
A REVIEW OF FEMALE GENITAL MUTILATION IN HARROW

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INTRODUCTION

Female genital mutilation (FGM) refers to procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. FGM is a criminal offence – it is child abuse and a form of violence against women and girls, and therefore should be treated as such. FGM has been illegal in the UK since 1985, with the law being strengthened in 2003 to prevent girls travelling from the UK and undergoing FGM abroad.

This report will

- Describe FGM
- Identify the law and guidance on FGM in England
- Present data on the prevalence of FGM in Harrow
- Identify local actions to raise awareness of FGM;
- Identify local actions to protect and safeguard those at risk of FGM
- Identify local actions to support those who have undergone FGM
- Describe the reporting pathways

PRINCIPLES UNDERPINNING WORK ON FGM

The following principles have been 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;
- 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)⁵ statutory guidance in England, and the Framework for the Assessment of Children in Need and their Families in Wales (2001)⁶).

WHAT IS FEMALE GENITAL MUTILATION? (FGM)

FGM is a procedure where the female genital organs are injured or changed and there is no medical reason for this. It is frequently a very traumatic and violent act for victims and can cause harm in many ways the practice can cause severe pain and there may be immediate and/or long-term health consequences, including mental health problems, difficulties in child birth, causing danger to the child and mother and/or death.

The age at which FGM is carried out varies enormously according to the community. The procedure may be carried out shortly after birth, during childhood or adolescence, just before marriage or during a woman's first pregnancy.

TYPES OF FGM

FGM has been classified by the World Health Organisation (WHO) into four types:

- **Type 1 – Clitoridectomy:** partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris);
- **Type 2 – Excision:** partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are the 'lips' that surround the vagina);
- **Type 3 – Infibulation:** narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris; and is the most severe type
- **Type 4 – Other:** all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterising the genital area.

FGM is a deeply embedded social norm, practised by families for a variety of complex reasons. It is often thought to be essential for a girl to become a proper woman and to be marriageable. FGM is believed to be a way of ensuring virginity and chastity. It is used to safeguard girls from sex outside marriage and from having sexual feelings. Although FGM is practiced by secular communities, it is most often claimed to be carried out in accordance with religious beliefs. FGM is not supported by any religious doctrine.

FGM has no health benefits, and it harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue, and interferes with the natural functions of girls' and women's bodies. Generally speaking, risks increase with increasing severity of the procedure.

Immediate/short term health problems include severe pain, difficulty passing urine, excessive bleeding, infection due to the instrument being used in multiple procedures, wound healing problems, shock and death.

In the long term, women who have suffered FGM may also have some or all of the following problems:

- **Pain:** due to tissue damage and scarring that may result in trapped or unprotected nerve endings.
- **Infections:**
 - **Chronic genital infections:** with consequent chronic pain, and vaginal discharge and itching. Cysts, abscesses and genital ulcers may also appear.
 - **Chronic reproductive tract infections:** May cause chronic back and pelvic pain.
 - **Urinary tract infections:** If not treated, such infections can ascend to the kidneys, potentially resulting in renal failure, septicaemia and death. An increased risk for repeated urinary tract infections is well documented in both girls and adult women.
- **Painful urination:** due to obstruction of the urethra and recurrent urinary tract infections.
- **Menstrual problems:** result from the obstruction of the vaginal opening. This may lead to painful menstruation (dysmenorrhea), irregular menses and difficulty in passing menstrual blood, particularly among women with Type III FGM.
- **Keloid scarring** where excessive scar tissue forms at the site of the cutting. Keloid scars grow lumpy and larger than the wound they're healing
- **Human immunodeficiency virus (HIV):** given that the transmission of HIV is facilitated through trauma of the vaginal epithelium which allows the direct introduction of the virus, it is reasonable to presume that the risk of HIV transmission may be increased due to increased risk for bleeding during intercourse, as a result of FGM.
- **Female sexual health problems:** removal of, or damage to highly sensitive genital tissue, especially the clitoris, may affect sexual sensitivity and lead to sexual problems, such as decreased sexual desire and pleasure, pain during sex, difficulty during penetration, decreased lubrication during intercourse, reduced frequency or absence of orgasm (anorgasmia). Scar formation, pain and traumatic memories associated with the procedure can also lead to such problems.
- **Obstetric complications:** FGM is associated with an increased risk of Caesarean section, post-partum haemorrhage, recourse to episiotomy, difficult labour, obstetric tears/lacerations, instrumental delivery, prolonged labour, and extended maternal hospital stay. The risks increase with the severity of FGM.
- **Obstetric fistula:** a direct association between FGM and obstetric fistula has not been established. However, given the causal relationship between prolonged and obstructed labour and fistula, and the fact that FGM is also associated with prolonged and obstructed labour it is reasonable to presume that both conditions could be linked in women living with FGM.
- **Need for later surgeries:** for example, the FGM procedure that seals or narrows a vaginal opening (type 3) needs to be cut open later to allow for sexual intercourse

and childbirth (known as deinfibulation). Sometimes genital tissue is stitched again several times, including after childbirth, hence the woman goes through repeated opening and closing procedures, further increasing both immediate and long-term risks;

- **Perinatal risks:** obstetric complications can result in a higher incidence of infant resuscitation at delivery and intrapartum stillbirth and neonatal death.
- **Psychological consequences:** some studies have shown an increased likelihood of post-traumatic stress disorder (PTSD), anxiety disorders and depression. The cultural significance of FGM might not protect against psychological complications.

FGM is a complex issue – despite the harm it causes, many women and men from practicing communities consider it to be normal to protect their cultural identity.

Terms used for FGM in other languages can be found in the multi-agency statutory guidance on female genital mutilation.

FIGURE 1 COMMON TERMS FOR FGM

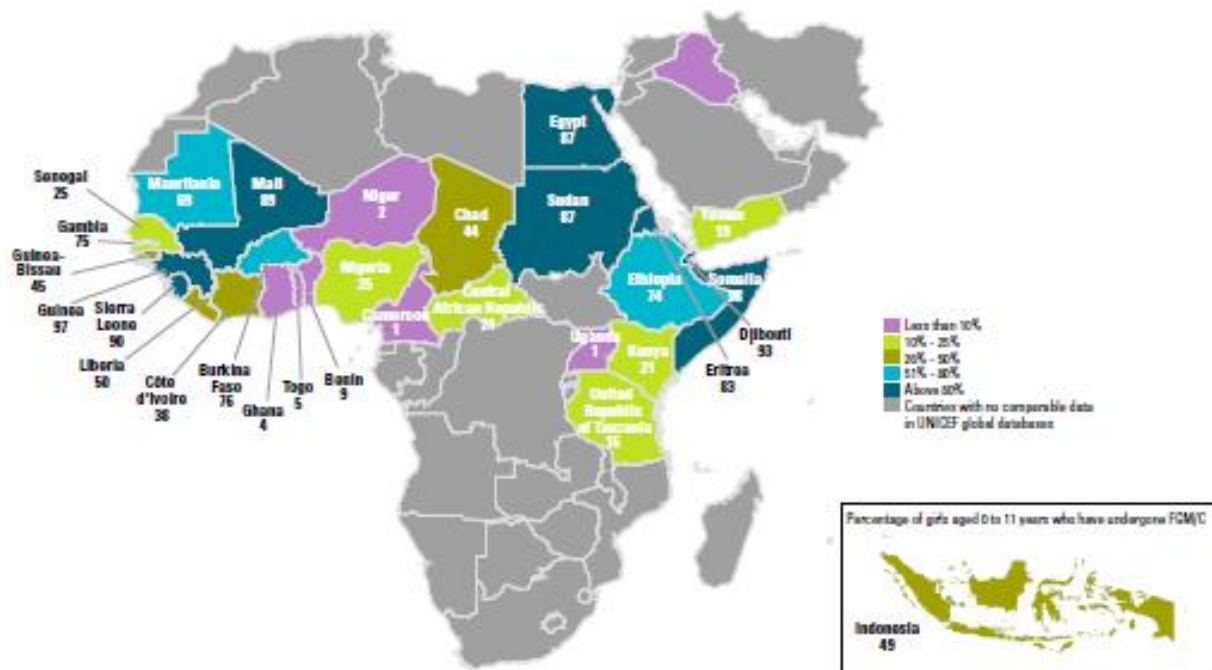
Country	Term used for FGM	Language	Meaning
EGYPT	Thara	Arabic	Deriving from the Arabic word 'tahar' meaning to clean/purify
	Khitan	Arabic	Circumcision – used for both FGM and male circumcision
	Khifad	Arabic	Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)
ETHIOPIA	Megrez	Amharic	Circumcision/cutting
	Absum	Harrari	Name giving ritual
ERITREA	Mekhnishab	Tigreña	Circumcision/cutting
KENYA	Kutari	Swahili	Circumcision – used for both FGM and male circumcision
	Kutari was Ichana	Swahili	Circumcision of girls
NIGERIA	Ib/Ugwu	Igbo	The act of cutting – used for both FGM and male circumcision
	Sunna	Mandingo	Believed to be a religious tradition/obligation by some Muslims
SIERRA LEONE	Sunna	Soussou	Believed to be a religious tradition/obligation by some Muslims
	Bondo	Temenee/ Mandingo/Limba	Integral part of an initiation rite into adulthood
	Bondo/Sonde	Mendee	Integral part of an initiation rite into adulthood
SOMALIA	Gudinlin	Somali	Circumcision – used for both FGM and male circumcision
	Halalays	Somali	Deriving from the Arabic word 'hala' ie. 'sanctioned' – implies purity. Used by Northern & Arabic speaking Somalis.
	Qodlin	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 subgroup	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 /weed clean'
	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'

Source: Female genital Mutilation Risk and Safeguarding: Guidance for Professionals

PREVALENCE OF FGM - WHO IS AT RISK OF FGM?

FGM is practiced in a swath of African countries from the Atlantic coast to the Horn of Africa, in parts of the Middle East, and in some Asian countries like Indonesia.

FIGURE 2. PERCENTAGE OF YOUNG AND ADULT WOMEN AGED 15-49 WHO HAVE UNDERGONE FGM.

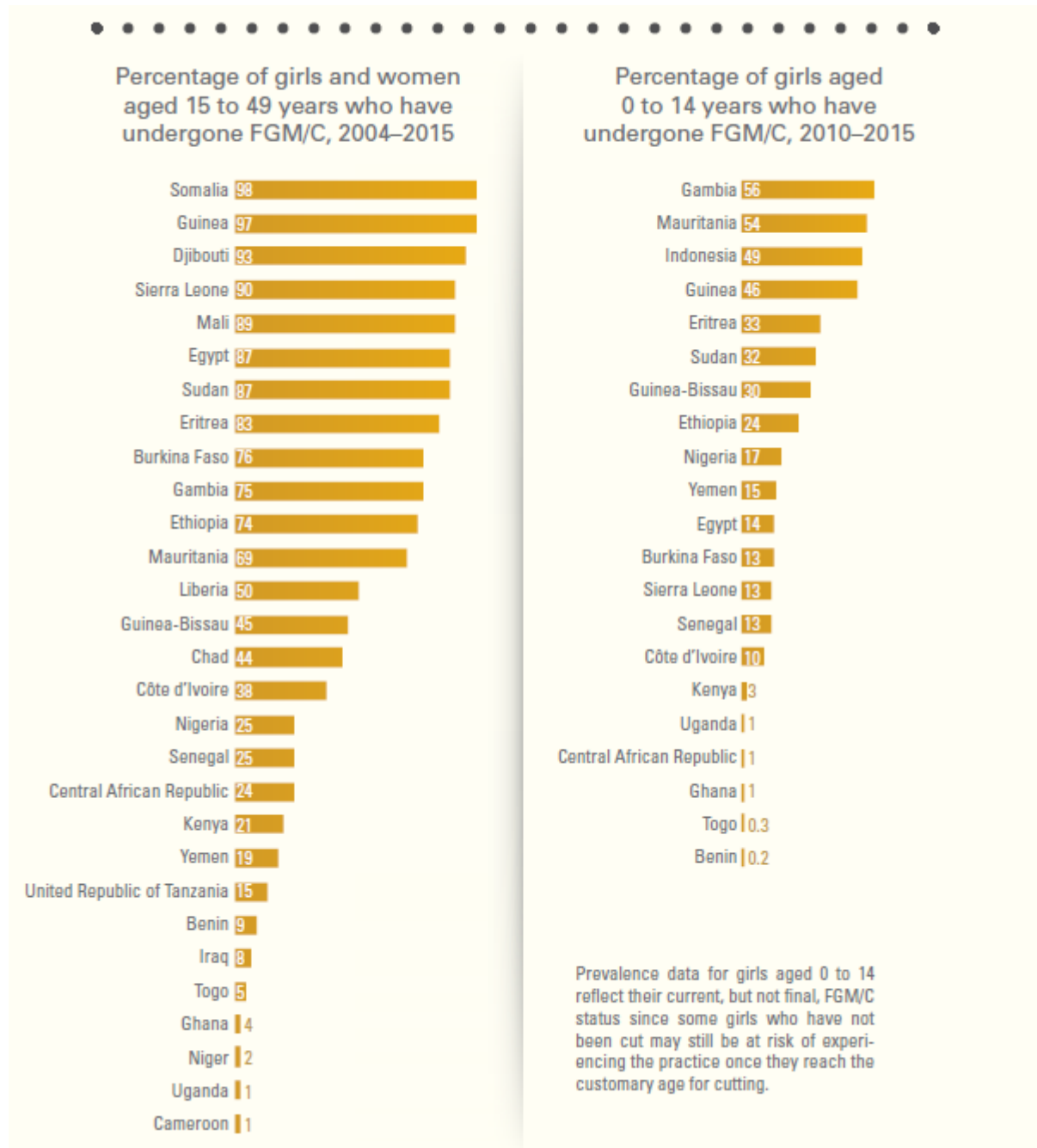


Source: *Female genital Mutilation Risk and Safeguarding: Guidance for Professionals*

Figure 3 shows the estimated prevalence of FGM in young and adult women aged 15-49 and amongst girls under 15 in different countries. This data is not complete and has been gathered from various household surveys in different countries but it illustrates the extent of the issue and that it is a global problem. Over the past 30 years, there have been huge efforts to reduce the prevalence of FGM. In many countries, there has been a movement against FGM and in some countries there have been significant reductions in prevalence – although not in the countries with the highest prevalence.

Female children and young people from these countries living in the UK are therefore at risk of FGM. FORWARD UK (Foundation for Women's Health Research and Development) estimates that as many as 6,500 girls are at risk of FGM within the UK. Estimating the numbers of girls and young women are at risk in Harrow is not possible as we have no data on the attitudes of the local communities who have their origins in high prevalence countries. In the school census, we are able to see that there are over 500 girls and young women attending schools in Harrow who speak languages of East African countries with FGM rates of over 80%.

FIGURE 3 PREVALENCE OF FGM/C AROUND THE WORLD



SOURCE: UNICEF

THE LAW IN ENGLAND AND WALES

There are a number of relevant pieces of legislation and guidance that consider FGM.

FEMALE GENITAL MUTILATION ACT

FGM is child abuse and illegal in England and Wales under the Female Genital Mutilation Act 2003¹. Under section 1(1) of the 2003 Act, a person is guilty of an offence if they excise, infibulate or otherwise mutilate the whole or any part of a girl's labia majora, labia minora or clitoris. Section 6(1) of the 2003 Act provides that the term "girl" includes "woman" so the offences in section 1 to 3 apply to victims of any age.

Other than in the excepted circumstances set out in section 1(2) and (3), it is an offence for any person (regardless of their nationality or residence status) to:

- Perform FGM in England or Wales (section 1 of the 2003 Act);
- Assist a girl to carry out FGM on herself in England or Wales (section 2 of the 2003 Act); and
- Assist (from England or Wales) a non-UK national or UK resident to carry out FGM outside the UK on a UK national or UK resident (section 3 of the 2003 Act.)

Any person found guilty of an offence under section 1, 2 or 3 of the 2003 Act is liable to a maximum penalty of 14 years' imprisonment or a fine (or both).

THE SERIOUS CRIME ACT

The Serious Crime Act 2015 strengthened the legislative framework around tackling FGM. One of the new measures introduced through Section 5B of the 2003 Act² 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 mandatory reporting duty). However, healthcare professionals are not expected to investigate or make decisions upon whether a case of FGM was a crime or not, under the legislation. All cases should be dealt with under existing safeguarding frameworks, which for children under 18 who have undergone FGM would mean a referral to Children's Social Care and the police.

Health professionals and organisations can access a range of support materials, including 2-page process guide. These can be found at www.gov.uk/dh/fgm.

Other measures were introduced through the Serious Crime Act 2015. This now includes:

- An offence of failing to protect a girl from the risk of FGM;
- Extra-territorial jurisdiction over offences of FGM committed abroad by UK nationals and those habitually (as well as permanently) resident in the UK;
- Lifelong anonymity for victims of FGM; and

¹ <http://www.legislation.gov.uk/ukpga/2003/31/contents>

² <http://www.legislation.gov.uk/ukpga/2015/9/part/5/crossheading/female-genital-mutilation>

- FGM Protection Orders which can be used to protect girls at risk.

WORKING TOGETHER TO SAFEGUARD CHILDREN

The Department for Education published statutory guidance in 2013 (updated in March 2015) titled Working together to safeguard children³. This guidance covers:

- the legislative requirements and expectations on individual local authority and school services to safeguard and promote the welfare of children; and
- a clear framework for Local Safeguarding Children Boards (LSCBs) to monitor the effectiveness of local services Whilst the guidance does not make specific provision for safeguarding activities relating to FGM, it sets out requirements around information sharing which are needed to effectively safeguard against FGM and all forms of child abuse.

MULTI-AGENCY GUIDANCE

No single agency can adequately meet the multiple needs of someone affected by FGM. In 2016, the government launched statutory multi-agency guidance on FGM.⁴ This guidance encourages agencies to cooperate and work together to protect and support those at risk of, or who have undergone, FGM. The guidance provides information on:

- Identifying when a girl (including an unborn girl) or young woman may be at risk of FGM and responding appropriately to protect them.
- Identifying when a girl or young woman has had FGM and responding appropriately to support them, and
- Measures that can be implemented to prevent and ultimately help end the practice of FGM.

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

³ www.workingtogetheronline.co.uk

⁴ www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation

WHAT DO WE KNOW ABOUT FGM LOCALLY?

Prior to 2014/15 there was no collection of data on the prevalence of FGM and so, although FGM was known to occur, the scale of the issue was unknown. The FGM Prevention Programme is a programme of work led by the Department of Health to improve the NHS response to FGM; this includes projects to improve awareness, provision of services and management of FGM, and the safeguarding of girls at risk. One of the first actions was to find out the scale of the issue so that the scale of response could be more accurately measured. It is important to note in all of these datasets, that if a patient is identified through the delivery of care from the NHS as having had FGM, this does not mean that she had FGM either recently or that the FGM was carried out in the UK or while she was resident in the UK.

In 2015, Macfarlane et al estimated the prevalence of FGM in two age groups 0-14 and 15-49. The data was only calculated for 2011. It has been extrapolated to give current (2016) estimates and estimates for the number of cases in 2021. This extrapolation assumes that in the absence of any change in FGM, the prevalence grows as the population grows, which is a solid and reliable assumption. It shows that for Harrow, the number of cases in under 14s and in 15-49 year olds not expected to change over the next five years but it is expected to increase in the over 50s. This type of prediction of future prevalence also assumes that nothing is being done to address FGM so that can be a very reliable benchmark to measure potential interventions against.

Estimated number of cases of FGM in		
Age	2016	2021
0-14 years	109	107
15-49 years	1190	1087
50+	511	642

From Macfarland et al (2015)

FGM PREVENTION PROGRAMME

Between September 2014 and March 2015, FGM Prevalence Dataset was collected and published at the level of acute trusts only. The data was non-identifiable aggregate data about the prevalence of FGM within the female population as treated by acute NHS trusts in England. As data was not identifiable, it could not be disaggregated to give numbers at a local authority level. In this period, 10 cases of FGM were identified at Northwick Park Hospital and 88 health contacts took place with women identified as having FGM (either within this year or previously). National data showed that these contacts were most commonly due to obstetrics, maternity and gynaecology. Due to the lack of personal identifiers in the data, it was possible for a woman to be identified as a 'new' case in more than one hospital causing over estimation of the number of cases.

An Enhanced Dataset has been introduced which contains a much wider range of data and is at an individual level. It has also been extended beyond acute trusts and now includes

mental health trusts, GP practices and community health services. Although it was initially discretionary, it became mandatory for all acute trusts to collect and submit the FGM Enhanced Dataset from 1 July 2015 and for all mental health trusts and GP practices from 1 October 2015. The full dataset contains 30 data items including: patient demographic data, specific FGM information and referral and treatment information. Disclosure control measures are taken so that individuals cannot be identified. This means that small numbers are suppressed although zero returns and blank returns are identified.

The women and girls newly recorded in the FGM Enhanced Dataset may have been previously identified and included in the FGM Prevalence Dataset. However, they will now be identified as 'newly recorded' on their first contact with a health provider. This will happen only once regardless of how many other health providers they see.

FGM DATA COLLECTION

The data collection records the first time a woman or girl is recorded in the FGM Enhanced Dataset during the reporting period. They may have FGM and be having treatment related to their FGM or they may be having treatment for something unrelated to it. In practice, the vast majority of women identified as having FGM are those accessing antenatal care.

As this information has not been collected previously, the first few years of collection will be predominantly identifying the prevalent cases in the community.

The second set of data is every subsequent contact that a woman or girl who has FGM has with the NHS – this includes new and previously recorded cases and women or girls may have more than one attendance within the data collection period at any number of NHS organisations. Again, this may be related or unrelated to FGM.

DATA DEFINITIONS

Newly Recorded: women and girls with FGM are those who have had their FGM information collected in the FGM Enhanced Dataset for the first time. This will include those identified as having FGM and those having treatment for their FGM. 'Newly recorded' does not necessarily mean that the attendance is the woman or girl's first attendance for FGM and it does not mean that the FGM is a recent occurrence for her.

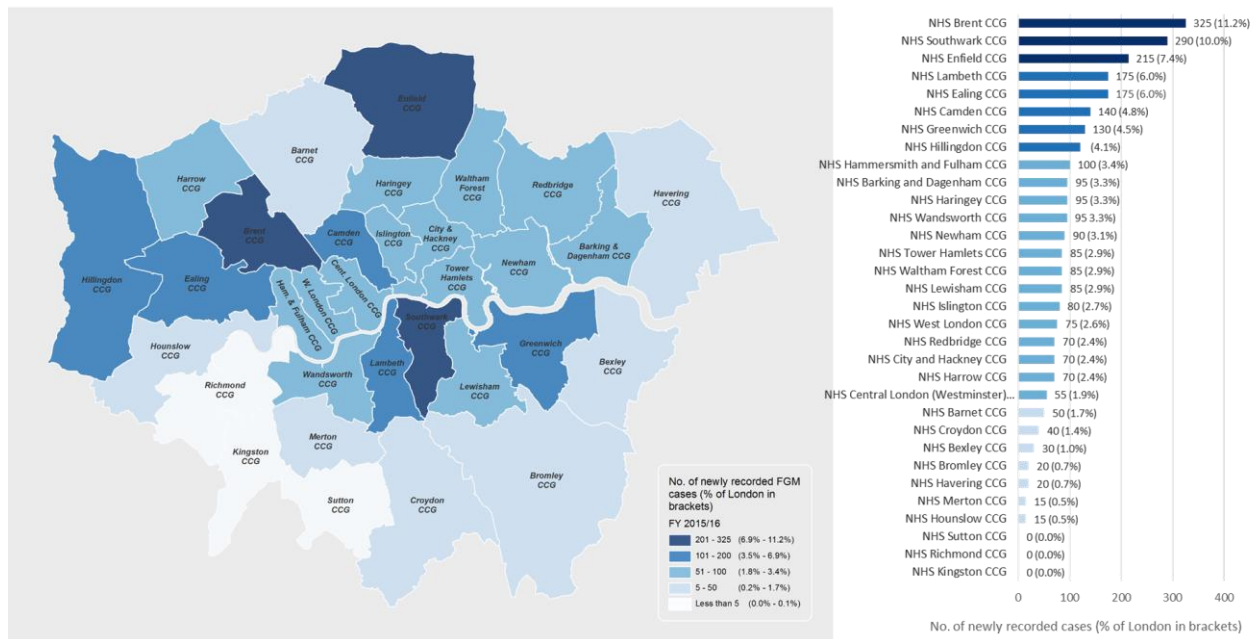
Total Attendances: refers to all attendances in the reporting period where FGM was identified or a procedure for 'reversal' of FGM was undertaken. Women and girls may have one or more attendances in the reporting period. This category includes both newly recorded and previously identified women and girls.

DATA QUALITY

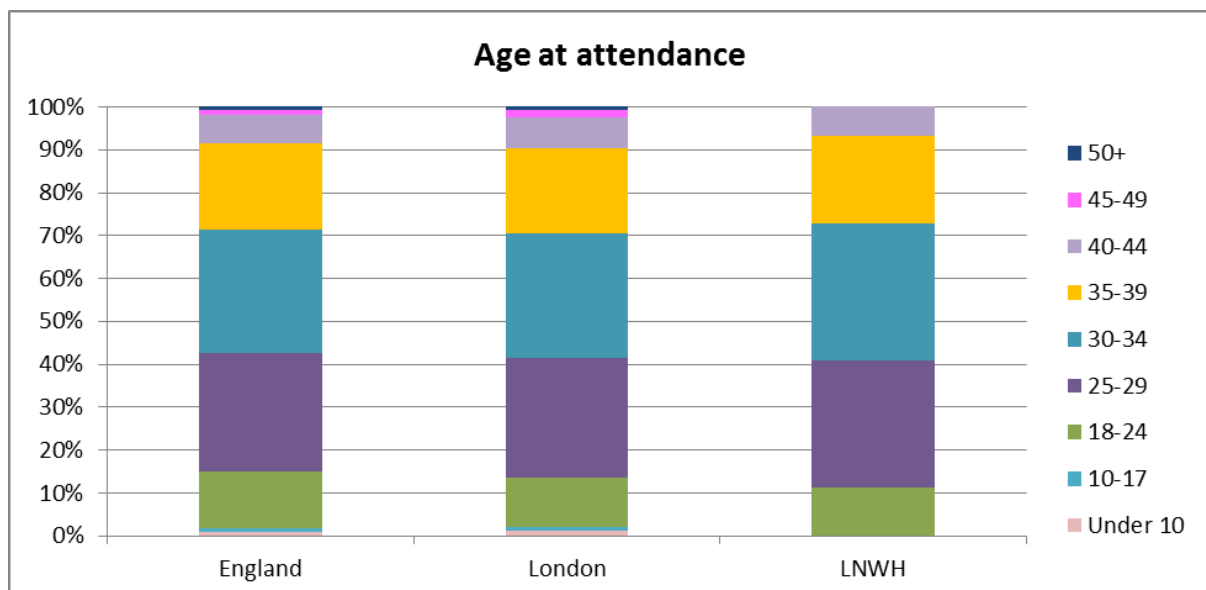
Although the collection of data is now mandatory, the quality and completeness of the data across the country is far from good. The FGM dataset is a relatively new one with only one year of data so far and, due to missing data and inconsistencies in recording across the country there are many caveats that must be heeded when trying to interpret the data.

FGM: NEW CASES

The number of newly recorded cases has been rounded to the closest 5 to prevent disclosure. Between April 2015 and March 2016, 70 women or girls (i.e. under 18) in Harrow were identified as having had FGM at some point in their lives. Compared to the rest of the local authorities in England, Harrow ranks joint 27th highest and joint 19th highest in London. Nationally, the highest numbers identified were seen in Birmingham, Bristol and Brent. In London, the highest numbers were seen in Brent and Southwark. Harrow identified 2.4% of the cases that were identified in London.

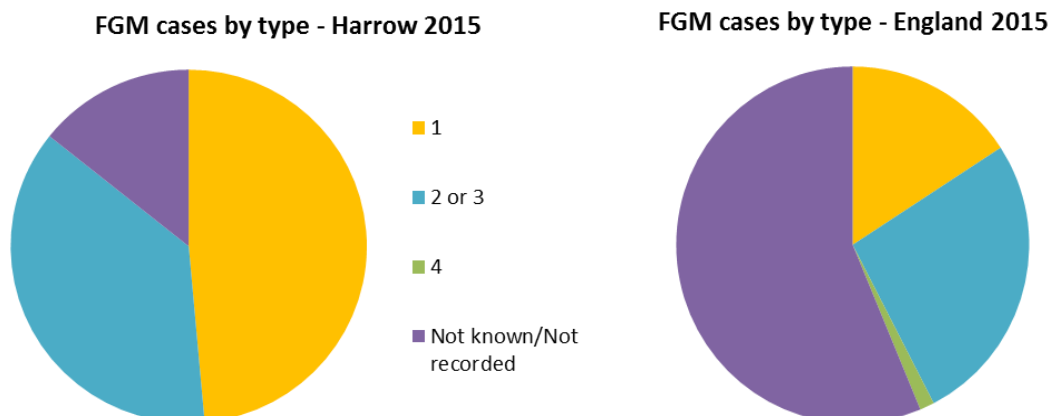


The small numbers do not allow us to divide the cases into age categories for Harrow but data is available at Trust level. The data shows that there was a slightly higher proportion of women in 25-39 age groups than nationally. There were no under 18s identified locally.



The recording of age at which FGM took place is very poorly recorded nationally and is not recorded on any cases at London Northwest NHS Trust, so it is not currently possible to say how many are recent cases, or indeed, if any of them are.

The majority of cases identified in Harrow were Type 1 FGM and 14% were either unknown or unrecorded. Across England the figure for unknown and unrecorded was significantly higher and accounted for more than half of all cases.

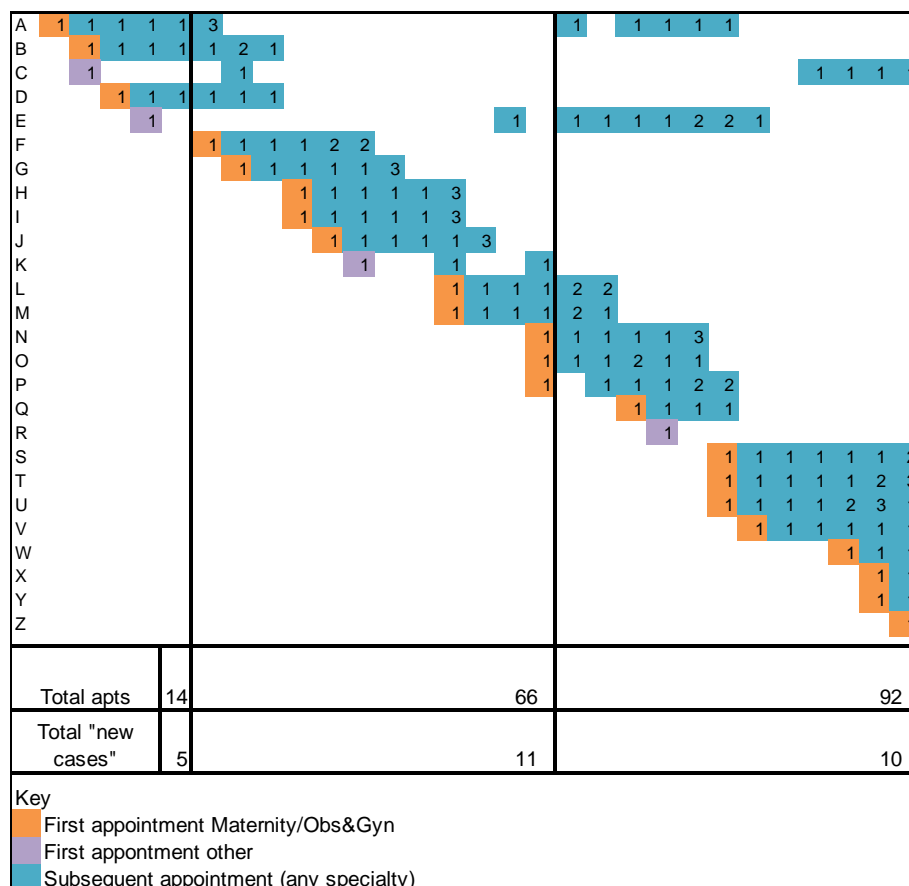


FGM: ATTENDANCES WITHIN THE YEAR

Harrow ranks 4th highest nationally in the rate of attendances for women or girls with FGM i.e. the number of contacts with the health services that any woman previously or concurrently identified as having FGM.

We do not have data on the reasons for these attendances as again, the data quality is poor nationally and the attendance type is not recorded in the LNWH dataset. We know anecdotally, that some/most are maternity cases and will be receiving a number of antenatal attendances while others may be having treatment for their FGM and other attendances could be completely unrelated to their FGM. What is clear is that LNWH are recording all attendances which may not be the cases in other Trusts. As a result, the number of attendances per new cases identified in LNWH is over 6 compared to only 1 or 2 attendances elsewhere. These figures do not however represent those women newly identified but also include those previously identified who have attended the hospital. The following figure attempts to illustrate this in a hypothetical population and their hospital attendance. It illustrates how the number of appointments can increase despite the number of “new” cases remaining static or even decreasing.

FIGURE 4 ILLUSTRATION OF APPOINTMENTS VS NEW CASES

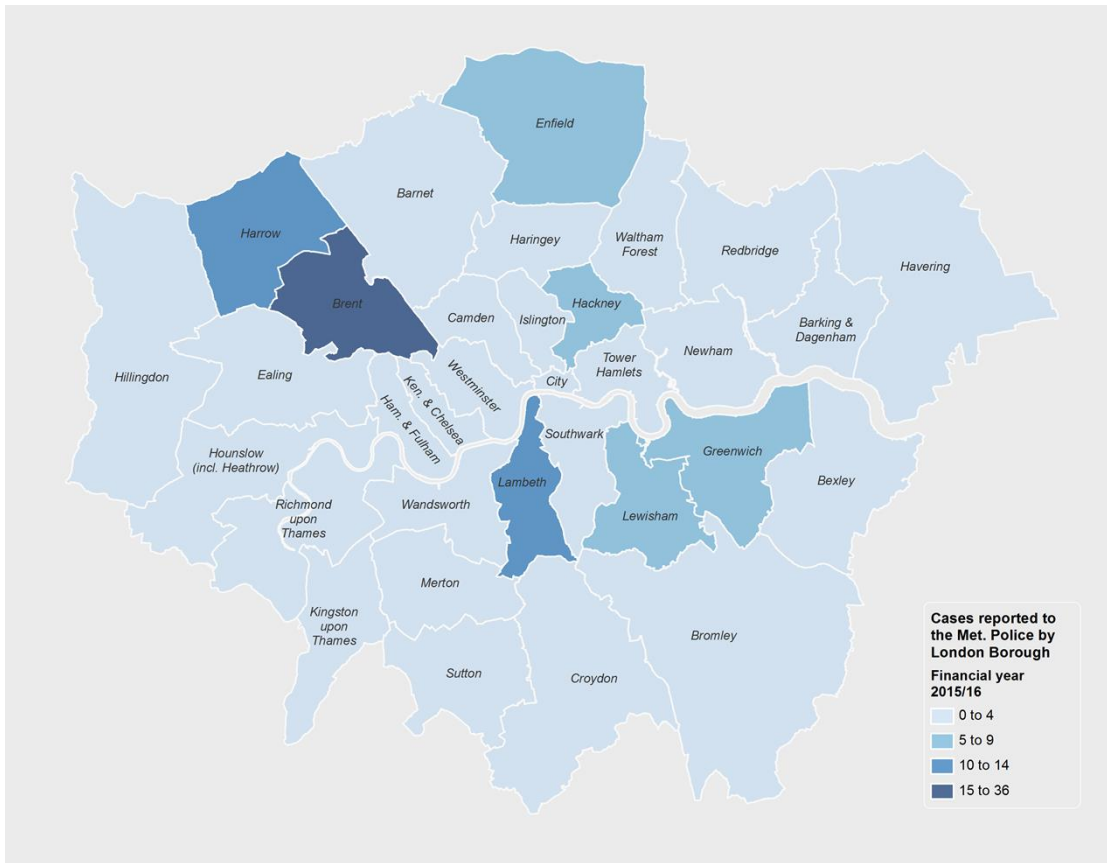


Although caution is advised on interpretation of current data released from the Department of Health, the current position would indicate that health staff in LNWH are complying with recording responsibilities. We know that LNWH are a good example of where recording of FGM has been integrated into hospital services. The safeguarding nurses have ensured that questions about FGM are routinely asked as part of the Trust’s safeguarding policy. These questions are asked regardless of whether the child or mother are attending accident and emergency, paediatrics, maternity or a surgical ward. However, the incompleteness of the data records still needs to be addressed.

REFERRALS TO MASH

Since the introduction of mandatory reporting for certain professions, combined with the local awareness raising activity, referral figures are increasing. The increased awareness and emphasis on FGM in Harrow have resulted in more cases being identified and reported than in other areas of London, with the exception of Brent.

Referral figures to the MASH have risen from an average of 3-4 per year prior to 2015 to 14 in 2015-6. While most of these cases were children identified as potentially “at risk” of FGM, one case was of a young woman who had already had FGM. This case was investigated and it was established that she had undergone FGM prior to arriving in the UK.



FGM AWARENESS AND TRAINING

As part of its on-going commitment to protect young girls from the practice of FGM, the HSCB ran briefings for staff on the new duties and to reinforce understanding about the harmful initial and long term effects of FGM. The lead outreach officer from the Home Office presented at a HSCB event to help embed an understanding of the new duties across the partnership.

Harrow has two named safeguarding health professionals who also lead on FGM. They are based at Northwick Park Hospital within London North West Healthcare Trust (LNWHT). They provide training, advice, and support to health professionals within the hospital community; to other health providers such as the mental health trust; and in general practice settings. In addition LNWHT run hospital based dedicated clinics for FGM. They have a recognised national profile, and contributed to the development of the Department of Health video “FGM: The Facts” on NHS choices: www.nhs.uk/fgm.

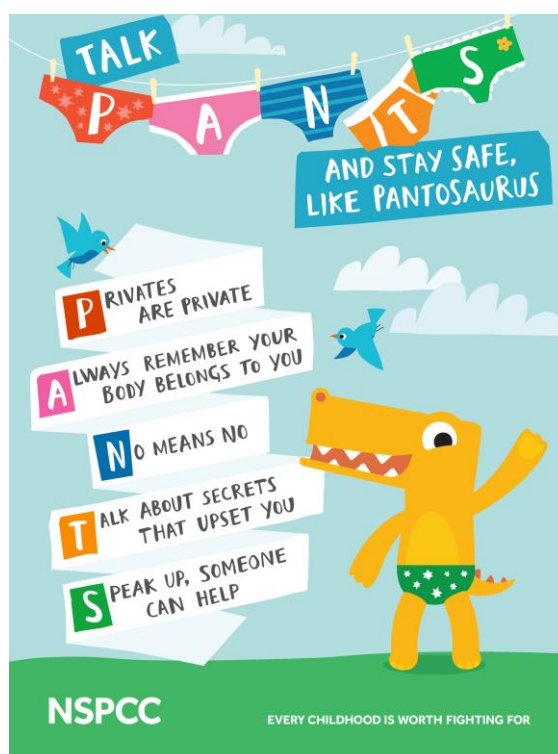
All GP practices have a safeguarding lead who has attended training on FGM. Further training has been provided for other practice staff and CCG Board members including non-executive members. This increased awareness has improved the quality and timeliness of GP referrals and their action plans. In turn, the GPs report that responses from MASH have improved so they know what is happening with their patients.

As part of the HSCB, colleagues in Public Health have FORWARD trained FGM trainers who deliver a cross agency session as part of our race, culture, faith and diversity implications for safeguarding children effectively course. These trainers work as part of our voluntary community and faith child safeguarding engagement.

Schools in Harrow have been working with NSPCC and FORWARD on FGM. Norbury School is the leading primary school in the NSPCC Talk PANTS programme and lead in Female Genital Mutilation education, working alongside the Azure Project with the Metropolitan Police. The school had six months of regular meetings with stakeholders including health services, children’s services, their parent group, the voluntary sector, the police, cluster schools and charities to understand the facts, the various educational approaches, training and engagement with communities.

Following these meetings the school created their own FGM lesson plans, resources and approaches which they were shared with their stakeholders and modified as required. All Year 5 & 6 pupils’ parents met the school and reviewed the resources before the lessons were piloted

FIGURE 5 NSPCC TALK PANTS POSTER



and INSETs were held for their staff, governors and parents. Under the slogan My Body My Rules, Norbury has specific FGM lessons from year 3-year 6

Norbury School has also delivered CPD Online seminar lessons and has participated in three conferences, a radio programme and has developed a video. They are also a case study championed by the Home Office and have shared the approach and learning with other schools. Their role in raising awareness of FGM has also been recognised by the United Nations, within the Big Bro Movement.

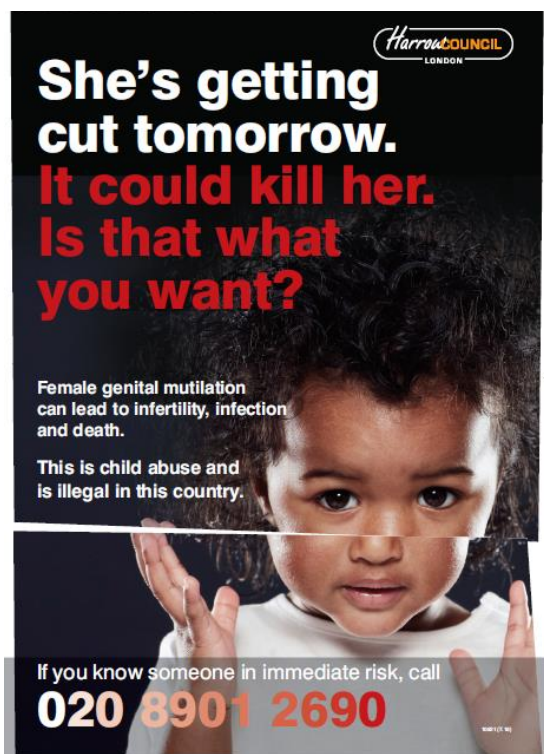
In a number of Harrow schools and colleges, lesson plans are being created and resources for schools to use in partnership with their community, under the support and guidance of Norbury Primary School. Norbury is also working with older students from a high school to train as providers in lessons. As local education champions on FGM, Norbury has developed the lesson plans for PANTS from Nursery through to year 6. Their staff have trained and facilitated assemblies, seminar lessons and taught across 10 different boroughs in London. Norbury is now a facilitator for a national training provider speaking at Conferences in Bristol, Manchester and London. The school has now introduced the Talk PANTS programme to Year 2.

Harrow High School met with KS3 parents to share Harrow High's Talk PANTS and FGM vision with the plan to deliver lessons. Elmgrove has received staff training and is working with Community Ambassadors to deliver Talk PANTS/FGM lessons. Grange have completely adopted the programme working with Norbury on a weekly basis in the Autumn Term. HASVO (Harrow Association of Somali Voluntary Organisations) are working with Rooks Heath School to support the FGM agenda and developing an FGM film. Harrow College has included FGM awareness in its health fair.

LOCAL ACTIONS TO PROTECT AND SAFEGUARD THOSE AT RISK OF FGM

The Harrow Domestic and Sexual Violence Forum has identified FGM as a priority area. In line with this, a series of posters and communication plan have been produced to raise the profile of this critical issue. They were distributed throughout the Borough at 26 on street

FIGURE 6 HARROW FGM POSTER



sites and in council publications, with the design options distributed to local sites for display at their discretion.

The Department of Health launched a campaign at the start of the 2016 summer school holidays when the numbers of girls taken outside of the UK to be cut increases, to raise awareness of the severe health implications of FGM for those living in UK who are members of communities affected by FGM. We have promoted the campaign locally.

<http://www.nhs.uk/Conditions/female-genital-mutilation/Pages/Introduction.aspx>

Harrow LSCB has a page on the website on FGM which gives background information for those with concerns as well as End FGM campaign materials.

[http://www.harrowlscb.co.uk/guidance-for-](http://www.harrowlscb.co.uk/guidance-for-practitioners/female-genital-mutilation/)

[practitioners/female-genital-mutilation/](http://www.harrowlscb.co.uk/guidance-for-practitioners/female-genital-mutilation/)

REPORTING PATHWAY

Using national examples of best practice and utilising the considerable local expertise in Harrow, the LSCB has developed a pathway for FGM reporting. If anyone is concerned that there is FGM occurring or that a woman or girl is in danger, they should follow the Harrow FGM pathway. Although this is strictly confidential, some people may not be comfortable reporting locally and so In addition, we also promote a national helpline:

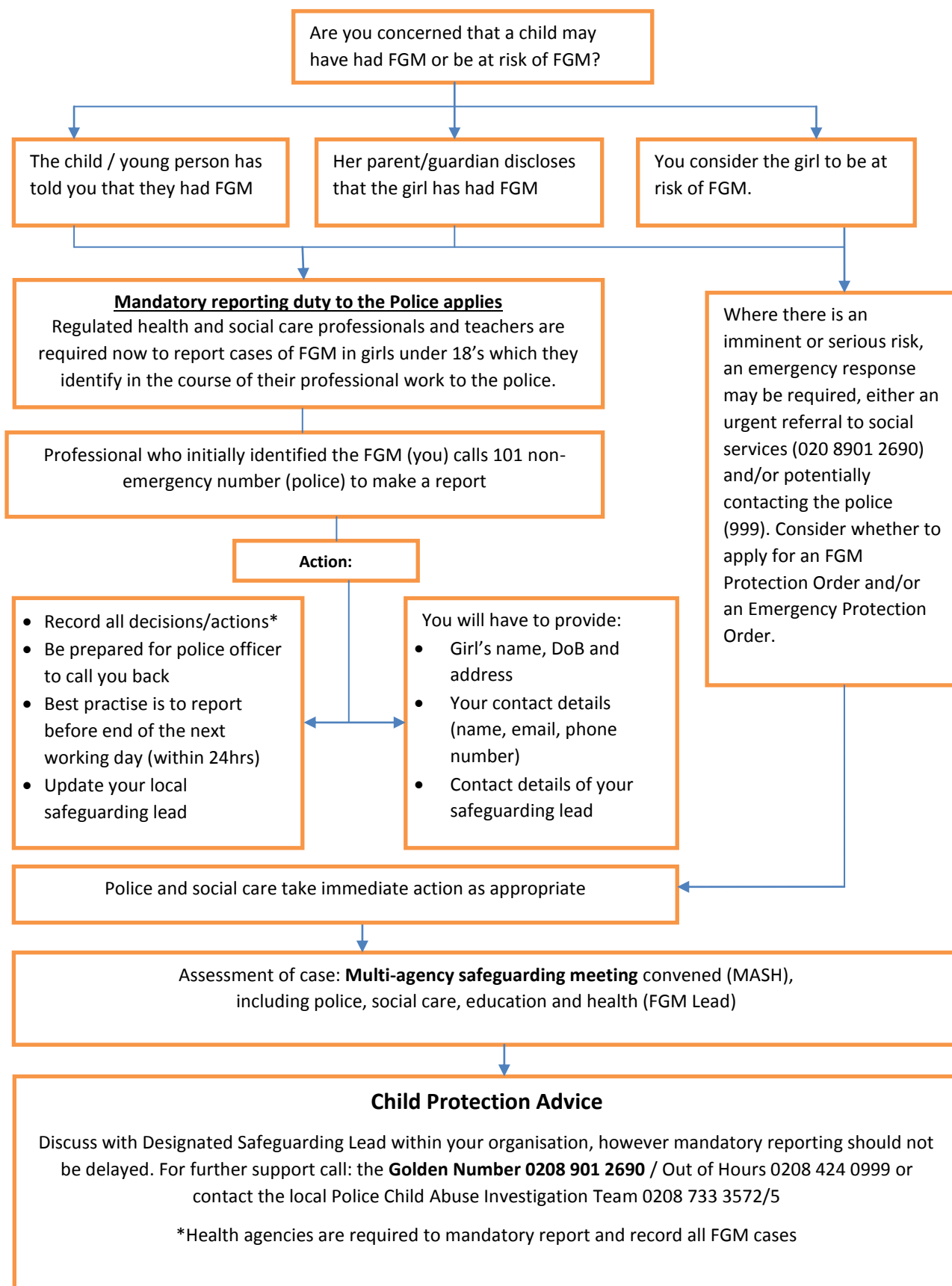
fgmhelp@nspcc.org.uk telephone: 0800 028 3550. The risk assessment templates are presented in the appendix.

Contact details for the lead health professionals in Harrow (based in Northwick Park Hospital)

Grace Nartey (gracenartey@nhs.net Tel: 020 8869 5046 or mobile 07825606008) and

Florence Acquah (florence.acquah@nhs.net Tel: 0208 869 3692/3695 or Mobile: 07879444682)

HARROW FGM REPORTING PATHWAY



LOCAL ACTIONS TO SUPPORT THOSE WHO HAVE UNDERGONE FGM

Supporting women who have undergone FGM can take many forms – from treating complications arising from their FGM to surgical interventions to emotional and psychological support.

Small procedures to open the scar -to de-infibulate - are possible. These interventions are also known as reversal but they cannot put back tissue that has been cut away. The procedure is done in a specialist clinic usually with a local anaesthetic and a nurse, doctor or midwife will perform it. The skin will be stitched at either side of the scar to keep it from healing together again and it will usually heal very quickly. This small operation can reduce symptoms such as painful or slow urination, painful periods (dysmenorrhoea), urinary tract infections and pain during sex. Although the procedure can be done any time, some women will chose to have the procedure when they are pregnant while others wait until they are in labour.

The closest FGM clinic is the African Well Women’s Clinic at Northwick Park Hospital Antenatal Clinic Watford Rd. Harrow Middlesex, HA1 3UJ. This clinic is held on Friday mornings. It is run by specialist midwives who will refer to a consultant if necessary. (Contact number for Northwick Park Hospital Harrow Antenatal clinic 020 8869 2880). <http://www.nwlh.nhs.uk/services/antenatal-care/>.

Traumatic experiences can often have psychological repercussions. Undergoing FGM can be one of those experiences -feelings of low self esteem, depression, anxiety and anger are commonly reported – even if at the time the girl shared the community expectations that this is what happens to all girls. Symptoms of post traumatic stress disorder such as flashbacks, panic attacks and nightmares which can be triggered by a smell, a sound or a situation are also common. Assessment and support is available from the local mental health services through the Single Point of Access for North West London Adult Community Mental Health Services. (contact: 0800 0234 650 or cnw-tr.spa@nhs.net <http://www.cnwl.nhs.uk/service/single-point-of-access-north-west-london-adult-community-mental-health-services/>)

MONITORING AND GOVERNANCE OF FGM IN HARROW

The Violence, Vulnerability and Exploitation (VVE) subgroup (formerly Child Sexual Exploitation subgroup) of the Community Safety Partnership has recently expanded its remit to encompass all aspects of VVE including FGM. A new VVE strategy and an action plan are in development. A new FGM action group will be established which will report into the VVE subgroup. The membership and frequency of this group are not yet agreed but it is hoped that this group will meet for the first time before schools break up in July.

Because of its relationship to the health and wellbeing of children and young people, FGM is also included in the Harrow Safeguarding Children's Board's data set and is scrutinised by the HSCB's Quality Assurance sub committee.

CCGs also have a responsibility in ensuring that all of the Acute and Mental Health Trusts they commission from have policies in place to report FGM cases. This is in place in Harrow.

Harrow Council's Ofsted inspection in February 2017, noted the local work on FGM as being "well integrated into broader safeguarding work" and there being "an understanding of the complex dynamics when there are concerns about abuse or neglect in a particular cultural context. This is apparent in a clear, effective and well-joined-up approach to the issue of female genital mutilation".

APPENDIX : RISK ASSESSMENT TEMPLATES

Part One (a): PREGNANT WOMEN (OR HAS RECENTLY GIVEN BIRTH)

Date: _____ Completed by: _____
Assessment: Initial/On-going

This is to help you make a decision as to whether the unborn child (or other female children in the family) are at risk of FGM or whether the woman herself is at risk of further harm in relation to her FGM.

Indicator	Yes	No	Details
CONSIDER RISK			
Woman comes from a community known to practice FGM			
Woman has undergone FGM herself			
Husband/partner comes from a community known to practice FGM			
A female family elder is involved/will be involved in care of children/unborn child or is influential in the family			
Woman/family has limited integration in UK community			
Woman and/or husband/partner have limited/no understanding of harm of FGM or UK law			
Woman's nieces, siblings and/or in-laws have undergone FGM			
Woman has failed to attend follow-up appointment with an FGM clinic/FGM related appointment			
Woman's husband/partner/other family member are very dominant in the family and have not been present during consultations with the woman			
Woman is reluctant to undergo genital examination			

Indicator	Yes	No	Details
SIGNIFICANT OR IMMEDIATE RISK			
Woman already has daughters who have undergone FGM			
Woman or woman's partner/family requesting reinfibulation following childbirth			
Woman is considered to be a vulnerable adult and therefore issues of mental capacity and consent should be considered if she is found to have FGM			
Woman says that FGM is integral to cultural or religious identity			
Family are already known to social care services – if known, and you have identified FGM within a family, you must share this information with social services			

ACTION

Ask more questions – if one indicator leads to a potential area of concern, continue the discussion in this area.

Consider risk – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/ designated safeguarding lead.

Significant or Immediate risk – if you identify one or more serious or immediate risks, or the other risks are, by your judgement, sufficient to be considered serious, you should look to refer to Social Services/CAIT team/ Police/MASH, in accordance with your local safeguarding procedures.

If the risk of harm is imminent, emergency measures may be required and any action taken must reflect the required urgency.

In all cases:-

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

Please remember: any child under 18 who has undergone FGM must be referred to police under the Mandatory Reporting duty using the 101 non-emergency number.

Part One (b): NON-PREGNANT ADULT WOMAN (over 18)

Date: _____ Completed by: _____
Assessment: Initial/On-going

This is to help decide whether any female children are at risk of FGM, whether there are other children in the family for whom a risk assessment may be required or whether the woman herself is at risk of further harm in relation to her FGM.

Indicator	Yes	No	Details
CONSIDER RISK			
Woman already has daughters who have undergone FGM – who are over 18 years of age			
Husband/partner comes from a community known to practice FGM			
A female family elder (maternal or paternal) is influential in family or is involved in care of children			
Woman and family have limited integration in UK community			
Woman's husband/partner/other family member may be very dominant in the family and have not been present during consultations with the woman			
Woman/family have limited/no understanding of harm of FGM or UK law			
Woman's nieces (by sibling or in-laws) have undergone FGM			
Woman has failed to attend follow-up appointment with an FGM clinic/FGM related appointment			
Family are already known to social services – if known, and you have identified FGM within a family, you must share this information with social services			

Indicator	Yes	No	Details
SIGNIFICANT OR IMMEDIATE RISK			
Woman/family believe FGM is integral to cultural or religious identity			
Woman already has daughters who have undergone FGM			
Woman is considered to be a vulnerable adult and therefore issues of mental capacity and consent should be triggered if she is found to have FGM			

Please remember: any child under 18 who has undergone FGM must be referred to police under the Mandatory Reporting duty using the 101 non-emergency number.

ACTION

Ask more questions – if one indicator leads to a potential area of concern, continue the discussion in this area.

Consider risk – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/ designated safeguarding lead.

Significant or Immediate risk – if you identify one or more serious or immediate risk, or the other risks are, by your judgement, sufficient to be considered serious, you should look to refer to Social Services/CAIT team/ Police/MASH, in accordance with your local safeguarding procedures.

If the risk of harm is imminent, emergency measures may be required and any action taken must reflect the required urgency.

In all cases:-

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

Part 2: CHILD/YOUNG ADULT (under 18 years old)

This is to help when considering whether a child is AT RISK of FGM, or whether there are other children in the family for whom a risk assessment may be required

Date: _____ Completed by: _____
 Assessment: Initial/On-going

Indicator	Yes	No	Details
CONSIDER RISK			
Child's mother has undergone FGM			
Other female family members have had FGM			
Father comes from a community known to practice FGM			
A female family elder is very influential within the family and is/will be involved in the care of the girl			
Mother/family have limited contact with people outside of her family			
Parents have poor access to information about FGM and do not know about the harmful effects of FGM or UK law			
Parents say that they or a relative will be taking the girl abroad for a prolonged period – this may not only be to a country with high prevalence, but this would more likely lead to a concern			
Girl has spoken about a long holiday to her country of origin/another country where the practice is prevalent			
Girl has attended a travel clinic or equivalent for vaccinations/anti-malarials			
FGM is referred to in conversation by the child, family or close friends of the child (see Appendix Three for traditional and local terms) – the context of the discussion will be important			
Sections missing from the Red book. Consider if the child has received immunisations, do they attend clinics etc.			
Girl withdrawn from PHSE lessons or from learning about FGM – School Nurse should have conversation with child			
Girls presents symptoms that could be related to FGM – continue with questions in part 3			
Family not engaging with professionals (health, school, or other)			
Any other safeguarding alert already associated with the family			

ACTION

Ask more questions – if one indicator leads to a potential area of concern, continue the discussion in this area.

Consider risk – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/ designated safeguarding lead.

Significant or Immediate risk – if you identify one or more serious or immediate risk, or the other risks are, by your judgement, sufficient to be considered serious, you should look to refer to Social Services /CAIT team/ Police /MASH, in accordance with your local safeguarding procedures.

If the risk of harm is imminent, emergency measures may be required and any action taken must reflect the required urgency.

In all cases:-

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

Indicator	Yes	No	Details
SIGNIFICANT OR IMMEDIATE RISK			
A child or sibling asks for help			
A parent or family member expresses concern that FGM may be carried out on the child			
Girl has confided in another that she is to have a 'special procedure' or to attend a 'special occasion'. Girl has talked about going away 'to become a woman' or 'to become like my mum and sister'			
Girl has a sister or other female child relative who has already undergone FGM			
Family/child are already known to social services – if known, and you have identified FGM within a family, you must share this information with social services			

ACTION

Ask more questions – if one indicator leads to a potential area of concern, continue the discussion in this area.

Consider risk – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/ designated safeguarding lead.

Significant or Immediate risk – if you identify one or more serious or immediate risk, or the other risks are, by your judgement, sufficient to be considered serious, you should look to refer to Social Services /CAIT team/ Police /MASH, in accordance with your local safeguarding procedures.

If the risk of harm is imminent, emergency measures may be required and any action taken must reflect the required urgency.

In all cases:-

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

Please remember: any child under 18 who has undergone FGM must be referred to police under the Mandatory Reporting duty using the 101 non-emergency number.

Part 3: CHILD/YOUNG ADULT (under 18 years old)

Date: _____ Completed by: _____

Assessment: Initial/On-going

This is to help when considering whether a child HAS HAD FGM.

Indicator	Yes	No	Details
CONSIDER RISK			
Girl is reluctant to undergo any medical examination			
Girl has difficulty walking, sitting or standing or looks uncomfortable			
Girl finds it hard to sit still for long periods of time, which was not a problem previously			
Girl presents to GP or A&E with frequent urine, menstrual or stomach problems			
Increased emotional and psychological needs e.g. withdrawal, depression, or significant change in behaviour			
Girl avoiding physical exercise or requiring to be excused from PE lessons without a GP's letter			
Girl has spoken about having been on a long holiday to her country of origin/ another country where the practice is prevalent			
Girl spends a long time in the bathroom/toilet/long periods of time away from the classroom			
Girl talks about pain or discomfort between her legs			
SIGNIFICANT OR IMMEDIATE RISK			
Girl asks for help			
Girl confides in a professional that FGM has taken place			
Mother/family member discloses that female child has had FGM			
Family/child are already known to social services – if known, and you have identified FGM within a family, you must share this information with social services			

ACTION

Ask more questions – if one indicator leads to a potential area of concern, continue the discussion in this area.

Please remember: any child under 18 who has undergone FGM must be referred to police under the Mandatory Reporting duty using the 101 non-emergency number.

If you suspect but do not know that a girl has undergone FGM based on risk factors presenting, you should look to refer to Social Services / CAIT Team / police / MASH, in accordance with your local safeguarding procedures.

In all cases:-

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

Please remember: any child under 18 who has undergone FGM must be referred to police under the Mandatory Reporting duty using the 101 non-emergency number.