Multi-Agency Strategy to Tackle Female Genital Mutilation
2015-2018

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<table>
<thead>
<tr>
<th>Contents</th>
<th>Page no(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
<td>3</td>
</tr>
<tr>
<td>2. Definition of Female Genital Mutilation (FGM)</td>
<td>4</td>
</tr>
<tr>
<td>3. The Practice of FGM</td>
<td>5</td>
</tr>
<tr>
<td>4. Key Changes to Legislation</td>
<td>7</td>
</tr>
<tr>
<td>5. The Strategic Vision</td>
<td>9</td>
</tr>
<tr>
<td>6. The Law and FGM</td>
<td>11</td>
</tr>
<tr>
<td>7. Links to Other Strategies and Legislation</td>
<td>12</td>
</tr>
<tr>
<td>8. Governance</td>
<td>12</td>
</tr>
<tr>
<td>9. Implementing the Strategy</td>
<td>13</td>
</tr>
<tr>
<td>10. Prevention</td>
<td>13</td>
</tr>
<tr>
<td>11. Protection</td>
<td>15</td>
</tr>
<tr>
<td>12. Provision of Service</td>
<td>16</td>
</tr>
<tr>
<td>13. Partnership Working</td>
<td>16</td>
</tr>
<tr>
<td>14. Effective outcomes</td>
<td>17</td>
</tr>
<tr>
<td>15. Managing Risk</td>
<td>17</td>
</tr>
<tr>
<td>17. FGM Mandatory Reporting</td>
<td>21</td>
</tr>
<tr>
<td>18. Equality Impact Assessment</td>
<td>23</td>
</tr>
<tr>
<td>19. References</td>
<td>28</td>
</tr>
</tbody>
</table>
1.0 **Introduction**

1.0 This document provides the context in which partner agencies including North East London NHS Foundation Trust (NELFT), Barking Havering Redbridge University Trust (BHRUT), Barts Health, Redbridge Local Authority, Barking and Dagenham Local Authority and Havering Local Authority, alongside other partnership agencies intend to provide services to tackle Female Genital Mutilation over the next three years. This collective group will be referred to in this document as *The Partnership*. The development of this strategy includes significant contributions from local community representatives. It is intended that agencies will continue to engage with local groups to help reduce tolerance to the practice of FGM. Furthermore, work will be undertaken via community engagement projects to ensure that the communities most affected are involved and influence the direction of the work and ensure a sensitive response to families who are affected by FGM.

1.1 The strategy acknowledges that FGM is a form of child abuse and is also a form of Violence Against Women and Girls (VAWG) with overlapping complexities within child sexual exploitation, forced marriage, human trafficking and other harmful practices. The lifelong health and social impacts often include physical and psychological trauma, such as post-traumatic stress disorder as well as influencing the comorbidity of pregnancy, childbirth and long-term systemic infection.

1.2 It is within this context that the LSCBs agreed to incorporate the findings and proposals from the intercollegiate recommendations for tackling FGM and to embed actions to tackle the problem within the safeguarding framework as well as the VAWG strategic objectives. Throughout this document the word *child* is taken to mean girls between the ages of 0-18 years old.

1.3 The strategy recognises the global and local interconnectedness to the practice as well as the overlapping complexities with domestic and sexual violence, child sexual exploitation and other forms of violence against women and girls. Since the practice adversely impacts upon the health, safety and wellbeing of women and girls this strategy has adopted the UK government and UN strategic principles which state that FGM is:

- A crime.
- A form of child abuse.
- A form of Violence Against Women and Girls.
- A Violation of Human Rights and a form of torture.
1.4 The Partnership will adopt a coordinated approach by ensuring that council, education, health, police and other agencies have the right services in place to identify girls who are at risk and take action to prevent FGM from happening. The Partnership will provide a sensitive safeguarding response, and help to build the resilience of women and girls affected by this problem by ensuring that sensitive, specialist support, information and advice is available to them.

1.5 The Partnership has established a proven commitment to eliminating violence and other harmful practices that negatively impact upon the lives of children, which might prevent them from reaching their full potential. The Partnership also recognises that much of the achievements in strengthening communities have taken place through effective partnership with statutory and voluntary agencies.

1.6 Although the practice of FGM mostly affects young girls, the impact is enduring beyond childhood and into adulthood. Evidence supporting the VAWG strategies also suggests that for women who have had FGM, the re-victimisation often takes place in the form of domestic and intimate partner violence for women in later life. Emerging evidence shows that women who have had FGM often endure incidents of violence and abuse over a much longer period of time and are less likely to report the problem. Therefore it is for this reason that efforts to address the issue of FGM must be viewed within the wider context of domestic and sexual violence, honour based crimes and child sexual exploitation.

2.0 Definition of Female Genital Mutilation (FGM)

2.1 Female genital mutilation (FGM) is defined by the World Health Organisation (WHO) as “the range of procedures which involves the partial or total removal of the external female genitalia or other injury to the female genital organ whether for cultural or other non-therapeutic reasons”.

2.2 FGM involves the procedures that include the partial or total removal of the female external genital organs for cultural or other non-therapeutic reasons. FGM can be performed on babies and toddlers but it is mostly common in girls aged 4-10 and it is usually performed before puberty. The practice is medically unnecessary, extremely painful and has serious health consequences, both at the time of when the mutilation is carried out and in later life (H.M Government, 2010).

2.3 The United Nations (UN) and the World Health Organisation joint statement on FGM defines the practice is a violation of the rights of the child and her entitlement to her bodily integrity. FGM causes death, disability, physical and psychological harm for millions of women every year and there is increasing evidence linking the practice with psychiatric disorder in young girls and women presenting with post-traumatic stress disorder. Therefore it is within these contexts that The Partnerships alongside other agencies intend to improve the quality of life and reduce the life limiting conditions that are linked to the practice of FGM.

2.4 The WHO classifies FGM into four types (see table 1 below). The most extreme involves the narrowing of the vaginal orifice. It is sometimes inappropriately referring to as female circumcision or Female Cutting. Some communities use local names for the practice, including the terms: Sunna, Gudniin, Hayalays, Tahir and Megrez.
2.5 Types of FGM:

Type 1: Cliteridectomy: partial or total removal of the clitoris including the fold of skin surrounding the clitoris.

Type 2: Excision: partial or total removal of the clitoris and labia minora, with or without excision of the labia majora.

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. Infibulation is strongly linked to virginity and chastity, and used to safeguard girls from sex outside marriage and from having sexual feelings.

Type 4: Other: all other harmful procedures to the female genitalia for non-medical purposes including piercing, tattoo and scraping.

3.0 The Practice of FGM

3.1 The practice of FGM is usually carried out on girls between infancy and the age of 15 with the majority of cases occurring between the ages of five and eight. It is occasionally carried out on adult women following child birth (infibulation) or where the woman is forced to undergo the procedure by her husband after marriage. In some countries it is more likely to be carried out by health professionals. However it is commonly performed by traditional practitioners with no formal medical training, without anaesthetics or antiseptics, using knives, scissors, scalpels, pieces of glass or razor blades. Often the girl is forcibly restrained throughout the procedure.

3.2 FGM is a practice based on customs and traditions. It is also based on the incorrect belief that it protects a girl’s virginity, protects family honour; the girl is perceived to be more hygienic, desirable, attractive, and it increases the sexual pleasure of men. It is practiced to enhance a girl’s prospect of marriage (Forward, 2012 and UN, 2013).

3.3 The World Health Organisation states that communities from 28 African countries, the Middle East, including Egypt, Yemen and Syria and the Kurdish community of northern Iraq practice FGM and it is estimated that between 130 and 140 million girls and women are victims of FGM. Evidence from the UN and UK government suggests that the largest population groups from practicing counties were from Ghana, Kenya, Nigeria, Somalia, and Uganda. The estimated number of women resident in England and Wales in 2001 who had been subjected to FGM was 65,000. The highest estimated numbers of women with FGM were from Kenya and Somalia. In more recent times emerging but unconfirmed evidence suggests that women in the UK from non-practicing communities are electing to undergo the procedure in circumstances of inter-racial marriages.

3.4 FGM is not a requirement of any religion. However it is practiced by Christians Muslims, Jews and non-believers in a variety of cultures and communities. Although the practice is often attributed to a number of religious beliefs, there is no evidence from the Bible, Koran, Torah or other religious text to support this practice. Despite this religion is often given as a justification for FGM. For instance some people from
Muslim communities argue that the practice is approved by the prophet Mohammed or it will make them a better Muslim (FORWARD, 2013, HM Government, 2011).

3.5 Since 1985 it has been a serious criminal offence under the Prohibition of Female Circumcision Act to perform FGM or to assist a girl to perform FGM on herself. In England, Wales and Northern Ireland, the practice is illegal under the FGM Act 2003. This offence captures mutilation of a female labia majora, labial minora or clitoris. The Partnership therefore adopts the perspective that FGM is a form of child abuse and also part of the wider understanding of Violence Against Women and Girls (VAWG).

3.6 Although the majority of victims are children, adults are affected by this practice and are especially vulnerable to re-infibulation following childbirth. Therefore this strategy is aimed at protecting children and adults who are at risk of FGM or at risk of re-suturing following childbirth. It is within this context that those responsible for carrying out the practice of FGM in the UK and abroad are held to account through the criminal justice system as well as preventive and protective measures.

3.7 Approximately 60,000 girls aged 0-14 have been born in England and Wales to mothers who have undergone FGM, however the prevalence in the UK is still emerging. The World Health Organisation states that communities from 28 African countries, the Middle East including Egypt, Yemen, Syria and the Kurdish communities and Northern Iraq practice FGM. It is estimated that 170,000 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 FGM. This number is likely to be higher as births to women affected by FGM have increased from 1.04% in 2001 to 1.67% in 2008. Evidence provided by a WHO collaborative study in six African countries showed that women with FGM were at higher risk of caesarean section, post-partum haemorrhage, prolonged maternal hospitalisation, infant resuscitation and perinatal death. The risk also increases with the severity of the FGM procedure. A similar study from the Gambia, where type 2 FGM is commonly practiced, found that women with FGM were more likely to experience other kinds of medical complications.

3.8 The practice of FGM remains one of the most pervasive types of violence against women and girls. This is because of the hidden nature of the problem, the cultural sensitivity of the issue and the historical tolerance of the practice. The Partnership is committed to working effectively to improve data collection and analysis so that it can develop an improved understanding of the nature and prevalence of the practice and target services to prevent FGM from happening.

3.9 There are a number of factors, in addition to a girl's or woman's community, that could increase the risk that she will be subjected to FGM. These include the position of the family and the level of isolation within UK society. It is believed that communities less integrated into British society are more likely to carry out FGM. However any girl born to a woman who has been subjected to FGM must be considered to be at risk as well as other female children in the extended family. Any girl withdrawn from Personal, Social and Health Education (PHSE) classes may be at risk.

4.0 Key changes brought about by the Serious Crime Act 2015
4.1 Summary of Serious Crime Act 2015 as it relates to FGM:

- Extension of extra-territorial jurisdiction relating to FGM;
- Anonymity of victims of FGM;
- Offence of failing to protect a girl from risk of FGM;
- Creation of Female Genital Mutilation Protection Order ("FGMPO");
- Duty to notify police of female genital mutilation
- Guidance about Female Genital Mutilation.

4.2 Extension of extra-territorial jurisdiction

Section 70(1) of the Serious Crime Act 2015 ("the 2015 Act") amends section 4 of the 2003 Act so that the extra-territorial jurisdiction extends to prohibited acts done outside the UK by a UK national or a person who is resident in the UK.

These changes will mean that the 2003 Act can captures offences of FGM committed abroad by or against those who are at the time are habitually resident in the UK, irrespective of whether they are subject to immigration restrictions. It will be for the courts to determine on the facts of individual cases whether or not those involved are habitually resident in the UK and thus covered by the 2003 Act.

4.3 Anonymity of victims of FGM

Reluctance to be identified as a victim of FGM is believed to be one of the reasons for the low incidence of reporting of this offence. It is anticipated that providing for the anonymity of victims of alleged offences of FGM will encourage more victims to come forward.

Section 71 of the 2015 Act amends the 2003 Act to prohibit the publication of any information that would be likely to lead to the identification of a person against whom an FGM offence is alleged to have been committed. Anonymity will commence once an allegation has been made and will last for the duration of the victim’s lifetime.

4.4 Offence of failing to protect a girl from risk of FGM

Section 72 of the 2015 Act inserts a new section 3A into the 2003 Act; this creates a new offence of failing to protect a girl from FGM. This will mean that if an offence of FGM is committed against a girl under the age of 18, each person who is responsible for the girl at the time of FGM occurred will be liable under this new offence. The maximum penalty for the new offence is seven years' imprisonment or a fine, or both.

To be “responsible” for a girl, the person will either have parental responsibility for the girl (such as mothers, fathers married to the mothers at the time of birth and guardians) or have frequent contact with her. Where the person is aged 18 or over they will have assumed responsibility for caring for the girl “in the manner of a parent”, for example family members to whom parents might send their child during the summer holidays.

The requirement for “frequent contact” is intended to ensure that a person who in law has parental responsibility for a girl, but whom in practice has little or no contact with her, would not be liable. Similarly, the requirement that the person should be caring for the girl “in the manner of a parent” is intended to ensure that a person who is looking after a girl for a very short period – such as a baby sitter – would not be liable.
18. It would be a defence for a defendant to show that at the relevant time, they did not think that there was a significant risk of FGM being committed, and could not reasonably have been expected to be aware that there was any such risk; or they took such steps as he or she could reasonably have been expected to take to protect the girl from being the victim of FGM. The onus would then be on the prosecution to prove the contrary.

4.5 Female Genital Mutilation Protection Order (FGMPO)

Section 73 of the 2015 Act provides for FGMPOs for the purposes of protecting a girl against the commission of a genital mutilation offence or protecting a girl against whom such an offence has been committed. Breach of an FGMPO will be a criminal offence with a maximum penalty of five years’ imprisonment, or as a civil breach punishable by up to two years' imprisonment.

The court may make a FGMPO on application by the girl who is to be protected or a third party. The court must consider all the circumstances including the need to secure the health, safety, and well-being of the girl.

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 documents; and not to enter into any arrangements, in the UK or abroad, for FGM to be performed on the person to be protected.

4.5 Duty to notify police of female genital mutilation

Section 74 inserts a new section 5B into the 2003 Act which creates a new mandatory reporting duty requiring specified regulated professionals in England and Wales to make a report to the police. The duty applies where, in the course of their professional duties, a professional discovers that FGM appears to have been carried out on a girl aged under 18 (at the time of the discovery).

The duty applies where the professional either:

- is informed by a professional that an act of FGM has been carried out on her, or the practitioner observes physical signs which appear to show an act of FGM has carried out.
  - This includes piercings, scrapings and tattoos of the genitalia

The duty applies to professionals working within health, social care and education. It therefore covers:

- Professionals regulated by a body overseen by the Professional Standards Authority (with the exception of the Pharmaceutical Society of Northern Ireland).
- This includes doctors, dentists, nurses, midwives and therapists
- Social Workers
- Teachers
The duty does not apply where a professional has reason to believe that another individual working in the same profession has previously made a report to the police in connection with the same act of FGM.

5.0 The Strategic Vision

5.1 This strategy does not affect existing safeguarding strategic arrangements. Instead, it complements the directions contained within the existing national and Pan London Safeguarding Procedures. Its purpose is to provide clarity around the prevention and protection and support of children, young people and adults affected by FGM.

5.2 Our aim is to ensure that The Partnership has the right services and response in place to prevent FGM from happening and to protect children, young girls and women who are at risk of having FGM. In particular, the strategic principles will seek to complement partnership working to end Violence Against Women and Girls (VAWG) (2012), incorporate the findings and recommendations from the intercollegiate document Tackling FGM in the UK (2013) and The Home Office Multi-agency Practice Guidelines FGM (2012) and outline responses to FGM within existing adult and children safeguarding frameworks.

5.3 Building the resilience of children and young girls who are at risk of or who have been affected by FGM is a fundamental part of the strategy to tackle the problem. This means that raising awareness about the problem and empowering local communities to work in partnership to eliminate the practice.

5.4 This document therefore strengthens The Partnership as well as the LSCBs’ commitment to tackling FGM as part of the VAWG strategy locally. This will be achieved by upholding The Partnership’s commitment to:

- **Prevention** of FGM from happening by reducing societal and community tolerance to the problem.
- **Provide services** sensitive to the needs of women and girls affected by FGM that reflect a therapeutic and safeguarding response.
- **Work in Partnership** with other agencies to ensure that services to tackle FGM are in place.
- **Prosecute** those who are responsible for perpetrating the practice and sending a clear message that the practice of FGM will not be tolerated.

5.5 The UK government upholds that FGM is a severe form of gender-based violence, and where it is carried out on a girl, it is an extreme form of child abuse. Therefore everyone who has responsibility for safeguarding children must view FGM in this way. For this reason The Partnership intends to ensure that the principles and activities to protect vulnerable girls and women who are at risk of or have had FGM can be assessed, implemented and evaluated.

5.6 The actions, performance measures and outcomes outlined in this document provide details of the focus of activities and how this will be achieved and. The Partnership will ensure that services to women and girls who are affected by FGM will help to minimise the long-term health and social impact of the problem and take action to redress the crime regardless of whether FGM was committed in the UK or abroad.

5.7 It should be noted that the population affected by FGM might face additional challenges in addressing the problem. These include practices that are linked so-
called honour-based violence (HBV), Modern Day Slavery (MDS), insecure and unclear immigration status. These are additional barriers which are embedded within the overarching VAWG strategy.

5.8 This strategy primarily focuses on women and girls because of the significant biases towards them as victims of these forms of violence. However it is acknowledged that men are also complicit with the practice as part of the sexual exploitation of children and other so-called honour crimes. Where necessary, The Partnership will work together to eradicate the practice and improve the health and wellbeing for girls, women and families.

5.9 Much of the provision and actions committed in this document will be applicable to women. However men who wish to support the eradication of this type of violence will be assisted by providing specialist services to help build their resilience to identify and report FGM. This strategy will be reviewed periodically at which point it will be possible to evaluate the wider impact on families and communities and identify further strategic activities that may be required.

5.10 The Partnership along with other agencies is committed to the UK government implementation of mandatory reporting of FGM. The strategic actions and outcome measurement are explicit within page 16 of this document.

5.11 In order to ensure that this strategy was given appropriate consideration, representatives from community voluntary services contributed to its development. The LSCBs unanimously supported the development of an FGM specific multi agency sub group to address these issues, supported by resources from the LSCB’s Development Officer and Business Support Officer and NELFT. The sub group met over a period of nine months and was attended by representatives from the voluntary sector, as well as the National FGM charity FORWARD.

5.13 This strategy has been agreed and supported by:
- Redbridge Safer Community partnership.
- Waltham Forest LSCB.
- NELFT.
- Redbridge LSCB.
- Barking Havering Redbridge University Hospitals Trust.
- Redbridge Somali Consortium.
- Havering LSCB.
- Barking and Dagenham LSCB and Community Safety Partnership.
- Barts Health.
- Waltham Forest CCG
- BHR CCGs

6.0 The Law and FGM

6.1 The Female Genital Mutilation Act (2003) made it illegal for UK residents (in England and Wales) and permanent residents to practice FGM within or outside in the UK. (This legislation does not apply to Scotland). The act made it illegal for someone to take a British Citizen abroad to perform the operation whether or not it is against the law in that country. It is also illegal to assist in carrying out FGM abroad for non-medical reasons. The law, however appears to allow surgery to the external genitalia for comfort, sexual confidence, body image and self-esteem.

6.2 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. Both Acts carry a maximum penalty of 14 years. Under the term 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 any person.
- Aid, abet, counsel or produce a girl to mutilate her own genitalia.
- Aid, abet, counsel or produce another person who is not a UK national to mutilate a girl's genital outside the UK.

Therefore all girls and women presenting with FGM within The Partnerships’ economy will be considered as potential victims of crime.

6.3 There have been no convictions under this act to date and it is unknown if the act has served as a deterrent and if FGM is still being practiced in the UK or if girls being taken abroad to undergo FGM. Research conducted by FORWARD (2009) found that women felt that the law has had an impact on FGM, as people are reluctant to take their daughters to their countries of origin to undergo the procedure due to the fear of police and social care involvement. Women who took part in the research stated that even if people’s attitudes towards FGM have not changed, the law has encouraged their behaviour to change.

6.4 As outlined earlier in the strategy, the Serious Crime Bill (2015) inserts a new section in the 2003 Act which will mean that if an offence of FGM is committed against a girl under the age of 16, each person who is responsible for the girl at the time of FGM occurred will be liable. The maximum penalty for the new offence will be seven years' imprisonment or a fine or both. To be “responsible” for a girl, the person will either have parental responsibility for the girl and have frequent contact with her, such as mothers, fathers married to the mothers at the time of birth, and guardians, or where the person is aged 18 or over they will have assumed responsibility for caring for the girl "in the manner of a parent", for example family members to whom parents might send their child during the summer holidays.

6.5 The requirement for "frequent contact" is intended to ensure that a person who in law has parental responsibility for a girl, but who in practice has little or no contact with her, would not be liable. Similarly, the requirement that the person should be caring for the girl "in the manner of a parent" is intended to ensure that a person who is looking after a girl for a very short period – such as a baby sitter – would not be liable.

7.0 Links to Other Strategies and Legislation

7.1 This strategy draws upon and should be read in conjunction with the Government’s national strategy to end violence against women and girls action plan 2014 as well as the Mayors’ office for police crime Violence Against Women and Girls strategy. This strategy contributes to the Mayor’s long-term aim to change attitudes in order to reduce the tolerance of violence against women and girls so that women can live without fear and or the reality of violence.

7.2 Therefore this document must be read in conjunction with the following national and local strategies aimed at strengthening the resolve to eliminate the practice of FGM:
7.3 These documents highlight the overlapping similarities and differences between other types of violence against women and girls as well as the actions required to realise the overarching strategic objective to eliminate this crime. In addition, this strategy must be developed in line with:

- Joint Strategic Needs Assessment
- Equality Strategy
- Emotional Health Wellbeing Mental Health Services
- Child Adolescence Mental Health Services

8.0 Governance

8.1 The LSCBs have identified addressing FGM as a priority and are committed to implementing the strategy to ensure a shared approach to tackle the problem. However agencies cannot address FGM alone or in isolation from other related safeguarding issues. Therefore LSCBs have a significant role in ensuring that the work of all agencies is coordinated, confirming unique and shared roles and functions to ensure that children and young people are protected and other important outcomes are achieved.

This strategy will be monitored through the VAWG or the Domestic and Sexual Violence strategic work-stream and it is the responsibility of each partner to publish outcomes of action plan. As part of the wider strategy to safeguard children and to prevent violence against women and girls, this strategy will be monitored and coordinated by The Partnerships’ governance arrangements.

8.2 The community safety partnerships (CSP) have a key responsibility in monitoring and updating the overarching strategy. The overarching governance remains the responsibility of the community safety partnership but with additional reporting arrangements to the health and wellbeing board, VAWG strategic groups. The strategic ownership of the issues linked to FGM and gender-based violence sits across a variety of strategic boards within partnerships

9.0 Implementing the Strategy

9.1 A number of small scale qualitative studies across the UK have highlighted the view of people affected by FGM on its prevention. 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. The Partnerships support the implementation of mandatory reporting of FGM and will ensure that services to support the identification and reporting are in place to implement this practice.

Work will continue with local community groups to ensure that services are responsive and meet the needs of the children and their families who are affected by FGM.

9.2 Evaluations of community-based studies have also shown that access to specialist FGM services (for instance, de-infibulation) are vital in 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 interventions to support breaking down the cycle of abuse (See appendix 1 for Risk factors associated with FGM).

10.0 Prevention

10.1 It is envisaged that activities to eradicate FGM will have greatest effect if there is early intervention to prevent the practice from happening in the first place. The activity proposed in this area is shaped by work detailed in The Partnerships’ early intervention strategies and the work carried out in schools, community health and maternity care.

10.2 Prevention and early help is predicted by having reliable intelligence (both hard and soft data), a well-informed workforce and appropriate services. The provision aspect of this strategy is outlined in section 2: page 18 of this document. Early intervention is crucial to prevention and eradication of this practice. However, it is acknowledged that ultimately this will depend upon the wider strategy to prevent Violence Against Women and Girls from happening in the first place.

10.3 Schools play a vital role in educating young girls, building their resilience and safeguarding vulnerable victims who are at risk of or have undergone FGM. The Partnership will continue to identify ways to engage schools and support the education of young people on the interconnectedness of the practice with violence against young girls. Work will take place with head teachers to highlight best practice by promoting case studies produced by the LSCBs and Safeguarding Adults Boards. The Personal Health Social Education (PHSE) Association recommends that one of the most sustainable ways of promoting the safety of girls and young women and seeking to prevent FGM is to make it a key component of the school’s PSHE education curriculum. This can be done within or as part of sex and relationships education or as part of a topic on personal safety. All pupils should be given the opportunity to be informed of the facts about FGM and curriculum time should be provided for them to explore issues which may impact on their personal safety or the safety of others. They should have the opportunity to discuss cultural attitudes relating to FGM and be made aware of how to protect themselves from the risk of abuse including knowing where to access help if they are worried or concerned.
10.4 It is important that work in this area is seen as a whole school responsibility. The school’s sex and relationships education policy should include teaching about FGM and references should also be made within safeguarding and child protection policies. In addition, school staff should receive appropriate training so that they are able to recognise pupils who may potentially be at risk. A presentation designed to support school staff can be accessed at: https://www.pshe-association.org.uk/content.aspx?CategoryID=1193.

10.5 Health professionals including GP surgeries, school, sexual health services, maternity care and primary care workers are more likely to encounter a girl or woman who has been subjected to FGM. This means that health professionals should take a lead role in targeted enquiry and mandatory reporting of FGM.

10.6 This approach compliments the work undertaken in in the practice of routine enquiry in relation to domestic violence and abuse disclosure. We are confident that partner agencies will work together to implement these initiatives.

10.7 The preventative work plan will continue to ensure that information sharing protocols reflect the national guidance. Evidence from the JSNA will inform the strategic development of data collection and robust data collection to map local prevalence and target services to reflect local needs. Schools, maternity and community child health services play a vital role in educating and identifying particularly vulnerable girls who are at risk of or may have undergone FGM and we will continue to work with these services to raise awareness about the impact and consequences of FGM.

10.8 This approach compliments the work undertaken in the past through VAWG strategies. Work will continue to develop and maintain the initiatives contained in the action plan in appendix 1 of this document.

10.9 The Partnership is committed to embed the preventative measures within the existing safeguarding and public health strategies to address the health and social impact of the problem and ensure that women who have undergone FGM and girls at risk can access specialist services for information, advice, support and necessary health treatment. This will include work to empower women to access support, address barriers to services, training staff as well as commissioning arrangements for specialist services. The actions specific to prevention includes:

- Ensure that issues relating to FGM are embedded within all aspects of service delivery.
- Develop the competences, knowledge and skills of all frontline professionals to ensure early identification, prevention and protection of girls who are at risk of FGM.
- Ensure that robust safeguards/sanctions are in place to respond to intentional non-reporting from employees.
- Raise awareness through local communities through key educational programs.
- Integrate innovative local community actions to reduce the practice of FGM within the existing VAWG strategies with local community action groups.
- Implement the UK national strategy of the mandatory reporting of FGM.
- Ensure that early identification of FGM where a child or vulnerable adult are identified and help is offered to the family.
- Integrate innovative preventative actions within the LSCBs safeguarding framework.
- Treat the Practice of FGM as a crime.

11.0 Protection
11.1 The arrangements to protect women who have undergone FGM and girls who are at risk are integrated within the local multi-agency safeguarding arrangements. The guidance will include a robust multi-agency response to ensure effective information sharing and joint risk assessments between health, police, education social care and other key agencies.

11.2 The protective strategies include training on safeguarding procedures in relation to FGM and how to respond to disclosure sensitively. The Partnership recognises that professionals have a legal duty to protect girls from FGM. Section 31 of The Children’s Act (1989) sets out the threshold for intervention if a child is likely to suffer or is suffering from significant harm. Where there is a suspicion or concerns that significant harm will be experienced, professionals have a duty to report and refer cases, document response and share information between agencies. This includes where there are concerns about FGM.

11.3 Evidence suggests that the problem remains mostly hidden because of a lack of professional awareness of the health and safeguarding risk, concerns by professionals that they might offend or stigmatise people from BMER communities and concerns that referrals of at-risk girls will overwhelm services.

11.4 The problem is believed to be further compounded by unclear referral thresholds, particularly within health, education and children’s social services as well as a lack of robust monitoring and surveillance systems. There is also a lack of accountability in relation to local performance DH, 2012 and Royal College of Obstetrician and Gynaecologists 2013.

11.5 The College of Policing advised on the role of police officers, suggesting that: all police officers, particularly senior officers who may have more contact with influential community members, should work closely with all communities within their policing area to challenge the practice of FGM. They should ensure that the communities are aware that FGM is a crime and that those involved in committing or facilitating FGM may be arrested, prosecuted and imprisoned for up to 14 years. Parents and guardians failing to protect a girl from the risk of FGM may also be liable to up to 7 years’ imprisonment. Officers have a duty to safeguard everyone, including women and girls, which reinforces that tackling FGM is an integral part of their role. They must take effective action to do so, without allowing themselves to be inhibited by fear of doing or saying the wrong thing or being accused of being racist. Effective action means making potential victims safe, investigating offences and bringing offenders to justice.

11.6 Work to address safeguarding concerns will:

- Develop and agree clear risk assessment and multi-agency threshold for actions.
- Name and treat child FGM as a form of child abuse.
- Ensure that all frontline professionals develop knowledge, skills and competencies to enable safe, effective and sensitive responses to FGM.
- Ensure that appropriate safeguarding services to respond to victims of FGM are in place and include clear and effective referral pathways.
- Ensure that services to protect children from the practice of FGM are embedded within the LSCBs accountability framework.
- Implement the UK national strategy of mandatory reporting as part of the safeguarding action to protect vulnerable children and adults who are at risk or have had FGM.
Take positive action to minimise the health and social impact of girls who have undergone FGM.

12.0 Provision of Service

12.1 The Partnership is committed to ensuring that local dedicated support services for victims continue to meet the complex needs of women and girls from local communities who are affected by FGM. It will collaborate with partner agencies to find new ways of working to ensure continued delivery of support services for victims. Where FGM is uncovered or reported, victims will be offered safeguarding as well as therapeutic services to help them overcome the health and social impact of living with the problem. The actions outlining the provision of services to local communities is contained within the action plan on page 19 of this document. The specific areas of work to be undertaken include:

- Developing an integrated VAWG approach to tackling FGM within the commissioning and delivery of services to victims/survivors.
- Provide a client centered holistic approach to supporting girls and women within which the safety of the victim and their families is prioritised.
- Actively ensure that the voices and views of service users and survivors of FGM inform future development of services.
- Ensure robust multi-agency safeguarding and therapeutic response pathways to FGM.
- Implement evidence-based commissioning which focuses on outcomes for victims and their families.
- Work effectively with local communities and specialist services to raise awareness about the problem and reduce tolerance to FGM.

13.0 Partnership Working

13.1 The Partnership finds the practice of FGM unacceptable and condemns the practice. It also recognises that women who have undergone FGM are victims of crime and have complex needs.

By signing up to this agreement The Partnership agree to support robust information sharing and working together to protect families who are at risk and to use data effectively to understand trends and prevalence and to inform future service development.

13.2 The Partnership believes that an integrated response to FGM is the most effective approach to tackling safeguarding and gender-based violence. The guiding principle is to ensure working in partnership to achieve best outcomes for victims and their families. The broad strategic outcomes that The Partnership want to achieve are as follows:

- Work effectively with agencies to ensure that services for FGM are informed by effective data intelligence and data analysis.
- Work together with statutory, voluntary and community sectors to share best practice and agree local outcomes.
- Provide effective support for victims and their families.
- Ensure that partner agencies have in place effective arrangements to safeguard children and adults affected by FGM.
- Ensure that multi-agency services to protect and support victims are aligned with work to hold perpetrators to account for their actions.
- Maintain strong corporate and political commitment to address FGM as part of the overarching strategy to tackle gender based violence.
• Work in partnership to prosecute those responsible for perpetrating the practice of FGM.

14.0 Effective outcomes

14.1 Effective outcomes will be measured against:
• Analysis of partnership data to identify patterns, trends and prevalence within the borough.
• Commissioning of reviews and publication of lessons learned to help The Partnerships to learn from handling of FGM cases.
• Base all relevant strategies on the updated version of statutory guidance (LSCB) Safeguarding Children at Risk through Female Genital Mutilation (2009) and the Royal college of Paediatrician and Child Health (2013) Tackling FGM in the UK intercollegiate recommendation for identifying, recording and reporting. This guidance sets out the roles and responsibilities of services and promotes the values of effective multi-agency working.
• Utilise existing arrangements for working with partners in health care, education and the criminal justice sector in securing excellence through the commissioning services for people who are affected by FGM.
• Effective multi-agency responses and strategic actions on pages 20 and 21 of this document.

15.0 Managing Risk

15.1 The Department of Health (2015) provides explicit guidance on a number of different responses that are linked to managing safeguarding risk and supporting families who do not support the practice of FGM. The guidance suggests that actions should be decided on the basis of expert input from all agencies involved. Wherever FGM is disclosed or identified, consider the following actions:

<table>
<thead>
<tr>
<th>Immediate/Urgent referral.</th>
<th>A credible threat exists and there is explicit evidence that a child or vulnerable person is at risk of undergoing FGM. E.g. a woman who has undergone FGM has given birth to female child and the women and/or her family refuse to denounce the practice.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active/on-going safeguarding support with social services lead.</td>
<td>It is likely that FGM will occur. However there are some protective measures already in place to prevent FGM. E.g. The mother is compliant with services and is working with professionals to protect the child but other family members are not in agreement. Consider travel restrictions, etc. and follow safeguarding procedures. <strong>Verify existing interventions and strategy.</strong> If unclear, refer.</td>
</tr>
<tr>
<td>Information-sharing between agencies with no specific protection is required.</td>
<td>If the mother who has been cut gives birth to a baby girl but clearly states that she would not carry out the procedure, there is no need for a referral. However the information must be shared with other agencies. No immediate or probable risk exists e.g. family denounce the practice. E.g. mother has had FGM and given birth to baby boy. On-going therapeutic support may be needed. <strong>Provide resource information to family if it is safe to do so.</strong></td>
</tr>
</tbody>
</table>


15.2 Working across agencies is essential to effective safeguarding efforts. This is reflected throughout the HM Government Multi-Agency Practice Guidelines on FGM, and should be a central consideration whenever discussing safeguarding girls from FGM. The introduction of mandatory reporting data recording and data collection in the NHS, require report to be made to the police for all cases of FGM identified in girls under 18 years old.

15.3 There is no requirement for automatic referral of adult women with FGM to adult social services or the police. All mandatory reporting of FGM from NELFT must be reported to the NELFT safeguarding duty desk in the first instance on: Safeguarding Adults Contact: Telephone Number: 0300 555 1201 Extension 64715 Email Address: Safeguarding.adults2@nhs.net

Safeguarding Children Contact: Telephone Number: 0300 555 1201 Extension 65022 Email Address: nem-tr.nelftsafeguardingchildren@nhs.net.

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**National And Local Services For FGM**

<table>
<thead>
<tr>
<th>National services</th>
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<tbody>
<tr>
<td>Non-emergency contact 101 or 999 to report emergency</td>
</tr>
<tr>
<td><a href="mailto:NationalFGMCentre@barnardos.org.uk">NationalFGMCentre@barnardos.org.uk</a>.</td>
</tr>
<tr>
<td>Open: Run three clinics every month at present. They have a procedure list which happens on the first Monday of the month and the other clinics take place on the third and fourth Mondays of the month.</td>
</tr>
<tr>
<td>e-mail: For complex cases <a href="mailto:sohier.elneil@uclh.nhs.uk">sohier.elneil@uclh.nhs.uk</a>, or <a href="mailto:fgmsupport@uclh.nhs.uk">fgmsupport@uclh.nhs.uk</a>.</td>
</tr>
<tr>
<td>Telephone: 07944 241992</td>
</tr>
<tr>
<td>For Dr Hodes contact 02034475241 or email <a href="mailto:Kirsty.phillips2@uclh.nhs.uk">Kirsty.phillips2@uclh.nhs.uk</a> and <a href="mailto:renara.begum@uclh.nhs.uk">renara.begum@uclh.nhs.uk</a> for an appointment.</td>
</tr>
</tbody>
</table>

**FORWARD**

Suite 2.1
Chandelier Building
8 Scrubs Lane
London
NW10 6RB Telephone: +44 (0)20 8960 4000
E-mail: forward@forwarduk.org.uk
### 19.0 Multi-Agency Action Plan

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Action</th>
<th>Lead Agency</th>
<th>Outcome</th>
<th>Time scale</th>
<th>Rag rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prevention</strong></td>
<td>Establish a performance baseline in relation to identifying FGM by October 2015.</td>
<td>NELFT Redbridge LA. Havering LA Waltham Forest LA BHRUT Waltham Forest CCG BHR CCG Education GPs</td>
<td>Baseline established with a performance target of an annual increase of 10% per year from October 2015.</td>
<td>April 2017</td>
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<td></td>
<td>Provide quarterly performance data on FGM to the VAWG and Domestic and Sexual Violence Strategic Group and the HSCIC where applicable.</td>
<td></td>
<td>Multi agency performance data is scrutinised at the VAWG and Domestic and Sexual Violence strategic groups and LSCB to monitor progress and identify strengths and any gaps in the current reporting process.</td>
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<tr>
<td></td>
<td>All agencies to implement the legislative recommendations for mandatory reporting of FGM.</td>
<td></td>
<td>Relevant agencies have implemented systematic recording and reporting of FGM as directed by the Health and Social Care Information Centre (HSCIC) from October 2015.</td>
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<td></td>
<td>Work with local communities at risk of FGM to raise awareness and prevent the practice of FGM.</td>
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<table>
<thead>
<tr>
<th>Protection</th>
<th>Actions</th>
<th>Lead Agency</th>
<th>Outcome</th>
<th>Time scale</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Partnership agencies to implement its internal FGM policy document to guide practice and response to FGM.</td>
<td>NELFT Redbridge LA. Havering LA Waltham Forest LA BHRUT Waltham Forest CCG BHR CCG Education GPs</td>
<td>All practitioners are competent and confident in their response to FGM</td>
<td>April 2017</td>
</tr>
<tr>
<td></td>
<td>Ensure that all frontline professionals develop knowledge skills and competencies to enable safe, effective and sensitive response to FGM.</td>
<td></td>
<td>All practitioners provide appropriate safeguarding responses to FGM</td>
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<td></td>
<td>To implement the London and or Essex Safeguarding Children procedures for FGM.</td>
<td></td>
<td>Knowledge and competencies on FGM are embedded in all safeguarding training packages delivered by the LSCB and the Adult Safeguarding Board.</td>
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<td></td>
<td>All agencies to provide training on FGM for staff.</td>
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<td>FGM Training Programme is in place and available to all frontline staff according to their role and</td>
<td></td>
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<tr>
<td>Provision of Service</td>
<td>Action</td>
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<tr>
<td>Commissioners to work with providers to develop an integrated approach to tackling FGM within the existing framework to address Violence Against Women and Girls. Actively seek feedback from service users and survivors of FGM, through community based activities ie. Clinical audits and specific community engagement with targeted groups by March 2016</td>
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<tr>
<th>Lead Agency</th>
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<tbody>
<tr>
<td>NELFT Redbridge LA. Havering LA Waltham Forest LA BHRUT Waltham Forest CCG BHR CCG Education GPs</td>
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<thead>
<tr>
<th>Outcome</th>
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<tbody>
<tr>
<td>Commissioners and Providers have combined existing VAWG support fundings and have commissioned an effective, holistic support service within each locality. The strategic objectives of this FGM strategy are embedded within the existing VAWG Domestic and Sexual Violence Strategic Group service delivery for each locality. Services are relevant and evidence-based according to the needs of women and girls affected by FGM.</td>
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<table>
<thead>
<tr>
<th>Rag rating</th>
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<tbody>
<tr>
<td>April 2017</td>
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<table>
<thead>
<tr>
<th>Partnership Working</th>
<th>Actions</th>
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<tbody>
<tr>
<td>All partners to work together with the statutory, voluntary and community sector to: ▪ share best practice ▪ agree local outcomes ▪ provide effective support for victims. Maintain strong corporate and political commitment to address FGM as part of the overarching strategy to tackle violence against women girls. Work in partnership to prosecute those responsible for the practice of FGM including parents that facilitate the practice regardless of where it happens.</td>
<td></td>
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<table>
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<tr>
<th>Lead Agency</th>
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</thead>
<tbody>
<tr>
<td>NELFT Redbridge LA. Havering LA Waltham Forest LA BHRUT Waltham Forest CCG BHR CCG Education GPs</td>
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<table>
<thead>
<tr>
<th>Outcome</th>
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<tbody>
<tr>
<td>A partnership performance framework is in place by October 2015 that quantifies and benchmarks the partnership activities to be monitored through the VAWG strategy. Efforts to tackle FGM are a prioritised as part of the wider health and social inequality agenda, using data collection form local hospitals, sexual health services, school and primary care to inform services. Increased criminal justice outcomes including the rate of convictions for perpetrators of FGM.</td>
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<table>
<thead>
<tr>
<th>Rag rating</th>
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<tbody>
<tr>
<td>April 2017</td>
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</table>
FGM Mandatory reporting

Are you concerned that a child may have had or be at risk of

- The child / young person has told you that they have had FGM.
- You have observed a physical sign appearing to show your patient has had FGM.
- Her parent / guardian discloses has had FGM.
- You consider the girl to be at risk of FGM. To consider what action to take, refer to the DH FGM safeguarding and risk assessment guidance (see link). A social care referral may not be required at this point. Follow local safeguarding.

Mandatory reporting duty
Professional who initially identified the FGM (you) calls 101 (police) to make a

Remember:
Record all decisions /actions
Be prepared for police officer to call you back
Best practice is to report before COP next working day
Update your local safeguarding

You will have to provide:
- girl’s name, DoB and address
- your contact details
- contact details of

IMMEDIATE RESPONSE REQUIRED for identified girl OR another child/other

Police and social care take immediate appropriate

Health professional (with relevant paediatric competencies) lead on the assessment of the health needs of the child.
- The assessment (with consent) may consider the need for:
  - Referral for genital examination using colposcope to the designated service in your area
  - General health assessment (physical and mental health)
  - Treatment and/or referral for any health needs identified (whether related to the FGM or not)
  - Include assessment of presence/absence of additional safeguarding concerns, and document and act accordingly

ASSESSMENT OF CASE. Multi-agency safeguarding meeting convened in line with local safeguarding arrangements, including police, social care and health as a necessary

Social care and police develop and appropriate pathway. This is likely to consider:
- Use of FGM Protection orders
- Whether a care plan or other safeguarding response is required
- If safeguarding response required for siblings / family members / others identified through the contact
- Referral to community / third sector
- If there is a need for criminal investigation

Follow local safeguarding procedures and refer to children’s social care

If a girl appears to have been recently cut or you believe she is at imminent risk, act immediately – this may include phoning 999.

REMEMBER: Mandatory reporting is only one part of safeguarding against FGM and other abuse.
Female Genital Mutilation (FGM) is child abuse and illegal.
Regulated health and social care professionals and teachers are required now to report cases of FGM in girls under 18, which they identify in the course of their professional work to the police.

How can I prepare?
- FGM eLearning: www.e-lfh.org.uk/programmes/female-genital-mutilation
- Videos: www.nhs.uk/fgmguidelines
- www.workingtogetheronline.co.uk
- Search for guidance from Royal Colleges and regulators

Remember:
- This is a personal duty; the professional who identifies FGM / receives the disclosure must make the report.
- If a woman is over 18 when she discloses / you identify FGM, the duty does not apply and you should follow local safeguarding processes.
- Do not undertake a genital examination unless this is already part of your role.
- Complying with the duty does not breach data protection rules or other confidentiality requirements.
- Non-regulated healthcare staff should report through existing safeguarding procedures.
- This duty is about reporting a crime. NHS organisations continue to be responsible for collecting and recording data on FGM.

FAQs
A girl is using another term which I think is FGM. Do I need to report?
Yes. Whether she uses the term ‘FGM’ or any other term or description, e.g. ‘sunna’ or ‘cut’, the duty applies.

Does the duty apply to professionals in private education/healthcare?
Yes, if working as a regulated professional, the duty will apply.

Should you only report if you are certain that FGM has been carried out?
Yes. When you see something which appears to show in your opinion that a girl has FGM, you should make the report. A formal diagnosis will be sought as part of the subsequent multi-agency response.

I have identified a case but the patient is over 18, what should I do?
The duty does not apply in this case. You should signpost the woman to services offering support and advice. You may also need to carry out a safeguarding risk assessment considering children who may be at risk or have had FGM.

Some FGM is very difficult to notice. What if I did not notice signs when I was caring for a patient who is later identified as having had FGM?
If an allegation of failure to report is made, all relevant circumstances will be taken into account by the regulators, including your experience and what could reasonably have been expected.

I am treating a girl under 18 with a genital piercing/tattoo. What should I do?
You should make a report.

How quickly should I make a report?
The safety of the girl or others at risk of harm is the priority. You should report ASAP with the same urgency as for all other safeguarding cases. If you believe reporting would lead to risk of serious harm to the child or anyone else, contact your designated safeguarding lead for advice; you may need longer to take action, in exceptional circumstances.

Should I tell the girl/family about the report?
Yes, wherever possible you should explain why the report is being made and what it means. If you believe reporting would lead to risk of serious harm to the child or anyone else, do not discuss it but instead contact your local designated safeguarding lead for advice.

Following a risk assessment for a girl I’ve identified as being at risk of FGM, it isn’t appropriate to refer to social care at this point. What should I do?
You should share information about the potential risk and your actions with your colleagues across health (GP, school nurse and health visitor as a minimum) and discuss next steps with your local safeguarding lead. A new system to support these cases from January 2015 is the FGM Risk Indicator System. See www.hscic.gov.uk/fgmrisk for details.
19.0 INITIAL SCREENING EQUALITY IMPACT ASSESSMENT FORM

Equality Impact Assessment Tool

The Equality Impact Assessment is a tool that supports the Trust makes sure their policies, and the ways they carry out their functions, do what they are intended to do for everyone fairly. Equality impact assessment (EQIA) is the process by which the Trust seeks to meet its legal requirements in conjunction with the Equality Act 2010 and to narrow the health inequalities that exist between people from different ethnic backgrounds, people with disabilities, men and women (including transgendered people), people with different sexual orientations, people in different age groups, people with different religions or beliefs and people from different social and economic groups.

Policymakers must screen all policies for their impact on people from each of the groups listed in point 1 below.

If you have identified a potential discriminatory impact of this procedural document which has not been mitigated within the document, please refer it to the Equality and Diversity Manager and arrange to complete a full Equality Impact assessment.

<table>
<thead>
<tr>
<th>Directorate/Department</th>
<th>Chief Nursing Officer &amp; Executive Director for Essex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Policy/Service/Function</td>
<td>Multi-agency Strategy to Tackle Female Genital Mutilation</td>
</tr>
<tr>
<td>New or Existing Policy/Service/Function?</td>
<td>New</td>
</tr>
<tr>
<td>Name and role of Person completing the EQIA</td>
<td>Harjit K Bansal</td>
</tr>
</tbody>
</table>
Please complete the following questions

<table>
<thead>
<tr>
<th></th>
<th>Yes/No</th>
<th>What/Where is the Evidence to suggest this?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Does the Policy/Service/Function effect one group less or more favourably than another on the basis of:</strong></td>
<td>Unicef estimates that at least 125 million girls and women have experienced FGM in 29 countries in Africa and the Middle East.</td>
</tr>
<tr>
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<td>30 million girls are at risk in the next decade. 500,000 women are girls living in Europe have undergone FGM and 180,000 girls at risk of FGM.</td>
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<td>137,000 women and girls living in England and Wales have undergone FGM.</td>
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<td>• Race, Ethnic origins (including, gypsies and travellers) and Nationality</td>
<td>Yes</td>
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<td></td>
<td></td>
<td>Countries with high prevalence of FGM are as follows:</td>
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<tr>
<td></td>
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<td>Somalia – 98% of girls have had FGM.</td>
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<td>Guinea – 96% of girls have had FGM.</td>
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<td>Egypt – 91% of girls have had FGM.</td>
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<td>Mali – 89% of girls have had FGM.</td>
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<td></td>
<td>Sudan – 88% of girls have had FGM.</td>
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<tr>
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<td></td>
<td>Burkina Faso – 76% of girls have had FGM.</td>
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<td>Gambia – 76% of girls have had FGM.</td>
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<td>Ethiopia – 74% of girls have had FGM.</td>
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<td>Mauritius – 69% of girls have had FGM.</td>
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<td>Liberia – 66% of girls have had FGM.</td>
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<td>Guinea Bissau – 50% of girls have had FGM.</td>
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<td>Chad – 44% of girls have had FGM.</td>
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<td>Nigeria – 27% of girls have had FGM.</td>
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<td>Kenya – 27% of girls have had FGM.</td>
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<td>Yemen – 23% of girls have had FGM.</td>
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<td></td>
<td>There is no data for Columbia, Jordan, Oman, Saudi Arabia, Indonesia or Malaysia although there are reports of FGM being practiced there.</td>
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</tbody>
</table>
Department of Health FGM data reports on the following:

Barking and Dagenham & Redbridge have the following members from FGM Countries:

<table>
<thead>
<tr>
<th>FMG Country</th>
<th>Barking and Dagenham</th>
<th>Redbridge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somalia</td>
<td>1188</td>
<td>1724</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>475</td>
<td>195</td>
</tr>
<tr>
<td>Tanzania</td>
<td>286</td>
<td>965</td>
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<tr>
<td>Gambia</td>
<td>173</td>
<td>66</td>
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<tr>
<td>Ethiopia</td>
<td>94</td>
<td>66</td>
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<tr>
<td>Sudan</td>
<td>71</td>
<td>85</td>
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<tr>
<td>Egypt</td>
<td>68</td>
<td>172</td>
</tr>
<tr>
<td>Liberia</td>
<td>66</td>
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<tr>
<td>Guinea Bissau</td>
<td>62</td>
<td></td>
</tr>
<tr>
<td>Guinea Conakry</td>
<td>43</td>
<td>34</td>
</tr>
<tr>
<td>Eritrea</td>
<td>42</td>
<td>47</td>
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<tr>
<td>Yemen</td>
<td>32</td>
<td>110</td>
</tr>
</tbody>
</table>

Therefore early intervention is crucial as is recording of patient data by country of origin, in order to minimise the risk of FGM. Services should have access to interpreting and translation services, for families whose English is limited.

- **Gender (males and females)** Yes
  FGM is carried out on girls and women. In the UK, since 2006, 2,100 women and girls sought hospital treatment for FGM. 708 needed admission and/or surgery.

- **Age** Yes
  Although FGM has no age limit, it is carried out on girls between infancy and the age of 15 with the majority of cases occurring between the ages of 5 and 8 years.

  Occasionally carried out on adult women following children birth (infibulation) or where she is forced to undergo the procedure by her husband (partner) after marriage.

- **Religion, Belief or Culture** Yes
  FGM is not a requirement of any religion. However, it is practiced by Christians,
<table>
<thead>
<tr>
<th>Group</th>
<th>Affected?</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muslims, Jews and non-believers in a variety of cultures and communities. There is no evidence in the Bible, Koran, Torah or other religious text to support FGM practices.</td>
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</tr>
<tr>
<td>Disability – mental, physical disability and Learning difficulties</td>
<td>Yes</td>
<td>Currently the data collected by Department of Health does not address those with a disability (the data is broken down by age and religion). Safeguarding children policy and procedures should be considered if there is a likelihood of a female child who might be at risk of FGM. Safeguarding Vulnerable Adults should be considered as meeting the remit of a form of violence against women and girls and other harmful traditional practices. Monitoring of patients by disability will better inform policy development. Services should ensure information is available about FGM in large print, pictorial and other formats to meet the needs of these groups of people.</td>
</tr>
<tr>
<td>Sexual orientation including lesbian, gay and bisexual people</td>
<td>No</td>
<td>There is no data available for a breakdown of FGM in LGBT groups; however, the risk of FGM in Lesbian groups and transgender groups is just as likely in communities coming from particular groups. Therefore data collection on LGBT will better inform national and local policy.</td>
</tr>
<tr>
<td>▪ Married/or in civil partnership</td>
<td>Yes</td>
<td>FGM is likely to take place after giving birth or forced to undergo after marriage.</td>
</tr>
<tr>
<td>▪ Pregnant/maternity leave</td>
<td></td>
<td>144,000 girls were born to mothers from FGM affected countries between 1996 and 2010. Over 3,500 women who gave birth in London had experienced FGM.</td>
</tr>
<tr>
<td>▪ Transgender reassignment</td>
<td>Yes</td>
<td>Data is not available for transgender groups but are just as likely in communities coming from particular groups, particularly those who change their biological gender from male to female. Therefore data collection on this group will better inform national and local policy.</td>
</tr>
<tr>
<td>Is there any evidence that some groups are affected differently? Is the impact of the policy/Guideline likely to</td>
<td>Yes</td>
<td>The impact of having a joint partnership policy will have a systematic approach to minimising the risk of FGM.</td>
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</tbody>
</table>
| 3 | **Is there a need for additional consultation e.g. with external organisations, service Users and carers, or other voluntary sector groups?** | **Yes**  
Local Authority Safeguarding Children’s Boards in; Redbridge, Barking and Dagenham, Waltham Forest, Havering and Newham, Barts Health, Barking, Havering and Redbridge University Hospital, staff in NELFT. |
| 4 | **If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?** | **Yes**  
The FGM Act 2003 makes it illegal to practice FGM in the UK, makes it illegal to take girls who are British nationals abroad for FGM and has a penalty of up to 14 years in prison or a fine. |
| 5 | **Can we reduce the impact by taking different actions?** | **Yes**  
- Ensure a system in place to flag cases of FGM on our patient electronic record systems.
- Improve monitoring data for patients across all services for the 9 protected characteristics.
- Annual audit and monitoring of FGM cases.
- Sharing of data across the parent agencies.
- Staff awareness and training sessions.
- Information leaflets. |

**Assessor’s Name:**  
**Date:**

**Name of Director:**

This section to be agreed and signed by the Equality and Diversity Manager in agreement with the Equality and Diversity Team
**Recommendation**

Full Equality Impact Assessment required:

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
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<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

*(Full EQIA to explore the implementation of the policy and to identify any gaps.)*

**Assessment authorised by:**

**Name:** Harjit K Bansal, Equality and Diversity Manager

**Date:** 21st of April 2015
20.0 References

15. Additional external links;
   - Quick guidance – a 2-page summary of the duty including a process flowchart
   - Poster – a poster for health organisations to display about the duty
- Training slides – a training presentation organisations can use to help them deliver 10 – 15 minute updates to staff to explain the duty
- Video interviews with Vanessa Lodge, NHS E National FGM Prevention lead

An information leaflet for patients and their families which professionals can use to help when discussing making a report to the police.

The website for written materials is: https://www.gov.uk/government/publications/fgm-mandatory-reporting-in-healthcare

The video can also be found at www.nhs.uk/fgmguidelines

Please access these links and download the materials.