Female Genital Mutilation

Calderdale Strategic Response

Contents **Page No.**

Calderdale Strategy to prevent Female Genital Mutilation 2015-2018 (FGM)

Forward by Richard Burrows Independent Chair Calderdale Safeguarding Children's Board

The Safeguarding Children Board (CSCB) supports the organisations and professionals who work with children and young people to do all they can to ensure that children and young people are protected from harm and abuse. For this to be effective it is also important that all members of the community are aware of and know what to do if they are concerned for the safety of a child or young person, and that they are able to approach any professional and be sure that timely and appropriate action will be taken.

This strategy sets out what partners (across both the Adult and the Children's Safeguarding Board) have agreed they will do to develop how we ensure that Female Genital Mutilation is identified responded to and ultimately ceases to be a form of abuse that women and girls suffer.

Like many forms of abuse, it can be a difficult thing for people to understand and accept. In the case of FGM we have come to recognise nationally and locally, that although it is a practice that is undertaken in certain parts of the world and therefore within communities who have links with those areas, it is sadly more common than we previously thought.

The strategy therefore sets out a series of commitments and actions that cross all professions and organisations, as well as showing how both the Children's and the Adults Safeguarding Boards will support and hold these commitments to account.

As with all forms of abuse, it is not only important that organisations and professionals work closely together, it is also important that all citizens whether they be parents, grandparents or have an interest in the welfare of children and young people are able to act within the law and to feel that they can come forward when they are concerned about the safety and well-being of a child, young person or adult at risk.

This is why the strategy has 4 clear aims;

To ensure that children, young people and adults at risk are protected from FGM

To make sure that services and professionals are able to provide services to achieve this and to ensure that the victims of FGM are able to come forward and be supported

To wherever possible prevent FGM from taking place and to work towards its eradication as a practice

To ensure that when the law is broken those responsible are prosecuted.

This strategy will be regularly reviewed especially as there is now a better understanding of both the incidence and sensitivity of this form of abuse, so that we can be as sure as possible that children, young people and adults at risk in Calderdale are safe and protected. It also contains a range of information and links that will help all concerned to better understand FGM.

Glossary of Terms

FGM	**Female Genital Mutilation**
ADULT AT RISK	An 'adult at risk' is someone who is 18 years or over who:- has care and support needs and is experiencing, or is at risk of, abuse or neglect and is unable to protect themselves because of their care and support needs.
CHILD	Includes all children and young people less than 18 years of age and below 25 if the young person has a disability
CiN	Child in Need
CLA	Child Looked After
CP	Child Protection
CPS	Crown Prosecution Service
CRC	Community Rehabilitation Company
CSC	Children's Social Care
CSP	Community safety Partnership
CSCB	Calderdale Safeguarding Children's Board
CSP	Community Safety Partnerships
CCG	Clinical Commissioning Group
CHFT	Calderdale & Huddersfield NHS Foundation Trust
GP	General Practitioner
EI	Early Intervention
EIP	Early Intervention Panel
EISA	Early Intervention Single Assessment
LAC	Looked After Child
MAST	Multi-Agency Screening Team
NPS	National Probation Service
PCC	Police and Crime Commissioner
PSW	Principle Social Worker
SAB	Safeguarding Adults Board
SCR	Serious Case Review
VAC	Voluntary Action Calderdale
WYP	West Yorkshire Police
YOT	Youth Offending Team

1.0 BACKGROUND AND DOCUMENTS THAT SUPPORT AND INFORM OUR RESPONSE TO FGM

Although Female Genital Mutilation (FGM) has been illegal in the United Kingdom since 1985, and councils have a statutory duty to safeguard adults at risk and children and to 'protect and promote the welfare of all women and girls'. It is only now that we are starting to openly talk about the practice, what it involves, the reasons communities carry it out, and how we can work towards eliminating it.

Female Genital Mutilation (FGM) is a serious form of abuse and violence against women and girls. In March 2014 the Government produced an action plan to end violence against women and girls. Eradicating female genital mutilation is one of the top priorities. But to really combat FGM we need to engage with at risk communities – and be absolutely clear that this is an illegal practice which will not be tolerated.

Much of the recent discussion about tackling FGM has focused on what can be done to protect women and girls at risk of being cut, how we can become better at identifying women who have already been subject to FGM and increasing the chances of a successful prosecution. As a result there has been an emphasis on what the police, Crown Prosecution Service and health services can do to reduce instances of FGM.

This strategy seeks to provide advice and support to frontline professionals who have responsibilities to safeguard children and protect and support women from the abuses associated with female genital mutilation (FGM). As it is unlikely that any single agency will be able to meet the multiple needs of someone affected by FGM, this document sets out a multi-agency response and strategies to encourage agencies to cooperate and work together.

FGM is much more common than most people realise, both worldwide and in the UK. Most of the women and girls affected live in Africa (Appendix 2), although some live in the Middle East and Asia. However, those who have undergone, or are at risk of undergoing, FGM are increasingly found in Western Europe and other developed countries, primarily among immigrant and refugee communities.

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

The 'Vision' for Calderdale is that Local communities will receive effective and sensitive services that enable women and girls in Calderdale to be free from the abusive practice of FGM. Those living with the consequences of FGM will receive appropriate care.

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 the 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.

The following principles should be adopted by all agencies in relation to identifying and responding to those at risk of, or who have undergone FGM, and their parent(s) or guardians:

- the safety and welfare of the child is paramount;
- all agencies should act in the interests of the rights of the child, as stated in the United Nations Convention on the Rights of the Child (1989);
- FGM is illegal in the UK (see Chapter 4);
- FGM is an extremely harmful practice - responding to it cannot be left to personal choice;
- accessible, high quality and sensitive health, education, police, social care and voluntary sector services must underpin all interventions;
- as FGM is often an embedded social norm, engagement with families and communities plays an important role in contributing to ending it; and
- all decisions or plans should be based on high quality assessments (in accordance with Working Together to Safeguard Children (2015)

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. 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:

National Guidance includes:

HM publication (2014) A Call to End Violence Against Women and Girls action plan (2014)

Multi-Agency Practice Guidelines - Female Genital Mutilation (HM Govt, 2011, updated April 2016).
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/380125/MultiAgencyPracticeGuidelinesNov14.pdf

Multi-agency statutory guidance on female genital mutilation (HM Govt, 2016)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/512906/Multi_Agency_Statutory_Guidance_on_FGM__-_FINAL.pdf

Department of Health 2015 - Female Genital Mutilation Risk and Safeguarding Guidance for professionals
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/418564/2903800_DH_FGM_Accessible_v0.1.pdf

Mandatory Reporting of FGM – procedural information
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/469448/FGM-Mandatory-Reporting-procedural-info-FINAL.pdf
Human Rights Act (1998) http://www.legislation.gov.uk/ukpga/1998/42/data.pdf

UN Convention on the rights of the child (1989)
http://www.unicef.org.uk/Documents/Publication-pdfs/UNCRC_PRESS200910web.pdf

Working Together to Safeguard children (HM Govt 2015)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

Information sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers (2015)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419628/Information_sharing_advice_safeguarding_practitioners.pdf

Other useful FGM resource sites

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/295056/HMG_FGM_Declaration.pdf

http://www.nspcc.org.uk/fgm.

Local Guidance includes:

West Yorkshire Consortium Procedures for Safeguarding Children and Young People 1.4.20
http://www.calderdale-scb.org.uk/

Referral Form to MAST http://www.calderdale-scb.org.uk/reporting-a-concern/

West & North Yorkshire Safeguarding Adults at Risk Procedures
https://**calderdale**.gov.uk/.../**safeguardingadults/safeguarding-adults**-policy. pdf

2.0 INTRODUCTION

Female Genital Mutilation (FGM) is illegal in the UK, is abuse and a form of extreme harm against women and girls. FGM leads to severe short and long term physical and psychological consequences, and survivors may not have spoken about their experience for many years (see appendix 1).

No single agency or statutory body can meet the multiple needs of someone affected by FGM, so a multi-agency response is required. This strategy aims to assist organisations, the services they provide, improve the protection of women and girls from Female Genital Mutilation (FGM).

In addition to partner organisations and professionals making this a priority and agreeing to work together we also recognise that we need to all do we can to encourage and support the people affected by FGM and those who hold influence to be a key part of this strategy and step forward.

The reasons why FGM occurs are varied. The justification for the practice is often cited as custom or tradition and FGM is often seen not as an abuse but as an initiation into adulthood. Some individuals and families who support the practice of FGM often see this as a natural and beneficial practice by a loving family who believe that it is in the girl's or a woman's best interests. This may limit a girl's/women's incentive to come forward to raise concerns or talk openly about FGM - reinforcing the need for all professionals to be aware of the issues and risks of FGM.

FGM is mostly found in Africa, the Middle East and Asia, and while cultural sensitivity to the girl, woman and her family is always paramount, it should not override the safety or wellbeing of individuals. The inquiry report into the death of Victoria Climbié clearly notes the danger of making assumptions about cultural background that conflict with ensuring children's safety (House of Commons Health Committee, 2003).

Lord Laming noted that children's needs for protection are the same whatever their cultural background, saying:

> *"a child is a child regardless of colour – if we are not careful we'll lose the whole emphasis on the child's welfare"* House of Commons Health Committee, 2003

Although the Laming inquiry relates to very different circumstances to FGM, comments made in the report are useful to review and the Counsel to the inquiry stated that:

> *"Fear of being accused of racism can stop people acting when otherwise they would. The evidence of one witness indicated her expressed need 'to be sensitive to feelings of people of all races and backgrounds'.* Lord Laming again noted that those involved in safeguarding *'should never feel inhibited from acting in a child's interests on the grounds that they are felt by others to have an insufficient grasp of the child's particular circumstances'."*

Health of Commons Health Committee, 2003 Lord Laming makes another statement that is helpful to practitioners involved in protecting girls at risk of FGM:

> *"The basic requirement that children are kept safe is universal and cuts across cultural boundaries. Every child living in this country is entitled to be given the protection of the law, regardless of his or her background. Cultural heritage is important to many people, but it cannot take precedence over standards of care embodied in law." Health of Commons Health Committee, 2003*

Ending FGM cannot be achieved through safeguarding policies alone. There is a need for a longer-term change in the attitudes towards the practice in affected communities. A community-led approach towards abandoning the practice is recommended in the multi-agency guidelines.

It requires the commitment of all partner organisations to agree to work together to achieve the objectives.

These are:

- To be able to identify when a child or adult at risk may be at risk of being subjected to FGM and responding appropriately to protect them;
- To be able to identify when a woman or child has been subjected to FGM and responding appropriately to support them; and
- Produce measures which can be implemented to prevent and ultimately eliminate the practice of FGM.

This strategy and the action plan were formally agreed by the Calderdale Safeguarding Children's Board on the 3rd December 2015 and it has also been endorsed by:

- Calderdale Safeguarding Adult's Board
- Calderdale Community Safety Partnership

The strategy is based on 4 key principles:

- Prepare
- Protect
- Prevent
- Pursue

This strategy will aim to explain how the safeguarding board's will make sure that the things that people have agreed to do are being monitored and evaluated. The Safeguarding Board's and partners are accountable for how this strategy succeeds and making sure that we learn from our own experience and experiences of victims of FGM.

3.0 WHAT IS FGM?

FGM is defined by the World Health Organisation as:

> ***"all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons".***

FGM is sometimes referred to as Female Circumcision or Female Genital Cutting however this does not depict the nature or impact of the practice. Communities use range of traditional and local names for this practice (Appendix 3). FGM is based in ancient beliefs surrounding the need to control women's fertility and sexuality. It is a cultural practice based on custom and tradition. It is also based on the incorrect belief that it protects a girl's virginity, protects family honour, is more hygienic, desirable, and attractive and increases sexual pleasure for men. It is practiced to enhance a girl's prospects of marriage. It is carried out in the name of culture and religion. FGM is not a requirement of any religion. It is practiced by Christians, Muslims, Jews and non-believers in a wide range of communities and cultures. FGM is most frequently carried out on young girls between infancy and the age of 15.

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

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 (2012). The WHO classifies FGM into four types the most extreme of which (Type III) involves narrowing of the vaginal orifice.

The WHO classification of FGM is:

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.

NB whilst the WHO's definition is clear cut, in reality, the practice is not. There is no instruction manual for FGM. Cutting methods are passed by word of mouth often through non-medically trained, elderly women. The result of cutting and degree of tissue damage varies dramatically according to the skill and preference of the practitioner, cutting implements used; extent of the girl's struggles and the healing process. A woman's FGM therefore may not fall neatly into any one of the four specified types. It is recommend that we use the WHO's classification for effective inter-professional communication and documentation however, we must do so with caution.

Female genital mutilation (FGM), in any form, is recognised internationally as a gross violation of human rights of girls and women. The practice amounts to human rights abuses, in particular of the:

- Right to physical and mental integrity
- Right to the highest attainable standard of health
- Freedom from discrimination on the basis of sex including violence against women
- Rights of the child
- Freedom from torture, cruel, inhuman and degrading treatments
- Right to life (when the procedure results in death)

The rights denied by the practice of FGM can be found in a range of treaties and consensus documents, including:

- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
- Covenant on Civil and Political Rights
- Covenant on Economic, Social and Cultural Rights
- Convention on the Elimination of all Forms of Discrimination against Women
- Convention on the Rights of the Child
- Convention relating to the Status of Refugees and its Protocol relating to the Status of Refugees
- African Charter on Human and Peoples' Rights (the Banjul Charter) and its Protocol on the Rights of Women in Africa (the Maputo Protocol)
- African Charter on the Rights and Welfare of the Child
- European Convention for the Protection of Human Rights and Fundamental Freedoms
- Charter of Fundamental Rights of the European Union
- Beijing Declaration and Platform for Action of the
- Fourth World Conference on Women
- UN General Assembly Declaration on the Elimination of Violence against Women
- Programme of Action of the International Conference on Population and Development
- UNESCO Universal Declaration on Cultural Diversity

Female Genital Mutilation has a devastating impact on the health and wellbeing of women and young girls, for some it may be fatal. Short term problems caused by FGM include severe pain, emotional shock, difficulty passing urine, bleeding and infection (which can lead to infertility). Long term problems include difficulty passing urine, painful periods and sexual problems (Appendix 1).

Women who have had Type 3 FGM are significantly more likely to experience difficulties during childbirth and their babies are more likely to die as a result of the practice. Serious complications during childbirth include the need to have a caesarean section, dangerously heavy bleeding after the birth of the baby and prolonged hospitalisation following the birth.

As a result of FGM girls and women may also feel angry, depressed and suffer from post-traumatic stress disorder.

Although the majority of victims are mostly 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 vulnerable to 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 criminal justice as well as preventive and protective measures.

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, must consider other female children in the extended family. Any girl withdrawn from personal, social and health education classes may be at risk.

The CSCB/SAB and its partners therefore have a clear position, this is that although Religious, social or cultural reasons are sometimes given for FGM it is abuse, It's dangerous and a criminal offence.

There are no medical reasons to carry out FGM. It doesn't enhance fertility and it doesn't make childbirth safer. It is used to control female sexuality and can cause severe and long-lasting damage to physical and emotional health. (Source NSPCC).

We also believe that this is a problem that can be solved, especially as communities and families come to understand that it is illegal and harmful. In this sense if the strategy is successful then there is a real possibility that we can eradicate the practice within a generation.

This strategy as with other safeguarding strategies seeks to join up systems and professionals to ensure that the practice of FGM is recognised and prevented whenever possible, that the law is firmly applied and that children and young people are supported and protected.

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

4.0 THE LAW AND FGM

In the UK, FGM has been a specific criminal offence since the Prohibition of Female Circumcision Act 1985. The Female Genital Mutilation Act 2003 replaced the 1985 Act in England, Wales and Northern Ireland. Section 1 of the 2003 Act provides that a person is guilty of an offence if he "excises, infibulates or otherwise mutilates the whole or any part of a girl's labia majora, labia minora or clitoris". The 2003 Act made it an offence for the first time for UK nationals or permanent UK residents to carry out FGM abroad, or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where FGM is legal.

Therefore it is not only practitioners of FGM who are liable to punishment, but parents/carers who seek this procedure for their children or indeed any person who advises or assists another to have FGM performed.

The Act also made it illegal for someone to take a British Citizen aboard 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. A person found guilty of an offence is liable to a fine and/or imprisonment up to 14 years.

It is unknown if the act has served as a deterrent and if FGM is still being practiced in the UK or if girls and adults at risk are being taken abroad to undergo FGM. While referrals to the police have increased in recent years, the numbers still remain small. The Metropolitan Police Service received 186 FGM related referrals between April 2012 and October 2014. The majority were concerns that a child may be at risk of FGM, prompting a multi-agency safeguarding response before any crime is committed.

Section 5B of the 2003 Act introduces a mandatory reporting duty which requires regulated health and social care professionals and teachers in England and Wales to report 'known' cases of FGM in under 18s which they identify in the course of their professional work to the police. **The duty applies from 31 October 2015 onwards.** (See section 4.1)

'Known' cases are those where either a girl informs the person that an act of FGM – however described – has been carried out on her, or where the person observes physical signs on a girl appearing to show that an act of FGM has been carried out and the person has no reason to believe that the act was, or was part of, a surgical operation within section 1(2)(a) or (b) of the FGM Act 2003.

To date there have been no confirmed crimes or prosecutions under this Act. The Police and Crime Commissioner have stated that tackling FGM is a priority in West Yorkshire, and this is documented in his Police and Crime Plan 2013-2017.

In 2014 the Chief Constable of West Yorkshire Police signed a protocol between the Police and the Crown Prosecution Service in relation to the investigation and prosecution of allegations of FGM to ensure both parties understand the complexities and deal positively with the allegation and prosecution of such abuse.

The Serious Crime Act 2015 reinforced existing FGM legislation and introduced mandatory

reporting of FGM in girls less than 18 years by healthcare workers, teachers and social workers to the police.

On the 17th July 2015 the Female Genital Mutilation Act 2003 was amended by section 73 of the Serious Crime Act 2015 to allow Courts to issue Female Genital Mutilation (FGM) Protection Orders. These are civil orders and very closely modelled on Forced Marriage Protection Orders.

Under the Act, the following three categories of person can make an application for a FGM Protection Order:

- the person to be protected, without leave of the court;
- a relevant third party, who can make an application on behalf of a victim or potential victim, without the leave of the court; and
- any other person on behalf of the person to be protected, as long as they obtain he court's permission to make an application.

Relevant third party

The Female Genital Mutilation Protection Orders (Relevant Third Party) Regulations 2015 enables local authorities to act as relevant third parties from 17 July 2015 and make an application without first needing to apply for the leave of the court to do so. It is clear from the guidance that the government anticipate local authorities will be the primary applicants.

An application for a FGM Protection Order is not an alternative to investigating and prosecuting crimes. Crimes may be investigated and offenders prosecuted at the same time as an application is made or an order is in force.

Examples of the types of orders the court might make are:

- to protect a victim or potential victim from FGM from being taken abroad;
- to order the surrender of passports or any other travel documents, including the passport/travel documentation of the girl to be protected;
- to prohibit specified persons from entering into any arrangements in the UK or abroad for FGM to be performed on the person to be protected;
- to include terms in the order which relate to the conduct of the respondent(s) both inside and outside of England and Wales; and
- to include terms which cover respondents who are, or may become involved in other respects (or instead of the original respondents) and who may commit or attempt to commit FGM against a girl.

Breach of the Order is a criminal offence.

http://www.legislation.gov.uk/ukpga/2015/9/contents/enacted

Both the Calderdale Safeguarding Adult's and Children's Boards and their partners fully support this approach.

4.1 Mandatory Reporting duty

The data about the number of girls or women who have been subjected to FGM while UK residents cannot currently be extracted from the prevalence data that is available. Despite this, the headline data indicates a significant disparity between the estimated prevalence of FGM and the number of referrals to police. The government is clear that this disparity needs to be addressed though a mandatory reporting duty for cases of FGM.

The government believes that mandatory reporting of FGM should lead to a greater number of victims and potential victims being identified to the police and social services. FGM is a crime in this country whether it takes place in the UK, or is committed by or inflicted on a UK national or permanent resident whilst they are abroad. Alerting the police through mandatory reporting of FGM will allow them to investigate the facts of each case and should increase the number of perpetrators apprehended and prosecuted for this crime. Prosecutions for FGM should in turn act as a deterrent to perpetrators and in turn prevent FGM from occurring. Depending on how the duty is framed, mandatory reporting of FGM could also lead to a greater number of potential victims being identified. This in turn can lead to strengthened risk assessments being carried out and further multi-agency safeguarding interventions being designed and implemented.

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

The mandatory duty:

- Applies in cases of ‘known’ FGM – i.e. instances which are disclosed by the victim and/or are visually confirmed. This is in line with the majority of the consultation responses
- Be limited to girls under 18 – those responding to the consultation held differing views on whether the duty should be limited to under 18s, but a number highlighted concerns regarding extending the duty to adults, including the risk that this could deter women from seeking medical advice and assistance
- Apply to all regulated healthcare and social care professionals, and teachers
- Require reports to be made to the police within one month of initial disclosure/identification – depending on the circumstances of the case, this will not necessarily trigger automatic arrests; the police will then work with the relevant agencies to ensure an appropriate safeguarding response is put in place which places the interests of the child front and centre.

The duty applies to all regulated professionals (as defined in section 5B(2)(a), (11) and (12) of the 2003 Act) working within health or social care, and teachers. It therefore covers:

- Health and social care professionals regulated by a body which is overseen by the Professional Standards Authority for Health and Social Care (with the exception of the Pharmaceutical Society of Northern Ireland). This includes those regulated by the:

- General Chiropractic Council
- General Dental Council
- General Medical Council
- General Optical Council
- General Osteopathic Council
- General Pharmaceutical Council
- Health and Care Professions Council
  (whose role includes the regulation of social workers in England)
- Nursing and Midwifery Council

- Teachers - this includes qualified teachers or persons who are employed or engaged to carry out teaching work in schools and other institutions, and, in Wales, education practitioners regulated by the Education Workforce Council;

- Social care workers in Wales.

Failure to comply with the duty will be dealt with via existing disciplinary measures, which may include referral to the professional regulator as appropriate – this will ensure that all breaches are dealt with appropriately and in accordance with the specifics of the individual case and is in line with the approach favoured by the majority of respondents to the consultation.

The full Mandatory Reporting of Female Genital Mutilation – procedural information can be accessed at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/469448/FGM-Mandatory-Reporting-procedural-info-FINAL.pdf

The purpose of this document is to give professionals subject to the duty and their employers an understanding of the legal requirements it places on them, a suggested process to follow, and an overview of the action which may be taken if they fail to comply with the duty. It also aims to give the police an understanding of the duty and the next steps upon receiving a report.

In addition to complying with the duty, professionals should continue to have regard to their wider safeguarding responsibilities, which require consideration and action to be taken whenever there is any identified or known risk to a child, whether in relation to FGM or another matter.

Ofsted should be notified of FGM incidents

The Department for Education has clarified that cases of FGM should be notified to Ofsted because they meet the criterion of a child being seriously harmed and abuse or neglect being known or suspected.

Specifically, local authorities should notify Ofsted of incidents where a child is known to have suffered FGM in England, or if a child who was normally resident in England was known to have been taken out of the country to have FGM performed on them and it had taken place.

It is not, however, necessary for local authorities to notify Ofsted of historical cases, for example, if a child is found to have suffered FGM while she was resident in another country, before coming to live in the UK.

Contacts: Anne Gair, Principal Officer, Safeguarding or Paul Armitage, Deputy Director, Social Care Inspection

4.2 Department of health and NHS England FGM Enhanced Dataset

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

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

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

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

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

5.0 CALDERDALE's STRATEGIC AIMS

Despite the national difficulties with obtaining accurate and reliable figures on FGM we recognise that there are girls and women who live within Calderdale who may have experienced FGM or are at risk of it happening to them.

Due to the impact that FGM has on the health, safety and wellbeing of girls and women, it has been identified as a priority by the West Yorkshire Police and Crime Commissioner and was agreed locally that the Calderdale Safeguarding Children's Board (CSCB) would lead on developing a sensitive response to FGM. This strategy outlines how whilst contributing to the mandatory reporting, we aim to prevent FGM from happening, improve services and professionals' responses to women and girls who have undergone or are at risk of FGM, and ensure sensitive specialist support, information and advice is available to them.

The strategy acknowledges that FGM is a form of violence against women and girls. The Department of Health Taskforce on the Health Aspects of Violence Against Women and Children set up a sub group on Harmful Traditional Practices and Human Trafficking. This strategy incorporates findings and recommendations of the taskforce and subgroup. The purpose of this strategy is not to duplicate any existing guidance, policy or procedures, but to strengthen our local response by setting out our vision for raising awareness, and improving our safeguarding of girls and women at risk of and affected by FGM, in partnership with community and faith groups.

This CSCB/SAB strategy will ensure a coordinated and joint approach is adopted to tackle the issues across Calderdale in consultation with the Police and Crime Commissioner, the Children's Trust Board, Community Safety Partnerships, Domestic Abuse and Sexual Violence Strategic Board and Health and Wellbeing Board.

Teachers, head teachers and school governors play a key role in an effective response to the abuse of children and through the LSCB, the headteachers forums and the support the Local Authority provides our response to FGM will be embedded across all schools in Calderdale.

Professionals and volunteers from all agencies have a statutory responsibility to safeguard children and adults at risk from being abused through FGM. If you require information on the safeguarding procedure for FGM, the procedures can be accessed through the CSCB website http://www.calderdale-scb.org.uk/ or for adults at risk the SAB website http://www.calderdale.gov.uk/socialcare/safeguardingadults/

This strategy is based on the agreed principles that FGM is:

- A violation of human rights
- A form of violence against women and girls
- Child abuse and a criminal act

Reflecting the cross government strategy to end violence against women and girls and in recognition of the impact on health and welfare of women and children subject to such violence, this strategy seeks to reduce FGM through addressing key overarching themes of Prevention, Provision and Protection. In respect of this framework for developing a multi-

agency, coordinated response FGM, it is expected that there will be frequent overlaps between the work themes of prevention, provision and protection.

5.1 Prepare

To prepare the multi-agency workforce is to equip it with the tools it needs to identify victims or future victims, support those who have suffered from FGM, to prevent FGM occurring and to disrupt and prosecute abusers and offenders. We need to make girls and women aware of the harmful effects of FGM. This not only empowers women to make choices, but it also educates the women who carry out the procedure. Because men and boys tend to have greater power and influence in cultures that practice FGM we also need to work to change attitudes among them – See more at: http://www.plan-uk.org/because-i-am-a-girl/female-genital-mutilation-fgm/#sthash.dpuf

5.2 Protect

To safeguard the physical safety and emotional health of girls and women who have undergone FGM; and girls at risk, by ensuring services, agencies and professionals:

- Identify and assess risk indicators present in children and in pregnant/non-pregnant women who have experienced FGM
- Establish a Multi-Agency consultation process in which all cases where there is evidence of FGM are reviewed
- Investigate individual cases of abuse and children and adults at risk suspected to be at high risk of FGM

These objectives will be supported by;

- strengthened referral and care pathways to implement more effective procedure
- Training for practitioners in relation to FGM, including how to sensitively ask women and girls about FGM and know how to respond appropriately.
- If the numbers of victims/potential victims are increasing then agencies will consider the setting up of a specialist operational group of FGM leads in Health, Children's and Adults Social Care and Police.

To ensure women who have undergone FGM and girls and women at risk can access specialist services for information, advice, support and necessary health treatment. This will include work to empower women to help them access services, address barriers to services, training staff as well as identifying care pathways for these women and girls addressing any issues within commissioning arrangements for specialist services.

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.

5.3 Prevent

To improve education, awareness and prevention work on FGM with agencies professionals, community groups (such as black & minority ethnic voluntary organisations and faith groups), education/youth services to inform and help address attitudes and myths about FGM. This work will include FGM awareness campaigns e.g. before school summer holidays to help raise the profile of this issue with professionals and girls at risk. Professionals and community groups will aim to grow and share their knowledge of 'what works' in reducing the risk of FGM to women and girls. Prevention work will also including support and education with pregnant women and new mothers to improve understanding of FGM (including legal position), children's safeguarding issues and access to help and advice.

The United Nations (UN) stated aim is to see FGM end "**within the next generation**." FGM has gained more attention and interest at the local, regional, national, and international levels recently. We need to build on this momentum. We are at an unprecedented point in history – **FGM could end within this generation**.

We believe ending FGM within a generation is entirely **achievable.** Given what we know about how the harmful traditional practice of **foot-binding ended in China within twenty years**, the UN believe this can be achieved, if abandonment can reach tipping point and critical mass in practicing communities, leading to exponential change.

The UK government is clear that political or cultural sensitivities must not get in the way of uncovering and stopping this terrible form of abuse.

5.4 Disrupt and Prosecute

In 2014 the Chief Constable of West Yorkshire Police signed a protocol between the Police and the Crown Prosecution Service in relation to the investigation and prosecution of allegations of FGM to ensure both parties understand the complexities and deal positively with the allegation and prosecution of such abuse.

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.

5.5 Adults at Risk

The prevention of abuse of adults at risk is the collective responsibility of all sections of society. Safeguarding Adults is everybody's business. Agencies, professionals, and voluntary groups in contact with people, who are potentially adults at risk, hold particular responsibilities. They must ensure they deliver safe and effective services, and that they work to prevent or detect abuse from whatever quarter, thus ensuring that appropriate

protective action can be taken.

Adults should be in control of their care and their consent is needed for decisions and actions designed to protect them. There must be clear justification where action is taken without consent such as lack of capacity or other legal or public interest justification. Where a person is not able to control the decision, they will still be included in decisions to the extent that they are able. Decisions made must respect the person's age, culture, beliefs and lifestyle.

There is a duty to support people to protect themselves. There is a positive obligation to take additional measures for people who may be less able to protect themselves.
Prevention of harm or abuse is a primary goal. Prevention involves helping the person to reduce risks of harm and abuse that are unacceptable to them.

Responses to harm and abuse should reflect the nature and seriousness of the concern. Responses must be the least restrictive of the person's rights and take account of the person's age, culture, wishes, lifestyle and beliefs. Proportionality also relates to managing concerns in the most effective and efficient way.

5.6 Children and Young People

Many different agencies, professionals and adults come into contact with children and young people in a wide variety of situations and may need to or come to the attention of the lead agencies, because they are have been a victim of or have been identified as being at risk of FGM.

As well as making sure that we listen to children and young people and fully recognise the significance of what we know, what we see and what they say, we also recognise that with support and help children and young people have an important contribution to make to help protect each other.

As a partnership, Calderdale Safeguarding Children Board encourages all agencies to seek the views of children and young people to understand their experiences of services. Understanding these experiences is a key element of service improvement. The CSCB will seek to assure itself those children and young people are listened to and their voice is taken into consideration when planning services for individuals and as a collective.

5.7 Parents and Families

It is acknowledged that some FGM practising families do not see it as an act of abuse However, FGM is child abuse and has severe significant physical and mental health consequences both in the short and long term (see Appendix 1), and as such must never be excused, accepted or condoned.

Despite the harm it causes, many women from FGM practising communities consider FGM normal to protect their 'cultural identity'. As a result of the belief systems of the cultural groups who practise FGM, many women who have undergone FGM believe they appear more attractive than women who have not undergone FGM. Women who have attempted

to resist exposing their daughters to FGM report that they and their families were ostracised by their community and told that nobody would want to marry their daughters. In some cases where women are deemed to have shamed the family honour, they have been subjected to 'honour' based abuse.

Safeguarding girls and adults at risk of harm through FGM poses specific challenges because the families may give no other cause for concern (such as parenting responsibilities or relationships with their children). Family members may believe FGM is the right thing to do and consider it is in the child's best interest, and adults may find it difficult to understand why the authorities should intervene in what they see as a cultural practice specific to their way of life. The family situation may be compounded by those who wish girls to be ritually cut when others disagree. Similarly there may be an inter-generational element, or a husband and wife may have differing views about their daughters. The desire to carry out FGM is also not confined to individuals within particular levels of education or social class. The pressure to undertake this procedure may be embedded in family structures. At all times it is important to 'think the unthinkable', and act with 'respectful uncertainty' (DH, 2003).

6.0 KEY PARTNERS, THEIR ROLE AND COMMITMENTS

The partnership finds the practice of FGM unacceptable and condemns the practice. The partnership also recognises that women who have undergone FGM are victims of crimes with complex needs.

All agencies that are part of the Calderdale Safeguarding Adults (SAB) and Children Boards (CSCB), or who are commissioned by member agencies are formally committed to the SAB /CSCB Inter-Agency Safeguarding Adults and Children Procedures. By signing up to this agreement the partnership agree to supporting robust information sharing and working together to protect families who are at risk and to use data effectively understand trends and prevalence and to inform future service development.

The Safeguarding Adult Board (SAB) and the Community Safety Partnership (CSP) work closely with the CSCB to ensure that professionals and services focus on the whole family and work closely to ensure that help and services ensure that children are protected.

This FGM strategy supplements these procedures and sets out in detail the expectations on all Calderdale agencies working with children, young people and adults at risk when FGM has been identified as having occurred or the child or adult is at risk of FGM.

All individual agencies have specific statutory responsibilities and aims, and can provide particular services that can be required to support children, young people and adults at risk of FGM. In addition to the shared and separate duties and responsibilities each agency holds, Working Together to Safeguard Children 2015 places a general obligation on all those who come into contact with children in respect of cooperation and responsibility for safeguarding.

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. We are determined to 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.

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. We also recognise that much of our achievements in strengthening our communities have been through effective partnership with statutory and voluntary agencies.

A number of the key partner agencies that work together to address FGM in the Calderdale District are listed below but this is not exhaustive and should not be assumed as the only agencies involved in protecting children at risk of FGM.

6.1 Calderdale Metropolitan Borough Council

Councils have an important role to play in protecting individual women and girls from

becoming victims of FGM, and in helping change attitudes in communities to end FGM.

Section 11 of the Children Act 2004 places a duty on all professionals "to safeguard and promote the welfare of children". This includes councils, schools, the police and health professionals. All have a role in ensuring that women and girls are protected. Councils also have a duty to protect women and girls from violence.

The Care Act 2014 puts adult safeguarding on a legal footing and from April 2015 each local authority must make enquiries, or ensure others do so, if it believes an adult is subject to, or at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to stop or prevent abuse or neglect, and if so, by whom.

Councils should be aware that families from affected communities may see FGM as good and necessary to raising a girl properly. Whilst councils and their partners must remain culturally sensitive in their dealings with families, this is not a practice that can be left to personal preferences. It is child abuse and it is illegal, and should be addressed as such. Engagement with the affected communities will be key to ensuring the abandonment of the practice in the long term.

Councils have considerable experience in engaging with their communities on a range of subjects, and by engaging with community leaders, religious leaders, community and voluntary groups and holding discussions around the practice, councils can help to facilitate this community approach. The use of champions from affected communities can be an effective method of engaging with men and women on FGM and its consequences.

Community engagement activity is crucial in ensuring the success of this strategy. Any work must facilitate the effective engagement with our local communities. It is anticipated that this engagement will be locality and district based and as such will seek to actively engage the Councils expertise as well as representatives of local communities and faith groups.

Our approach presumes the need for the consideration of changes in cultural norms and practice, and this is informed by our understanding from experiences elsewhere, how this is understood and responded to locally will in part be reflected in the success of how the strategy engages particular groups and interests. The active engagement by the communities in education and awareness raising, openly discussing the impact of FGM and human rights issues is known to be an important part of achieving such an impact and Such activities may allow greater understanding in relation to the issues and promote empowerment of those within the community to lead in eradicating this practice.

A change in cultural norms and practice requires active engagement by the communities in education and awareness raising, openly discussing the impact of FGM and human rights issues. Such activities allow greater understanding in relation to the issues and promote empowerment of those within the community to lead in eradicating this practice.

6.2 Adult Services including Adult Social Care

FGM may also affect adult women, who may be considered 'adults at risk'. Women who

fall into this category are most likely to come to the attention of services during pregnancy related care. In the context of FGM, an adult at risk is likely to be any person who is:

- Aged 18 and over and
- Who is or may be in need of community care services because of frailty; learning; physical; sensory disability or mental health issues and
- Who is or may be unable to take care of herself, or take steps to protect herself from significant harm or exploitation. This statement could apply to women who are migrants, refugees or asylum seekers.

Abuse is a violation of an individual's human and civil rights by any other person or persons.

Abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or omission to act, it may occur where a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented or cannot consent.

6.3 Calderdale's Children and Young People's Services, including Children's Social Care Services

Children and Young people's Services provide statutory Council services to assess, support, care for and protect vulnerable children in the Calderdale District.

Children's Social Care has the duty to investigate children in need and at risk of significant harm and intervene to protect those children. Services work to improve outcomes for vulnerable children and young people ensuring they are safe and healthy, able to achieve their potential and able to enjoy and contribute to their local community and economy, whether in the care of the Local Authority, at home in the community with Social Care interventions or support by other targeted/universal services.

All other services that actively work with young people throughout their provision have a duty to raise their awareness of personal safety and staff are able to focus on the identification of young people who need additional support. Additional need is assessed, action planned and delivered through one to one work, group work, partnership and referral to other organisations.

The services provided derive from the Local Authority duties prescribed by principal acts of parliament, ensuing plans and statutory guidance, they include the following named services however the list is not absolute:

- Early Intervention Services
- Youth Service
- Family intervention Team (FIT)
- Multi- Agency Screening Team (MAST)
- Children's Assessment Team (CAT)
- Locality Social Work Teams
- Disabled Children's Team (DCT)

- Safeguarding/Education Child Protection
- Children Looked After Services
- Adoption and Fostering
- Residential Children's Homes
- Pathways (Leaving Care Team)
- Youth Offending Team (YOT)

Other Calderdale Metropolitan Borough Council service areas with high levels of involvement in protecting children from FGM are:

- Public Health who commission key areas of services such as school nursing services, health visiting services and family nurse partnerships and inform future priorities for meeting the needs of the population
- Community Services

6.4 West Yorkshire Police

The main roles of the police are to uphold the law, prevent crime and disorder and protect citizens. Children, like all citizens, have the right to the full protection offered by the criminal law. Under section 11 of The Children Act 2004, the police must ensure their functions are discharged having regard to the need to safeguard and promote the welfare of children.

Officers have a duty to safeguard everyone, including women and girls, which means 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.

All 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 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.

In addition to their duty to investigate criminal offences the police have emergency powers to enter premises and ensure the immediate protection of children believed to be suffering or likely to suffer from significant harm.

Sections 70–75 of the Serious Crime Act 2015 introduced the following new measures:

- extension of extra-territorial liability to 'habitual' UK residents
- lifelong victim anonymity
- parents' and guardians' liability for failing to protect a child from FGM
- civil protection orders for FGM
- mandatory reporting for relevant professionals.

The first three provisions took effect on 3 May 2015, FGM protection orders (FGMPOs) came into force on 17th July 2015 and the duty to report commenced on 31st October

2015. (Appendix 4 Referral form into West Yorkshire Police)

More guidance for the Police is available at:

https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/female-genital-mutilation/

6.5 Health Services

Health services within Calderdale are the key agencies in being able to recognise adults or children and young people who have experienced or may be at risk of FGM. Health professionals are in a prime position to gather information and build trusting relationships. Strong relationships and links with health professionals as features of specialised support services can result in positive outcomes in both meeting the needs of adults or children and young people at risk (FGM Risk and Safeguarding: Guidance for Health Professionals 2015). This guidance has provided a risk assessment tools to assist healthcare practitioners when considering the safeguarding risks posed to both girls and women (pregnant or non-pregnant).

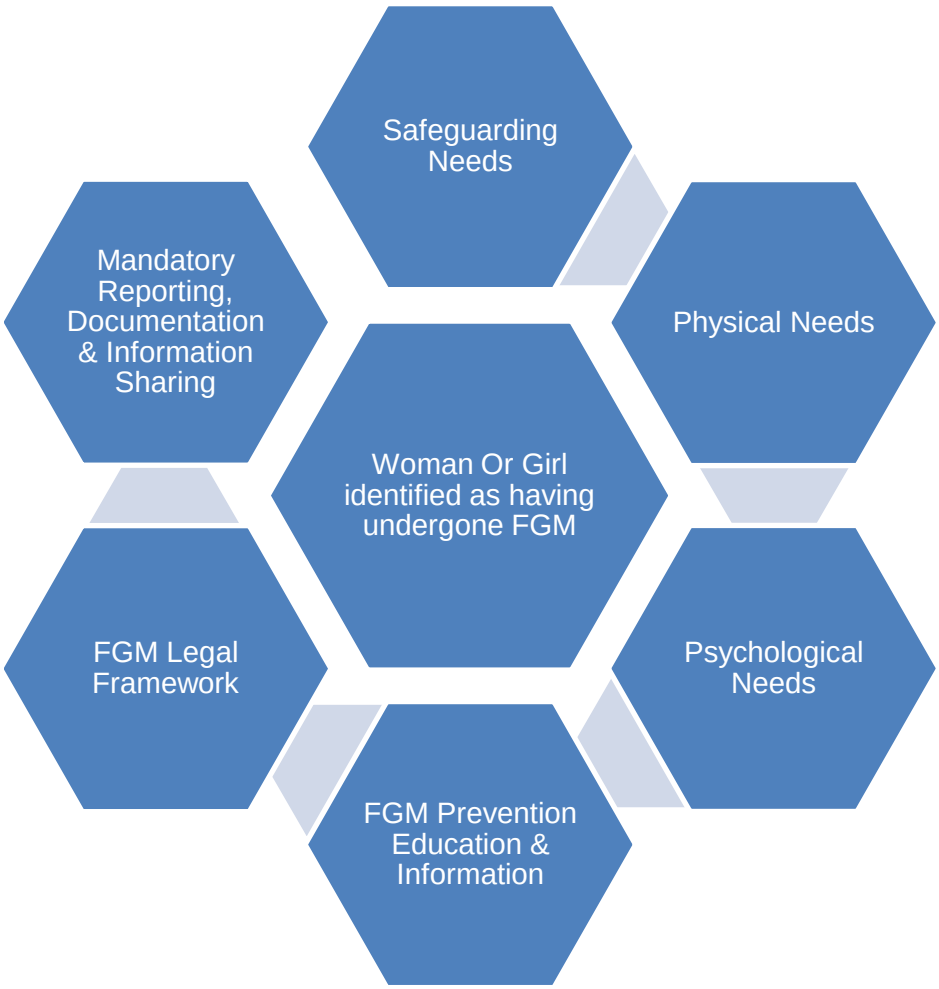
These health services include staff employed through Calderdale and Huddersfield NHS Foundation Trust, South West Yorkshire Partnerships Foundation NHS Trust, Locala Community Partnerships and, General Practitioners, though other health providers may also come into contact with this vulnerable group.

There is *no* requirement for automatic referral of adult women with FGM to adult social services or the police. Healthcare professionals should be aware that any disclosure may be the first time that a woman has ever discussed her FGM with anyone. Referral to the police must not be introduced as an automatic response when identifying adult women with FGM, and each case must continue to be individually assessed. The healthcare professional should seek to support women by offering referral to community groups who can provide support, and clinical intervention or other services as appropriate, for example through an NHS FGM clinic. The wishes of the woman must be respected at all times. If she is pregnant, the welfare of her unborn child or others in her extended family must be considered at this point, as these children are potentially at risk and safeguarding action must be taken accordingly.

Health professionals such as school health nurses, practitioners in young persons' advisory/sexual health clinics (Appendix 5), GPs and maternity services (Appendix 4) and Child and Adolescent mental Health Services have a crucial role in promoting the young person's health which includes identification of immediate and on-going health needs (including sexual health needs and emotional needs). As a universal service, health is well placed to offer support, counselling and information to enable young people to understand the risks and develop strategies for staying safe.

GPs will increasingly see adult women with health consequences of FGM and young girls who may be at risk of FGM and have a key role in identifying girls and women who have had, or are at risk of, FGM. Opportunities for asking about FGM arise at antenatal booking, sexual health screening, cervical smears, new patient registration and vaccination clinics.

Healthcare Management Primary Considerations must include:



Data collection has been hampered in the past by lack of specific codes for a history of FGM and for deinfibulation. However, from April 2014, the UK Terminology Centre developed specific codes for FGM. There are now designated FGM codes in Read V2, CTV3 and SNOMED (Systematized Nomenclature of Medicine--Clinical Terms).

In addition, the new version of the OPCS (Operating Procedure Codes) classification of interventions and procedures includes codes for deinfibulation. GPs are required to record in the patient's notes when FGM is identified.

Midwives are most likely to encounter women who have had FGM, and it is important to ask the question during pregnancy to ensure a safe birth and postnatal care for both mother and baby (Appendix 5).

If a pregnant woman is found to have FGM, she will need referral to specialist FGM services to assess whether intervention, such as deinfibulation (a procedure to open the lower vagina) is required before delivery. These services will also assess whether there is a potential risk to her unborn child if female.

There has been some suggestion that all pregnant women should be referred to social services, but this is not currently required. At present, careful judgment by the clinician is sufficient, but it is possible this situation will change. Accurate data about the number of women and girls affected by FGM are needed to plan services. It is hoped this will lead to a better understanding of FGM patterns in the UK and contribute to its prevention.

Documentation of conversations and concerns are vital to ensure better continuity of care going forward. However, if there are any concerns then further action is essential and can be carried out via safeguarding leads. Equally, midwives may also become concerned about a girl being at risk while attending a family for the birth of a subsequent child (RCOG - Female Genital Mutilation and its Management Guideline No 53 July 2015).

https://www.rcog.org.uk/globalassets/documents/guidelines/gtg-53-fgm.pdf

One specific consideration when putting in place safeguarding measures against FGM is that the potential risk to a girl born in the UK can usually be identified at birth, because through the ante-natal care and delivery of the child, NHS professionals can and should have identified that the mother has had FGM. However FGM can be carried out at any age throughout childhood, meaning that identifying FGM at birth can mean that any safeguarding measures adopted may have to be in place for more than 15 years over the course of the girl's childhood. This is a significantly different timescale and profile compared with many of the other forms of harm, against which the safeguarding framework provides protection.

In 2013 an intercollegiate group launched a report *Tackling FGM in the UK: Intercollegiate Recommendations for identifying, recording and reporting.*

http://www.equalitynow.org/sites/default/files/Intercollegiate_FGM_report.pdf

The report recognises that implementing a multi-agency action plan is required to ensure that young girls at risk of undergoing FGM are protected by the existing UK legal framework. This strategy will ensure that the nine recommendations within the report are adequately accounted for within action plan.

NHS organisations and staff should manage information in a way that is open and transparent to safeguard children who may be at risk of FGM. Staff should be clear that safeguarding considerations override the usual requirements for confidentiality and be confident to act accordingly, following the advice of the safeguarding professional. The child should be informed as appropriate and their consent to share information sought wherever possible.

As discussed in **section 4.2** in April 2014, the Information Standards Board published *ISB 1610 Female Genital Mutilation Prevalence Dataset Standard Specification* and supporting documentation. This standard required all NHS organisations to record information about FGM within the patient population in healthcare records, and introduced a requirement for acute trusts to report this to the Health and Social Care Information Centre on a monthly basis, by September 2014.

In April 2015, the Standardisation Committee for Care Information (SCCI) published the *SCCI 2026 – FGM Enhanced Dataset Requirements* and supporting documentation. This extends the data collection requirements to include all Mental Health Trusts and GP practices, and confirms the local data sharing practices which must be adopted.

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:

Immediate/ Urgent referral	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.
Active/on-going safeguarding support with social services lead.	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. **Verify existing interventions and strategy**. If unclear, refer.
Information-sharing between agencies with no specific protection is required.	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. **Provide resource information to family if it is safe to do so.**

As Commissioners of health services Calderdale Clinical Commissioning Group, NHS England and Local Authority Public Health Services need to be assured that the services they commission are alert and responsive to issues of FGM in their work with both children and adults.

6.6 Education and Schools

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. We will continue to identify ways to engage schools and support the education of young people on the interconnectedness of the practice of violence against young girls. We will also work with head teachers to highlight best practice by promoting case studies produced by the LSCB and Adult Safeguarding Board. The PHSE Association recommend 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 given 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.

Education Services, Schools (including Academies and Free Schools), further education and higher education providers are well placed to recognise children and young people who may be at risk of FGM as they will often notice changes in children's attendance, performance and behaviour, as well as often knowing about planned family trips abroad. Children and young people often confide in their fellow pupils and or teachers.

Education Services hold statutory duties to safeguard and promote the welfare of children and young people under the Education Act 2002 section 175 (maintained schools) section 157 (independent schools). The statutory guidance 'Keeping Children safe in Education' published in April 2014, asks schools to ensure that they raise awareness of FGM. Staff should be aware of FGM and it should be included in school policies where the different types of abuse and neglect are set out.

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.psheassociation.org.uk/content.aspx?CategoryID=1193.

Where schools identify concerns regarding FGM, they operate within the locally agreed Calderdale Safeguarding Children Board procedures. Education Services support and assist schools in both recognition and in reporting procedures.

The Schools Safeguarding Advisor is able to offer to school based staff and frontline education staff training regarding FGM. FGM is also included as part of the Designated Safeguarding Lead Initial and Refresher Training.

Boards of Governors and Head Teachers are well placed, through their curriculum and PHSE arrangements to provide information, advice and guidance to pupils to support the prevention of FGM and the education of children and young people to help them to identify risks of FGM for themselves and their peers.

6.7 Voluntary Sector

Any professional, volunteer or community group member who has information or suspicions that a child or adult is at risk of FGM should consult with their agency or group's safeguarding adviser (if they have one) and should make an immediate referral to either the local children's social care team, local Police or the NSPCC help line tel: 0808 800 5000 about making a referral to them. The referral should not be delayed in order to consult with the safeguarding adviser, a manager or group leader, as multi-agency safeguarding intervention needs to happen quickly. If there is a concern about one child or adult at risk, consideration must be given to whether siblings are at similar risk. It is expected that

individuals that make a referral to the police or children's social care in their role with a voluntary sector organisation will not normally be able to remain anonymous unless there are specific reasons to consider keeping their details confidential.

6.8 Crown Prosecution Service (CPS)

The CPS Violence Against Women and Girls Strategy provide an overarching framework for crimes that have been identified as primarily being committed by men, against women, within a context of power and control.

It reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women. It is not necessarily an offence committed by men on women, as women also commit the offence. However, it is regularly carried out on minors and is a violation of the rights of children. The practice also violates a person's rights to health, security and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death.

FGM prosecutions should therefore be addressed within an overall framework of violence against women and an overall human rights framework. Where appropriate, prosecutors should make links with other topics such as domestic violence, rape and sexual offences, honour crimes, forced marriage, child abuse, crimes against the older person, pornography, human trafficking and prostitution.

Prosecutors should recognise the diversity of victims. Victims' experiences of FGM are undoubtedly affected by identities distinct from gender, like their ethnicity, age, sexuality, disability, immigration status and religion or belief. Each victim's individual experiences of violence will be different, and some victims may encounter additional barriers to accessing justice. For example, a young woman forced into agreeing to these procedures may find it difficult to report domestic violence because she fears she will not be taken seriously as a result of her age. The safety and needs of each victim should be assessed on an individual basis.

6.9 The Role of the Adult Principal Social Worker and the Child and Family Social Worker

The Adult Principal Social Worker and the Child and Family Social Worker role provides practice leadership across the whole of the social care workforce. The focus is on promoting the quality of social care services through a well-skilled workforce.

The PSW will be able to identify any training issues for frontline practitioners and managers and any additional learning involving partnership working with all partners.

7.0 INFORMATION SHARING

All partner agencies and professionals are required by legislation and the LSCB/SAB to share information in order to ensure that children, young people and adults are effectively protected.

This means that when working together professionals and partner agencies need to be able to make sure that any information they have is shared with all those who are involved or need to become involved. We note that we have undertaken significant learning from our experience of developing successful approaches to Child Sexual Exploitation (CSE) and Sexual Exploitation (SE), especially in respect of the different types of "intelligence" professionals often have. This is particularly important with FGM because the indicators when seen by themselves can mean that the full significance is hard to recognise, so the pathways and information sharing arrangements that are being introduced as a part of this strategic response intend to improve how we recognise and act when there is a concern that FGM may take place or has taken place.

The principle of sharing information to protect children and adults at risk is widely understood especially when there is a need to prevent significant harm. This strategy builds on this and extends this across the "Inform – identify – prevent – support – disrupt – prosecute framework. This means that the strategy requires all partners to develop capacity to identify – understand and share intelligence relating to FGM in relation to children and adults at risk for whom there may be a concern and in relation to the behaviour of adults who may be a cause for concern.

This also requires all agencies to have in place the necessary arrangements and systems to collect, process and share data and information.

Six key documents provide the main national framework and the local procedural arrangements for information sharing:

- **Data Protection Act 1998** – This Act provides the main legislative framework for confidentiality and information sharing issues. The Act stipulates eight principles that must be followed when personal information is "processed" by organisations. ("Processing" refers to any work done with personal information including obtaining, recording, viewing, listing, disclosing and destroying.) The Act stipulates the conditions under which information may be shared i.e. the legal justifications.
- **Human Rights Act 1998** – This Act incorporates Article 8 of the European Convention of Human Rights which provides that everyone has the right to respect for their private and family life, home and correspondence.
- **Caldicott Guidance** – The Caldicott Committee produced their report on the "Review of Patient Identifiable Information" in December 1997. Caldicott guidance applies to all NHS organisations and local authority Social Services Departments. Guidance is based on six key principles). Organisations are required to appoint Caldicott Guardians to oversee the confidentiality / information sharing process.
- **NHS Confidentiality Code of Practice –** The Code of Practice was issued in July 2003 and applies to all NHS organisations. It is a guide to required practice on confidentiality, security and disclosure of personal information.

- **Crime and Disorder Act 1998** - The Crime & Disorder Act 1998 is the primary legislative tool, common to all crime reduction protocols. It does not override existing legal safeguards on personal information.
- **Multi-Agency Policy and Procedure for Safeguarding Adults for West and North Yorkshire** states that **-** Information sharing between organisations is essential to safeguard adults at risk of abuse, neglect and exploitation. In this context 'organisations' mean not only statutory organisations but also voluntary and independent sector organisations, housing authorities, the police and Crown Prosecution Service, and organisations which provide advocacy and support. The relevant procedure can accessed via this link:

  http://www.calderdale.gov.uk/socialcare/safeguardingadults/for-professionals.html

- **Calderdale Safeguarding Children Board Inter-Agency Safeguarding Procedures** contain guidance for all professionals working with children and families. This guidance sets out key practice points on information sharing and sets out confidentiality and public interest tests to be considered when considering whether to share information with other professionals. The relevant procedure can accessed via this link:

  http://westyorkscb.proceduresonline.com/chapters/p_info_shar_confid.html

"*Fears about information cannot be allowed to stand in the way of the need to promote the welfare and protect the safety of children.*

Data and reporting

This strategic response builds on the Department of Health led response to FGM which seeks to ensure that monitoring and reporting of FGM across the health service continuum is in place. Local health partners and this response set out how we will manage and coordinate reporting and other forms of intelligence so that:

a) we can build a better local understanding of FGM and its incidence/prevalence and
b) that we can be sure that our joint working arrangements are effective.

FGM is clearly understood as a form of abuse and an illegal act, as with other forms of abuse this requires the LSCB/SAB and partners to have in place and be assured that the joint working response is focused, measurable and effective. In achieving this outcome for vulnerable children and young people will be improved in the short and medium. It is also of note that the commitment partners are making to a strategic response which seeks to eliminate this form of abuse will result in permeant positive outcomes.

8.0 PROTECTION OF ADULTS AT RISK AND CHILDREN

FGM is a form of abuse and violence against women and girls, and therefore should be dealt with as part of existing adult and child safeguarding policies and procedures. This means that the Board and partners need to have a clear view of and capacity for ensuring that the response is not defused or obscured by and perceived cultural sensitivities.

8.1 Adults Social Care

Chapter 14 of the Care and Support Statutory Guidance (published February 2016) provides guidance in section 42-46 of the Care Act 2014: Safeguarding.

Safeguarding duties apply to an adult who:

- Has need for care and support (weather or not the Local Authority is meeting any of these needs).
- Is experiencing or at risk of abuse or neglect.
- As a result of these care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

Any Adult who is at risk of or has had FGM performed should be deemed an adult at risk and all cases referred.

The Care Act 2014 sets responsibility for adult safeguarding in primary legislation, endorsing the principle of wellbeing, placing safeguarding adult's duties on a statutory basis. Thus new responsibilities for the Calderdale Safeguarding Adults Board now exist including safeguarding duties having legal effect on partners with clear statutory responsibility to ensure enquiries into abuse and neglect are made or caused to be made. Safeguarding Adults Boards are placed on a statutory footing, with a legal requirement for Safeguarding Adult Reviews to take place and a duty to cooperate is placed on and between the Board Members and relevant partners.

Calderdale SAB has agreed and signed up to the West and North Yorkshire Multi-Agency Safeguarding Adults Policy and Procedures and also endorse the Multi-Agency Practice Guidelines - Female Genital Mutilation (HM Govt, 2011, updated July 2014) (see above link).

8.2 Children Social Care

A local authority may exercise its powers under section 47 of the Children Act 1989 if it has reason to believe that a child is likely to suffer or has suffered FGM. Under the Children Act 1989, local authorities can apply to the Courts for various Orders to prevent a child being taken abroad for mutilation.

Parents who seek FGM for their children often consider it an act of love, essential for their economic and social survival. Indeed, in many practicing communities, not circumcising ones daughter is considered bad parenting, tantamount to neglect. However well-meaning parent's actions, FGM remains a medically unnecessary, harmful, illegal act to which a child is unable to resist or consent. FGM places a child at risk of **significant harm.** The

Children Act 1989 introduced the concept of '**significant harm'** as the threshold that justifies compulsory intervention in family life in the best interests of children and young people. Harm is defined at section 31(9), Children Act 1989, whilst section 31(10) provides limited guidance as to what will be considered significant harm. It is classified as a form of **physical child abuse** therefore, must be addressed within the framework of child protection. Local authorities have a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering, or likely to suffer, significant harm under section 47 of the Children Act 1989. The definition of harm at section 31(9) was amended by the Adoption and Children Act 2002 to include, "for example, impairment suffered from seeing or hearing the ill-treatment of another".

Early Intervention Panel

The Calderdale Early Intervention Strategy (EIS) has been developed to deliver a co-ordinated approach to multi agency locality working. This provides Calderdale Council and its partners a robust framework to ensure the delivery of efficient and effective services to families. The priority is to deliver intervention which is early and focused for children, young people (aged 0 to 19) and their families who have been identified as being most at risk of needing support from a specialist service.

If a child is at risk of having FGM and has been assessed as non-urgent or further information is required then the relevant professional should complete the referral form for Early Intervention Panel (EIP) for the appropriate professional to be identified who will complete the Early Intervention Single Assessment (EISA) or go straight to completing the EISA or if actively involved with the family once the assessment is complete if child considered at risk then a referral must be made to children's social care (See flow chart).

An assessment of the presenting concerns of FGM and potential risks of FGM being undertaken on a child within the family should be undertaken by the relevant professional taking account the indicators previously listed. An open honest discussion should take place with the parent/carer about the family's own experiences of FGM and their views about FGM being undertaken on the child during a visit to family members or within the UK. The parent/carer should clearly be advised that as the child is resident in the UK that this is a criminal offence for a child to have FGM within the UK or abroad and subsequently will be subject to a criminal investigation and a Child Protection investigation would be undertaken jointly by the Police and Children's Social Care.

The CSCB has agreed and signed up to the West Yorkshire Consortium Procedures - 1.4.20 and endorses the Multi-Agency Practice Guidelines - Female Genital Mutilation (HM Govt, 2011, updated July 2014).

> ***If any agency becomes aware of a child who may have been subjected to or is at risk of FGM they must notify Children's Social Care***

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

An adult or child may be considered at risk of FGM if:

General Indicators

- They come from a community that practices FGM.
- The mother/older females in family circumcised.
- The family hold positive attitude towards FGM.
- The grandmother is present/has great influence in the family.
- No one has raised the issue of FGM with the child/family or provided accessible/age specific information.
- A girl makes reference to FGM, exhibits fear/excitement.
- Family intends to take child(ren) to homeland for a significant time period/to familiarise with local traditions.
- Adult at Risk or Child refers to going away for other reasons e.g. "Mother says I am to go home and I will come back a woman". "I am going on holiday and will come back with a sore bottom".
- Adult at Risk or Child refers to a female relative visiting for a "special ceremony".

Physical indicators

- Presents suddenly with urogenital/gynaecological difficulties.
- Suddenly makes frequent/prolonged trips to toilet
- Abruptly ceases to take part in/avoids physical activities.
- Noticeable changes in gait/general movements.
- Psychosomatic responses resulting from a traumatic event.

Psychological/behavioural indicators

- Profound behavioural/personality changes e.g. a formerly talkative, outgoing girl becomes timid, anxious, withdrawn, rejects contact.
- Sudden decline in school performance/attendance.
- Noticeable changes in parent child relationship/family dynamics.
- Post-Traumatic Stress Disorder.

Referral: Adult at Risk

If the adult female is an **adult at risk**, the adult safeguarding process should be initiated and an urgent Strategy Meeting arranged. Note however if the adult has **Capacity** and does not give consent the safeguarding process would not be taken forward unless there was a wider 'public interest' element to the case. Any safeguarding alert that alleges FGM of an adult at risk should be referred immediately to the Police and followed up in partnership with them. Immediate protection may be secured through the **Court of Protection** or the High Court.

Referral: Child Protection

The threshold for referral is low, **at the point of suspicion**, of noting Signals or Indicators of FGM, a **Referral** to **Children and Young Peoples Social Care** must be made. Ultimately,

the same rule applies at any stage of care.

Any suspicion that a child <18 has undergone, or is at risk of undergoing FGM, refer to children's social care and the police (see flow chart page **)

8.3 Assessment of Adults and Children who are 'at Risk' or who have undergone FGM

Whatever an individual's circumstances, they have rights that should always be respected, such as the right to personal safety and to be given accurate information about their rights and choices. Professionals should listen to the victim and respect their wishes whenever possible.

However, there may be times when a victim wants to take a course of action that may put them at risk – on these occasions, professionals should explain all the outcomes and risks to the victim and take the necessary child or adult protection precautions. Professionals should also be clear that FGM is a criminal offence in the UK and must not be permitted or condoned.

If the need to safeguard a child or adult at risk is urgent, the normal adult safeguarding and child protection processes should be followed.

Where a female has been identified as at risk or has been mutilated, it may not be appropriate to take steps to remove the child or an adult at risk from an otherwise loving family environment. Experience has shown that often the parents themselves can experience pressure to agree to FGM and see it as the best thing they can do for their daughter's marriageable status. It is also important to recognise that those seeking to arrange the mutilation are unlikely to perceive it to be harmful and, on the contrary, believe it to be legitimised by longstanding traditions. Therefore it is essential that when first approaching a family about the issue of FGM a thorough assessment should be undertaken, with particular focus on:

- Parental/carer attitudes and understanding about the practice and where appropriate;
- The wishes and views of the Adult at Risk/Child/Young person's is to their knowledge, understanding and views on the issues. For Adults at Risk a **Capacity** assessment may be required to see whether the legislation of the Mental Capacity Act 2005 applies. With regard to the Adult at Risk, An assumption of capacity to make their own decisions is made. However if there appears to be impaired understanding, then considerations needs to be made of the Mental Capacity Act 2005 and associated guidance.

Every attempt should be made to work with parents/carers on a voluntary basis to prevent abuse. It is the duty of the professional/agency to look at every possible way that parental/family co-operation can be achieved. However, the child's/adults best interest is always paramount.

Some thought and consideration should be given to where the assessment is undertaken. For example it may be beneficial to talk to the family/affected female outside the home

environment to encourage them to talk freely and acknowledge the impact FGM would have.

An interpreter must be used in all interviews with the family, and more importantly the affected female, if their first language is not English. The interpreter must not be a family relation and must not be known by the family. The interpreter should be female.

In cases where an interpreter is not used, and English is not the female's first language, the reasons for not using an interpreter must be recorded, as part of the assessment.

Appropriate communication aids must be offered for affected females who have difficulties communicating due to disability/illness and this should be documented within the record.

All interviews should be undertaken in a sensitive manner, and should only be carried out once.

With regards to children - parental consent and the child's agreement should be sought before interviews take place dependant on the child/young person's age. All attempts must be made to work in partnership with parents, and to endeavour for parents to retain full parental rights in these circumstances; where consent is not given, legal advice should be sought.

8.4 Adult's at Risk and Child Protection Procedures

Adults who are vulnerable need to be interviewed alone and a Capacity assessment completed, if appropriate. Capacity is decision-specific – the decisions to be assessed may include whether they can consent to travel abroad when there is a risk of their family arranging for them to undergo FGM. If they are not able to make a decision or safeguard themselves, then a **Best Interests** decision should be made. When an adult lacks Capacity and needs to be safeguarded the Local Authority can apply to the **Court of Protection** to give them powers to protect an individual. Adults at Risk who are assessed as having Capacity but are at risk of coming to harm can be protected using the powers contained within the inherent jurisdiction of the high court. Other adults may be protected for example through non molestation orders.

The Strategy Meeting should reconvene as agreed to discuss the outcomes and recommendations from the assessment and continue to plan the protection of the female. At all times the primary focus is to prevent the female undergoing any form of FGM by working in partnership with parents, carers and the wider community to address risk factors. However where the assessment identifies a continuing risk of FGM then, the first priority is protection and the local authority should consider the need for:

- Legal action;
- Criminal prosecution;
- An **Initial Child Protection Case Conference**.

- Legal Action/FGM Protection Orders

If a Child Protection Case Conference is deemed necessary and a **Child Protection Plan** is to be formulated, the Category of Abuse or Neglect should be **Physical Abuse**.

Following all enquiries into FGM, regardless of the outcome, consideration must be given to the therapeutic/counselling needs of the female and the family.

Medical examination, if necessary must only be undertaken with the child's and the parents' consent or the consent of the adult female. If the adult lacks the Capacity to consent to the examination; then a Best Interests decision can be made for them. Where parents do not consent, legal advice should be sought.

In the majority of cases there should only be one medical examination of the child or woman. In cases where subsequent medicals are required, clear reasons for this decision should be recorded as part of the assessment.

If a medical/surgical procedure is required, and parents refuse consent, legal advice must be sought immediately.

High Risk Time

All agencies in particular Education Staff need to be aware this procedure often takes place in the summer, as the recovery period after FGM can be 6 to 9 weeks. Schools should be alert to the possibility of FGM for a reason why a girl in a high risk group is absent from school or where the family request an 'authorised absence' for just before or just after the summer holidays.

Although, it is difficult to identify girls before FGM takes pace, where girls from these high risk groups return from a long period of absence with symptoms of FGM, advice should be sought from the police or social care.

Adults in Immediate Danger

Adults in immediate danger – When an adult is in immediate danger, contact the police. Protection can also be obtained by an emergency order by the Court of Protection where an adult lacks Capacity under the Mental Capacity Act 2005. Where an adult is being put under duress to comply with a situation, seek immediate legal advice; in some instances it will be necessary to approach the High Court for an emergency interim order.

Children in Immediate Danger

Where the child appears to be in immediate danger of FGM and parents cannot satisfactorily guarantee that they will not proceed with it, and then an **Emergency Protection Order** should be sought or Police Protection and appropriate place of safety for the child.

If there is no evidence of risk

If the enquiry concludes that there is no clear evidence of risk to the female then the relevant professional will:

- Consult the female's GP and a child's Health Visitor or School Nurse about this conclusion and invite her/him to notify Social Care if any further information challenges it;
- Notify appropriate professionals involved with the family of the enquiry and the stage at which it was concluded;
- Inform the family that the enquiry has been concluded;
- Consider whether any child may be a Child in Need or if the adult requires a community care assessment and, if so, offer appropriate services and offer the family/carers any appropriate support services.

If FGM has taken place

- Refer to flow chart on page 42
- If the FGM seems to have been performed in the UK, or whilst was resident in the UK or returned to the UK the police will undertake an investigation;
- The relevant professional will notify the Police who will notify the CHFT Safeguarding Team for health follow up.

FGM REFERRAL ROUTES

URGENT CASES CONTACT 999

NON URGENT CONTACT 101

MAST REFERRAL Tel: 01422 393336

POLICE NOTIFICATION FORM Appendix 4

ROUTE 1

Confirmation FGM has taken place in the PAST

Confirmation FGM has taken place on an under 18 year old whilst a resident of the UK – Immediate referral to Police. Refer to Children's Social Care if still under 18 and has siblings 0-18

Health appointment to be arranged

If presenting with immediate health needs medical intervention needs to arranged immediately

0-18

Refer to Police

Consent & co-operation will be required from parents/carer if requiring health follow up – if this does not take place immediate referral to Children's Social Care

ROUTE 2

Confirmation Female is at risk of having FGM in the FUTURE

Non Urgent

e.g. concern female will undergo FGM in the future

0-18

Refer to Police then to Children's Social Care who will make the decision whether an assessment/investigation needs to take place or advise what further action the referring agency needs to take

18 +

If adult refer to Adult Social Care who will determine their role. inform the Police

Urgent

e.g. suspicion female is going abroad to have FGM performed imminently

0-18

Refer to Police

Refer to Children's Social Care

Social Care & Police Strategy Discussion

18 +

Refer to Adults Social Care

Refer to Police if Immediate Risk

Adult Social Care & Police will co-ordinate the response

9.0 ROLE OF THE CALDERDALE SAFEGUARDING CHILDREN'S AND ADULT'S BOARDs

The Calderdale Safeguarding Children's and Adult's Boards provide a strategic oversight role to examine, challenge and support each of the partner agencies who have a role in safeguarding children.

The Government Guidance requires that all LSCB/SABs ensure their policies and procedures regarding FGM reflect their local areas and include guidance on how to recognise CSE, how to respond and preserve evidence.

To see how the LSCB addresses this and how it ensures this is effective please see the Performance Management and Quality Assurance Framework and the Learning and Improvement Framework links here.

Working Together to Safeguard Children 2015 Chapters 1-3 provide guidance on the legislative requirements and expectations on services to safeguard and promote the welfare of children, covering: assessing need and providing help; organisational responsibilities, including the requirement to appoint a qualified social worker to the role of designated officer for the management of allegations, unless the candidate has previous experience in the role; and, the statutory objectives and functions of Local Safeguarding Children Boards (LSCBs).

Local Safeguarding Children Boards' (LSCBs) duties and responsibilities include promoting activity amongst local agencies and in the community to:

- Identify and prevent maltreatment or impairment of health or development, and ensure children are growing up in circumstances consistent with safe and effective care;
- Safeguard and promote the welfare of groups of children who are potentially more vulnerable than the general population;

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

The LSCB should undertake initiatives in relation to FGM which fulfil these duties and responsibilities.

LSCBs are responsible for ensuring that single agency and inter-agency training on safeguarding and promoting welfare is provided in order to meet local needs, i.e. that staff who have responsibility for child protection work are acquainted with child protection procedures in relation to FGM and are confident working with local preventative programmes relating to FGM.

The Care Act 2014 puts adult safeguarding on a legal footing and recognises that local authorities cannot safeguard individuals on their own; it can only be achieved by working together with the Police, NHS and other key organisations as well as awareness of the wider public. Fears of sharing information must not stand in the way of protecting adults at risk of abuse or neglect. The Act includes new duties for SABs to work more closely

together and share information. The statutory guidance also introduces Designated Adult Safeguarding Managers (DASMs) in organisations concerned with adult safeguarding.

The Care Act says that if a SAB requests information from an organisation or individual who is likely to have information which is relevant to the SAB's functions, then they must share it with the Board. Additionally agencies should have drawn up a common agreement relating to confidentiality and the sharing of information between themselves based on the well-being of the adult at risk of abuse or neglect. It should also set out in what circumstances information will be shared without the agreement of the individual. The Act says that the SAB must:

- develop shared plans for safeguarding, working with local people to decide how best to protect adults in vulnerable situations.

The key principles in this strategy are:

Inform
Awareness of FGM amongst key groups of professionals and community organisations is a critical protective factor for adults at risk, children and their families. The partnership will achieve this through the following:

- Partnership agencies to maintain and review/ develop new and innovative arrangements to raise awareness of indicators.
- Promote the importance of sharing information / intelligence in a timely manner
- Maintain training of frontline practitioners for all partnership agencies
- Set progressive targets for increasing front line professional capacity, knowledge and skills
- Work with families regarding the law surrounding FGM and associated health risks
- Utilise all forms of media and technology, public facing initiatives to raise awareness across Calderdale
- Develop strategies to engage and inform adults, children, young people and communities through raising awareness.
- Raising awareness includes the promotion of the FGM leaflet/passport

Identify
How we will achieve this:

- Local procedures and pathways for responding to safeguarding concerns in relation to FGM have been developed reviewed and updated.
- A Multi-Agency consultation process in which all cases where there is evidence of FGM are reviewed
- The investigation of individual cases of abuse and adults at risk and children suspected to be at high risk of FGM
- Ensuring early identification of all adults at risk and children and young people who may be at risk of FGM
- Develop community participation groups in order to raise awareness of the

legislation in respect of FGM

Support
How we will achieve this:

- Training / Awareness-raising is undertaken for all professionals working with adults at risk and children
- A specialist pathway for women who have undergone FGM.
- The school health nursing service and health visiting services to provide on-going monitoring and preventative work with vulnerable groups and identified individuals

Prevent
How we will achieve this:

- Training of professionals to ensure knowledge of issues, procedures and pathways
- FGM awareness information and resources to raise the profile with at risk groups in community settings
- Develop resources for professionals to enable them to engage appropriately with at risk groups.
- Development of a community engagement programme including a multi-agency programme coordinator
- Scoping document to establish prevalence in Calderdale
- Identification of funding streams to support FGM work in Calderdale

Disrupt
How we will achieve this**:**

- Pro-actively identify, work with and support adults at risk and families who come from communities where FGM is practiced to understand the risks and laws related to FGM in the UK

Prosecution
How we will achieve this**:**

- Make best use of legislation
- Establish close liaison with Criminal Justice Partners
- Work collaboratively with partners and communities

In order to ensure that the key principles of this strategy are fulfilled by the LSCB/SAB on behalf of the local partnerships:

- Board members need to be assured that all elements of the strategic response and in place and achievable

- Board members need to form a view as to any further implications for the LSCB in terms of implantation and evaluation

- Board members are asked to decide whether further consultation and or development is required?
- Board members are asked to decide whether implementation should take place and that the necessary arrangements are in place to ensure this is a success.

To support this approach an action plan has been produced (Appendix 6) which will be a living document and amended as work progresses. The action plan will be reviewed and monitored by the Proactive and Responsive Sub Group of the LSCB with data collection and outcomes being incorporated in the LSCBs Performance Monitoring Indicator Report. The Proactive and Responsive (P&R) Safeguarding Sub Group's purpose of is to work on behalf of CSCB to coordinate and ensure effectiveness in the Calderdale District in its proactive work that targets particular groups of children that have been or who may be, identified as vulnerable. The Sub group and its multi-agency membership ensures that along with the other sub groups Board Members are able to fulfil their responsibilities

The P and R sub group will review and challenge where necessary strategies and plans that address, both single agency and interagency working arrangements and seek ways to improve / maintain current joint working arrangements. The Sub Group will on the basis of the problem profile and the Board's scrutiny of all aspects of joint working arrangements in response to FGM will identify any significant risks and deficits and bring these to the attention of the Board, the Independent Chair and partners.

The CSCB supports effective challenge on the basis of evidence and expects Board members to fully exercise this aspect of their role and responsibility to ensure that each organisation plays its part collectively to ensure the best outcomes for children and young persons

The SAB will receive the action plan at the main board and the two Board's will work together to ensure progression of the work and monitor progress.

Updates will be provided to the Community Safety Partnerships on a 6 monthly basis.

Tackling FGM requires a multi-agency approach and response through a recognised pathway that supports quality, evidence-based care and safeguarding. A further challenge for many is to consider how awareness raising can be enhanced simply by voicing concerns, speaking to colleagues and engaging in the campaign to end this violation of basic human rights.

10.0 ROLE OF THE HEALTH AND WELLBEING BOARD

The '*Call to end violence against Women and Girls Report*' (2011) outlines aspirations for a multi-agency local response which focuses on high risk victims, and a commitment to more preventative work. The prevention agenda focuses on reducing violence and abuse by 'challenging attitudes and behaviours', and by providing 'adequate levels of support' for victims, although this is not defined. To achieve the best outcomes for victims and families, the report advocates partnership working, and the need to 'take action' to reduce risk and bring perpetrators to justice.

The Government also outline some of the broader issues they wish to address, such as:

- 'challenging the culture of disbelief' around domestic abuse
- 'ensuring that services do not add to difficulties by apportioning blame'
- 'local areas should take more responsibility for tackling this issue, supported by joint working to ensure that the issue itself does not get marginalised'
- evidence of 'models of effective practice', interventions and approaches that are working, so that future provision can draw from, and build on that knowledge and skill

11.0 COMMUNITY ENGAGEMENT

FGM is a deeply embedded social norm within practising communities. Families and individuals uphold the practice because they believe that their wider communities expect them to do so, and that they will face social punishment if they do not conform. These social pressures are a major barrier to tackling FGM, and mean that legislating against the practice and pushing for prosecutions will not be sufficient to end it. Rather, improving understanding of these social norms, and working with communities to break them down, is essential to ending the generational cycle of FGM.

There are a number of reasons why it has been difficult to address the social norms surrounding FGM. First, communities are often unaware of the law criminalising the procedure, or believe that it only applies to Type 3 FGM. They may also believe that the law does not apply for children taken out of the country, or that it only applies to the cutters and not the ones organising it. Second, there is often a lack of awareness of the health effects associated with FGM.

Effective communication with the public and professionals regarding the problem of FGM is a crucial strand. Community engagement activity is crucial in ensuring the success of this strategy. Any work must facilitate the effective engagement with our local communities.. It is anticipated that this engagement will be locality and district based.

A change in cultural norms and practice requires active engagement by the communities in education and awareness raising, openly discussing the impact of FGM and human

rights issues. Such activities allow greater understanding in relation to the issues and promote empowerment of those within the community to lead in eradicating this practice.

There are numerous examples of programmes across the UK, some initiated by women and others by professionals working across agencies who have invested in campaigns to raise consciousness and understanding of the consequences of FGM. These include community groups and the police, as well as education and health and social care practitioners.

The education of male partners and community leaders may also reduce the number of children, and young and older women who suffer in the future. However, cultural practices such as FGM have been ingrained for many generations and require extensive education to address the issues thoroughly and effectively.

As an often embedded 'cultural practice', engagement with families and communities will be required to achieve a long-term abandonment and eradication of FGM.

12.0 IMPLEMENTATION

The strategy will be delivered by the CCSB FGM task-and-finish group. This group comprises representatives from across agencies in Calderdale with specific interest and skills in combating FGM. The group is accountable to the CSCB and will report progress on the implementation plan through the CSCB Business Management Group (BMG). Progress may also be reported through other related forums and Boards such as Calderdale Community Safety Partnerships and Calderdale Safeguarding Adults Board. An action plan detailing the delivery of the strategy is in appendix 1. It defines the work through the three key strategic themes of Care, Protection and Prevention. These three themes are inter-linking and actions detailed under one theme may well be relevant to the others.

13.0 EVALUATING THE FGM STRATEGY

We will evaluate how this FGM strategy has improved outcomes through the following measures:

- Quantitative evaluation. Data relating to FGM identified through:
    - **i)** Health reporting requirements to Health and Social Care Information Centre
    - ii) FGM Enhanced Dataset reporting for Health – Primary Care; NHS Mental Health Trusts and NHS Hospital Trusts.
    - iii) Numbers of FGM referrals to the MAST/Early Intervention Panels. We would expect to see increased identification of FGM/risk of FGM
- Qualitative evaluation of responses to FGM/risk of FGM through:
    - i) Sampling of outcomes from referrals to the MAST/Early Intervention Panels
    - ii) Sampling of use of CSCB FGM screening tool.
    - iii) Feedback from affected communities and those receiving services.

iv) Children and young people have increased awareness of FGM, their rights and sources of support

14.0 FUTURE REVISIONS OF THE FGM STRATEGY

It is vital that the key principles outlined in this document are underpinned by a commitment to develop effective arrangements for:

- Ensuring that all staff with safeguarding responsibilities receive training in relation to FGM issues
- Developing data collection around all cases where concerns have been raised in relation to FGM
- Annual review of the Calderdale Strategic Response to FGM

15.0 EQUALITY IMPACT ASSESSMENT

This strategy has taken account of national and local data relating to the impact of FGM and prevalence rates. This includes:

- HM Government Multi-Agency Practice Guidelines FGM 2014
- DH Commissioning Services to Support Women and Girls with Female Genital Mutilation 2015
- Foundation for Women's Health Research and Development (FORWARD) prevalence report 2007
- Female Genital Mutilation Risk and Safeguarding; Guidance for Professionals Department of Health 2015 FGM disproportionately and adversely affects women and girls who were born or whose heritage is from countries where FGM is practiced.

FGM is a deeply rooted tradition, widely practiced among specific ethnic populations in Africa and parts of the Middle East and Asia. It serves as a complex form of social control of women's sexual and reproductive rights.

The strategy aims to combat FGM and therefore has a positive impact on redressing inequality particularly for groups with the following protective characteristics:

- Age – as FGM may be committed as part of an age-related initiation
- Sex – FGM solely affects females
- Pregnancy and maternity – FGM has significant effect on women's reproduction and ability to give birth
- Race – FGM disproportionately affects women and girls from specific ethnic populations

The strategy has also taken account of Human Rights violated by the practice of FGM. The strategy and action plan will positively uphold the following rights:

- Right to Life – FGM can cause fatalities

- Freedom form Inhuman Treatment – FGM has no health or religious basis and leads to short and long-term severe physical and psychological consequences
- Right to Liberty – those at risk of FGM may be taken against their will to perform the FGM
- Right to Privacy and Family Life – individuals and their families may experience extreme undue influence and pressure from their communities to carry out FGM
- Right to Freedom of Expression – individuals may experience pressure and exclusion from their communities for trying to eradicate FGM within their community

APPENDIX 1 - COMPLICATIONS RESULTING FROM FGM

FGM can generate an array of physical, psychological and sexual health complications. Severity of complications vary according to the type of FGM performed, skill of the practitioner use of anaesthetic, Individual coping mechanisms and the extent to which social messages around FGM internalised. Those resulting from Type III however are more severe and long lasting. These complications can be divided in to three basic groups, those experienced in the **short term**, the **long term** and in **pregnancy and childbirth.**

Short Term Complications

- **Haemorrhage –** common, from severing the clitoral artery. If not remedied promptly/effectively can lead to exsanguination.
- **Pain –** due to lack of anaesthesia/analgesia.
- **Shock –** haemorrhagic due to blood loss, neurological due to severe pain, septic due to infection, can be fatal.
- **Urinary Retention –** common, due to pain, inflammation, injury to the urethra or fear of urinating on the raw wound. May last hours/days, ascend and cause renal damage/failure.
- **Injury to Adjacent Tissue –** urethra, vagina, perineum, rectum. Attributable to the use of crude instruments, poor light, failing eyesight of elderly practitioner and girl's struggles.
- **Infection –** tetanus, septicaemia, gangrene common, due to unhygienic conditions, un-sterile instruments, application of traditional herbs/ashes, contamination with urine/faeces, or binding of the legs which prevents wound drainage.
- **Fracture/Dislocation of Bones -** clavicle, femur, hip joint, reported due to the sheer force required by a number of adults to restrain an un-anaesthetised girl during the procedure.
- **Failure to Heal –** due to infection, irritation from urine/faeces, anaemia or malnutrition.
- **Anxiety related disorders -** disordered eating/sleeping, difficulty concentrating/learning, panic attacks.
- **Death –** in Dr Harry Gordon's research, 10% of respondents reported clear memories of a sibling or friend that died as a result of FGM.

Long Term Complications

Physical

- **Difficulties with Micturition -** due to urethral damage/obstruction. Tightly Infibulated girls can take >5-10 min to fully empty their bladder.
- **Recurrent UTI's –** due to occlusion of, or damage to the urethra. With Type III, normal urine flow is deflected; the perineum remains constantly wet and susceptible to bacterial growth. Retrograde UTI's may occur affecting the bladder and kidneys.
- **Vesico/Recto-Vaginal Fistulae –** from injury during FGM, repeat deinfibulation reinfibulation.
- **Transmission of Blood Born Infections –** e.g. HIV, Hep B, due to consecutive use of instruments without sterilisation, also, from lacerations/abrasions during intercourse.
- **Vulval Abscesses -** deep infection from faulty healing or an embedded stitch.
- **Genital Ulcers**
- **Neuroma/Chronic pain –** can develop when the dorsal nerve of the clitoris is cut/trapped in a stitch/scar tissue. Surrounding area becomes hypersensitive.
- **Dermoid Cysts –** from inclusion of the epithelium during healing, vary in size, can be extremely painful and cause obstruction.

- **Keloid Scars –** overgrowth of fibrous tissue in the scar.
- **Difficulties with Menstruation –** partial or total occlusion of the vaginal opening often results in dys/amenorrhea. Haematocolpos may occur through retention of menstrual blood.
- **Calculus Formation -** due to menstrual debris/urinary deposits in the vagina or behind the bridge of the scar tissue.

Sexual

- **Confusion of Feminine Identity**
- **< Sexual Sensation/Ability to Orgasm**
- **Dysparunea**
- **Vaginismus**
- **> risk of Sexually Transmitted Infections (Herpes, HIV)**
- **Chronic Reproductive Tract Infections –** Bacterial Vaginosis, PID.
- **Sub/Infertility -** Due to chronic infections, or inability to achieve penetration at intercourse.
- **> Marital Breakdown/Divorce Rate**

Psychological

- **Negative -** Fear, anger, betrayal, helplessness, difficulty forming trusting relationships, chronic anxiety, phobias, conversion reactions, PTSD, nightmares, < appetite, < self esteem, panic attacks, shame, depression.
- **Positive -** pride, virtue, beauty, identity cultural/gender.

Obstetric Complications

FGM in pregnancy and childbirth significantly increases maternal morbidity and fetal morbidity/mortality. In the UK however, with early identification, timely referral and appropriate management of care, many of FGM's complications can be prevented. It is therefore **essential that FGM is identified at the beginning of pregnancy, or ideally pre-pregnancy**. Severities of complications vary depending on the size of the introitus, density and nature of the scar tissue, a woman's parity and may include:

Antenatal

- At miscarriage, products of conception may be retained due to scar tissue/stenosis. Evacuation of uterus may prove difficult/impossible.
- Greater risk of Urinary tract infections .
- Infibulated women's urine is often contaminated with vaginal secretions showing false proteinuria. Passing a catheter to obtain an uncontaminated sample may be impossible. FGM can thus interfere with identification/monitoring progression of PET.
- Woman's altered anatomy may obstruct routine investigations and management of complications e.g. inability to pass speculum to confirm SROM, assess vaginal bleeding or swab for infection.
- Induction of labour may prove difficult or impossible.
- Pregnancy and fear of labour often heighten/trigger onset of anxieties and depression.

Intrapartum

- Labour may induce traumatic flashbacks to original FGM experience, akin to rape.

- Limited access to the vagina can lead to ineffective monitoring of labour e.g. if we are unable to perform VE's, we cannot confirm onset of labour, adequately monitor progress of labour, or confirm, where there is doubt, fetal presentation/position.
- Limited access can lead to ineffective monitoring of fetal wellbeing e.g. inability to perform ARM, FBS or attach FSE.
- Inadequate monitoring of labour/fetal wellbeing may hasten decision to perform an unnecessary LSCS, indeed, women with FGM are at increased risk of LSCS.
- Difficulty identifying obstetric emergencies, e.g. cord prolapse.
- increased risk of urine retention.
- FGM may cause obstruction to catheterising during labour or prior to LSCS.
- Possible risk of prolonged/obstructed labour due to tough fibrous scar tissue, urine retention.
- Significantly increased risk of severe vaginal/perineal trauma due to inelasticity of scar tissue.
- Increased risk of low birth weight.
- Increased risk birth asphyxia, low Apgar's.
- Increased risk of still birth, neonatal death. The WHO estimate an additional 1-2 babies per 100 deliveries die as result FGM. The likelihood of this Increases with the severity of FGM e.g. compared to women without FGM, babies of mothers with Type I FGM are 15% more likely to be stillborn or die in the neonatal period, for women with Type II FGM there is a 32% increase, with Type III FGM, a 55% Increase.

Postnatal

- Increased risk of PPH due to lacerations, prolonged labour/uterine inertia.
- Significantly increased perineal pain, risk of wound infections and breakdown.
- Extended hospital stay.
- ? Increased Maternal Mortality.

APPENDIX 2 PREVALENCE OF FGM

The true extent of FGM prevalence is unknown; it is a "hidden crime". FGM is a practice which takes place worldwide in African countries and in parts of the Middle and Far East. However, with increased mobility of world populations and migration due to war and famine, FGM is increasingly reported in Europe, USA, Canada, Australia and New Zealand. FGM has thus become an issue of **global concern**.

UK communities that are at risk of FGM include Somali, Kenyan, Ethiopian, Sierra Leonean, Sudanese, Egyptian, Nigerian, Eritrean, Yemeni, Jordanian, Oman, the Palestinian Territories (Gaza) and Kurdish communities in Iraq. FGM is also reported to be practiced by some groups in India, Pakistan, Indonesia and Malaysia; however it is believed that the majority of cases of FGM are carried out in 28 of the African countries. In some countries (e.g. Egypt, Ethiopia Somalia and Sudan) prevalence rates have been reported to be as high as 98 per cent. In other countries (such as Nigeria, Kenya, Togo and Senegal) the reported prevalence rates vary between 20-50%.

The prevalence of FGM in England and Wales is difficult to estimate because of the hidden nature of the crime. However, a study by Macfarlane and Dorkenoo in 2015 estimated that:

- approximately 60,000 girls aged 0-14 were born in England and Wales to mothers who had undergone FGM; and
- approximately 103,000 women aged 15-49 and approximately 24,000 women aged 50 and over who have migrated to England and Wales are living with the consequences of FGM.
- In addition, approximately 10,000 girls aged under 15 who have migrated to England and Wales are likely to have undergone FGM.

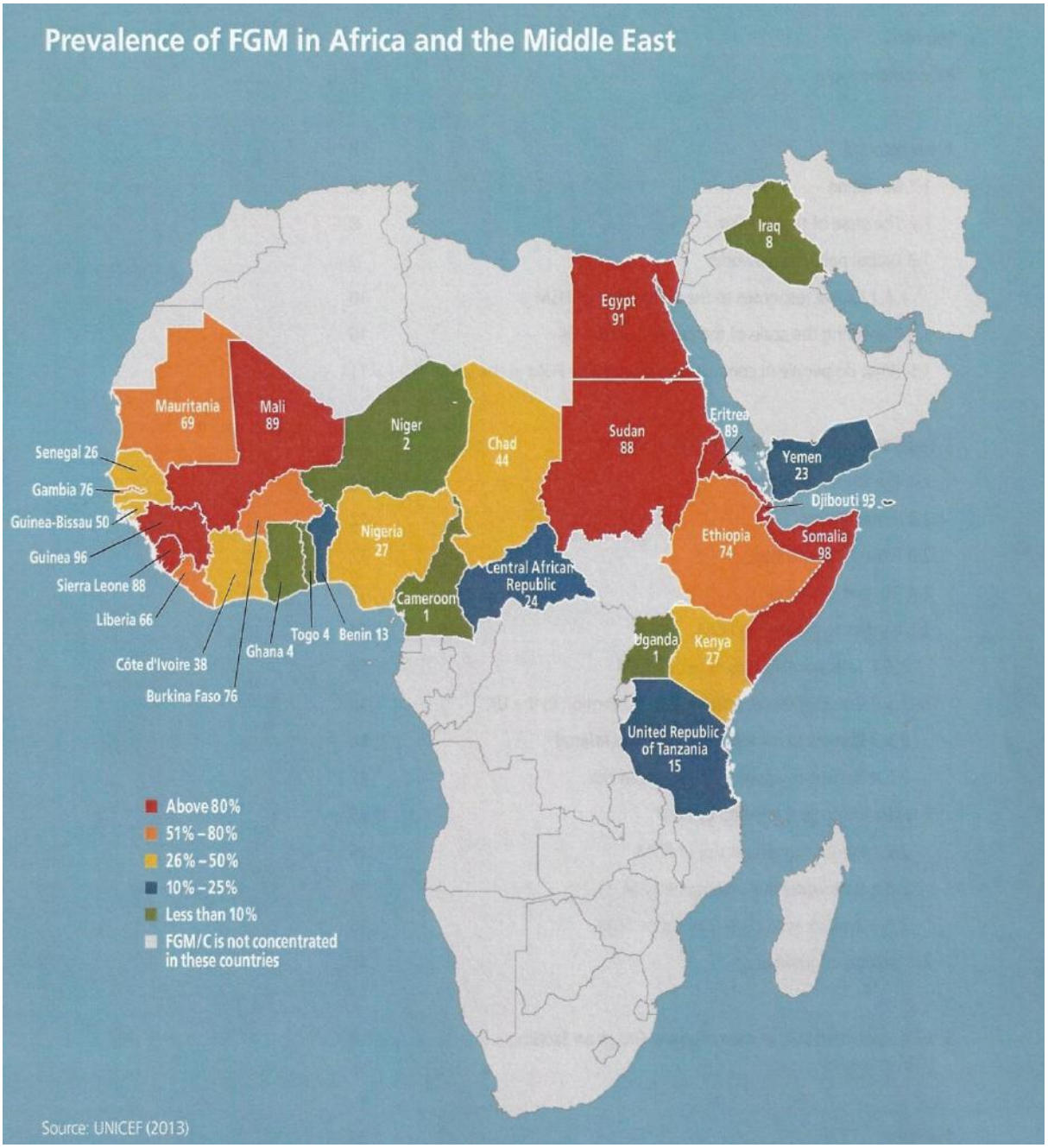
Calderdale district has a total population of 191,000 with the minority ethnic communities making up 10% of the population. Using 2011 census data it is known that across Calderdale there are 1,012 people who were born on the African Continent. This figure does not account for second and third generations family members who may have been subject to or at risk of FGM

Individuals from practicing communities settle in the UK for numerous reasons e.g. to increase employment or education prospects to seek asylum and refugee status due to civil unrest and war. This wide range of social and economic backgrounds cannot be overlooked. This means that at the time of the writing of this strategy we are not yet fully aware of how often FGM takes place or has taken place either locally or away from Calderdale. Therefore a significant part of our action plan is to put in place arrangements for recognising and counting actual reported incidences and to draw on expert advice to form a provisional view of the likely scales of the problem. This will in turn help partners to judge how best to use their limited resources.

Calderdale's Ethnic breakdown (2011)						
ID	**Place**	**% White, British**	**% Mixed**	**% Asian or Asian British**	**% Black or Black British**	**% Chinese**
101	Calderdale	87	1.34	6.99	0.94	0.25
National Ethnic breakdown (2011)						
ID	**Place**	**% White, British**	**% Mixed**	**% Asian or Asian British**	**% Black or Black British**	**% Chinese**
		86.0	2.2	7.5	3.3	1.0

Prevalence/Type of FGM by Country

African countries have the highest prevalence rates of FGM, but there are also countries with high prevalence rates in the Middle East, South, Southeast and Central Asia



FGM has also been documented in communities including:

- **Iraq**
- **Israel**
- **Oman**
- **The United Arab Emirates**
- **The Occupied Palestinian Territories**
- **India**
- **Indonesia**
- **Malaysia**
- **Pakistan**

Prevalence by country

Country	% Prevalence	Type
Africa		
Benin	13%	2
Burkina Faso	77%	2
Cameroon	1.4	1,2
Central African Republic	25.7	1,2
Chad	45%	2,3
Côte d'Ivoire (Ivory Coast)	42%	2
Democratic Republic of the Congo (DRG)	5%	2
Djibouti	90-98%	1,2,3
Egypt	78–97%	1,2,3
Eritrea	89%	1,2,3
Ethiopia	69.7-94.5%	1,2,3
Gambia	76%	1,2,3,4
Ghana	4%	1,2,3
Guinea	96%	1,2,3
Guinea-Bissau	45%	1,2,3
Kenya	27%	1,2,3
Liberia	58%	2
Mali	92%	1,2,3
Mauritania	71%	1,2
Niger	2-20%	2
Nigeria	30%	1,2,3,4
Senegal	28%	2,3
Sierra Leone	91%	1,2
Somalia	98%	1,2,3
Sudan	91%	1,2,3
Tanzania	14.6%	2,3
Togo	50%	2
Uganda	<5%	1,2
There are reports that FGM takes place in the following countries but there are no figures available to indicate prevalence: Algeria, Comoros, Congo, Libya, Malawi, Mozambique, South Africa and Zimbabwe.		
Middle East		
Iraq, Iraqi Kurdistan	72.7%	1,2
United Arab Emirates	31%	-
Yemen	23%	-
There are reports that FGM takes place in the following countries but there are no figures available to indicate prevalence: Bahrain, Iran, Jordan, Kuwait, Oman, Palestinian territories, Qatar, Saudi-Arabia, Syria and Turkey.		
South, Southeast and Central Asia		
Malaysia	93.3%	1,4
Indonesia	86%	1,4
Prevalent in parts of Philippines, where FGM is called Pag-Sunnat. There are reports that FGM takes place in the following countries but there are no figures available to indicate prevalence: Afghanistan, Brunei (Type IV), Maldives, Pakistan, India and Tajikistan.		

APPENDIX 3 - Traditional and local terms for FGM

COUNTRY	Term used for FGM	Language	Meaning
EYGYPT	Thara	Arabic	Deriving from the Arabic word 'tahar' meaning to clean/purify
	Khitan	Arabic	Circumcision – used for both FGM and male circumcision
	Khifad	Arabic	Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)
ETHIOPIA	Megrez	Amharic	Circumcision/cutting
	Absum	Harrari	Name giving ritual
ERITREA	Mekhnishab	Tigregna	Circumcision/cutting
KENYA	Kutairi	Swahili	Circumcision – used for both FGM and male circumcision
	Kutairi was ichana	Swahili	Circumcision of girls
NIGERIA	Ibi/Ugwu	Igbo	The act of cutting - used for both FGM and male circumcision
	Sunna	Mandingo	Religious tradition/obligation for Muslims
SIERRA LEONE	Sunna	Soussou	Religious tradition/obligation for Muslims
	Bondo	Temenee/Mandingo/ Limba	Integral part of an initiation rite into adulthood – for non-Muslims
	Bondo/Sonde	Mendee	Integral part of an initiation rite into adulthood – for non-Muslims
SOMALIA	Gudniin	Somali	Circumcision – used for both FGM and male circumcision
	Halalays	Somali	Deriving from the Arabic word 'halal' ie. 'sanctioned' – implies purity. Used by Northern & Arabic speaking Somalis.
	Qodiin	Somali	Stitching/tightening/sewing refers to infibulation
SUDAN	Khifad	Arabic	Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)
	Tahoor	Arabic	Deriving from the Arabic word 'tahar' meaning to purify
CHAD – the Ngama	Bagne		Used by the Sara Madjingaye
Sara sub group	Gadja		Adapted from 'ganza' used in the Central African Republic
GUINEA-BISSAU	Fanadu di Mindjer	Kriolu	'Circumcision of girls'
GAMBIA	Niaka	Mandinka	Literally to 'cut clean/weed'
	Kuyango	Mandinka	Meaning 'the affair' but also the name for the shed built for initiates
	Musolula Karoola	Mandinka	Meaning 'the women's side'/'that which concerns women'

APPENDIX 4 – Referral Form to Police re mandatory reporting

West Yorkshire Police Headquarters
PO Box 9
Wakefield
WF1 3QP

Phone 01924 293956
Fax: 01924 293999
cib@westyorkshire.pnn.police.uk

FGM RECOGNISING AND PREVENTING

*For internal use only: Storm no. Niche no

Section 1 – About You		
Reporting Persons Name		
Address		
Postcode		
Date of Birth		
Contact Telephone Number		
E-mail Address		
Occupation		
Preferred Means of contact		
Section 2 – About the Victim		
Name of Victim		
Address		
Postcode		
Date of birth		
Contact Telephone Number		
E-mail Address		
Occupation (if applicable)		
Ethnic Origin		
Nationality		
Preferred Means of Contact		

Please tell us if the victim needs and interpreter or other support when we contact them		
Section 3 – FGM Report		
Where did it occur?		
When did it occur?		
Please provide circumstances regarding the discovery		
Please provide details of any action already taken		
Please provide details of any known family members		

Please submit your completed form to cib@westyorkshire.pnn.police.uk

APPENDIX 5 –Referral pathway to sexual health services for women with FGM

Identify and discuss

- Ask women from affected communities if they have undergone FGM
- Find out relevant details

Give information

- Offer **examination** to explain what has happened (use diagrams)
- Discuss possible **harmful effects**
- Give **FGM leaflet / ' passport'**
- Offer follow-up as appropriate

Refer to specialist services

- Offer referral to:
  - **Specialist NHS clinic** for physical and psychological treatment
  - **Specialist midwife clinic** if pregnant
  - **Community organisations** for peer/psychological support

Child safeguarding

- Find out intention towards present or future daughters / female relatives
- Explain FGM is illegal
- Explain harmful effects of FGM
- If any concerns about of FGM or actual FGM refer to **social care and police**

Communication

- Document in notes
- SRH healthcare professionals : Discuss information sharing with GP

APPENDIX 6 – Referral pathway for pregnant women with FGM

Identify and discuss

- Ask ALL women at antenatal screening booking
- Find out relevant details

Give information

- Offer **examination** to explain what has happened (use diagrams)
- Discuss possible **harmful effects**
- Discuss **deinfibulation** if appropriate
- Give **FGM leaflet / 'passport'**

Refer to specialist services

- Offer referral to:
  - **Specialist midwife clinic** for deinfibulation and psychological treatment
  - **Community organisations** for peer/psychological support

Child safeguarding

- Find out intention towards present or future daughters / female relatives
- Explain FGM is illegal
- Explain harmful effects of FGM
- If any concerns about of FGM or actual FGM **refer to social care and police**

Communication

- Document in **maternity notes** and **maternal discharge summary**
- Document in **baby's red book page 6** and **baby discharge summary**

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http://www.equalitynow.org/sites/default/files/Intercollegiate_FGM_report.pdf

National services and advice

Metropolitan Police Project Azure 020 7230 8324

Foreign and Commonwealth Office
Tel: 020 7008 1500
Internet: www.fco.gov.uk/fgm

Calderdale Safeguarding Children's Board calderdale-scb@calderdale.org.uk

Childline
Tel: 0800 1111 (24 hour free helpline for children)
Internet: www.childline.org.uk

AFRUCA – Africans Unite Against Child Abuse
Tel: 020 7704 2261
Internet: www.afruca.org

Peacemaker International
West Bowling Centre, Clipstone Street, Bradford, BD5 8AE
Tel: 01274 736859
Mobile: 07405 820814
Email: info@peacemaker-international.org

National Society for Prevention of Cruelty to Children (NSPCC)
Confidential 24 hour FGM helpline: 0800 028 3550
Email: fgmhelp@nspcc.org.uk
Internet: www.nspcc.org.uk/fgm

Equality Now
5th floor, 6 Buckingham Street, London WC2N 6BU
Tel: 020 7839 5456
Fax: 020 7839 4012
Email: ukinfo@equalitynow.org
Internet: www.equalitynow.org

Foundation for Women's Research and Development (FORWARD)
Suite 2.1 Chandelier Building, 2nd Floor, 8 Scrubs Lane, London NW10 6RB
Tel: 020 8960 4000
Fax: 020 8960 4014
Email: forward@forwarduk.org.uk
Internet: www.forwarduk.org.uk

International Planned Parenthood Federation
Newhams Row, London SE1 3UZ
Tel: 020 7939 8200
Fax: 020 7939 8300
Email: info@ippf.org Internet: www.ippf.org

Black Women's Health and Family Support (BWHAFS)
82 Russia Lane, London E2 9LU
Tel: 020 8980 3503
Fax: 020 8980 6314
Email: bwhafs@btconnect.com Internet: www.bwhafs.com