



House of Commons
Home Affairs Committee

Female genital mutilation: the case for a national action plan

Second Report of Session 2014–15

*Report, together with formal minutes relating
to the report*

*Ordered by the House of Commons to
be printed 25 June 2014*

HC 201
[Incorporating HC 1091, 2013–14]
Published on 3 July
by authority of the House of Commons
London: The Stationery Office Limited

Home Affairs Committee

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Key Facts

- It is estimated that 125 million women and girls worldwide have undergone FGM.
- It is estimated that 3 million girls are subjected to FGM every year.
- It is estimated that 170,000 women and girls are living with FGM in the UK.
- It is estimated that 65,000 girls aged 13 and under are at risk of FGM in the UK.
- Over 200 FGM-related cases investigated by the police nationally in the last five years.
- It has taken 29 years since the criminalisation of FGM for the first prosecutions to be brought.

1 Introduction

1. The World Health Organization (WHO) defines female genital mutilation (FGM) as “all procedures involving the partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons”.¹ It has four classifications:

- **Type 1** (clitoridectomy), which involves partial or total removal of the clitoris and, in rare cases, only the prepuce;
- **Type 2** (excision), which involves partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora;
- **Type 3** (infibulation), which involves narrowing of the vaginal opening through the creation of a covering seal, which is formed by cutting and repositioning the inner or outer labia, with or without removal of the clitoris; and
- **Type 4** (other), which comprises all other harmful procedures to the female genitalia for non-medical purposes, such as pricking, piercing or incision of the clitoris and/or the labia; stretching of the clitoris and/or labia; and cauterisation or burning of the clitoris and surrounding tissues.

2. FGM is usually carried out on girls between infancy and the age of 15, with the majority of cases occurring between the ages of five and eight. It is also occasionally carried out on adult women, for example, reinfibulation following childbirth, or where a woman is forced into the procedure by her husband after marriage. Though in some countries it is more likely to be carried out by a health professional, it is commonly performed by a traditional practitioner with no formal medical training, without anaesthetics or antiseptics, using knives, scissors, scalpels, pieces of glass, or razor blades.² Often the girl is forcibly restrained. Leyla Hussein, a survivor and campaigner, described to us her experience of being cut when she was eight:

They brought this other man to hold me down. I remember just feeling ashamed because they were seeing my private parts. I think that is what I was worried about more than anything. He said, “We are going to give you an injection and everything will be fine. You won’t feel a thing”. I felt everything. I felt the injection. I felt being cut. I felt being sewn.³

3. For girls and women who undergo FGM the health consequences are often devastating. The immediate effects include severe pain, bleeding, shock, urine retention, infections, injury to neighbouring organs, and sometimes death from uncontrolled bleeding. Longer-term complications arising from Type 1 and 2 FGM include failure of the wound to heal,

¹ World Health Organization, *Female genital mutilation, Factsheet No. 241*, February 2014

² [FGM 0048](#) (Equality and Human Rights Commission), para 6

³ [Q2](#) (Leyla Hussein, *Daughters of Eve*)

abscess formation, urinary tract infection, dermoid cysts, vulval adhesions, neuromas, and painful sexual intercourse. Type 3 FGM can result in any of the above complications, as well as reproductive tract infections, which can lead to pelvic inflammatory disease, dysmenorrhoea, chronic urinary tract obstruction, and urinary incontinence, as well as a range of other severe complications.⁴ In addition, many women and girls experience long-term mental health problems, such as depression and post-traumatic stress.

4. The United Nations Children's Fund, UNICEF, estimates that 125 million women and girls worldwide have undergone FGM, the majority in a belt of 29 African countries that stretches from the Atlantic to the Horn of Africa. In Egypt alone, 27.2 million women and girls have undergone FGM, with 23.8 million in Ethiopia, and 19.9 million in Nigeria.⁵ Prevalence rates vary significantly. In Somalia, Guinea, Djibouti and Egypt, for example, more than 90 per cent of the female population aged between 15 and 49 have been cut, whereas in Niger, Cameroon and Uganda it is less than two per cent. Prevalence may also vary greatly within countries, and can be more closely associated with particular ethnic groups. Overall, it is believed that up to 3 million girls are subjected to FGM every year.

5. The origins of FGM are complex and go back thousands of years. It is a cultural practice, which does not have any basis in religion, although there is a commonly-held misconception that it is a religious requirement. In practising groups it is rooted in patriarchy, and is seen as a rite of passage to adulthood and a prerequisite for marriage. For some African women, marriage and reproduction are the only means of ensuring economic security and social status. Without undergoing FGM, a woman may be denied the right of marriage, with the potential consequence of casting her out from society. The Hawa Trust, an organisation which works with local communities in Hackney to tackle FGM, told us:

The young uncircumcised girl is still considered today as a second-class citizen, impure, a *bilekoro*, according to a typical expression in Mali and Guinea. Such a young girl can neither marry nor even be allowed to prepare the family meal until she agrees to be circumcised.⁶

6. Many adherents to the practice believe that FGM has an important role in preserving virginity and chastity before marriage. After marriage, it is assumed to ensure the faithfulness of the woman to her husband. Other commonly-held, erroneous beliefs include the suggestions that the procedure enhances fertility, increases sexual pleasure for the man, and ensures the health of babies. Notwithstanding such mistaken beliefs, families within practising communities often feel a strong sense of obligation to conform, fearing that failure to do so will lead to social exclusion, ridicule, and an inability to find a suitable marriage partner for their daughters. In short, it is a powerful and deeply rooted social

⁴ *Tackling FGM in the UK: Intercollegiate recommendations for identifying, recording and reporting*, November 2013

⁵ UNICEF, *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*, 2013

⁶ [FGM 0017](#) (Hawa Trust)

norm founded on the subordination of women. As Nimco Ali, a survivor and campaigner, told us:

It is about controlling women's sexuality and women's aspirations to do anything. If a woman is in pain [...] and she is scared about what is going to happen to her, then ultimately she is never going to attain her full potential.⁷

7. Internationally, FGM is recognised increasingly as a severe form of violence against women and girls. This was also acknowledged in the overwhelming majority of evidence received as part of our inquiry.⁸ The 1993 UN Declaration on the Elimination of Violence against Women defines FGM as a form of violence against women. Article 5 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa requires states to prohibit traditional practices that are harmful to women, including FGM, and to take all necessary measures, legal or otherwise, to protect women from FGM. In recent years an increasing number of countries have legislated against the practice. Indeed, FGM is now prohibited to varying degrees in 24 out of 29 of the countries in Africa and the Middle East where it is most prevalent.⁹ However, there is a growing consensus that legislation is just one part of a range of interventions governments must undertake to end the practice.

8. FGM is a severe form of gender-based violence, and where it is carried out on a girl, it is an extreme form of child abuse. Everyone who has a responsibility for safeguarding children must view FGM in this way.

FGM in the UK

9. FGM has been a criminal offence in the UK since 1985. Its existence in the UK is largely as a result of migration from practising countries. Its prevalence has been difficult to determine because of the hidden nature of the crime. The most widely cited estimates are from a study published by FORWARD UK in 2007.¹⁰ Using 2001 census data, this estimated that approximately 66,000 women between the ages of 15 and 49 in England and Wales had undergone FGM. This figure includes women who were cut before entering the country, and women who have been cut since becoming residents. The study also estimated that at least 24,000 girls under the age of 15 were at high risk or may have already undergone FGM, Type 3. This included girls born abroad who had migrated to England and Wales, and girls born here to mothers from practising countries. In addition, the study

⁷ [Q19](#) (Nimco Ali, Daughters of Eve)

⁸ For example, [FGM 0003](#) (Buckinghamshire County Council), para 1.1, [FGM 0004](#) (NSPCC), para 2, [FGM 0008](#) (Bar Human Rights Committee), para 26, [FGM 0010](#) (28 Too Many), para 2.1, [FGM 0011](#) (International Association of Women Police), para 10, [FGM 0015](#) (Movement for Justice), [FGM 0022](#) (Intercollegiate Group on FGM), para 1, [FGM 0024](#) (Victoria Climbié Foundation UK), para 1.2, [FGM 0025](#) (Metropolitan Police), para 1, [FGM 0028](#) (Rights of Women and Asylum Aid), para 11, [FGM 0029](#) (Government), para 1, [FGM 0048](#) (Equality and Human Rights Commission), para 5, and [FGM 0052](#) (Royal College of General Practitioners), para 5

⁹ UNICEF, *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*, 2013

¹⁰ Efua Dorkenoo, Linda Morison and Alison Macfarlane, *A statistical study to estimate the prevalence of female genital mutilation in England and Wales*, 2007

estimated a further 9,000 girls were at high risk or may have already undergone FGM, Type 2.

10. Because of increased migration from practising countries, notably Somalia and the rest of the Horn of Africa, as well as population growth over the last decade, it is likely that the prevalence of FGM and the number of girls at risk have increased significantly since the 2007 study.¹¹ A more recent study using 2011 census data estimated that around 170,000 women and girls were living with FGM in the UK, and that 65,000 girls aged 13 and under were at risk of being cut.¹² Leyla Hussein and Nimco Ali from the Daughters of Eve told us they believed the true figure for the number of girls at risk was likely to be more than triple that estimated in the 2007 study.¹³

11. There is also a lack of data on the geographical spread of girls at risk of FGM. The 2007 study found that, between 2001 and 2004, maternities to women who were likely to have undergone FGM accounted for 6.3 per cent of maternities in inner London and 4.6 per cent in outer London. In the London boroughs of Southwark and Brent, almost one in ten maternities were to women likely to have undergone FGM. Outside of London, areas that had a prevalence of two per cent or more included Cardiff, Manchester, Sheffield, Northampton, Birmingham, Oxford, Crawley, Reading, Slough and Milton Keynes. Our written evidence also highlighted Leeds and Bedford as areas with large potential at-risk groups. ACCM (UK), a non-governmental organisation, noted too that the Government's dispersal policy will have created large migrant communities in small towns, some of whom are from FGM-practising countries.¹⁴ Even then, as FORWARD argued, those at risk are not a homogenous group, and include British citizens born in the UK, migrant groups, asylum seekers, refugees and students from affected communities.¹⁵ There are also varying trends within communities. For example, the Tackling FGM Initiative told us that dialogue on FGM within the Somali community had resulted in support for the practice waning amongst settled members in recent years.¹⁶

12. The paucity of data extends also to where the cutting takes place. Anecdotal evidence suggests it is common for girls subjected to FGM to be taken back to their country of origin during the holidays to undergo the procedure. But there is also evidence that FGM takes place in the UK.¹⁷ The Metropolitan Police, for example, told us information it had gathered from communities suggested that cutters were operating in London.¹⁸ However, there is no reliable information on the extent to which FGM is taking place in this country

¹¹ [FGM 0029](#) (Government), para 14, and [FGM 0049](#) (Alison Macfarlane and Efua Dorkenoo), para 1.3

¹² Julie Bindel for the New Culture Forum, *An Unpunished Crime: The lack of prosecutions for female genital mutilation in the UK*, 2014

¹³ [Q15](#) (Leyla Hussein and Nimco Ali)

¹⁴ [FGM 0018](#) (ACCM (UK))

¹⁵ [FGM 0047](#) (FORWARD), para 25

¹⁶ [FGM 0026](#) (Tackling FGM Initiative)

¹⁷ For example, [FGM 0010](#) (28 Too Many); [Q18](#) (Leyla Hussein) and [Q333](#) (Professor Janice Rymer, Royal College of Obstetricians and Gynaecologists)

¹⁸ [Q214](#) (Metropolitan Police Service)

as opposed to abroad. Furthermore, FORWARD noted that community members reporting FGM were more likely to say that it happened abroad before they became a British citizen to avoid the risk of further investigation.¹⁹

13. The Home Office and the Metropolitan Police are part-funding a new study into the prevalence of FGM in England and Wales using data from the 2011 census, which will update the figures in the 2007 study, and provide new estimates broken down by local authority area. The results of this work are expected this summer. In addition, earlier this year the Department of Health announced that all acute hospitals would begin reporting information about the prevalence of FGM within their patient population each month from September 2014.²⁰ The Parliamentary Under Secretary of State for Public Health told us the new reporting arrangements would give, for the first time, a clear picture of what is happening in the UK.²¹

14. Even conservative estimates of the number of girls at risk of FGM indicate that it could be one the most prevalent forms of severe physical child abuse in the UK. In two London boroughs, for example, almost one in ten girls are born to a woman who has undergone FGM, and are therefore at risk of being cut themselves. Yet, apart from a small number of high-level statistical analyses and anecdotal evidence, we have very little information on the children who are most at risk, and even the extent to which the cutting is occurring in this country or by taking girls abroad. Meanwhile, as many as 170,000 women in the UK may already be living with the life-long consequences of FGM. We welcome efforts by the Government and others to draw a more accurate picture. However, even in the absence of precise data, it is clear that the extent of the problem is very significant, and therefore needs to be matched by a response by all those who have a responsibility for safeguarding children that is similar in scale.

Recent developments and our Report

15. Until recently, there has been relatively little public awareness of FGM in the UK. In 2000 the All Party Parliamentary Group (APPG) on Population, Development and Reproductive Health made 35 recommendations in respect of legislation, education policy, community-based work, and health strategy, though the majority of these were never translated into policy action.²² In 2003 the law against FGM was strengthened by extending its coverage and increasing the potential punishments, though until 2014 there had not been a single prosecution. In the last two years there has been a significant increase in media and parliamentary awareness of the issue. Campaigns by The Evening Standard, the Guardian, and The Times have created much greater public awareness of FGM, highlighting gaps in the provision of services, the lack of sufficient data, and the absence of

¹⁹ [Q234](#) (FORWARD)

²⁰ [FGM 0029](#) (Government), para 24

²¹ [Q267](#) (Parliamentary Under Secretary of State for Public Health)

²² [Q47](#) (FORWARD), para 6

any FGM-related prosecutions. The APPG on FGM has also been successful in pushing the issue up the political agenda.

16. Underpinning greater political and media interest in FGM has been the tireless work and lobbying of third sector groups such as Equality Now, Daughters of Eve, FORWARD, Integrate Bristol, and others, as well as a small number of health professionals who see day-to-day the consequences of FGM. Efforts by these organisations and individuals have created a step-change in awareness and finally forced the Government, the Crown Prosecution Service, and others to strengthen their response. Indeed, earlier this year the Prime Minister announced that he will host a major event in July 2014 on tackling FGM, as well as early and forced marriage. The summit will consider the need for action both domestically and internationally.

17. Although it is outside the scope of this inquiry, we appreciate that FGM is unlikely to end in the UK before it is abandoned by practising communities in Africa.²³ To help achieve this, the Department for International Development has recently provided £35 million over five years to support the Africa-led movement to end FGM.²⁴ Whilst we welcome this funding we note, however, the conclusion of the International Development Committee in 2013 that “the UK’s credibility in calling to end the practice overseas is undermined by the failure to tackle the problem at home”.²⁵

18. Evidence we received from the Bar Human Rights Committee and the Equality and Human Rights Commission (EHRC) argued that the state has a duty of care to protect women and girls from FGM.²⁶ Furthermore, the failure of the state to do so represents a breach of the UK’s international law obligations under the Convention on the Elimination of All Forms of Discrimination against Women 1979, and the UN Convention on the Rights of the Child 1984.²⁷ The EHRC also told us the fact that FGM is prohibited by law is not in itself sufficient to discharge the state’s responsibilities. A number of witnesses told us that a comprehensive national action plan led by the Government was the only way to tackle FGM in the UK effectively.²⁸ This call has also received the backing of 109,000 people who have signed the e-petition set up by Leyla Hussein and Efua Dorkenoo calling on the Government to put in place such a plan.

19. The failure to respond adequately to the growing prevalence of FGM in the UK over recent years has likely resulted in the preventable mutilation of thousands of girls to whom the state owed a duty of care. This is a national scandal for which successive governments, politicians, the police, health, education and social care sectors all share responsibility. We pay tribute to the efforts of a small number of individuals and

²³ [Q269](#) (Minister of State for Crime Prevention)

²⁴ [FGM 0029](#) (Government), para 5

²⁵ [International Development Committee, Violence against Women and Girls, Second Report of Session 2013–14, HC 107](#)

²⁶ [FGM 0008](#) (Bar Human Rights Committee), and [FGM 0048](#) (Equality and Human Rights Commission), para 19

²⁷ [FGM 0008](#) (Bar Human Rights Committee), para 11-12

²⁸ [FGM 0010](#) (28 Too Many), para 3.4.1, [FGM 0012](#) (Professor Lisa Avalos), para 12, [FGM 0026](#) (Tackling FGM Initiative), [FGM 0047](#) (FORWARD), para 47, and [FGM 0048](#) (Equality and Human Rights Commission), para 5

organisations who have worked to raise public awareness of FGM and the impact it has on those who have undergone the procedure. Many of those campaigners who have spoken out have had to withstand criticism and ostracism by those in their own communities who do not wish to see an end to the practice. We also acknowledge the work of the Evening Standard, The Guardian, and The Times in raising public awareness of FGM in the last year. The Government has started to take action, and we welcome the stated commitment to end FGM in a generation. It must now implement a comprehensive and fully-resourced national action plan for tackling FGM. The plan should provide clear leadership and objectives, setting out the standards expected of all relevant bodies, and to which they will be held accountable. It should incorporate a number of interlinked aspects, including:

- the achievement of successful prosecutions for FGM;
- working with professionals in the health, education, social care and other sectors to ensure the safeguarding of at-risk girls;
- changes to the law on FGM;
- improved working with communities to abandon FGM; and
- better services for women and girls living with FGM.

20. We consider each of these in the subsequent chapters of this Report. Finally, we welcome the Prime Minister's planned summit on FGM and forced marriage. We urge him to consider the recommendations in this Report. We welcome the fact that the summit will reflect the international dimension of the problem, and we hope that the relevant heads of government of affected states are invited to attend. We believe the Government should aspire to the UK being a world leader in the policy response to FGM.

2 Prosecuting FGM

21. It has been a crime to carry out FGM in the UK for almost 30 years, and for more than a decade it has been illegal for a UK citizen or permanent resident to aid, abet, counsel or procure the carrying out of FGM abroad on a UK national or permanent resident. Yet until 2014 there had not been a single FGM-related prosecution in the UK. The Government told us it was frustrated by the lack of progress.²⁹ Other witnesses highlighted the importance of a successful prosecution for the message it would send to practising communities. For example, the International Association of Women Police told us that “a successful prosecution, along with the publicity surrounding it, could assist women within affected communities to resist pressure to subject their daughters to FGM”.³⁰ The Health Minister told us: “a number of successful prosecutions would send an important signal that the law is taken seriously and will be enforced”.³¹ In this Chapter we look at the work the Crown Prosecution Service (CPS) has undertaken to date to investigate FGM cases. We also examine the reasons why it has proven difficult to achieve a prosecution, and the steps the CPS is taking to address the situation.

Cases considered by the Crown Prosecution Service to date

22. Whilst there have been several police investigations since the criminalisation of FGM, the CPS told us it was not until 2010 that it received its first referral from the police. Since then it has examined 14 cases. In the first case the decision was taken not to charge on the basis that the victim had given several different accounts of what happened. The reviewing CPS lawyer concluded that, without any supporting evidence and with the victim accepting that some of her accounts were false, no charges could be brought.³² In 2012, a case referred to the CPS by the police for advice involved the allegation that a girl might have been at risk of FGM. However, the police investigation did not find sufficient evidence that she was at risk, and so no further action was taken. Another case in 2013 resulted in no further action because the victim withdrew her allegation. The CPS told us that, due to the victim’s health and vulnerability, it would not have been appropriate to use a witness summons, and so there was no further action. In a further case the CPS considered the allegation made by a newspaper that two doctors in Birmingham were willing to undertake FGM on girls. Again, however, insufficient evidence led to no further action.

23. In 2014, the CPS has been examining a further 11 cases, seven of which are new cases, and four are a re-review of old cases from the Metropolitan Police Service, where the police or prosecutors had originally decided that no further action should be taken. It includes the first case outlined above. In March the CPS determined that there was insufficient evidence to proceed with three of the four re-reviews, and one of the new cases. One of the re-

²⁹ [FGM 0029](#) (Government), para 4

³⁰ [FGM 0011](#) (International Association of Women Police), para 32

³¹ [Q247](#) (Parliamentary Under Secretary of State for Public Health)

³² [FGM 0050](#) (Crown Prosecution Service), Para 9-12

reviews included a case where the suspect was alleged to have contacted an FGM helpline to request FGM for his two daughters. On 21 March 2014, the Director of Public Prosecutions announced her intention to bring the first ever prosecutions under the Female Genital Mutilation Act 2003.³³ The case is currently *sub judice*.

Why it has been difficult to secure a prosecution

24. The main reason why the CPS has struggled to achieve a prosecution until this year is because there have been very few investigations by the police. For example, between 2010 and 2013, the Metropolitan Police recorded just 20 referrals made to it as an FGM crime. The police and others told us two factors contributed to the small number of investigations—a reliance on victims or witnesses to report to the police, which they are unlikely to do, and the failure of health, education and social care professionals to refer cases to the police where they suspect FGM to have taken place.

25. A number of interlinked factors contribute to the low level of reporting by victims themselves. First, they are usually very young when it takes place, with the majority being under the age of 10, and some under five.³⁴ As such, they are unlikely to realise that what has happened is a crime. Second, older girls will have been taught to think of the procedure as a positive thing, representing their rite of passage into adulthood, and again may not view FGM as a crime.³⁵ Third, even where the child subsequently becomes aware that a crime has been committed against them, they may be reluctant to give evidence against their parents and relatives for fear of losing them.³⁶ For most children their experience will have taken place in what is otherwise a loving and caring environment. Fourth, victims may face huge social pressure from their families and communities to remain silent, fearing reduced marriage prospects, ostracism, and at worst violence if they try to speak out.³⁷ This pressure may be amplified for women and girls who are new to the UK, and so may already feel isolated. Fifth, the prospect of giving evidence at trial has the potential to be hugely traumatic for the individual concerned. The risk to the victim may be so great that it is not in their interest for a prosecution to go ahead. Overall, as the Director of Public Prosecutions put it: “if you wait for the archetypal young girl to come through the door to tell you what has happened to her [...] that is not going to happen”.³⁸

26. Even when a woman or girl comes forward, the CPS told us it can be difficult for the police to build sufficient evidence to mount a prosecution. Investigators may face silence from the community, or the woman may have come forward some years after the act had taken place. If the procedure occurred outside the UK it can be difficult to obtain reliable

³³ [CPS announces first prosecutions for female genital mutilation](#), Crown Prosecution Service Blog, 21 March 2014

³⁴ [FGM 0022](#) (Intercollegiate Group), para 2, and [FGM 0025](#) (Metropolitan Police Service), para 11

³⁵ [FGM 0046](#) (Association of Chief Police Officers), para 33

³⁶ [FGM 0001](#) (Children and Families across Borders), para 1, [FGM 0022](#) (Intercollegiate Group), para 3, [FGM 0029](#) (Government), para 8, and [FGM 0042](#) (Lancashire Constabulary)

³⁷ [FGM 0018](#) (ACCM (UK)), and [FGM 0042](#) (Lancashire Constabulary)

³⁸ [Q83](#) (Director of Public Prosecutions)

and admissible evidence from the country in which it took place. The victim's evidence may also not be reliable enough because of their age or inability to identify the cutter because of the traumatic nature of the act.³⁹

27. Because of the lower likelihood of self-reporting, the police are reliant instead on referrals from other sources. These should include health professionals, including midwives, GPs, gynaecologists, and paediatricians who come into contact with women and girls who have undergone FGM or are seen as at-risk. It also includes education professionals who may observe girls being taken out of school for an extended trip to their home country. Where a girl is already flagged as being at-risk, referrals may come from social care workers. Referrals may also come via the third sector, especially where a girl feels unable to approach a person seen to be in authority. However, the police told us the number of referrals it received from these sectors was much lower than it would expect given the prevalence of FGM. The table below provides the figures for the Metropolitan Police Service between 2010 and 2013. A large proportion of the referrals (122) during this period related to girls who were seen as at risk of FGM, therefore requiring preventative safeguarding activity. As noted above, a relatively small number of referrals were classified by the MPS as an FGM-related crime.

Table 1: Total FGM-related referrals to the MPS between 2010 and 2013

Referral source	Number of referrals
Social care	57
Police	44
Health	34
Education	17
Other	9
Total	161

Source: [FGM 0025](#) (Metropolitan Police Service)

28. The low level of reporting by those frontline practitioners who have a responsibility for child safeguarding is in part because of a lack of awareness of the indicators of a girl who might be at risk or has undergone the procedure. Even when they are aware, professionals may be reluctant to intervene because of cultural sensitivity and a fear of being seen as racist, or because they are unsure how to make a referral.⁴⁰ However, this reluctance is based at least in part on a failure to perceive FGM as a safeguarding issue like other forms of child abuse. There has been some improvement in the number of referrals from frontline professionals in the last year. The Met told us it received 69 referrals in 2013, as

³⁹ [FGM 0050](#) (Crown Prosecution Service), para 15

⁴⁰ [FGM 0004](#) (NSPCC), para 18, [FGM 0011](#) (International Association of Women Police), para 3, [FGM 0022](#) (Intercollegiate Group), para 5

opposed to 26 in 2012 and 24 in 2011.⁴¹ But these figures are still low relative to the likely number of girls at risk, or who have undergone FGM.

Recent steps by the Crown Prosecution Service

29. The CPS told us that the lack of prosecutions for FGM until 2014 was an issue it was very aware of, and determined to change.⁴² To this end, in 2011 it published the first piece of specific guidance to prosecutors on dealing with FGM.⁴³ This sets out the legislation under which FGM can be prosecuted. It also emphasises the need to consider the willingness of the victim to give evidence, the consequences for them of doing so, and the measures that can be taken to help vulnerable and potentially intimidated witnesses to give their best evidence in court. As one witness told us, “it is imperative that women and girls are protected and supported before, during and after any interaction with the criminal justice system”.⁴⁴ The CPS will consider whether a prosecution is possible without the victim giving evidence, but the Director of Public Prosecutions acknowledged to us that in the majority of cases a prosecution would only stand a chance of success if the victim was prepared to go to court and give evidence.

30. Special measures available to help vulnerable witnesses to give evidence include the use of screens, live links, evidence given in private, the removal of wigs and gowns by judges and barristers, video-recorded evidence, witness examination through an intermediary, and aids to communication.⁴⁵ The CPS can also arrange for a court familiarisation visit for the witness. The Director of Public Prosecutions told us an additional support for witnesses could be the right to anonymity in the press and broadcast media, so that they can give evidence without fear of the general public and people in their communities knowing what has happened to them.⁴⁶ This is already the case for certain types of case, such as rape, under the Sexual Offences (Amendment) Act 1992, although FGM is not explicitly covered by the legislation.

31. In addition to providing support for witnesses, the CPS has put in place an action plan to increase the number of prosecutions. Steps taken have included exploring the possibility of prosecuting offences under other legislation, and the development of a protocol for the police to refer all cases of FGM to the CPS for early advice on the lines of enquiry and evidential issues so that the police can build a strong case. To facilitate this the DPP has identified lead prosecutors on FGM in each of the 13 CPS areas and CPS Direct, who will be the main contact points for police and communities. The CPS told us that as a result of

⁴¹ [FGM 0025](#) (Metropolitan Police Service), para 17

⁴² [FGM 0050](#) (Crown Prosecution Service), para 32

⁴³ Crown Prosecution Service, *Female Genital Mutilation Legal Guidance*

⁴⁴ [FGM 0045](#) (Mayor of London’s Harmful Practices Taskforce)

⁴⁵ [FGM 0050](#) (Crown Prosecution Service), para 21

⁴⁶ [Q106](#) and [Q109](#) (Director of Public Prosecutions)

this work it was now much better prepared to identify cases where there is sufficient evidence for a realistic prospect of conviction.⁴⁷

Comparisons with France

32. A further aspect of the CPS action plan has been to consider the approach taken in other countries to prosecuting FGM-related cases. France has been a leading example in this respect, having achieved more than 40 prosecutions since 1979, resulting in the punishment of more than 100 parents and cutters.⁴⁸ There is no specific law against FGM in France. Instead perpetrators are prosecuted under general provisions of the penal code, such as acts involving intended bodily harm, causing permanent infirmity or mutilation.⁴⁹ It is an aggravating factor in these crimes when they are committed against a minor. The comparative success of France is in part thanks to the efforts of a few individuals, including the barrister, Linda Weil-Curiel, who told us prosecutions had played a vital role in encouraging parents to abandon the practice.⁵⁰

33. A key feature of the French system is the use of regular medical check-ups on children up to the age of six, which includes examination of the genitals. The system is not mandatory, though receipt of social security is dependent on participation.⁵¹ Furthermore, girls identified to be at risk of FGM are required to have medical examinations every year, and whenever they return from abroad.⁵² This approach is reinforced by a requirement on medical practitioners to set aside patient confidentiality and report cases of physical abuse against children. French law also criminalises acts of omission—failure to assist a person in danger can result in a heavy fine or imprisonment.⁵³ Again, this approach has proven effective both in protecting girls in France from FGM, but also providing the evidence to mount a prosecution where FGM has taken place.

34. The UK does not have an equivalent system of regular checks for all children, and at present the Government has no plans to go down this route. The Children and Families Minister told us mandatory checks would be “a hugely intrusive practice upon young girls and that would cause its own problems”, whilst the Public Health Minister said, “there are so many better ways we can focus our efforts on prevention and support”.⁵⁴ Indeed the system in France has proven controversial. In some cases it has had the effect of increasing the age at which girls may be forced to undergo the procedure, with parents more likely to

⁴⁷ [FGM 0050](#) (Crown Prosecution Service), para 28

⁴⁸ [Q417](#) (Linda Weil-Curiel)

⁴⁹ [FGM 0014](#) (UCL Graduate Law Society), para 4.4

⁵⁰ [Q437](#) (Linda Weil-Curiel)

⁵¹ [Q279](#) (Parliamentary Under Secretary of State for Public Health); [FGM 0014](#) (UCL Graduate Law Society), para 4.6

⁵² Julie Bindel for the New Culture Forum, *An Unpunished Crime: The lack of prosecutions for female genital mutilation in the UK*, 2014

⁵³ [FGM 0014](#) (UCL Graduate Law Society), para 4.5

⁵⁴ [Q279](#) (Parliamentary Under Secretary of State for Public Health) and [Q282](#) (Parliamentary Under Secretary of State for Children and Families)

wait until their child is 12–14, before sending them abroad to be cut.⁵⁵ The Royal College of General Practitioners told us that, while routine screening could have positive outcomes, it could alienate hard-to-reach individuals and communities, and could in itself be a traumatic experience.⁵⁶ The Association of Chief Police Officers, however, told us it would support mandatory testing for cases where it was known that a child was likely to be at risk.⁵⁷ The recent intercollegiate report on tackling FGM stated:

[...] it is important to underline the principle that in specific situations where there is a suspicion that girls have undergone FGM, FGM assessments and medical examinations are helpful and it should not be seen as abusive to undertake such examinations [...] In the experience of the Royal College of Paediatricians and Child Health (RCPCH) Child Protection Standing Committee, children and their parents do not find such examination traumatic.⁵⁸

35. A number of successful prosecutions would send a clear message to practising communities that FGM is taken seriously in the UK and will be punished accordingly. There has rightly been increasing public outrage at the failure to achieve a prosecution in the 29 years that FGM has been a crime, with the first prosecutions taking place only this year, after the Committee commenced its inquiry and only a matter of days before the DPP appeared before this Committee. This compares starkly with the approach in France, where a large number of successful prosecutions has played a key role in discouraging the practice. One reason behind the UK's poor record is that the police and Crown Prosecution Service have historically been far too passive in their approach to FGM by waiting for survivors to come forward and report. Yet, the nature of FGM means it is unlikely that this will happen. Often victims do not become aware that FGM is a crime until some years after it has happened to them. Even then, they face huge social pressure not to report it.

36. We welcome the more recent proactive work the CPS has undertaken to secure prosecutions, which we hope will bear fruit. A key difficulty, though, remains the ability to gather sufficient evidence on which to base a prosecution. The police must do more within practising communities to publicise the fact that information can be reported anonymously. In addition, if victims had the protection of press and broadcast anonymity, this might encourage more to come forward. To allow this, we recommend the Government bring forward proposals to extend the right to anonymity under the Sexual Offences (Amendment) Act 1992 to include victims of FGM.

37. The use of regular examinations of all children in France has been a key factor in obtaining evidence that has underpinned a large number of prosecutions. It would be a disproportionate response to introduce such a universal system in the UK. However, we

⁵⁵ [Q445](#) (Linda Weil-Curiel)

⁵⁶ [FGM.0052](#) (Royal College of General Practitioners), para 11

⁵⁷ [Q158](#) (Association of Chief Police Officers)

⁵⁸ *Tackling FGM in the UK: Intercollegiate recommendations for identifying, recording and reporting*, November 2013

do believe there is a case for a system that empowers medical professionals to make periodic FGM assessments where a girl is identified as being at high risk. Any such system would need to form part of a much wider scheme of preventative and safeguarding work, which we consider in the next two chapters.

3 Safeguarding at-risk girls

38. Although prosecutions have an important role to play in deterring FGM, each instance represents a child or woman that the state has failed to protect. The NSPCC, for example, told us the main focus should be on prevention and intervention with each child that is at risk.⁵⁹ The key to achieving this is to treat FGM as a child protection matter, mainstreaming it as part of the existing safeguarding framework. In this Chapter we consider the guidance available to frontline practitioners, and examine the roles and responsibilities of each group in protecting children from FGM.

Training and the multi-agency practice guidelines

39. One of the main barriers to identification and intervention is a lack of understanding among health, education, social care and other professionals of the risk factors, signs, and how to respond.⁶⁰ FGM differs from other forms of child abuse in that it is a one-off event in the child's life that usually takes place in an otherwise loving and caring environment. As such it is not usually accompanied by a pattern of behaviour and indicators that would normally alert the authorities that a child was at risk. Several witnesses raised concern at the current level of awareness of FGM by practitioners. The Police and Crime Commissioner for Avon and Somerset, for example, told us she was still meeting frontline professionals who did not know what FGM stood for.⁶¹ A recent NSPCC survey of 1,000 teachers in England found that one in six did not know FGM was illegal in the UK, and that there was a legal duty on them to take action to safeguard children at risk.⁶² Another survey conducted in Wales showed that whilst a large proportion of frontline professionals were aware of FGM, more than half were unsure who was at risk and had never received any formal training. Inevitably, this results in situations where the first time professionals have to deal with a case involving FGM is in a crisis intervention.⁶³ The Intercollegiate Group told us this was a particular problem in the NHS outside London. Women presenting at hospitals with FGM have reported experiencing reactions of shock, revulsion and confusion shown to them by NHS staff.⁶⁴

40. A number of witnesses argued that mandatory and high-quality training was the only way to ensure all practitioners were capable of recognising the risks of FGM, or understanding when it has taken place, and how to respond.⁶⁵ The Tackling FGM Initiative

⁵⁹ [FGM 0004](#) (NSPCC), para 1

⁶⁰ [FGM 0010](#) (28 Too Many), para 3.3.2, [FGM 0022](#) (Intercollegiate Group on tackling FGM), para 11, [FGM 0026](#) (Tackling FGM Initiative), para 3, and [FGM 0030](#) (Bawso), para 4.4

⁶¹ [FGM 0019](#) (Avon and Somerset Constabulary), para 25

⁶² [FGM 0004](#) (NSPCC), para 16-17

⁶³ [FGM 0010](#) (28 Too Many), para 3.3.2

⁶⁴ [FGM 0022](#) (Intercollegiate Group on tackling FGM), para 22

⁶⁵ [FGM 0011](#) (International Association of Women Police), para 21, [FGM 0023](#) (Juliet Albert), para 3, [FGM 0030](#) (Bawso), para 8.1-8.2, and [FGM 0047](#) (FORWARD), para 37

and the Equality and Human Rights Commission told us it needed to be included as part of statutory child protection training, highlighting the legal duties on relevant professionals to report any suspicion that a child might be or has been subjected to FGM.⁶⁶ Juliet Albert, a specialist FGM midwife, told us this should include midwives, health visitors, GPs, practice nurses, teachers, obstetricians and gynaecologists, social workers, nurses, and teaching assistants.⁶⁷ The Intercollegiate Group called for the incorporation of FGM at all levels—pre-registration education, undergraduate medical education, and postgraduate speciality education, as well as continued professional development for health professionals, teachers and social workers.⁶⁸ The Bar Human Rights Committee recommended introducing a legal requirement to make training mandatory.⁶⁹

41. An introduction to the Multi-Agency Practice Guidelines on FGM should form a key part of the provision of training for practitioners. The Government published these in 2011 to help promote a joined-up approach across frontline agencies. They provide guidance on identifying girls and young women at risk of FGM, or who have been subjected to it, and the steps that can be taken to prevent the practice. The Guidelines state clearly that “FGM is a form of child abuse and violence against women and girls, and therefore should be dealt with as part of the existing child and adult protections structures, policies and procedures”. They are designed for all frontline professionals and volunteers within agencies that have a responsibility to safeguard children and young people from abuse.

42. The Guidelines are highly regarded by practitioners, although the National Association of Head Teachers and ACPO told us they needed updating to reflect current reforms to the National Curriculum and to include the role of education authorities.⁷⁰ However, there is limited awareness that they exist. FORWARD told us that through their training provision for professionals, generally between only five and 10 per cent of the people attending had previously heard of the Guidelines.⁷¹ As Leyla Hussein put it, the guidance “would only be effective if someone actually picks it up and reads it”.⁷²

43. The Daughters of Eve and a number of other witnesses, including the Mayor of London’s Harmful Practices Taskforce, ACCM (UK), FORWARD and ACPO, called for the Guidelines to be given a statutory basis to ensure their use.⁷³ Indeed, ACPO noted that this would give the Guidelines a similar footing to the Government’s Multi-Agency Practice Guidelines for handling cases of forced marriage. Section 63Q of the Forced Marriage (Civil Protection) Act 2007 states that: “A person exercising public functions to

⁶⁶ [FGM 0026](#) (Tackling FGM Initiative), para 3, and [FGM 0048](#) (Equality and Human Rights Commission), para 28)

⁶⁷ [FGM 0023](#) (Juliet Albert), para 3

⁶⁸ [FGM 0022](#) (Intercollegiate Group on tackling FGM), para 29

⁶⁹ [FGM 0008](#) (Bar Human Rights Committee), para 4

⁷⁰ [FGM 0029](#) (Government), para 20, [FGM 0036](#) (National Association of Head Teachers), para 3.1, and [FGM 0046](#) (Association of Chief Police Officers), para 73; [Q24](#) (Leyla Hussein) and [Q339](#) (Royal College of General Practitioners)

⁷¹ [Q240](#) (FORWARD)

⁷² [Q24](#) (Leyla Hussein)

⁷³ [FGM 0018](#) (ACCM (UK)), [FGM 0045](#) (Mayor of London’s Harmful Practices Taskforce), [FGM 0046](#) (Association of Chief Police Officers), and [FGM 0047](#) (FORWARD), para 28

whom guidance is given under this section must have regard to it in the exercise of those functions". The Government, however, told us the Guidelines were not statutory because it believed the policies and procedures necessary to tackle FGM already existed through the child protection system—a view shared by the Royal College of General Practitioners.⁷⁴

44. It is deeply concerning that so many frontline practitioners do not recognise the indicators of when a girl or young woman is at risk, or has undergone FGM, and, even when they do recognise the signs, they do not know how to respond. It is unacceptable that those in a position with the most access to evidence of these crimes do nothing to help the victims and those at risk. The record of referrals by healthcare practitioners and others is extremely poor and a lack of training, awareness or ethical concerns can no longer prevent positive action being taken. To remove one of the obstacles to referring, high-quality training for all professionals, including midwives, GPs, health visitors, practice nurses, teachers, obstetricians and gynaecologists, social workers and teaching assistants, is therefore vital both during education and through continued professional development. This should form an essential part of all child protection training. Furthermore, we welcome and support the recommendations of the Intercollegiate Group, though we believe that this work could be better communicated. We note with disappointment that the Royal College of General Practitioners is not a signatory to the report. GPs have a vital role in responding to FGM, and we hope that the Royal College will now work with the Intercollegiate Group to implement its recommendations.

45. The Multi-Agency Practice Guidelines on FGM have a valuable role to play as a tool for all practitioners. However, they will only ever be useful if they are read, and that is more likely to happen if they are mandatory. We recommend the Government update the Guidelines and place them on a statutory footing, giving them parity with guidelines for handling cases of forced marriage. We believe this will provide a much stronger incentive for agencies responsible for training to ensure the inclusion of FGM. To support this, the Department of Health should improve the accessibility of the Guidelines, rather than simply publishing them online, and provide funding for the development of e-learning materials for practitioners. The Department of Health and Department for Education should also ensure arrangements are in place to monitor compliance and hold to account bodies who are responsible for training provision.

Overcoming cultural sensitivities

46. One of the primary reasons why there has traditionally been a reluctance for practitioners to report FGM cases, or discuss it with pupils or patients, is a fear of being accused of racism. The Home Office identified this as a barrier to reporting 10 years ago.⁷⁵ School head teachers, for example may be fearful of undermining good relations they have established with practising communities. Elsewhere, the Tackling FGM Initiative told us

⁷⁴ [FGM 0029](#) (Government), para 19; [Q340](#) (Royal College of General Practitioners)

⁷⁵ [FGM 0011](#) (International Association of Women Police), para 7

women who have undergone Type 3 FGM regularly report that they are never asked about what has happened to them during medical checks.⁷⁶ However, the Government told us it was clear that “political and cultural sensitivities must not get in the way of preventing and uncovering this terrible form of child abuse”.⁷⁷ The Royal College of General Practitioners has clear guidance that misplaced concerns around cultural sensitivity should not prevent reporting where it is suspected that FGM has taken place, or that a girl is at risk.⁷⁸ Leyla Hussein put it more starkly:

For me, you are being racist if you stay silent because you are saying, “A girl who is a brown colour is allowed to go through this, but for a girl who is white, blonde and blue-eyed, it would be an outrage”.⁷⁹

Linda Weil-Curiel made a similar point:

People talk of culture and tradition, but children have a fundamental human right not to be mutilated. It is racist to think otherwise.⁸⁰

47. Misplaced concern for cultural sensitivities over the rights of the child is one of the main reasons why the UK has failed to tackle FGM to date. A key objective for a national action plan on FGM must be to overcome practitioners’ own reluctance to address FGM so that they respond to it in the same way as other forms of child abuse. Practitioners must be given the confidence to know that they will not suffer any detriment as a result of raising legitimate concerns about FGM. Again, training is important for practitioners to have the confidence to talk about FGM. But it is also about making such conversations routine so that professionals overcome any awkwardness about having them.

The role of health professionals

48. Health professionals have a vital part to play in identifying both at-risk girls and women and girls who have already been subjected to FGM. However, witnesses told us many practitioners often failed to identify these groups, and when they did the information was not always passed on to those agencies who were best-placed to respond. The royal medical colleges in the Intercollegiate Group advocate a ‘life-course’ model to monitoring at-risk children.⁸¹ This operates on the basis of early identification and protection, with a shared responsibility for child safeguarding between the NHS, social services, and others.

49. A key starting point is when women contact their GP, local maternity unit or midwifery clinic during the early stages of pregnancy. For many women from migrant

⁷⁶ [FGM 0026](#) (Tackling FGM Initiative), para 26

⁷⁷ [FGM 0029](#) (Government), para 2

⁷⁸ [Q321](#) (Royal College of General Practitioners)

⁷⁹ [Q33](#) (Leyla Hussein, Daughters of Eve)

⁸⁰ [Q419](#) (Linda Weil-Curiel, Lawyer at the Paris Bar)

⁸¹ [FGM 0018](#) (Intercollegiate Group), para 20

communities this may be their first contact with the NHS. If the future mother is identified as having undergone FGM or is from a practising country, it is likely that if they give birth to a girl, that child will in the future be at risk unless preventative steps are taken. An early opportunity to raise the issue with prospective mothers, therefore, is during the antenatal booking interview, which usually takes place with a midwife around 10 weeks into pregnancy. This interview already collects a range of information on the patient's lifestyle, such as smoking and alcohol consumption, as well as family history, breastfeeding intentions, etc. However, there is no requirement to ask about FGM. Not only does this pose potential risks for the mother later on in terms of managing her pregnancy and birth, but it also misses an opportunity to flag the future child as being at-risk if they are a girl.⁸² The Intercollegiate Group's view is that "every woman from, or partner to someone from, an FGM-practising community who attends antenatal appointments should be asked about FGM as early on in pregnancy as possible, and the outcome of that discussion accurately recorded".⁸³

50. If the FGM status of the mother has not been picked up and discussed during pregnancy, there is still an opportunity at the point the child is born. Again, the midwife has a key role by passing on the information to other agencies, such as children's social care, the police, health visitors, and GPs so that the risk to the child can be monitored and managed over time. One way of doing this is to refer the case to children's social care, or where they exist, the local multi-agency safeguarding hub (MASH), which many local authorities have established in the last couple of years. The MASH co-locates a multi-disciplinary team from children's social care, the police, health, education, housing and probation services to respond where someone is concerned about the safety or well-being of a child. It assesses the level of risk and determines what action to take, such as a children's social care assessment, a home visit by the health visitor, or intervention by another agency.

51. The Intercollegiate Group has recommended a policy of automatic referral to children's social care for girls born to mothers who have undergone FGM, so that an action plan can be put into place.⁸⁴ At present across the NHS only a handful of women are referred at this stage, although there are pockets of good practice.⁸⁵ For example, the London Borough of Newham told us maternity units are required to make a referral for child safeguarding when it is known that the mother has undergone FGM. They are also invited to access the FGM Prevention Service, which is designed to help them to understand the negative consequences of FGM and not allow FGM for their daughters.⁸⁶ The Police and Crime

⁸² [FGM 0041](#) (Dr Comfort Momoh, African Well Women's Clinic, Guy's and St Thomas' Hospitals)

⁸³ [FGM 0022](#) (Intercollegiate Group on tackling FGM)

⁸⁴ [FGM 0022](#) (Intercollegiate Group on tackling FGM)

⁸⁵ [FGM 0051](#) (Yana Richens OBE and Sarah Creighton), para 4

⁸⁶ [FGM 0037](#) (London Borough of Newham), para 4.1

Commissioner for Northumbria highlighted a similar practice of systematic referrals by midwives to social services in one part of the county.⁸⁷

52. This summer, a two-year pilot will launch in six London boroughs where midwives will provide information to social workers on new mothers who have undergone FGM. It will be managed by the charity Children and Families Across Borders, alongside the Mayor's Office for Policing and Crime, the Metropolitan Police Service, the Royal College of Midwives, NHS England, and others. As part of the pilot, social workers and health staff will undertake a risk assessment of potential victims. All families will receive literature on the long-term health effects of FGM, and will be clearly told the law on FGM and the potential penalties for allowing or enabling a child to undergo the procedure. For children identified as most at risk, social workers will work directly with the family, but will also escalate the matter if they believe FGM is likely to occur or has occurred. At this point the police will become involved. If it is thought FGM has occurred a child protection medical may be requested. If it is believed the child will be taken out of the UK to undergo FGM the family will be flagged with the border authorities to prevent the child from travelling.

53. Another way in which the FGM risk to the child can be passed on to other agencies is through the Personal Child Health Record, known as the "Red Book". This is given to all parents and carers at a child's birth, and is the main record of their health and development. The parent or carer retains the Red Book, which is updated by health professionals each time the child is seen. An electronic version of the Red Book is currently being developed and piloted. The evidence we received called for a specific reference to FGM in the Red Book.⁸⁸ This would enable all those in healthcare settings who come into contact with the child to monitor on an ongoing basis the level of risk, raise the issue with the mother, and if necessary refer the child again to social care or the police. Leyla Hussein told us:

The moment a girl is born, it should be alerted on her red book. The red book will go to the health visitor. The health visitor should pass that on to the nursery. The nursery should pass that on the primary school teacher. Without even physically examining them, the parent knows that these children are being monitored.⁸⁹

Muna Hasan from Integrate Bristol told us about her mother's experience in Sweden:

Her midwife brought up the subject the day she found out she was pregnant. Even though they did not know the sex of the child they still brought up FGM and said, "Do you know the laws in this country?" They followed that up all the way till I was in nursery and so on.⁹⁰

⁸⁷ [FGM 0016](#) (Police and Crime Commissioner for Northumbria)

⁸⁸ [FGM 0022](#) (Intercollegiate Group on tackling FGM) and [FGM 0023](#) (Juliet Albert), para 1

⁸⁹ [Q46](#) (Leyla Hussein, Daughters of Eve)

⁹⁰ [Q55](#) (Muna Hasan, Integrate Bristol)

54. There are various ways in which girls may continue to come into contact with the NHS throughout their childhood, and at which point the health professional should consider discussing FGM with the parent. In Sheffield, for example, safeguarding intervention has taken place after families sought vaccinations at GPs' surgeries for girls travelling to FGM-practising countries.⁹¹ Girls or women at any age may seek medical attention as a result of complications arising from having undergone FGM. Elsewhere, instances where a patient from a practising community refuses a smear test or experiences pain or distress during the test, may indicate that they have undergone FGM.⁹² School nurses may be approached by children who have either returned from or are due to take an extended holiday in their home country. The Intercollegiate Group has also recommended including questions on country of origin when registering for the first time at GP practices to determine whether the patient and their family are from an FGM-practising country.⁹³ Indeed, from June this year GPs will have specific codes to record FGM on their patient files.⁹⁴ All of these situations present an opportunity to raise the issue sensitively with the patient, record the outcome, refer on to social care or the police if appropriate, or refer them to support services. As one of the royal colleges told us: "the most important thing is having that conversation and safeguarding the child".⁹⁵

55. The Royal College of General Practitioners raised concern that often it was difficult to ask questions about FGM sensitively, but directly.⁹⁶ However, Dr Kerry Robinson, a consultant paediatrician, told us such conversations became much easier once they were conducted as a matter of routine.⁹⁷ The Royal College also noted that a desire to maintain patient confidentiality was often a factor in GPs' reluctance to refer patients. A wider concern raised by witnesses was a lack of certainty among health professionals about when and how to refer cases to social children's care or the police.⁹⁸ FORWARD told us: "people don't feel able to refer or are not sure who to refer to, so there needs to be more clarity around the referral pathways: do you go to social services or the police".⁹⁹ Dr Comfort Momoh, a midwife who specialises in the treatment of FGM, told us that, in her experience, over half of health professionals were not aware of how to refer cases on to social care, noting: "we all need to know what our roles and responsibilities are".¹⁰⁰

56. Healthcare professionals have a vital role in breaking the generational cycle of FGM. When a woman is identified as having undergone FGM or being from a country

⁹¹ [FGM 0018](#) (ACCM (UK))

⁹² [FGM 0052](#) (Royal College of General Practitioners)

⁹³ [FGM 0022](#) (Intercollegiate Group of tackling FGM)

⁹⁴ [Q348](#) (Royal College of General Practitioners)

⁹⁵ [Q407](#) (Dr Robinson, Royal College of Paediatrics and Child Health)

⁹⁶ [FGM 0052](#) (Royal College of General Practitioners)

⁹⁷ [Q408](#) (Dr Kerry Robinson, Consultant Paediatrician, Whittington Health)

⁹⁸ [FGM 0012](#) (Professor Lisa Avalos), [FGM 0022](#) (Intercollegiate Group on tackling FGM), [FGM 0026](#) (Tackling FGM Initiative), [FGM 0041](#) (Dr Comfort Momoh), and [FGM 0052](#) (Royal College of General Practitioners)

⁹⁹ [Q231](#) (FORWARD)

¹⁰⁰ [Q379](#) (Dr Comfort Momoh, African Well Women's Clinic, Guy's and St Thomas' Hospitals)

where FGM is practised, then her daughters, future children, younger sisters and other younger female family members should be considered at risk, and preventative measures put in place. But at present there is no consistent approach for identifying at-risk girls and monitoring them throughout their childhood. This process should start before the child is even born. We recommend that the FGM status of the mother and her intentions for the child if it is a girl be made a compulsory question at the antenatal booking interview. This would provide an opportunity to discuss the issue frankly, but sensitively. It would enable better preparation for the delivery, and where the question is not relevant to the mother, it will serve to raise awareness of the issue.

57. Where a girl is born to a mother who has undergone FGM, or where there is perceived to be a risk to the child, we believe the NHS should, as a matter of policy, make a referral to children's social care, or the local multi-agency safeguarding hub, so that an action plan for the safeguarding of that child can be developed and implemented. We welcome the pilot in London to implement such an approach, and hope that it will inform a national roll-out as soon as possible. Furthermore, we recommend the Royal College of Paediatrics and Child Health amend the Personal Child Health Record, or Red Book, to include a specific reference to the risk of FGM to the child, and any safeguarding steps that have been taken. FGM should also form part of the standard questioning for women registering for the first time at GP practices. To support these recommendations, the NHS in conjunction with social care agencies must establish clear referral pathways, which are understood by health professionals so that they feel confident using them. We do not accept that patient confidentiality should prevent practitioners from making a referral where a child is at risk: as with any other form of child abuse, the law allows for disclosure where it is in the best interests of the child.

The role of schools

58. Schools potentially have an important dual role in tackling FGM—first by identifying potential or actual victims, and second by raising awareness about the practice among pupils. In respect of the former, teachers, particularly in primary schools, may be the first to become aware that a girl who is from an FGM-practising country is due to take an extended holiday to her home country. They may also be the first person with safeguarding responsibilities to become aware that a girl has taken an extended break from school, or may be displaying behaviour that indicates they are in pain or discomfort. In these situations it should be the school's duty to make a referral to children's social care and the police, in the same way as would happen for other forms of child abuse. However, as noted above, many teachers do not know how to respond in these situations. For example, a YouGov survey of 1,000 teachers in 2013 found that four out of five had not had FGM child protection training on identifying at-risk girls, and seven out of 10 were not aware

that there was Government guidance on how they should respond.¹⁰¹ Muna Hasan from Integrate Bristol summed up the implications of this lack of awareness:

Teachers [...] will be the first point of contact. A child might go to them and be like, "I am scared of having FGM", or "I know someone who will have FGM". If your teacher does not even know what it is, how are they supposed to protect you?¹⁰²

59. The key role of schools in responding to FGM was the subject of an e-petition in 2014, which gathered more than 234,000 signatures. Launched by the Fahma Mohamed, a student in Bristol, it called on the Secretary of State for Education to write to headteachers before the summer holidays to take all steps to protect children in their schools from the risk of FGM.¹⁰³ In response, the Department wrote to all headteachers on 3 April, launching *Keeping Children Safe in Education*, the Department's updated safeguarding guidance for schools, which for the first time contains explicit reference to FGM. Between 3 and 29 April, the web page hosting the guidance received 65,729 page views, but we were disappointed to learn that as of 30 April, only 43 per cent of recipients had opened the email, and that only 30.5 per cent of recipients had clicked through to the guidance itself.¹⁰⁴

60. A number of witnesses told us teachers needed to be fully trained to have an awareness and understanding of FGM as part of their safeguarding responsibilities.¹⁰⁵ However, the National Association of Head Teachers told us it believed many schools were ignorant about FGM.¹⁰⁶ In 2013 Ofsted wrote to all head teachers to highlight that it had updated its supplementary guidance on inspecting safeguarding to include forced marriage and FGM. For example, inspectors are now encouraged, where appropriate, to ask whether designated senior staff for child protection are aware of the issue and have ensured that staff in the school are aware of the potential risks. However, it is not clear to what extent Ofsted inspectors have asked questions on these issues in school inspections to date.¹⁰⁷

61. The second role for schools in tackling FGM is by talking about the subject with pupils. At present, discussion of FGM in schools varies considerably across England, with pockets of good practice in areas such as Bristol, for example, thanks to the work of the charity Integrate Bristol. But many schools do not address the issue at all. One respondent to Fahma Mohamed's e-petition said: "My school has a large Somali majority. We know FGM is a big issue, but we never mention it". Another said: "I am very aware of the trauma this causes girls I have taught. It is something they can't talk about because there is no 'box' for

¹⁰¹ [FGM 0004](#) (NSPCC), para 13

¹⁰² [Q68](#) (Muna Hasan, Integrate Bristol)

¹⁰³ [FGM 0033](#) (Fahma Mohamed) and [FGM 0039](#) (Guardian News Media)

¹⁰⁴ Official Report, 6 May 2014, column 61W, pupils: safety

¹⁰⁵ [FGM 0012](#) (Professor Lisa Avalos), [FGM 0019](#) (Avon and Somerset Constabulary), [FGM 0022](#) (Intercollegiate Group on tackling FGM), and [FGM 0041](#) (Dr Comfort Momoh, African Well Women's Clinic, Guy's and St Thomas' Hospitals); [Q68](#) (Muna Hasan, Integrate Bristol)

¹⁰⁶ [FGM 0036](#) (National Association of Head Teachers), para 2.3

¹⁰⁷ [FGM 0039](#) (Guardian News and Media), para 6

it in Personal, Social and Health Education (PSHE) or in pastoral programmes with form tutors".¹⁰⁸

62. Many of our witnesses told us FGM should form a compulsory part of personal, social and health education provision, that it should be taught within the wider context of violence against women, and that it should include both girls and boys.¹⁰⁹ The NSPCC, for example, said it was perhaps the most important aspect of preventative work that could be done with young women because educating the current generation to question the practice has the potential to break the inter-generational cycle of FGM.¹¹⁰ Leyla Hussein and Muna Hasan told us this already happened in countries such as the Netherlands and Sweden, where FGM is discussed openly among pupils within the context of tackling violence against women and girls.¹¹¹ The Metropolitan Police also noted that encouraging greater discussion around FGM in schools was likely to increase the level of reporting. Assistant Commissioner Rowley told us, "it is education that changes it from being socially acceptable [...] to socially unacceptable, which generates more witnesses and victims coming forward and would help achieve more prosecutions".¹¹²

63. At present PSHE is a non-statutory subject. The Government's policy is to allow teachers flexibility to develop a PSHE programme that meets the needs of their pupils, rather than to set a standardised curriculum. The PSHE Association provides learning tools to help teachers who wish to give lessons on FGM, but schools are not under an obligation to include FGM in the curriculum. Christine Townsend from Integrate Bristol, for example, told us how she had to battle every year to ensure timetable space was available for the issue.¹¹³ However, the Children and Families Minister told us that "there are many who feel that if all those aspects that are not compulsory were made compulsory, that would skew the balance too much away from the parental responsibility that still exists where it comes to children's education".¹¹⁴ However, the Parliamentary Under-Secretary of State for International Development announced in the Chamber that education on FGM "needs to be a required part of the curriculum here in high-prevalence areas".¹¹⁵ The Deputy Prime Minister said: "We want to guarantee that young men and women learn about FGM at school. We want to ensure these young people can speak out if they, their

¹⁰⁸ [FGM_0033](#) (Fahma Mohamed)

¹⁰⁹ [FGM_0008](#) (Bar Human Rights Committee), para 9, [FGM_0010](#) (28 Too Many), [FGM_0019](#) (Avon and Somerset Constabulary), para 30, [FGM_0022](#) (Intercollegiate Group on tackling FGM), [FGM_0033](#) (Fahma Mohamed), para 4, [FGM_0041](#) (Dr Comfort Momoh, African Well Women's Clinic, Guy's and St Thomas' Hospitals), [FGM_0045](#) (Mayor of London's Harmful Practices Taskforce), and [FGM_0048](#) (Equality and Human Rights Commission), para 26; [Q21](#) (Leyla Hussein, Daughters of Eve), [Q56](#) (Muna Hasan and Christine Townsend, Integrate Bristol), [Q207](#) (Metropolitan Police Service), and [Q244](#) (NSPCC and FORWARD)

¹¹⁰ [Q244](#) (NSPCC)

¹¹¹ [Q30](#) (Leyla Hussein, Daughters of Eve) and [Q50](#) (Muna Hasan, Integrate Bristol)

¹¹² [Q216](#) (Metropolitan Police Service)

¹¹³ [Q55](#) (Christine Townsend, Integrate Bristol)

¹¹⁴ [Q277](#) (Parliamentary Under Secretary of State for Children and Families)

¹¹⁵ House of Commons Official Report, 18 June 2014, column 1101

sisters, cousins or friends are in danger and that they know where to go if they need help".¹¹⁶

64. Professionals in schools, including teachers and school nurses, have the most regular and ongoing interaction with young people outside of their homes. They are in the best position to detect the warning signs that a girl may be at risk of FGM, or has already undergone the procedure. It is vital that school staff have an awareness of these indicators, and know when to refer the matter to children's social care and the police.

65. We commend the Secretary of State for Education's decision to write to every school to highlight his Department's revised safeguarding guidance, which for the first time raises FGM. However, it is deeply disappointing that almost 70 per cent of the recipients of the guidance did not even look at it in the month after its publication. We recommend that the Secretary of State for Education resend the guidance to all head teachers and child protection officers. To ensure that the guidance has been looked at, the Department for Education should link the receipt of a proportion of school funding that relates to social education and child protection to the electronic notification that the guidance has been viewed.

66. We further recommend that head teachers and child protection officers, where they have not already done so, undergo compulsory safeguarding training which specifically deals with FGM. This training should be disseminated to all teaching staff through schools dedicating time during the remaining in-service training days in 2014 to provide guidance on child safeguarding in respect of FGM and forced marriage. In addition, we recommend that Ofsted publish a progress report setting out the number and proportion of its inspections to date that have explicitly asked about safeguarding against FGM, and the outcome of those inspections.

67. We note that the large majority of our witnesses felt that Personal, Social and Health Education (PSHE) should be made compulsory, with FGM included as part of a wider curriculum on tackling violence against women and girls. It is important that teachers and pupils have an opportunity to discuss issues such as FGM, especially where a proportion of the school population may come from a practising community. We recommend that, where Ofsted assesses PSHE provision in schools, it explicitly examines the school's approach to education on FGM and violence against women. Empowering children to discuss the issue openly will increase the likelihood of breaking the inter-generational cycle of FGM, and will also increase the level of reporting, in so doing helping to ensure the safeguarding of at-risk girls. We recommend that PSHE be made compulsory, including teaching children about FGM in high-prevalence areas.

¹¹⁶ Speech given on 28 May 2014 by the Deputy Prime Minister

The role of children's social care

68. It is the duty of social care professionals to co-ordinate the most appropriate response when it receives a referral for a child from either health or education practitioners. Where the referral is for a girl who is seen to be at risk, children's social care should draw up an action plan in collaboration with, for example, health visitors, school nurses and FGM voluntary organisations, to follow the matter up with the parents through ongoing education and by monitoring the girl throughout her childhood.¹¹⁷ Where the girl has already undergone FGM or is seen as being at immediate risk, the response should include the police. If FGM has taken place, as well as providing counselling and medical support for the child, social care should also look at whether there are other girls at-risk within the family, and draw up an action plan for their protection.

69. Several witnesses raised concern that when health and education professionals do make a referral to children's social care, it is either ignored, or they are told that the case does not meet their risk threshold for intervention.¹¹⁸ The Royal College of General Practitioners told us, for example, it would like to see referral thresholds clarified and developed both nationally and at the level of local safeguarding children boards.¹¹⁹ The Metropolitan Police Service also raised concern that social services in London did not always inform the police when an FGM-related referral had been made.¹²⁰ It pointed to the London Safeguarding Children Board's *Safeguarding children at risk of female genital mutilation* guidance, which states that: "A girl who has undergone FGM should not normally be subject to a child protection conference or registered unless additional child protection concerns exist. However, she should be offered counselling and medical help". The MPS argued that if it did not receive such information where a crime had been committed, this made its efforts to prosecute for FGM more difficult. However, the London Safeguarding Children's Board told us the guidance stated clearly elsewhere that the police should automatically be included in any strategy meeting arising from an FGM-related referral.¹²¹

70. When social services consider a referral it is important that it results in an appropriate response. However, witnesses also expressed concern in this regard. Dr Comfort Momoh told us her efforts to work with social services in two south London boroughs had been hampered because they were not aware of what their roles and responsibilities were. She said: "Each time they say, 'Even if you refer cases to us, what are we going to? We don't have the capacity and we don't know what to do'".¹²² In other cases social workers who were unsure about how to respond to information about girls at risk had simply passed the responsibility for their protection on to community organisations. At the other end of the

¹¹⁷ [FGM 0022](#) (Intercollegiate Group on tackling FGM)

¹¹⁸ [FGM 0018](#) (ACCM (UK)), [FGM 0022](#) (Intercollegiate Group on tackling FGM), para 16, and [FGM 0026](#) (Tackling FGM Initiative), para 1; [Q311](#) (Royal College of Midwives)

¹¹⁹ [FGM 0052](#) (Royal College of General Practitioners), para 52

¹²⁰ [FGM 0025](#) (Metropolitan Police Service), para 20-21

¹²¹ [FGM 0057](#) (London Safeguarding Children Board)

¹²² [Q379](#) (Dr Comfort Momoh, African Well Women's Clinic, Guy's and St Thomas' Hospitals)

spectrum social services have also been criticised for overreacting because they have not known how to assess the risk. The Tackling FGM Initiative told there had been a number of cases where social services had removed children from their families following reported concerns, without conducting any investigations or assessments.¹²³ However, there have also been examples of good practice, especially where social services have worked closely with community groups to visit families together. The practice of signing agreements to not perform FGM with families at risk has also proven effective.¹²⁴

71. Children’s social care has an essential role in responding to referrals made by healthcare and education professionals, and others, and in developing an appropriate response that safeguards the child. It is concerning that many of those who make FGM-related referrals believe that the threshold for social care intervention is often too high. We recommend that the Department for Education investigate this issue with local safeguarding children boards. We are also concerned that some children’s social care services fail to respond to referrals effectively either by not responding at all, or by overreacting. All local safeguarding children boards need to develop clear and consistent risk assessment protocols so that an appropriate action plan is put in place for every child referred to social services. This is particularly the case if efforts to increase the number of referrals from the health and education sectors are to be successful.

The role of the police

72. Whilst the overall responsibility for leading any response for at-risk children lies with the local authority through social services, the police will usually assist with their safeguarding duties, particularly where the child is at immediate risk, or is believed to have already undergone FGM. ACPO told us that in the last five years the police had dealt with over 200 FGM-related cases nationally, though mostly in London and the West Midlands, of which 11 had been referred on to the Crown Prosecution Service for consideration.¹²⁵

73. Most police activity on FGM involves child safeguarding rather than investigating a crime allegation. For example, of the 69 referrals made to the Metropolitan Police Service in 2013, only 10 were recorded as an FGM offence. The circumstances of the 59 other referrals included instances where a referral had been made by a third party about a perceived risk; where a child had come to the attention of the authorities as having had FGM abroad prior to coming to the UK; and where a mother has had FGM and a risk assessment has been undertaken on the family as to whether the newborn is at risk. In all these cases the MPS told us it undertook a review and safeguarding activity alongside other agencies. Indeed, the Met noted that “Safeguarding is the optimal outcome as it prevents harm, but this does not form part of current debates on the policing response to FGM”.¹²⁶

¹²³ [FGM 0026](#) (Tackling FGM Initiative), para 1

¹²⁴ *Ibid.*

¹²⁵ [Q135](#) and [Q136](#) (Association of Chief Police Officers)

¹²⁶ [FGM 0025](#) (Metropolitan Police Service), para 25, 26 and 29

Elsewhere, Avon and Somerset Constabulary told us its officers consider visiting every family relating to an FGM referral irrespective of whether there is evidence of a crime, partly to collect better intelligence, but also to reinforce the message about the law and to signpost for advice.¹²⁷

74. The low level of reporting means that responding police officers often do not have the experience or competence required to feel confident in the investigation of FGM cases.¹²⁸ Although the Police and Crime Commissioner for Northumbria told us training in honour-based violence and FGM was provided to all new police recruits, community support officers, call handlers and investigators, the PCC for Greater Manchester told us: “There is little awareness of the issue within current policing procedures and practices, and minimal training”.¹²⁹ Avon and Somerset Constabulary also noted that the low level of reporting made it difficult to bid for further investment in the police’s work against other policing priorities.¹³⁰

75. In response to the low level of reporting to the police, some forces have sought to take a more proactive and intelligence-led approach. For example, this year eight police forces will be working together at five airports on airport-side operations during a period when it is most likely that girls will be taken out of the country.¹³¹ These kinds of operations have been successful in the past when undertaken in partnership with community organisations. For the last few years under the banner of Project Azure, the Metropolitan Police has taken a more proactive approach through a range of initiatives. For example, it leads the FGM Strategy Group, which led to the creation of an information sharing protocol between the police and the NHS, as well as intelligence development and greater engagement with schools and the third sector. It also provides training to child abuse investigation teams who undertake all FGM-related investigations. In addition, it implemented Operation Limelight—an awareness and intervention campaign targeted at people travelling to and from high-risk countries.¹³² However, a former consultant to the MPS told us that, despite these activities, the Metropolitan Police had still not succeeded in securing a conviction for FGM, and that this was due in part to the fact that the level of resource provided to Project Azure had not reflected the scale of the problem in London.¹³³

76. The police have an important dual role to play in tackling FGM, both by working with children’s social care and other agencies to safeguard at-risk children, and in investigating where a crime may have taken place. Given the low level of referrals to the police to date, we welcome the more proactive approach recently taken by forces such as

¹²⁷ [FGM 0019](#) (Avon and Somerset Constabulary), para 27

¹²⁸ [FGM 0019](#) (Avon and Somerset Constabulary), para 16

¹²⁹ [FGM 0016](#) (Police and Crime Commissioner for Northumbria) and [FGM 0040](#) (Police and Crime Commissioner for Greater Manchester)

¹³⁰ [FGM 0019](#) (Avon and Somerset Constabulary), para 15

¹³¹ [Q147](#) (Association of Chief Police Officers)

¹³² [FGM 0025](#) (Metropolitan Police Service), para 9

¹³³ [FGM 0021](#) (Ralph Tilby)

the Metropolitan Police Service, particularly its recent operations in airports. We believe forces need to ensure that officers receive training to respond appropriately to referrals, and are able to work effectively with grass-roots organisations to break down barriers with affected communities. We were extremely disappointed in the role of ACPO and its lead, who appear to have made little effort to tackle the problem faced, and have shown a distinct lack of leadership in this matter.

The role of the third sector

77. Third sector organisations such as FORWARD, Daughters of Eve, Orchid Project, 28 Too Many, Bawso, the Tackling FGM Initiative, the Hawa Trust, Integrate Bristol and others have arguably been responsible for raising FGM up the political agenda in recent years and shaping Government policy. Despite very little funding, such groups have worked in a variety of ways to raise awareness of FGM and tackle the practice. For example, some groups have been responsible for developing awareness-raising programmes within communities in partnership with health, education and safeguarding professionals. The Tackling FGM Initiative told us grass-roots organisations were often best-placed to carry out this type of work because they were more likely to be trusted by the communities they worked within.¹³⁴ For the same reason, such groups have also been effective at working with social services to conduct family visits where there are at-risk children in order to inform them about the law, and also by taking part in safeguarding case conferences. In addition, third sector organisations have been at the forefront in providing training for frontline practitioners on their responsibilities, and how to raise FGM sensitively. FORWARD, for example, trained more than 1,500 professionals in 2013.¹³⁵ Elsewhere, the teacher and youth worker-run Integrate Bristol organisation has been carrying out pioneering work in recent years, empowering pupils to talk openly about FGM and challenge the practice within their communities.¹³⁶ Overall, the National Association of Head Teachers told us the voluntary sector was leading the way, and that: “The depth of knowledge and expertise possessed by these and other bodies is a rich resource”.¹³⁷

78. The NSPCC has also done a considerable amount of work on FGM in recent years. In June 2013 it established a specialist FGM hotline, in conjunction with the MPS and the Home Office. The hotline exists for anyone who is concerned that a child’s welfare is at risk. Although callers’ details can remain anonymous, any information that could protect a child is referred to the police or social services.¹³⁸ As of 31 March 2014 the line had received 198 calls and emails, resulting in 87 referrals to the police.¹³⁹ However, the NSPCC described this as “just the tip of the iceberg”, noting that more people were coming forward

¹³⁴ [FGM 0026](#) (Tackling FGM Initiative)

¹³⁵ [FGM 0047](#) (FORWARD), para 34

¹³⁶ [Q47](#) (Christine Townsend, Integrate Bristol) and [Q48](#) (Muna Hasan, Integrate Bristol)

¹³⁷ [FGM 0036](#) (National Association of Head Teachers), para 3.4

¹³⁸ [FGM 0004](#) (NSPCC), para 8

¹³⁹ [FGM 0056](#) (NSPCC)

to report concerns in recent months because of the increased level of awareness and debate around the issue.¹⁴⁰ The charity also received 20 FGM-related calls to its ChildLine between 1 April 2013 and the end of the year—17 from children contacting about a personal concern, and the remainder from children with concerns for another child.

79. The importance of third sector organisations in working with other agencies to safeguard at-risk girls cannot be understated. Their role in raising awareness, training professionals, and working with affected communities is vital to tackling FGM in the UK. To date they have achieved this with very little financial support. The Government must provide additional funding to increase significantly the capacity of grass-roots groups, and to encourage the roll-out of best practice from groups such as Integrate Bristol. We support the NSPCC’s FGM helpline, which has significantly increased the number of police referrals, though the charity itself believes this is the tip of the iceberg. The Government therefore needs to do much more to promote awareness of the helpline’s existence among frontline practitioners and practising communities.

80. Overall, the safeguarding of girls and young women at risk of FGM requires the development of a multi-agency approach with co-operation between all those who come into contact with children—health, education, social care, the police and others. FGM is child abuse and needs to be treated accordingly through existing child protection and safeguarding system. This requires a much greater emphasis on the collection and sharing of information, and the development of clear referral pathways that are well-understood and used by frontline practitioners.

Raising awareness

81. A consistent message from our evidence was the importance of the Government’s role in raising awareness of FGM. At present there is a lack of awareness of the legislation on FGM, of how to make a referral, and of the services available for survivors. To date, however, support for awareness-raising has been poorly funded, piecemeal, and largely left to grass-roots organisations and campaigns in the national media. In November 2013 the Government received an award of €300,000 from the European Union to fund a communications campaign on FGM. It has also supported initiatives such as the International Day of Zero Tolerance to FGM, on which this year the Government published a declaration setting out the programme of work it had underway to tackle FGM.

82. One Government initiative has been the ‘Statement Opposing Female Genital Mutilation’ leaflet, which it launched in October 2012. This is a pocket-sized document, which explains the law and potential penalties that can be used against those who commit, or assist someone else to commit, FGM.¹⁴¹ It is designed to be carried in a purse or the back of a passport, and is for families who have recently entered the UK, who do not wish their

¹⁴⁰ [Q235](#) (NSPCC)

¹⁴¹ [FGM 0029](#) (Government), para 31

children to undergo FGM, but are subject to social pressure to do so when visiting their families abroad. It is based on the 'Health Passport', introduced in 2011 in the Netherlands, where an estimated 21,000 women have undergone FGM.¹⁴² The UK Government has distributed over 41,000 statements to date. The Tackling FGM Initiative told us they had been well-received, though it was not clear to what extent girls were taking them abroad. Other concerns raised about the statements included the fact that use of the term 'female genital mutilation' risked alienating their target audience; that the language in the statement could be simpler and less legalistic; that the statement could also explain better the health consequences of FGM; and that there had been a lack of publicity and promotion for the statement.¹⁴³ It was also noted that the statement should be integrated as part of a much wider range of initiatives with communities.¹⁴⁴

83. Many of our witnesses, including the Intercollegiate Group, 28 Too Many, the Tackling FGM Initiative, FORWARD, and ACPO, emphasised the need for a comprehensive and ongoing national awareness campaign.¹⁴⁵ They told us it should be multifaceted—separately targeting health, education, social care and other frontline professionals, practising communities, and the wider general public. For example, ACPO told us: "it is essential that there is a unified communication strategy at a national level".¹⁴⁶ Such a campaign would need to operate at different levels and use a range of media. This should include the use of leaflets and posters in GPs' practices, A&E, nurseries, schools, community centres, youth clubs, churches, mosques etc.¹⁴⁷ It should also make use of community media, as well as the wider media. It could also take the form of information provided routinely to new arrivals to the UK from FGM-practising countries. Witnesses suggested that the content of such a campaign should seek to raise awareness of the illegality of FGM and the health risks associated with it, as well as providing information to practitioners seeking advice on making a referral, and signposting women who have undergone FGM to the services that are available to them.

84. There is a clear case for a national FGM awareness campaign, on the same scale as historic public health campaigns on domestic violence and HIV/AIDS. For too long it has been left to grass-roots campaigners and the national media to do this work. And whilst we welcome the €300,000 of EU funding for awareness-raising, it is not sufficient. We recommend the Government provide funding to implement a national

¹⁴² Marja Exterkate, *Female Genital Mutilation in the Netherlands: Prevalence, Incidence and Determinants*, January 2013

¹⁴³ [FGM 0010](#) (28 Too Many), para 3.5.2, and [FGM 0012](#) (Professor Lisa Avalos)

¹⁴⁴ [FGM 0012](#) (Professor Lisa Avalos)

¹⁴⁵ [FGM 0008](#) (Bar Human Rights Committee), para 8, [FGM 0010](#) (28 Too Many), para 3.5.3, [FGM 0011](#) (International Association of Women Police), [FGM 0019](#) (Avon and Somerset Constabulary), para 40, [FGM 0022](#) (Intercollegiate Group on tackling FGM), para 25, [FGM 0023](#) (Juliet Albert), [FGM 0026](#) (Tackling FGM Initiative), [FGM 0040](#) (Police and Crime Commissioner for Greater Manchester), [FGM 0043](#) (Dr Deborah Hodes), [FGM 0046](#) (Association of Chief Police Officers), and [FGM 0047](#) (FORWARD), para 46; [Q371](#) (Royal College of Midwives), [Q387](#) (Dr Kerry Robinson, Consultant Paediatrician, Whittington Health), and [Q394](#) (Dr Comfort Momoh, Guys' and St Thomas' African Well Women's Clinic, and the Community Practitioners and Health Visitors Association)

¹⁴⁶ [FGM 0046](#) (Association of Chief Police Officers), para 84

¹⁴⁷ [FGM 0022](#) (Intercollegiate Group on tackling FGM), para 25 and [FGM 0043](#) (Dr Deborah Hodes)

campaign that targets frontline professionals, practising communities, including at-risk girls, as well as the wider general public. The campaign should carry the unambiguous message that FGM is a serious crime and child abuse. It should also signpost practitioners who are unsure as to how to make a referral, and women who have undergone FGM and are seeking support.

4 Changing the law

85. FGM was first made a specific criminal offence in England and Wales under the Prohibition of Female Circumcision Act 1985. This was repealed and replaced by the Female Genital Mutilation Act 2003 in England, Wales and Northern Ireland, and the Prohibition of Female Genital Mutilation (Scotland) Act 2005 in Scotland. Both Acts extended the offence of FGM to cover acts committed outside the UK by UK nationals or permanent UK residents. They also increased the maximum penalty on conviction from five to 14 years' imprisonment. The failure to achieve any prosecutions under existing legislation has caused many to question the effectiveness of the 2003 Act. Leyla Hussein from Daughters of Eve, and Muna Hasan from Integrate Bristol argued that existing legislation should be sufficient to safeguard at-risk girls and prosecute where necessary.¹⁴⁸ However, we also received evidence suggesting various potential improvements to the law, which would improve child protection and increase the likelihood of a successful prosecution.

Residency status

86. Section 3 of the 2003 Act makes it a criminal offence to aid, abet, counsel or procure FGM for a girl outside of the UK. However, the Act applies only to UK nationals or permanent UK residents. A number of witnesses told us this created a loophole that failed to protect girls who had a different residency status who were taken out of the country to undergo FGM.¹⁴⁹ For example, girls whose parents have temporary residency status, such as refugees or students, would not be covered under the legislation. The Bar Human Rights Committee argues that "this gap in the law not only fails to reflect the highly mobile nature of the affected communities, but is morally indefensible".¹⁵⁰ FORWARD noted that as a signatory to the Council of Europe Convention on preventing and combating violence against women and domestic violence (known as the Istanbul Convention), the UK had a responsibility to protect all girls and young women at risk of FGM, regardless of their residency status.¹⁵¹ The Metropolitan Police told us it was currently investigating a number of cases where the residency status of the individuals concerned potentially hampered the ability to proceed to a prosecution.¹⁵² Indeed, FORWARD also told us:

In some cases where people do not have permanent residency—if they are here on work visas, student visas [...] Their daughters are not protected, and

¹⁴⁸ [Q36](#) (Leyla Hussein, Daughters of Eve) and [Q64](#) (Muna Hasan, Integrate Bristol)

¹⁴⁹ [FGM 0008](#) (Bar Human Rights Committee), para 38, [FGM 0010](#) (28 Too Many), para 3.1.5, [FGM 0022](#) (Intercollegiate Group on tackling FGM), [FGM 0025](#) (Metropolitan Police Service), para 34, [FGM 0026](#) (Tackling FGM Initiative), para 6, [FGM 0028](#) (Rights of Women and Asylum Aid), para 15, [FGM 0031](#) (Muslim Women's Network), para 13, [FGM 0046](#) (Association of Chief Police Officers), para 14-15, [FGM 0047](#) (FORWARD), para 15-16, and [FGM 0050](#) (Crown Prosecution Service), para 29

¹⁵⁰ [FGM 0008](#) (Bar Human Rights Committee), para 38

¹⁵¹ [FGM 0047](#) (FORWARD), para 16

¹⁵² [FGM 0025](#) (Metropolitan Police Service), para 34

there have been cases where people have said, “Our intention is to have FGM done. We will have it when we leave the country. There is nothing really anyone can do”.¹⁵³

87. In February 2014 the Director of Public Prosecutions wrote to Ministers in the Home Office, Ministry of Justice, and Department of Health identifying possible ways of strengthening the criminal law on FGM. She raised extending the scope of extra-territorial offences as one potential area for improvement. We were pleased to see, therefore, that in June 2014 the Government announced in the Queen’s Speech that it intended to extend the provisions of the 2003 Act to cover foreign nationals who are ‘habitually resident’ in the UK.

Reinfibulation

88. The Director of Public Prosecutions’ letter to Ministers also asked for clarification of the law in respect of reinfibulation. Because infibulation, also referred to as Type 3 FGM, involves the narrowing of the vaginal orifice, it needs to be opened up during childbirth. The Intercollegiate Group told us there have been cases where women who were de-infibulated during delivery had returned in subsequent pregnancies having undergone re-stitching, i.e. reinfibulation. However, the existing legislation refers only to infibulation. The Crown Prosecution Service, the Metropolitan Police, ACPO, the Intercollegiate Group and others all told us this meant there was a lack of clarity as to whether reinfibulation was covered by legislation.¹⁵⁴

Female genital cosmetic surgery

89. Female genital cosmetic surgery (FGCS) is an increasingly popular form of surgery. For example, there has been a fivefold increase in the number of labiaplasty procedures—the most common form of FGCS—in the last 10 years. However, FORWARD told us such procedures are often very similar to Type 1 and Type 2 FGM, and can result in comparable health complications such as reduced sensation, infection and bleeding, and wound dehiscence.¹⁵⁵ FGCS is mainly performed in the private sector, and so is not subject to the same level of regulation or monitoring as in the NHS. Both ACPO and the Metropolitan Police argued that at present there is a perceived “double standard” whereby there is a focus on practising black and ethnic minority communities, whilst in the wider community the ‘designer vagina’ private medical industry is flourishing.¹⁵⁶

90. Furthermore, section 1 of the 2003 Act allows for “a surgical operation on a girl which is necessary for her physical or mental health”, which the Mayor of London’s Harmful

¹⁵³ [Q239](#) (FORWARD)

¹⁵⁴ [FGM 0003](#) (Buckinghamshire County Council), para 6.1, [FGM 0022](#) (Intercollegiate Group on tackling FGM), para 7, [FGM 0025](#) (Metropolitan Police Service), para 36, [FGM 0045](#) (Mayor of London’s Harmful Practices Taskforce), [FGM 0046](#) (Association of Chief Police Officers), para 18-23, and [FGM 0050](#) (Crown Prosecution Service), para 29

¹⁵⁵ [FGM 0047](#) (FORWARD), para 18-19

¹⁵⁶ [FGM 0025](#) (Metropolitan Police Service), para 37-39, and [FGM 0046](#) (Association of Chief Police Officers), para 27-30

Practices Taskforce argued creates a loophole that potentially allows medical practitioners in the private cosmetic industry to conduct FGM with impunity.¹⁵⁷ FORWARD pointed to a recent position paper by the Royal College of Obstetricians and Gynaecologists and the British Society for Paediatric and Adolescent Gynaecology, which recommended that FGCS should not be carried out on girls under the age of 18.

Protection orders

91. The Ministry of Justice is currently considering whether to introduce a civil law option as an additional tool for tackling FGM. The idea would be that those afraid of being subjected to FGM, or those concerned for someone seen to be at risk, could apply for an order to place the potential victim under the protection of the court.¹⁵⁸ The Bar Human Rights Committee, the Muslim Women's Network and ACPO all advocated the introduction of 'FGM protection orders', modelled on existing forced marriage protection orders, which have been used more than 600 times to date.¹⁵⁹ The potential powers under such orders could include the prohibition of foreign travel, residence reporting, and mandatory examinations. They would also have the advantage of not requiring the removal of children from their parents, which remains the option of last resort for children's social care and the police, for children seen as at immediate risk. The Government told us it plans to seek the views of stakeholders on the merits of such a civil law measure, and how it might work alongside the criminal legislation, before proceeding further.

Parental responsibility

92. A further legislative measure would be to place a positive duty on parents or carers to prevent their children from being mutilated by someone else, or on the instigation of someone else. A number of witnesses supported this proposal, in part because it would alleviate the need for children to give evidence or identify who performed the procedure on them.¹⁶⁰ The Intercollegiate Group, for example, told us: "The law does not see FGM as a criminal dereliction of parents' and guardians' duty to protect their children [...] there is a need to shift responsibility onto parents".¹⁶¹ Elsewhere, ACPO told us: "Where parents of a potential victim of FGM have been aware that their child is to undergo the procedure, consideration must be given to their liability".¹⁶² The Director of Public Prosecutions also made this proposal, which would require an amendment to the Domestic Violence,

¹⁵⁷ [FGM 0045](#) (Mayor of London's Harmful Practices Taskforce)

¹⁵⁸ [FGM 0029](#) (Government), para 12

¹⁵⁹ [FGM 0008](#) (Bar Human Rights Committee), and [FGM 0031](#) (Muslim Women's Network), para 12; [Q153](#) and [Q154](#) (Association of Chief Police Officers)

¹⁶⁰ [FGM 0001](#) (Children and Families Across Borders), para 1, [FGM 0019](#) (Avon and Somerset Constabulary), para 5-6, [FGM 0022](#) (Intercollegiate Group on tackling FGM), para 4, [FGM 0031](#) (Muslim Women's Network), para 10, [FGM 0046](#) (Association of Chief Police Officers), para 24-26, and [FGM 0050](#) (Crown Prosecution Service), para 29; [Q337](#) (Royal College of Midwives)

¹⁶¹ [FGM 0022](#) (Intercollegiate Group on tackling FGM), para 4

¹⁶² [FGM 0046](#) (Association of Chief Police Officers), para 24

Children and Victims Act 2004, in her letter to Ministers in February. In oral evidence, she highlighted the fact that in Spain the first prosecutions have been brought against parents using this approach.¹⁶³

Statutory reporting

93. Section 47 of the Children Act 1989 places a statutory duty on professionals who work with children to make a report to children's social care where they have concerns that the child is suffering, or likely to suffer, significant harm. This is supported by, for example, the Department for Education's guidance, *Keeping children safe in education*, which we discussed in Chapter 3. However, as the Royal College of Midwives noted: "the existing imperatives upon professionals to report have been around for a long while, but professionals have failed to do so".¹⁶⁴ This has been reflected in the very low number of FGM-related referrals relative to the likely number of girls who are at risk.

94. Despite the existing obligation to report concerns, a number of witnesses were in favour of strengthening the statutory requirements further, for example, by making the failure to report a criminal offence. This is the case in France where non-assistance to a person in danger can lead to five years' imprisonment or a €75,000 fine.¹⁶⁵ The Director of Public Prosecutions told us she had called on the Government to introduce "a new statutory duty on health and education professionals to report cases where they suspect a girl has undergone FGM or is at risk of FGM".¹⁶⁶ ACPO, FORWARD, the Bar Human Rights Committee, 28 Too Many, and others also supported the need to strengthen the existing legislation.¹⁶⁷

95. However, other witnesses, including the Government, the NSPCC, and the Royal College of General Practitioners, believed the existing statutory system for reporting was sufficient.¹⁶⁸ Rather, it was a failure of professionals to view FGM as child abuse and respond accordingly that was the problem. The NSPCC, for example, noted that strengthening the requirements on professionals to report could lead to over-reporting, and may deter children from making a disclosure in the first place.¹⁶⁹ The Royal College of Obstetricians and Gynaecologists and the Government also expressed concern that such a requirement would result in the reporting of adult women who had undergone FGM many years previously at a time when it may not have been a criminal offence, and who did not

¹⁶³ [Q96](#) and [Q102](#) (Director of Public Prosecutions)

¹⁶⁴ [Q330](#) (Royal College of Midwives)

¹⁶⁵ [FGM 0014](#) (UCL Graduate Law Society), para 4.5

¹⁶⁶ [FGM 0050](#) (Crown Prosecution Service), para 29

¹⁶⁷ [FGM 0008](#) (Bar Human Rights Committee), para 1, [FGM 0010](#) (28 Too Many), para 3.4.1, [FGM 0016](#) (Police and Crime Commissioner for Northumbria), [FGM 0027](#) (Hilary Burrage), and [FGM 0031](#) (Muslim Women's Network), para 19; [Q140](#) (Association of Chief Police Officers) and [Q231](#) and [Q242](#) (FORWARD)

¹⁶⁸ [Q242](#) (NSPCC), [Q258](#) (Parliamentary Under Secretary of State for Public Health), and [Q298](#) (Royal College of General Practitioners)

¹⁶⁹ *Ibid.*

plan to have the procedure carried out on their daughters.¹⁷⁰ The Equality and Human Rights Commission told us existing sanctions for professionals who fail to report child abuse must be enforced rigorously against those who fail to report children who are at risk of, or victims of, FGM.¹⁷¹ In the health sector, for example, this could include the bringing of disciplinary proceedings by the General Medical Council.

96. We have previously considered the mandatory reporting of child abuse in our 2013 Report on localised child grooming, which recommended that the Government should examine the case for strengthening the law.¹⁷² In response the Government told us:

The international evidence on the effectiveness of mandatory reporting systems keeping children safer is far from conclusive. Much of the evidence suggests that mandatory reporting systems cause a steep rise in the number of reports made, a large percentage of which are not substantiated. Consequently, child protection services are likely to be overloaded with work in investigating unsubstantiated reports, with an adverse impact on the resources available to help children and families in need. A mandatory reporting system could also potentially act as a barrier to children disclosing issues or seeking help, especially perhaps in a sexual health context.

The Government, therefore, has no plans to introduce mandatory reporting of child abuse and neglect, given the robust reporting procedures already in place. There is sufficient legislation and statutory guidance to tell professionals what should happen if they are concerned about a child.

97. We believe there is a strong case for strengthening the law on FGM, principally to ensure the safeguarding of at-risk girls, but also to increase the likelihood of achieving successful prosecutions. We welcome the Government's plans to broaden the scope of the 2003 Act so that it covers girls who are habitually resident in the UK. The state has a duty of care to all those who live within its borders, regardless of their immigration status. We also recommend that the Government amend the 2003 Act to include reinfibulation. We further recommend that the Government examine the extent to which there is a double standard in the current treatment of female genital cosmetic surgery and FGM under the law, and whether there is a case for prohibiting all such surgery on girls under the age of 18, except where it is clinically indicated. We also support the introduction of FGM protection orders, and look forward to seeing proposals from the Ministry of Justice in this respect.

98. We note the Government's reluctance to strengthen the statutory reporting requirements for child abuse. It is clear, however, that many professionals still fail to view FGM as child abuse and respond accordingly. This is why the level of referrals has

¹⁷⁰ [Q302](#), [Q304](#), [Q315](#) (Royal College of Obstetricians and Gynaecologists) and 259 (Parliamentary Under Secretary of State for Public Health)

¹⁷¹ [FGM 0048](#) (Equality and Human Rights Commission), para 30

¹⁷² [Second Report of the Home Affairs Committee, Session 2013–14, Child sexual exploitation and the response to localised grooming, HC 68](#)

been much lower than the likely prevalence of FGM in the UK. New initiatives such as the pilot for automatic referral to children's social care of newborn girls to mothers with FGM, should help to address this issue, as would a fully-funded national awareness campaign. However, if in a year's time the level of reporting has not reached the level that would be expected, we recommend the Government should take steps to make the failure to report child abuse a criminal offence.

5 Working with communities

99. Consideration of practising communities in the UK must form a central part of the Government's policy on FGM. In this Chapter we make the case for engaging more effectively with communities to abandon the practice. We also assess the provision of services and support for women and girls within communities who have undergone FGM.

Community engagement

100. 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.¹⁷³ Rather, improving understanding of these social norms, and working with communities to break them down, is essential to ending the generational cycle of FGM. ACPO, for example, told us that “community-driven solutions are fundamental to engender and drive sustained change”.¹⁷⁴

101. 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.¹⁷⁵ Second, there is often a lack of awareness of the health effects associated with FGM. The Intercollegiate Group told us women suffering health complications as a result of FGM often fail to connect it with having undergone the procedure.¹⁷⁶ Third, where people believe mistakenly that it is a religious requirement, they do not feel able to challenge it. Fourth, in many communities the issue is surrounded in silence. It is taboo for young women to talk about it with their mothers or family members, and in some cases they do not know what type they have, or whether they have had it at all.¹⁷⁷ Fifth, there are some people in practising communities, such as young men, who condone FGM, but are unclear as to what it entails and the harm it causes.¹⁷⁸ Finally, an increasing difficulty for organisations working with communities is a trend away from Type 3 FGM towards what many describe as Sunna, which may vary from Type 1 to a level of infibulation.¹⁷⁹ There is only anecdotal evidence for this at present, but it has been

¹⁷³ [FGM 0004](#) (NSPCC), para 14, [FGM 0016](#) (Police and Crime Commissioner for Northumbria), [FGM 0040](#) (Police and Crime Commissioner for Greater Manchester), and [FGM 0047](#) (FORWARD), para 38

¹⁷⁴ [FGM 0046](#) (Association of Chief Police Officers), para 38

¹⁷⁵ [FGM 0026](#) (Tackling FGM Initiative), para 4, and [FGM 0030](#) (Bawso), para 3.1

¹⁷⁶ [FGM 0022](#) (Intercollegiate Group on tackling FGM), para 23

¹⁷⁷ [FGM 0026](#) (Tackling FGM Initiative), para 4

¹⁷⁸ [FGM 0031](#) (Muslim Women's Network), para 17

¹⁷⁹ [FGM 0047](#) (FORWARD), para 41

justified on the basis that it does not entail the same health effects. It is also harder to detect on children.

102. Most of our witnesses emphasised the importance of community engagement programmes as part of any national plan to tackle FGM. The range of barriers identified above means that these programmes need to adopt a variety of approaches. It is also important to have a background understanding of the distinctive features of the culture, values and beliefs of each community.¹⁸⁰ Approaches may include the provision of safeguarding lessons which include FGM as part of citizen awareness education for adults and children who have newly arrived from practising communities; engaging with community leaders, such as pastors, imams, youth leaders, and community leaders; education workshops for young unmarried women and men; and tailor-made parenting programmes.¹⁸¹ In addition, witnesses identified the importance of empowering women to question the practice, but also ensuring that men are included in the dialogue.¹⁸² For example, it is often the case that spouses do not know about their partner's attitude towards FGM.¹⁸³ FORWARD also told us that communities themselves played a crucial role in providing the advocates for change, as they were more likely to be listened to than the authorities.¹⁸⁴

103. Organisations such as the Tackling FGM Initiative and FORWARD already do a large amount of work with practising communities, despite relatively little funding. The Mayor of London's Harmful Practices Taskforce told us community engagement work needed to be expanded so that there was more consistent coverage rather than pockets of good practice.¹⁸⁵ In February 2014 the Home Office announced a new £100,000 engagement initiative, which would allow voluntary sector organisations to bid for up to £10,000 to carry out work aimed at raising awareness of FGM. However, the Equality and Human Rights Commission described this as “woefully inadequate given the seriousness of this issue and the intensive engagement needed to reach the right communities and have an impact”.¹⁸⁶

104. FGM will continue to be a problem in the UK until communities themselves choose to abandon the practice. The Government has a crucial role to play in enabling community-based initiatives that seek to break down the powerful social norms that underpin FGM. We welcome the £100,000 of funding from the Home Office to support greater engagement work by voluntary organisations. But it is not enough. To support a full-scale national action plan that is commensurate with the extent of the problem,

¹⁸⁰ [FGM 0041](#) (Dr Comfort Momoh, African Well Women's Clinic, Guy's and St Thomas' Hospitals)

¹⁸¹ [FGM 0020](#) (London Borough of Havering), and [FGM 0043](#) (Dr Deborah Hodes, Consultant Paediatrician)

¹⁸² [FGM 0035](#) (FPA and Brook), para 4.6, and [FGM 0020](#) (London Borough of Havering); [Q44](#) (Leyla Hussein, Daughters of Eve)

¹⁸³ [FGM 0043](#) (Dr Deborah Hodes, Consultant Paediatrician); [Q400](#) (Dr Kerry Robinson, Consultant Paediatrician, Whittington Health)

¹⁸⁴ [FGM 0047](#) (FORWARD), para 39

¹⁸⁵ [FGM 0045](#) (Mayor of London's Harmful Practices Taskforce)

¹⁸⁶ [FGM 0048](#) (Equality and Human Rights Commission), para 25

the Government needs to provide long-term funding that is an order of magnitude greater than that which it has committed to date.

Services and support for women and girls with FGM

105. Whilst the focus of this Report has been on preventing FGM from happening in the first place, it is important to remember that there are many thousands of women and girls in the UK who are already living with the consequences of FGM. As noted in Chapter 1, the health effects are both physical, in the form of gynaecological, reproductive and urinary complications, as well as mental. The long-term psychological effects can include strong feelings of shame and isolation, as well as depression and post-traumatic stress disorder. Many women and young people do not seek help, if they do so at all, until a number of years after undergoing the procedure. This means that FGM survivors require a number of different specialist and culturally sensitive support services and treatments. These may range from the provision of trauma counselling and safe spaces where women can share similar experiences without being judged, to the provision of deinfibulation services. Both FORWARD and the NSPCC emphasised the importance of such services being focused around the needs of the individual.¹⁸⁷

106. However, many women and girls face difficulty accessing appropriate services. This is partly because of a lack of awareness of the support that is available. It also reflects the fact that there are no clear referral pathways.¹⁸⁸ More often than not, GPs are not aware of who they need to refer women and girls on to so that they receive the right support. Even then, the level of provision itself is not sufficient. There are specialist clinics run by experienced professionals, which provide healthcare and assistance to girls and women affected by FGM. They offer gynaecological and routine antenatal care as well as deinfibulation services. They are run by female staff who have an understanding of FGM and usually provide translation services. However, there are only a small number of these clinics, and they are mostly based in London.¹⁸⁹ For example, there is no specialist clinic in Wales. FORWARD illustrated the difficulty many women face:

In one case I had a young girl in Sheffield who had undergone FGM—she was 14—the closest specialist clinic to her was Birmingham. How does a 14 year-old travel from Sheffield to Birmingham, particularly [...] if her parents were not pro her getting support or deinfibulation?¹⁹⁰

107. The provision of psychological support is particularly lacking. There is only one specialist counselling service in the country. The NSPCC told us there is no integrated support to provide therapeutic help as well as health support for survivors, other than that provided by FORWARD and other third sector organisations.¹⁹¹ Overall, Dr Comfort

¹⁸⁷ [FGM 0004](#) (NSPCC), para 6, and [FGM 0047](#) (FORWARD), para 57

¹⁸⁸ [FGM 0012](#) (Professor Lisa Avalos), [FGM 0030](#) (Bawso), para 9.1, and [FGM 0038](#) (Professor Sarah Creighton)

¹⁸⁹ [FGM 0026](#) (Tackling FGM Initiative)

¹⁹⁰ [Q243](#) (FORWARD)

¹⁹¹ [Q243](#) (NSPCC)

Momoh from the African Well Women's Clinic at Guy's and St Thomas' Hospitals described the current provision of services as "not acceptable".¹⁹²

108. Not only is the provision of clinical support and mental health services for women and girls with FGM important in its own right, the Tackling FGM Initiative highlighted the role that they play in breaking the generational cycle of FGM. It is often only in these settings that survivors begin to recognise the negative consequences FGM has had on them, and can be supported in deciding not to let their daughters undergo the procedure.¹⁹³

109. Overall, a number of witnesses told us there needed to be a significant increase in the level of funding for support services. 28 Too Many, ACCM (UK), FORWARD and others said there needed to be a significant increase in the number of specialist FGM clinics.¹⁹⁴ Such services needed to be accessible for children as well as women, and there also needed to be a much greater emphasis on the provision of services to support the mental and psychological needs of women and girls affected by FGM.

110. There is too little provision of clinical and mental health support services for the many thousands of women and girls in the UK who have undergone FGM. The NHS and commissioning groups need to ensure that the provision of services better reflects the prevalence of FGM. The services available should specifically include the provision, through NGOs or local authorities, of dedicated FGM shelters to enable women and girls to remove themselves from a position of danger. These will also provide the pastoral, medical and psychological support needed to enable those at risk to break the cycle of abuse. Overall, services should be widely publicised, sustainable, and tailored to cater to different age groups. Frontline health professionals need better training to ensure women and girls who have undergone FGM are referred appropriately and sensitively to these services. Not only would much greater investment in such services improve the lives of a great many women and girls, it would also contribute significantly to breaking the cycle of violence, so protecting future generations.

¹⁹² [FGM 0041](#) (Dr Comfort Momoh, African Well Women's Clinic, Guy's and St Thomas' Hospitals)

¹⁹³ [FGM 0026](#) (Tackling FGM Initiative)

¹⁹⁴ [FGM 0010](#) (28 Too Many), para 3.6.4, [FGM 0018](#) (ACCM (UK)), and [FGM 0047](#) (FORWARD), para 43; [O398](#) (Dr Comfort Momoh, African Well Women's Clinic, Guy's and St Thomas' Hospitals)

Conclusions and Recommendations

Introduction

1. FGM is a severe form of gender-based violence, and where it is carried out on a girl, it is an extreme form of child abuse. Everyone who has a responsibility for safeguarding children must view FGM in this way. (Paragraph 8)

2. Even conservative estimates of the number of girls at risk of FGM indicate that it could be one the most prevalent forms of severe physical child abuse in the UK. In two London boroughs, for example, almost one in ten girls are born to a woman who has undergone FGM, and are therefore at risk of being cut themselves. Yet, apart from a small number of high-level statistical analyses and anecdotal evidence, we have very little information on the children who are most at risk, and even the extent to which the cutting is occurring in this country or by taking girls abroad. Meanwhile, as many as 170,000 women in the UK may already be living with the life-long consequences of FGM. We welcome efforts by the Government and others to draw a more accurate picture. However, even in the absence of precise data, it is clear that the extent of the problem is very significant, and therefore needs to be matched by a response by all those who have a responsibility for safeguarding children that is similar in scale. (Paragraph 14)

3. The failure to respond adequately to the growing prevalence of FGM in the UK over recent years has likely resulted in the preventable mutilation of thousands of girls to whom the state owed a duty of care. This is a national scandal for which successive governments, politicians, the police, health, education and social care sectors all share responsibility. We pay tribute to the efforts of a small number of individuals and organisations who have worked to raise public awareness of FGM and the impact it has on those who have undergone the procedure. Many of those campaigners who have spoken out have had to withstand criticism and ostracism by those in their own communities who do not wish to see an end to the practice. We also acknowledge the work of The Evening Standard, The Guardian, and The Times in raising public awareness of FGM in the last year. The Government has started to take action, and we welcome the stated commitment to end FGM in a generation. It must now implement a comprehensive and fully-resourced national action plan for tackling FGM. The plan should provide clear leadership and objectives, setting out the standards expected of all relevant bodies, and to which they will be held accountable. It should incorporate a number of interlinked aspects, including:

- a) the achievement of successful prosecutions for FGM;
- b) working with professionals in the health, education, social care and other sectors to ensure the safeguarding of at-risk girls;
- c) changes to the law on FGM;
- d) improved working with communities to abandon FGM; and

e) better services for women and girls living with FGM. (Paragraph 19)

4. We consider each of these in the subsequent chapters of this Report. Finally, we welcome the Prime Minister's planned summit on FGM and forced marriage. We urge him to consider the recommendations in this Report. We welcome the fact that the summit will reflect the international dimension of the problem, and we hope that the relevant heads of government of affected states are invited to attend. We believe the Government should aspire to the UK being a world leader in the policy response to FGM. (Paragraph 20)

Prosecuting FGM

5. A number of successful prosecutions would send a clear message to practising communities that FGM is taken seriously in the UK and will be punished accordingly. There has rightly been increasing public outrage at the failure to achieve a prosecution in the 29 years that FGM has been a crime, with the first prosecutions taking place only this year, after the Committee commenced its inquiry and only a matter of days before the DPP appeared before this Committee. This compares starkly with the approach in France, where a large number of successful prosecutions has played a key role in discouraging the practice. One reason behind the UK's poor record is that the police and Crown Prosecution Service have historically been far too passive in their approach to FGM by waiting for survivors to come forward and report. Yet, the nature of FGM means it is unlikely that this will happen. Often victims do not become aware that FGM is a crime until some years after it has happened to them. Even then, they face huge social pressure not to report it. (Paragraph 35)

6. We welcome the more recent proactive work the CPS has undertaken to secure prosecutions, which we hope will bear fruit. A key difficulty, though, remains the ability to gather sufficient evidence on which to base a prosecution. The police must do more within practising communities to publicise the fact that information can be reported anonymously. In addition, if victims had the protection of press and broadcast anonymity, this might encourage more to come forward. To allow this, we recommend the Government bring forward proposals to extend the right to anonymity under the Sexual Offences (Amendment) Act 1992 to include victims of FGM. (Paragraph 36)

7. The use of regular examinations of all children in France has been a key factor in obtaining evidence that has underpinned a large number of prosecutions. It would be a disproportionate response to introduce such a universal system in the UK. However, we do believe there is a case for a system that empowers medical professionals to make periodic FGM assessments where a girl is identified as being at high risk. Any such system would need to form part of a much wider scheme of preventative and safeguarding work, which we consider in the next two chapters. (Paragraph 37)

Safeguarding at-risk girls

8. It is deeply concerning that so many frontline practitioners do not recognise the indicators of when a girl or young woman is at risk, or has undergone FGM, and, even

when they do recognise the signs, they do not know how to respond. It is unacceptable that those in a position with the most access to evidence of these crimes do nothing to help the victims and those at risk. The record of referrals by healthcare practitioners and others is extremely poor and a lack of training, awareness or ethical concerns can no longer prevent positive action being taken. To remove one of the obstacles to referring, high-quality training for all professionals, including midwives, GPs, health visitors, practice nurses, teachers, obstetricians and gynaecologists, social workers and teaching assistants, is therefore vital both during education and through continued professional development. This should form an essential part of all child protection training. Furthermore, we welcome and support the recommendations of the Intercollegiate Group, though we believe that this work could be better communicated. We note with disappointment that the Royal College of General Practitioners is not a signatory to the report. GPs have a vital role in responding to FGM, and we hope that the Royal College will now work with the Intercollegiate Group to implement its recommendations. (Paragraph 44)

9. The Multi-Agency Practice Guidelines on FGM have a valuable role to play as a tool for all practitioners. However, they will only ever be useful if they are read, and that is more likely to happen if they are mandatory. We recommend the Government update the Guidelines and place them on a statutory footing, giving them parity with guidelines for handling cases of forced marriage. We believe this will provide a much stronger incentive for agencies responsible for training to ensure the inclusion of FGM. To support this, the Department of Health should improve the accessibility of the Guidelines, rather than simply publishing them online, and provide funding for the development of e-learning materials for practitioners. The Department of Health and Department for Education should also ensure arrangements are in place to monitor compliance and hold to account bodies who are responsible for training provision. (Paragraph 45)

10. Misplaced concern for cultural sensitivities over the rights of the child is one of the main reasons why the UK has failed to tackle FGM to date. A key objective for a national action plan on FGM must be to overcome practitioners' own reluctance to address FGM so that they respond to it in the same way as other forms of child abuse. Practitioners must be given the confidence to know that they will not suffer any detriment as a result of raising legitimate concerns about FGM. Again, training is important for practitioners to have the confidence to talk about FGM. But it is also about making such conversations routine so that professionals overcome any awkwardness about having them. (Paragraph 47)

11. Healthcare professionals have a vital role in breaking the generational cycle of FGM. When a woman is identified as having undergone FGM or being from a country where FGM is practised, then her daughters, future children, younger sisters and other younger female family members should be considered at risk, and preventative measures put in place. But at present there is no consistent approach for identifying at-risk girls and monitoring them throughout their childhood. This process should start before the child is even born. We recommend that the FGM status of the mother and her intentions for the child if it is a girl be made a compulsory question at the antenatal booking interview. This would provide an opportunity to discuss the issue frankly, but sensitively. It would enable

better preparation for the delivery, and where the question is not relevant to the mother, it will serve to raise awareness of the issue. (Paragraph 56)

12. Where a girl is born to a mother who has undergone FGM, or where there is perceived to be a risk to the child, we believe the NHS should, as a matter of policy, make a referral to children's social care, or the local multi-agency safeguarding hub, so that an action plan for the safeguarding of that child can be developed and implemented. We welcome the pilot in London to implement such an approach, and hope that it will inform a national roll-out as soon as possible. Furthermore, we recommend the Royal College of Paediatrics and Child Health amend the Personal Child Health Record, or Red Book, to include a specific reference to the risk of FGM to the child, and any safeguarding steps that have been taken. FGM should also form part of the standard questioning for women registering for the first time at GP practices. To support these recommendations, the NHS in conjunction with social care agencies must establish clear referral pathways, which are understood by health professionals so that they feel confident using them. We do not accept that patient confidentiality should prevent practitioners from making a referral where a child is at risk: as with any other form of child abuse, the law allows for disclosure where it is in the best interests of the child. (Paragraph 57)

13. Professionals in schools, including teachers and school nurses, have the most regular and ongoing interaction with young people outside of their homes. They are in the best position to detect the warning signs that a girl may be at risk of FGM, or has already undergone the procedure. It is vital that school staff have an awareness of these indicators, and know when to refer the matter to children's social care and the police. (Paragraph 64)

14. We commend the Secretary of State for Education's decision to write to every school to highlight his Department's revised safeguarding guidance, which for the first time raises FGM. However, it is deeply disappointing that almost 70 per cent of the recipients of the guidance did not even look at it in the month after its publication. We recommend that the Secretary of State for Education resend the guidance to all head teachers and child protection officers. To ensure that the guidance has been looked at, the Department for Education should link the receipt of a proportion of school funding that relates to social education and child protection to the electronic notification that the guidance has been viewed. (Paragraph 65)

15. We further recommend that head teachers and child protection officers, where they have not already done so, undergo compulsory safeguarding training which specifically deals with FGM. This training should be disseminated to all teaching staff through schools dedicating time during the remaining in-service training days in 2014 to provide guidance on child safeguarding in respect of FGM and forced marriage. In addition, we recommend that Ofsted publish a progress report setting out the number and proportion of its inspections to date that have explicitly asked about safeguarding against FGM, and the outcome of those inspections. (Paragraph 66)

16. We note that the large majority of our witnesses felt that Personal, Social and Health Education (PSHE) should be made compulsory, with FGM included as part of a wider

curriculum on tackling violence against women and girls. It is important that teachers and pupils have an opportunity to discuss issues such as FGM, especially where a proportion of the school population may come from a practising community. We recommend that, where Ofsted assesses PSHE provision in schools, it explicitly examines the school's approach to education on FGM and violence against women. Empowering children to discuss the issue openly will increase the likelihood of breaking the inter-generational cycle of FGM, and will also increase the level of reporting, in so doing helping to ensure the safeguarding of at-risk girls. We recommend that PSHE be made compulsory, including teaching children about FGM in high-prevalence areas. (Paragraph 67)

17. Children's social care has an essential role in responding to referrals made by healthcare and education professionals, and others, and in developing an appropriate response that safeguards the child. It is concerning that many of those who make FGM-related referrals believe that the threshold for social care intervention is often too high. We recommend that the Department for Education investigate this issue with local safeguarding children boards. We are also concerned that some children's social care services fail to respond to referrals effectively either by not responding at all, or by overreacting. All local safeguarding children boards need to develop clear and consistent risk assessment protocols so that an appropriate action plan is put in place for every child referred to social services. This is particularly the case if efforts to increase the number of referrals from the health and education sectors are to be successful. (Paragraph 71)

18. The police have an important dual role to play in tackling FGM, both by working with children's social care and other agencies to safeguard at-risk children, and in investigating where a crime may have taken place. Given the low level of referrals to the police to date, we welcome the more proactive approach recently taken by forces such as the Metropolitan Police Service, particularly its recent operations in airports. We believe forces need to ensure that officers receive training to respond appropriately to referrals, and are able to work effectively with grass-roots organisations to break down barriers with affected communities. We were extremely disappointed in the role of ACPO and its lead, who appear to have made little effort to tackle the problem faced, and have shown a distinct lack of leadership in this matter. (Paragraph 76)

19. The importance of third sector organisations in working with other agencies to safeguard at-risk girls cannot be understated. Their role in raising awareness, training professionals, and working with affected communities is vital to tackling FGM in the UK. To date they have achieved this with very little financial support. The Government must provide additional funding to increase significantly the capacity of grass-roots groups, and to encourage the roll-out of best practice from groups such as Integrate Bristol. We support the NSPCC's FGM helpline, which has significantly increased the number of police referrals, though the charity itself believes this is the tip of the iceberg. The Government therefore needs to do much more to promote awareness of the helpline's existence among frontline practitioners and practising communities. (Paragraph 79)

20. Overall, the safeguarding of girls and young women at risk of FGM requires the development of a multi-agency approach with co-operation between all those who come into contact with children—health, education, social care, the police and others. FGM is child abuse and needs to be treated accordingly through existing child protection and safeguarding system. This requires a much greater emphasis on the collection and sharing of information, and the development of clear referral pathways that are well-understood and used by front-line practitioners. (Paragraph 80)

21. There is a clear case for a national FGM awareness campaign, on the same scale as historic public health campaigns on domestic violence and HIV/AIDS. For too long it has been left to grassroots campaigners and the national media to do this work. And whilst we welcome the €300,000 of EU funding for awareness-raising, it is not sufficient. We recommend the Government provide funding to implement a national campaign that targets frontline professionals, practising communities, including at-risk girls, as well as the wider general public. The campaign should carry the unambiguous message that FGM is a serious crime and child abuse. It should also signpost practitioners who are unsure as to how to make a referral, and women who have undergone FGM and are seeking support. (Paragraph 84)

Changing the law

22. We believe there is a strong case for strengthening the law on FGM, principally to ensure the safeguarding of at-risk girls, but also to increase the likelihood of achieving successful prosecutions. We welcome the Government's plans to broaden the scope of the 2003 Act so that it covers girls who are habitually resident in the UK. The state has a duty of care to all those who live within its borders, regardless of their immigration status. We also recommend that the Government amend the 2003 Act to include reinfibulation. We further recommend that the Government examine the extent to which there is a double standard in the current treatment of female genital cosmetic surgery and FGM under the law, and whether there is a case for prohibiting all such surgery on girls under the age of 18, except where it is clinically indicated. We also support the introduction of FGM protection orders, and look forward to seeing proposals from the Ministry of Justice in this respect. (Paragraph 97)

23. We note the Government's reluctance to strengthen the statutory reporting requirements for child abuse. It is clear, however, that many professionals still fail to view FGM as child abuse and respond accordingly. This is why the level of referrals has been much lower than the likely prevalence of FGM in the UK. New initiatives such as the pilot for automatic referral to children's social care of newborn girls to mothers with FGM, should help to address this issue, as would a fully-funded national awareness campaign. However, if in a year's time the level of reporting has not reached the level that would be expected, we recommend the Government should take steps to make the failure to report child abuse a criminal offence. (Paragraph 98)

Working with communities

24. FGM will continue to be a problem in the UK until communities themselves choose to abandon the practice. The Government has a crucial role to play in enabling community-based initiatives that seek to break down the powerful social norms that underpin FGM. We welcome the £100,000 of funding from the Home Office to support greater engagement work by voluntary organisations. But it is not enough. To support a full-scale national action plan that is commensurate with the extent of the problem, the Government needs to provide long-term funding that is an order of magnitude greater than that which it has committed to date. (Paragraph 104)

25. There is too little provision of clinical and mental health support services for the many thousands of women and girls in the UK who have undergone FGM. The NHS and commissioning groups need to ensure that the provision of services better reflects the prevalence of FGM. The services available should specifically include the provision, through NGOs or local authorities, of dedicated FGM shelters to enable women and girls to remove themselves from a position of danger. These will also provide the pastoral, medical and psychological support needed to enable those at risk to break the cycle of abuse. Overall, services should be widely publicised, sustainable, and tailored to cater to different age groups. Frontline health professionals need better training to ensure women and girls who have undergone FGM are referred appropriately and sensitively to these services. Not only would much greater investment in such services improve the lives of a great many women and girls, it would also contribute significantly to breaking the cycle of violence, so protecting future generations. (Paragraph 110)

Formal Minutes

Wednesday 25 June 2014

Members present:

Keith Vaz, in the Chair

Michael Ellis
Dr Julian Huppert

Yasmin Qureshi
Mark Reckless

Draft Report (*Female genital mutilation: the case for a national action plan*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 110 read and agreed to.

Resolved, That the Report be the Second Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Tuesday 1 July at 2.30 pm]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the Committee's inquiry page at <http://www.parliament.uk/business/committees/committees-a-z/commons-select/home-affairs-committee/inquiries/parliament-2010/female-genital-mutilation/>.

Tuesday 11 March 2014

Question number

Leyla Hussein and Nimco Ali, Daughters of Eve [Q 1-46](#)

Christine Townsend and Muna Hassan, Integrate Bristol [Q 47-72](#)

Tuesday 25 March 2014

Alison Saunders, Director of Public Prosecutions, Crown Prosecution Service [Q 73-124](#)

Tuesday 29 April 2014

Commander Mak Chishty, Association of Chief Police Officers [Q 125-186](#)

Assistant Commissioner Mark Rowley and Detective Chief Superintendent Keith Niven, Metropolitan Police [Q 187-226](#)

Saria Khalifa, Youth Programme Lead, Forward UK, and **Lisa Harker**, Director of Strategy, Policy and Evidence, NSPCC [Q227-245](#)

Norman Baker MP, Minister of State for Crime Prevention, **Jane Ellison MP**, Parliamentary Under-Secretary of State for Public Health, and **Edward Timpson MP**, Parliamentary Under-Secretary of State for Children and Families [Q 246-295](#)

Tuesday 6 May 2014

Professor Nigel Mathers, Royal College of General Practitioners, **Janet Fyle**, Royal College of Midwives, and **Professor Janice Rymer**, Royal College of Obstetricians and Gynaecologists [Q 296-374](#)

Obi Amadi, Community Practitioners and Health Visitors Association, **Dr Kerry Robinson**, Consultant Paediatrician, Whittington Health, and **Dr Comfort Momoh**, African Well Women's Clinic, Guys' and St Thomas' Hospitals [Q 375-414](#)

Linda Weil-Curiel, Lawyer at the Paris Bar, and **Dr Emmanuelle Piet**, French gynaecologist and County Medical Officer of Seine Saint-Denis [Q 415-453](#)

Published written evidence

The following written evidence was received and can be viewed on the Committee's inquiry web page at <http://www.parliament.uk/business/committees/committees-a-z/commons-select/home-affairs-committee/inquiries/parliament-2010/female-genital-mutilation/>. INQ numbers are generated by the evidence processing system and so may not be complete.

1. Children and Families Across Borders ([FGM 0001](#))
2. Buckinghamshire County Council ([FGM 0003](#))
3. NSPCC ([FGM 0004](#))
4. Genital Autonomy ([FGM 0005](#))
5. Bar Human Rights Committee of England and Wales (BHRC) ([FGM 0008](#))
6. Local Government Association ([FGM 0009](#))
7. 28 Too Many ([FGM 0010](#))
8. International Association of Women Police ([FGM 0011](#))
9. Professor Lisa Avalos ([FGM 0012](#))
10. British Medical Association ([FGM 0013](#))
11. UCL Graduate Law Society ([FGM 0014](#))
12. Movement for Justice ([FGM 0015](#))
13. PCC for Northumbria ([FGM 0016](#))
14. Hawa Trust ([FGM 0017](#))
15. ACCM (UK) ([FGM 0018](#))
16. Avon and Somerset Constabulary and PCC ([FGM 0019](#))
17. London Borough of Havering ([FGM 0020](#))
18. Ralph Tilby ([FGM 0021](#))
19. Intercollegiate Group on FGM ([FGM 0022](#))
20. Juliet Albert ([FGM 0023](#))
21. The Victoria Climbié Foundation UK ([FGM 0024](#))
22. Metropolitan Police ([FGM 0025](#))
23. Tackling FGM Initiative ([FGM 0026](#))
24. Hilary Burrage ([FGM 0027](#))
25. Rights of Women and Asylum Aid ([FGM 0028](#))
26. Government ([FGM 0029](#))
27. Bawso ([FGM 0030](#))
28. Muslim Women's Network UK ([FGM 0031](#))
29. Fahma Mohamed ([FGM 0033](#))
30. FPA and Brook ([FGM 0035](#))
31. NAHT ([FGM 0036](#))
32. London Borough of Newham ([FGM 0037](#))
33. Professor Sarah Creighton ([FGM 0038](#))
34. Guardian News & Media ([FGM 0039](#))
35. Tony Lloyd, Greater Manchester PCC ([FGM 0040](#))
36. Dr Comfort Momoh MBE ([FGM 0041](#))
37. Lancashire Constabulary ([FGM 0042](#))
38. Dr Deborah T Hodes ([FGM 0043](#))
39. Mayor of London's Harmful Practices Taskforce ([FGM 0045](#))
40. Association of Chief Police Officers (ACPO) ([FGM 0046](#))
41. Foundation for Women's Health Research and Development (FORWARD UK) ([FGM 0047](#))

42. Equality and Human Rights Commission ([FGM 0048](#))
43. Alison Macfarlane and Efua Dorkenoo ([FGM 0049](#))
44. Crown Prosecution Service ([FGM 0050](#))
45. Yana Richens OBE ([FGM 0051](#))
46. Royal College of General Practitioners ([FGM 0052](#))
47. Graham Senior-Milne ([FGM 0053](#))
48. Peer Exchange ([FGM 0054](#))
49. Liberal Democrats for Seekers of Sanctuary ([FGM 0055](#))
50. NSPCC supplementary ([FGM 0056](#))
51. London Safeguarding Children Board ([FGM 0057](#))
52. Government supplementary ([FGM 0058](#))
53. Crown Prosecution Service supplementary ([FGM 0059](#))

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the Committee's website at <http://www.parliament.uk/business/committees/committees-a-z/commons-select/home-affairs-committee/publications/>

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First Report	Tobacco smuggling	HC 200
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Session 2013–14

First Report	Police and Crime Commissioners: Register of Interests	HC 69
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Second Report	Child sexual exploitation and the response to localised grooming	HC 68
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Third Report	Leadership and standards in the police	HC 67
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Fourth Report	The work of the UK Border Agency (Oct–Dec 2012)	HC 486
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Fifth Report	E-crime	HC 70
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Sixth Report	Police and Crime Commissioners: power to remove Chief Constables	HC 487
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Tenth Report	Leadership and Standards in the Police: follow-up	HC 756
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Eleventh Report	Khat	HC 869
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Twelfth Report	Drugs: new psychoactive substances and prescription drugs	HC 819
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Thirteenth Report	The work of the Permanent Secretary	HC 233
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Fourteenth Report	The Government's Response to the Committees' Reports on the 2014 block opt-out decision	HC 1177
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Fifteenth Report	The work of the Immigration Directorates (April–September 2013)	HC 820
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Sixteenth Report	Police and Crime Commissioners: Progress to date	HC 757
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Seventeenth Report	Counter-terrorism	HC 231
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Eighteenth Report	Reform of the Police Federation	HC 1163
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Session 2012–13

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Second Report	Work of the Permanent Secretary (April–Dec 2011)	HC 145
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Third Report	Pre-appointment Hearing for Her Majesty's Chief Inspector of Constabulary	HC 183
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Fourth Report	Private Investigators	HC 100
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Fifth Report	The work of the UK Border Agency (Dec 2011–Mar 2012)	HC 71
Sixth Report	The work of the Border Force	HC 523
Seventh Report	Olympics Security	HC 531
Eighth Report	The work of the UK Border Agency (April–June 2012)	HC 603
Ninth Report	Drugs: Breaking the Cycle	HC 184-I
Tenth Report	Powers to investigate the Hillsborough disaster: interim Report on the Independent Police Complaints Commission	HC 793
Eleventh Report	Independent Police Complaints Commission	HC 494
Twelfth Report	The draft Anti-social Behaviour Bill: pre-legislative scrutiny	HC 836
Thirteenth Report	Undercover Policing: Interim Report	HC 837
Fourteenth Report	The work of the UK Border Agency (July–Sept 2012)	HC 792

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Second Report	Policing: Police and Crime Commissioners	HC 511
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Sixth Report	Police Finances	HC 695
Seventh Report	Student Visas	HC 773
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Tenth Report	Implications for the Justice and Home Affairs area of the accession of Turkey to the European Union	HC 789
Eleventh Report	Student Visas–follow up	HC 1445
Twelfth Report	Home Office–Work of the Permanent Secretary	HC 928
Thirteenth Report	Unauthorised tapping into or hacking of mobile communications	HC 907
Fourteenth Report	New Landscape of Policing	HC 939
Fifteenth Report	The work of the UK Border Agency (April–July 2011)	HC 1497
Sixteenth Report	Policing large scale disorder	HC 1456
Seventeenth Report	UK Border Controls	HC 1647
Eighteenth Report	Rules governing enforced removals from the UK	HC 563
Nineteenth Report	Roots of violent radicalisation	HC 1446
Twentieth Report	Extradition	HC 644
Twenty-first Report	Work of the UK Border Agency (August–Dec 2011)	HC 1722