professional organisations and trade unions for incorporating FGM into pre-registration education/ undergraduate level training and continue professional development appropriate to the individual's levels of responsibility and accountability. This should include a mix of face-to-face and the development of e-learning resources on FGM, which all relevant frontline professionals can access. • A lead agency should be involved in producing e-learning materials for healthcare and other practitioners. This agency should involve the main health professional bodies such as the relevant medical royal colleges and health trade unions in developing training materials. • High quality information on the effects of FGM (health, psychological, and rights-based) should be provided to all women identified as having FGM. • Healthcare practitioners need to consider the needs of both the future child, as well as any other female children who may already be born, or resident in the household with the woman. • Healthcare practitioners need to follow the “one chance” rule. This states that the attending professional may only have one chance to speak to the victim and prevent future harm.

Target audience	Policy recommendations/ rationale	Expectations of action to carry out this recommendation
<p>Health, Social Care, Education and the Police</p>	<p>Identify girls at risk and refer them as part of child safeguarding obligation:</p> <p>Early identification of risks of FGM to girls, referral, planned and sustained information and support to families are needed to protect girls from undergoing FGM.</p>	<ul style="list-style-type: none"> • Professionals should identify girls at risk of FGM as early as possible. All suspected cases should be referred as part of existing child safeguarding obligations. Sustained information and support should be given to families to protect girls at risk. • In cases where FGM is identified in a woman who presents at maternity services, the implications for the woman and her future child should be discussed by the midwife or doctor and a clear plan of action including communication with relevant agencies detailed in paper and electronic records. • Professionals should refer all women identified as having undergone FGM who give birth to female children to the Multi-Agency Safeguarding Hub (MASH) for discussion and review. A home visit should be made by social services and further information on the law on FGM and support provided to women. This has been tried in Waltham Forest before the FGM Services closed down. Such visits have been welcomed by women. • It is important to share this information with the GP, the health visitor, school nurse and safeguarding leads in schools so that they can engage in continuous dialogue and provide information to parents about the illegality of FGM and monitor girls at risk. • Health practitioners offering travel vaccinations to children from practising communities for travel to countries where FGM is prevalent must be sensitive to the possible risk of FGM. • Girls from FGM-practising communities who are put on child protection registers for other forms of abuse and those who come into contact with youth offending teams and Children's and Adolescent Mental Health Services (CAMHS), should be asked about their risk or experiences of FGM by trained professionals. • All responsible agencies should promote and signpost at-risk girls and women to age-appropriate information and support services such as the NSPCC helpline and specialist FGM clinics. • Refer all girls and women identified with FGM for support and further medical and psychological assessment as appropriate. Referral pathways must be developed so that all health and social care agencies are aware of their respective roles and responsibilities.
<p>All agencies</p>	<p>All girls and women presenting with FGM within the NHS must be considered as potential victims of crime, and should be referred to the police and support services.</p> <p>FGM is illegal in the UK. All professionals to be aware of the FGM Act (2003), and able to act on cases of FGM where a crime has been committed. All girls and women who were UK residents since March 2004 and have had FGM are victims of a crime, with rights to redress, regardless of whether FGM was committed in the UK or abroad.</p>	<ul style="list-style-type: none"> • Protocols for information sharing between health, the police and other relevant agencies such as social care and education should be developed. These protocols should be based on national guidance and should regularly be reviewed for their effectiveness by public health directors and GP commissioners.

Target audience	Policy recommendations/ rationale	Expectations of action to carry out this recommendation
<p>Local authorities, service commissioners and social services</p>	<p>The NHS and local authorities should systematically measure the performance of frontline health professionals against agreed standards for addressing FGM and publish outcomes to monitor the progress of implementing these recommendations.</p> <p>Directors of Public Health, Health and Wellbeing Boards and Clinical Commissioning Groups to consider the needs of people affected by FGM within Joint Strategic Needs Assessments (JSNAs) and local strategies (e.g. 'Violence against Women and Girls' strategies), particularly in areas where communities affected by FGM reside.</p> <p>Local Safeguarding Children Boards (LSCBs) should be charged with leading a preventative response to FGM, including ensuring that information on girls at-risk is shared across health, social care and education with information sharing protocols based on national guidance, and regular reviews of how information is shared and used.</p> <p>Practitioners should refer all women from FGM affected communities who have had FGM and who have female children to the Multi-Agency Safeguarding Hub (MASH) for discussion, review and assessment.</p>	<ul style="list-style-type: none"> • Directors of Public Health, Directors of Social Care and Children's services, Clinical Commissioning Groups, Health and Wellbeing Boards should include FGM in the Strategic Needs Assessments (JSNA) and Violence against Women and Children strategies. • JSNAs should inform preventive strategies led by the Local Safeguarding Children Boards (LSCBs), in collaboration with the local authority, and Health and Wellbeing Boards (HWB). • In the absence of local prevalence data, local authorities to use socio-demographic data: e.g. Primary Level Annual Schools Census (PLASC), to map communities affected by FGM in their local area, and to plan for services to meet those needs. • In all areas, training on FGM should be integrated into all safeguarding training conducted by LSCBs. • Practitioners should be aware of their role in prevention during the life-course of the girl at-risk, and be able to sensitively discuss FGM and prevention of harm with them. • In areas with high densities of communities affected by FGM, prevention should be explicit in local Child Protection policies. • LSCBs should publish and share their preventative strategies in high density areas. • Preventive agendas should consider the need for empowering girls at risk to prevent harm, as well as support services for those affected by FGM. • The NSPCC's dedicated FGM helpline service is promoted across all settings, including health, social care and education, as a resource for practitioners with concerns, and girls at risk to claim their rights to protection. • Some practitioners – teachers, school nurses, GPs – are well placed to talk with girls at risk about prevention of harm. LSCBs should support such interventions. • Strategies for early identification of girls at risk should be put in place: <p>At national level – Health, Social Care and Education performance in these areas should be monitored against the CQC and Ofsted inspections regime which are published.</p> <p>At local level – Develop FGM into quality standards for commissioning, by which health and social care institutions / service providers can be judged.</p>

Target audience	Policy recommendations/ rationale	Expectations of action to carry out this recommendation
<p>UK departments for education</p>	<p>Empowering and supporting affected girls and young women should be a priority consideration.</p> <p>Many girls are too young to understand the implications of FGM for them. Young people may support FGM because they lack facts about it.</p>	<ul style="list-style-type: none"> • In areas where affected communities reside, schools should explicitly include discussions and information on FGM within Personal, Social and Health Education (PSHE) curriculum. • Teachers, school nurses, health visitors, counsellors and safeguarding leads in schools should provide time for one-to-one conversations and information to girls from practising communities. These could be integrated into other messages (NSPCC 'Pants' campaign), encouraging girls and young women to report harm such as in the prevention of physical and sexual abuse. • Young people should be sign posted to the NSPCC FGM Helpline on 0800 028 3550 for advice, information and counselling.
<p>Home Office, UK public health authorities and social services</p>	<p>Develop and implement national public health and legal awareness campaigns on FGM, similar to previous campaigns on domestic abuse and HIV.</p> <p>Current Information provision about the health consequences is not reaching the affected communities and the general public is not aware of the illegality of FGM. There is support for stronger and effective action by the UK governments, particularly among young women from affected communities, who want to see the practice stopped.</p>	<ul style="list-style-type: none"> • Well designed public health and legal awareness campaign about FGM, targeted at women and girls from at-risk communities about the health and legal implications of FGM. These campaigns should also emphasise to the general public that FGM is illegal in the UK, a message endorsed by key professional organisations and NGOs.

4. Annex

Following the initial discussions held at the Crown Prosecutions Service (CPS) in 2012, the Royal College of Midwives (RCM), Royal College of Nursing (RCN), Royal College of Obstetricians & Gynaecologists (RCOG), Equality Now and Unite/Community Practitioners' and Health Visitors' Association (Unite/CPHVA) convened an Intercollegiate Group to examine the collaborative role of health and social care education and the police in tackling FGM in the UK.

This group met and discussed information sharing, reporting and referrals of FGM, identified by the Director for Public Prosecutions as being the gaps in the protection of girls and care of women.

The group commissioned an external consultant (Options UK) to co-ordinate the work on its behalf and engaged with experts who work on FGM issues, health and social care, education, child protection experts, paediatricians, General Practitioners and local government for advice. The Intercollegiate recommendations were developed through the following processes:

- Key stakeholder consultations: semi-structured in-depth consultation (phone interviews and face-to-face) with 19 individuals/organisations with a strategic or operational role across the health, education and social services, including inspectorate regimes.
- An expert symposium was convened with key stakeholders from voluntary sector and statutory agencies to elicit their views and experience and this enabled the Intercollegiate Group to further refine the recommendations. A full list of contributors to these recommendations can be found opposite and on page 25.

Organisations consulted

Vickie Wilkes – Care Quality Commission

Dr Anne-Marie Connolly – Public Health England

Elaine Cass – Social Care Institute for Excellence

Sharon Burton – General Medical Council

Anne Akamo – Safeguarding Lead Tutor, City University

Alison McFarlane – Statistician, City University

Professor Cathy Warwick – Royal College of Midwives

Professor Jimmy Walker – Royal College of Obstetricians and Gynaecologists

Amy Weir – Independent social worker consultant and LSCB Chair

Louise Douglas – Ministry of Justice

Wendy Nicholson – Lead Nurse Advisor – Department of Health

Jenny Coles – Director of Children's Safeguarding & Specialist Services

Policy Group – Association for Directors of Children's Services

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Claire Knights – Unison

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Debbie Walmsley – Comic Relief

Deborah Hodes – Central & North West London NHS Found Trust

Denise Boulter – Northern Ireland Government

Eleanor Brown – Options

Geetha Subramanian – Faculty of Sexual & Reproductive Healthcare

Granville Ward – West Yorkshire Police

Hawa Sesay - Hawa Trust Limited

Hekate Papadaki – Rosa, the UK Fund for Women and Girls

Jane Miller – Department of International Development

Janice Rymer – Guy's and St Thomas' NHS Foundation Trust

Jason Ashwood – Metropolitan Police Service

John Cameron – National Society of Prevention of Cruelty to Children

Juliet Albert – Imperial College Healthcare NHS Trust

Katie Defreitas – Mary Seacole awardee

Keith Niven – Metropolitan Police Service

Kelly Simmons – Newham Lead on Commissioning on VAWG

Khusbu Patel – Action Aid UK

Leethan Bartholomew – London Schools Black Child Hackney

Lucy Thorpe – Royal College of Psychiatrists

Mwenya Chimba – Black Women Step Out Wales

Naana Otoo-Oyortey, MBE – FORWARD

Natalie Reseigh – Metropolitan Police Service

Nick Libell – Royal College of Paediatrics and Child Health

Nicola Butler – Metropolitan Police Service

Nimco Ali – Daughters of Eve

Rebecca Mussell – British Medical Association

Sarian Karim – Manor Gardens Health Advocacy Project

Sioned Churchill – Trust for London

Stephen Chapman – Welsh Government

Susan Bookbinder – Journalist and Broadcaster

Tracy Grey – NHS England

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- ⁴ UN General Assembly (2012) *Intensifying Global Efforts for the Elimination of Female Genital Mutilations*, A/RES/67/146.
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The Project Group

The Intercollegiate Group is made up of:

Royal College of Midwives

Equality Now

Royal College of Obstetricians & Gynaecologists

Community Practitioners' and Health Visitors' Association

Royal College of Nursing

Janet Fyle

Professional Policy Advisor

Royal College of Midwives

Rebecca Jones

PR Officer

Royal College of Obstetricians & Gynaecologists

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Advocacy Director

Equality Now FGM Programme

Gerald Chan

Director, Health Policy and Public Relations

Royal College of Obstetricians & Gynaecologists

Obi Amadi

Lead Professional Officer

Unite/CPHVA

Carmel Bagness

Midwifery & Women's Health Adviser

Royal College of Nursing

Samantha Manners

Administrator

Royal College of Nursing

Glossary

De-infibulation:

Sometimes referred to as defibulation or FGM reversal, meaning the surgical procedure to open up the closed vagina of FGM Type III.

Female Genital Mutilation:

All procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.

Infibulation:

Refers to Type III of FGM, the most extensive form of FGM, which involves closing the vaginal orifice.

Selective enquiry:

Refers to asking girls or women directly about their experiences, based on concerns or suspicions.

Routine enquiry:

Refers to asking all service users about their experiences of violence/abuse, regardless of any signs of abuse or whether abuse is suspected.

Acronyms

FGM – Female Genital Mutilation

BMER – Black and Minority Ethnic and Refugee Groups

JSNA – Joint Strategic Needs Assessment

MASH – Multi-agency Safeguarding Hub

PTSD – Post-traumatic Stress Disorder

VAWG – Violence against Women and Girls

