Brent	**Community and Wellbeing Scrutiny Committee** 19 September 2017 **Report from Brent Clinical Commissioning Group**
For information	Wards affected: ALL

Identification of Female Genital Mutilation (FGM) in Brent

1.0 Summary

1.1 Female Genital Mutilation (FGM) is illegal in the UK. This report outlines Brent Clinical Commissioning Group's (CCG) work identifying cases of FGM in Brent and seeks the support of the Committee for the work locally to address this.

2.0 Recommendation(s)

2.1 Ensure there is an effective pathway for the transfer of relevant information from maternity services to health visiting services and GP's.
This will be undertaken by commissioners of services.

2.2 Engage further with the local community to raise awareness of the impact of FGM.

2.3 Continue with training provision in order support agencies with identifying and responding to FGM, including improvements with data collection.
This will be undertaken by the Brent Safeguarding Children Board.

2.4 Monitor service user feedback to service delivery and design and respond accordingly.
This will be undertaken by relevant commissioners

2.5 Brent Safeguarding Children Board to seek assurance from across the partnership that relevant agencies have offered the required level of training and awareness on FGM as per training guidance and key performance indicators.

3.0 Detail

3.1 It is estimated that more than 200 million girls and women alive today (worldwide) have undergone female genital mutilation. Furthermore, there are an estimated 3 million girls at risk of undergoing female genital mutilation every year. The majority of girls are cut before they turn 15 years old.

3.2 Female genital mutilation has been documented in 30 countries, mainly in Africa, as well as in the Middle East and Asia. Some forms of female genital mutilation have also been reported in other countries, including among certain ethnic groups in South America. Moreover, growing migration has increased the number of girls and women who have undergone female genital mutilation - or who may be at risk of being subjected to the practice - in Europe, Australia and North America.

3.2 FGM usually happens to girls whose mothers, grandmothers or extended female family members have had FGM themselves or if their father comes from a community where it's carried out. FGM is a manifestation of gender inequality that persists for many reasons for example, in some societies it is considered a rite of passage, in others it is a prerequisite for marriage and in others it may be attributed to religious belief.

3.3 Because FGM may be considered an important part of a culture or identity, it can be difficult for families to decide against it. People who reject the practice may face condemnation or ostracism and as a result, even parents who do not want their daughters to undergo FGM may feel compelled to participate in the practice.

3.4 Girls are sometimes taken abroad for FGM, but they may not be aware that this is the reason for their travel. Girls are more at risk of FGM being carried out during the summer holidays, as this allows more time for them to "heal" before they return to school.

3.5 There are no health benefits to FGM and it can cause serious harm to physical and mental health. Cutting the nerve ends and sensitive genital tissue causes extreme pain. Proper anaesthesia is rarely used and, when used, is not always effective. The healing period is also painful. Ongoing issues can include:

- constant pain
- pain and/or difficulty having sex
- repeated infections, which can lead to infertility
- bleeding, cysts and abscesses
- problems passing urine or incontinence
- depression, flashbacks and self-harm

- problems during labour and childbirth, which can be life-threatening for mother and baby
- death from blood loss or infection as a direct result of the procedure

3.6 FGM can be an extremely traumatic experience that can cause emotional difficulties and negatively impact mental health throughout life. Some studies have shown an increased likelihood of post-traumatic stress disorder (PTSD). Women may also suffer with depression, anxiety, flashbacks to the time of the cutting, nightmares and other sleep problems. The pain, shock and the use of physical force by those performing the procedure are mentioned as reasons why many women describe FGM as a traumatic event. In some cases, women may not remember having the FGM at all, especially if it was performed when they were an infant.

3.7 Women and girls who are at risk of, or are suffering as a result of FGM can speak to their GP and other healthcare professionals. They can refer to a special therapist who can help. In some cases, a surgical procedure called a deinfibulation may also be recommended, which can alleviate and improve symptoms for those suffering with ongoing pain for example during sex. Women expecting a baby should also ensure their midwife is aware so they can arrange appropriate care for mother and baby.

3.8 Girls who were born in the UK or are resident here, but whose families originate from an FGM practising community are at greater risk. Communities at particular risk of FGM in the UK originate from:

- Egypt
- Eritrea
- Ethiopia
- Gambia
- Guinea
- Indonesia
- Ivory Coast
- Kenya
- Liberia
- Malaysia
- Mali
- Nigeria

- Sierra Leone
- Somalia

3.9 The percentage at which the identified population in Brent are recorded as having undergone FGM before the age of 18 years is 67%, with the remaining number recorded as not stated or not recorded. FGM is a particular concern for Brent compared to other boroughs nationally. A significant proportion of the population of Brent originate from countries where FGM is prevalent. The young population of Brent means that many of these women are identified through maternity services, and GP practices for ante natal care.

3.10 The Department of Health's FGM prevention programme requires NHS staff to record FGM in a patient's healthcare record only if and when it is identified during the delivery of any NHS healthcare. Professionals are reminded to be aware of the risk factors, including country of origin (see multi-agency guidelines for list of countries), and to use their professional judgement to decide when to ask the patient if they have had FGM. Local health provider policies on FGM detail this in training as well as in their policies.

3.11 In March 2014 the Tackling Violence against Women and Girls in Brent: an Overview and Scrutiny Task Report was released. The recommendations have all been progressed including:

- *Developing services to protect women and girls at risk, to include developing services to support women and girls subjected to harmful practices:* London North West Healthcare Trust is a large provider of health services for the local population. Their services for FGM are detailed in appendix 6, as is the services offered by Imperial College Healthcare. Forward UK also provide services in Brent, detailed in appendix 6.

- *Robust recording and better quality of data and sharing of data from all partners:* Data recording has improved, as evidenced by the enhanced dataset. However, there is still work to be undertaken in relation to data completeness, and understanding why the figures relating to not reported or unknown feature as highly as they do. The national data collection is helping to establish the scale of FGM and although there is work to be undertaken in relation to improving the completion of data fields, this knowledge helps to inform further training.

- *Clear and consistent guidance for reporting risk, pathways for referrals and services*: training currently delivered includes details of how undertake conversations re FGM, how to report, when to report, and when to make referrals. Additionally, information on how to undertake/complete risk assessments is covered, so that appropriate referrals are submitted to the Local Authority.

- *Provide clear guidance to all key staff and the public on how to report a crime against women affected by these issues*: the national guidance is

distributed at training events, and contact details are given. Current legislation is also referred to and details about how to access up to date information is given.

- *Single point of contact is established for those affected*: for those affected by FGM there is a range of services available. Choice is important in order to facilitate access. However, specialist practitioner's details are available, see appendix 7.

- *The adoption of good practice from elsewhere, health service, local authorities, voluntary sector organisations and educational institutions*:
    - One of the largest health providers (London North West Healthcare Trust) has invested in FGM services. Regular training events are held, and FGM is discussed at all level 3 safeguarding children training events. The current compliance rate with level 3 training at LNWHT is 79%.
    - In addition there is bespoke FGM training available to practitioners more closely involved with service users who have undergone FGM e.g. midwives, emergency department staff, urology staff, and those working in obstetrics and gynaecology.
    - Brent Safeguarding Children Board also delivers FGM training to multi agency audiences and to date 47 professionals have attended this training. It can also be delivered to smaller cohorts during dedicated team meetings. This has been taken up by both police and health. There are a further four FGM training session available between September 2017-March 2017.
    - The national guidance is distributed at training events, and contact details are given. Current legislation is also referred to and details about how to access up to date information is given.
    - Central London Community Health currently provides the health visiting and school nursing service to the population of Brent. Their compliance with level 3 training is currently 81% with a further whole day's training dedicated to level 3 scheduled for 5th September 2017. This will include FGM, as does all their level 3 training.

3.12 The multi-agency partnership has worked together through the Local Safeguarding Children Board to deliver relevant training, as well as individual agencies delivering in house training to try to meet demand. The Violence against Women and Girls Group has oversight of the FGM activity undertaken by the multi-agency partnership.

3.13 Following identification of FGM by health professionals, safeguarding referrals are submitted through the Brent Family Front Door. A robust safeguarding process is then followed in accordance with the latest pan London safeguarding procedures. Any themes arising from the Brent Family Front Door work are elicited via monthly audits. Each case is considered and responded to on individual basis with appropriately coordinated multi-agency input.

4.0 Financial Implications

4.1 None stated

5.0 Legal Implications

5.1 FGM is illegal in the UK. It has been a criminal offence since 1985. In 2003 it also became a criminal offence for UK nationals or permanent UK residents to take their child abroad to have female genital mutilation. The Serious Crime Act 2015 amended the Female Genital Mutilation Act to include FGM protection orders (FGMPOs).

5.2 It is an offence to:

- perform FGM (including taking a child abroad for FGM)
- help a girl perform FGM on herself in or outside the UK
- help anyone perform FGM in the UK
- help anyone perform FGM outside the UK on a UK national or resident
- fail to protect a girl for whom you are responsible from FGM

Anyone who performs FGM can face up to 14 years in prison. Anyone found guilty of failing to protect a girl from FGM can face up to seven years in prison.

5.3 Section 73 of the Serious Crime Act 2015 provides for an FGM protection order to be applied for. It is a civil measure which can be applied for through a family court. The FGM protection order offers the means of protecting actual or potential victims from FGM under the civil law. Breach of an FGM protection order is a criminal offence carrying a sentence of up to 5 years in prison. As an alternative to criminal prosecution, a breach could be dealt with in the family court as a contempt of court, carrying a maximum of 2 years' imprisonment. Applications for an order can be made by:

- the person who is to be protected by the order
- a relevant third party (such as the local authority)
- any other person with the permission of the court (for example, teachers, health care professionals, police, family member).

5.4 FGM protection orders are unique to each case and contain legally binding conditions, prohibitions and restrictions to protect the person at risk of FGM. These may include:

- confiscating passports or travel documents of the girl at risk and/or family members or other named individuals to prevent girls from being taken abroad

- ordering that family members or other named individuals should not aid another person in any way to commit or attempt to commit an FGM offence, such as prohibiting bringing a “cutter” to the UK for the purpose of committing FGM.

The court can make an order in an emergency so that protection is in place straightaway. FGM protection orders came into force on 17 July 2015 and apply to England, Northern Ireland and Wales.

5.5 Section 74 of the Serious Crime Act 2015 amended the Female Genital Mutilation Act 2003 to introduce the legal duty for regulated health and social care professionals and teachers to make a report to the police if:

- they are informed by a girl under the age of 18 that she has undergone an act of FGM
- they observe physical signs that an act of FGM may have been carried out on a girl under the age of 18.

It is recommended that the report is made by phone by calling 101, the single non-emergency number. When 101 are called, the system will determine the location of the caller and connect to the police force covering that area. If the call relates to a report outside the force area where the call took place, the caller can ask to be directed to the correct force.

5.6 Brent data from April 2016 – March 2017 shows newly recorded cases from the following referring organisations:

- General practice = 105 cases (45%)
- NHS organisations = 55 cases (24%)
- Not recorded = 40 cases (17%)
- Self-referral = 10 cases (4%)
- Other = 10 cases (4%)
- Not stated = 10 cases (2%)

It is worth noting caution needs to be taken when making comparisons with historic data. It became mandatory for all acute trusts to collect and submit to the FGM Enhanced Dataset from 1 July 2015 and for all mental health trusts and GP practices from 1 October 2015. Therefore only partial information is available from July 2015.

6.0 Equality Implications

6.1 The underlying trends of FGM identification demonstrate that most FGM is seen in the 30-34 year age group, closely followed by the 25-29 age groups.

6.2 The age at which the FGM was undertaken is recorded as 5-9 years of age, with a slightly smaller number recorded as unknown. This may be due to the service user not recalling their age at the time of the procedure.

6.3 Most FGM is self-reported as opposed to following examination or assessment. Self-reporting demonstrates the improved awareness of FGM in particular with the health impacts.

6.4 Country of birth and origin for the service users is most commonly recorded as Eastern Africa, as per the Brent population, with 115 and 100 recorded respectively. Most data shows the country where the FGM is either not known or not stated. This is an area for staff/practitioners to improve upon with submitting complete data, as far as possible, in order to facilitate further analysis of the information.

7.0 Analysis

In order to continue to raise awareness of the mandatory reporting of FGM and the safeguarding implications, ongoing engagement with the local community is essential:

"*The strengthening of UK legislation was seen as necessary by those who want to end FGM and a useful tool to support ending the practice. However, greater community involvement has been crucial to ensure that increased government intervention is not seen as punitive, particularly around the implementation of 'mandatory reporting'*." https://www.trustforlondon.org.uk/wp-content/uploads/2016/07/The-Tackling-FGM-Initiative-Overview.pdf

The Brent multi agency partnership has been working under the Brent Safeguarding Children Board to deliver the activity in relation to preventing and managing cases of FGM. This work continues, with the additional oversight of the Violence against Women and Girls Group. The effectiveness of this work is demonstrated through the training compliance and development of FGM services locally.

The Department for Health's prevention programme has led to a number of referrals to social care, however, there has not been any applications for FGM protection orders, unlike in other areas of the Country. In December 2015 it was reported that 18 had been granted, out of 28 applications in England. This may indicate that there is an increased recognition that FGM is illegal and harmful. However, children are not examined unless there is a clear and justifiable reason to do so, therefore there may be more unidentified cases than known. There have been no prosecutions nationwide for FGM related activity.

Background Papers

NHS Digital FGM Enhanced Dataset April 2016-March 2017

Tackling Violence against Women and Girls in Brent: an overview and scrutiny task group report March 2014

HM Government Multi-agency statutory guidance on female genital mutilation 2016

NHS England Female Genital Mutilation Prevention Programme: Requirements for NHS staff 2014

NHS Brent Clinical Commissioning Group Annual Report 2016-2017

Contact Officers

Gilly Attree,
Wembley Centre for Health & Care, Chaplin Rd
g.attree@nhs.net
Tel: 0208 900 5383

GILLY ATTREE
Designated Nurse Safeguarding Children
NHS Brent Clinical Commissioning Group

Appendix 1

The World Health Organisation classifies FGM in to four categories

Type 1. (clitoridectomy) – removing part or all of the clitoris.

Type 2 (excision) – removing part or all of the clitoris and the inner labia (lips that surround the vagina), with or without removal of the labia majora (larger outer lips).

Type 3 (infibulation) – narrowing of the vaginal opening by creating a seal, formed by cutting and repositioning the labia.

Type 4 Other harmful procedures to the female genitals, including pricking, piercing, and cutting, scraping or burning the area.

Prevalence of FGM

It is estimated that more than 200 million girls and women alive today have undergone female genital mutilation in the countries where the practice is concentrated. Furthermore, there are an estimated 3 million girls at risk of undergoing female genital mutilation every year. The majority of girls are cut before they turn 15 years old (see Figure 1).

Why is FGM carried out?

FGM is carried out for various cultural, religious and social reasons within families and communities in the mistaken belief that it will benefit the girl in some way (for example, as a preparation for marriage or to preserve her virginity).

However, there are no acceptable reasons that justify FGM. It's a harmful practice that isn't required by any religion and there are no religious texts that say it should be done. There are no health benefits of FGM.

FGM usually happens to girls whose mothers, grandmothers or extended female family members have had FGM themselves or if their father comes from a community where it's carried out.

Health Consequences

There are no health benefits to FGM and it can cause serious harm, including:

- constant pain
- pain and/or difficulty having sex
- repeated infections, which can lead to infertility
- bleeding, cysts and abscesses
- problems passing urine or incontinence

- depression, flashbacks and self-harm
- problems during labour and childbirth, which can be life-threatening for mother and baby

Some girls die from blood loss or infection as a direct result of the procedure.

FGM and sex

FGM can make it difficult and painful to have sex. It can also result in reduced sexual desire and a lack of pleasurable sensation.

Talk to your GP or another healthcare professional if you have sexual problems that you feel may be due to FGM, as they can refer you to a special therapist who can help.

In some cases, a surgical procedure called a deinfibulation (see below) may be recommended, which can alleviate and improve some symptoms.

FGM and pregnancy

Some women with FGM may find it difficult to become pregnant, and those who do conceive can have problems in childbirth.

If you're expecting a baby, your midwife should ask you at your antenatal appointment if you've had FGM. It's important to tell your midwife if you think this has happened to you, so they can arrange appropriate care for you and you baby.

FGM and mental health

FGM can be an extremely traumatic experience that can cause emotional difficulties throughout life, including;

- depression
- anxiety
- flashbacks to the time of the cutting
- nightmares and other sleep problems

In some cases, women may not remember having the FGM at all, especially if it was performed when they were an infant.

Appendix 2

Where FGM is practised

Girls are sometimes taken abroad for FGM, but they may not be aware that this is the reason for their travel. Girls are more at risk of FGM being carried out during the summer holidays, as this allows more time for them to "heal" before they return to school.

If you think there's a risk of this happening to you, you can download the Statement Opposing FGM and take it with you on holiday to show your family.

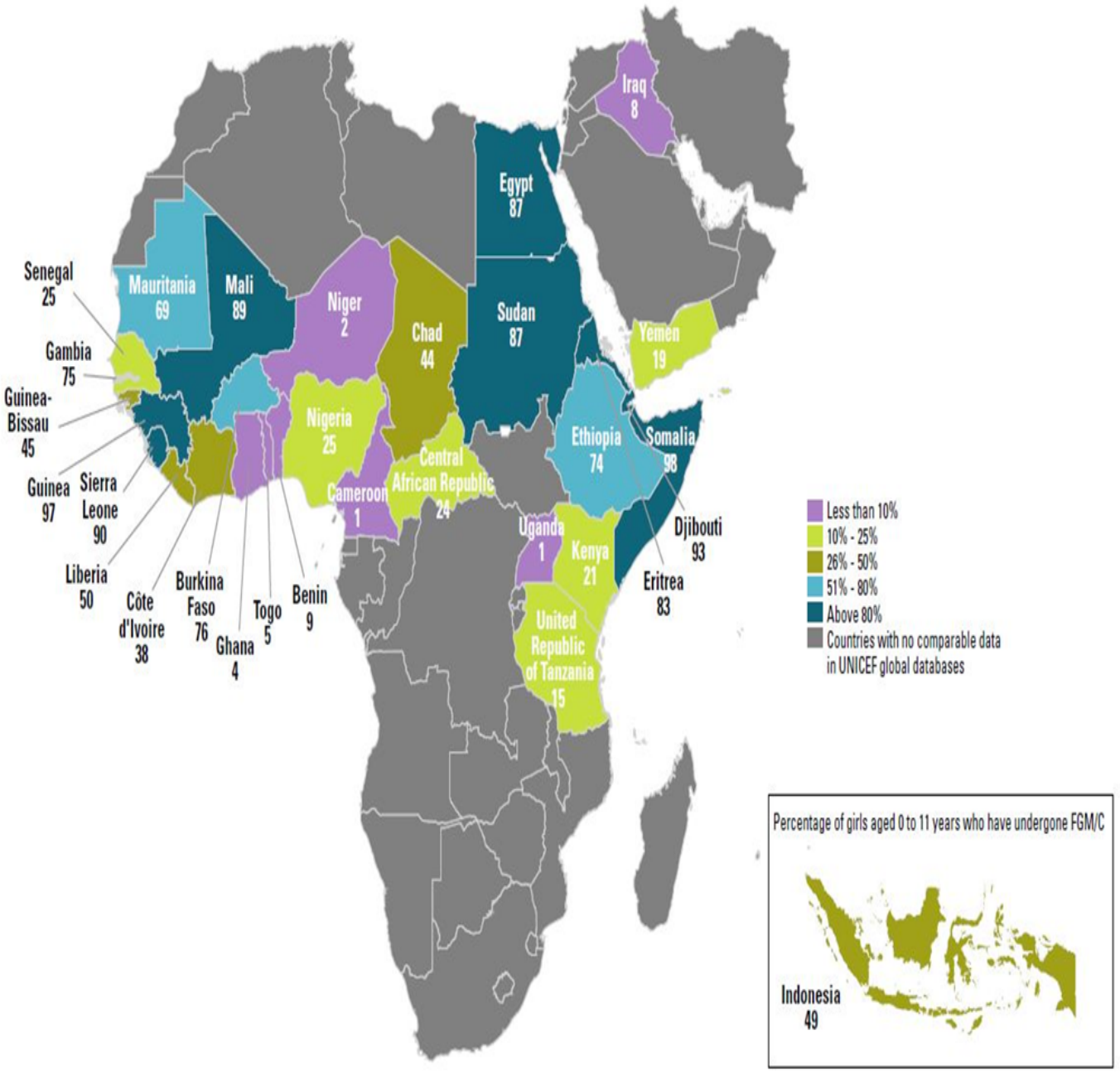
Communities that perform FGM are found in many parts of Africa, the Middle East and Asia. Girls who were born in the UK or are resident here but whose families originate from an FGM practising community are at greater risk of FGM happening to them.

Communities at particular risk of FGM in the UK originate from:

- Egypt
- Eritrea
- Ethiopia
- Gambia
- Guinea
- Indonesia
- Ivory Coast
- Kenya
- Liberia
- Malaysia
- Mali
- Nigeria
- Sierra Leone
- Somalia

Map indicating international prevalence of FGM

Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change -July 2016 www.unicef.org/esaro/FGCM_Lo_res.pdf



Appendix 3

Health consequences of FGM for women and girls

The effects of FGM depend on a number of factors, including the type performed, the expertise of the practitioner, the hygiene conditions under which it is performed, the amount of resistance and the general health condition of the girl/woman undergoing the procedure. Complications may occur in all types of FGM, but are most frequent with infibulation.

The short-term health risks of FGM include:

Severe pain: cutting the nerve ends and sensitive genital tissue causes extreme pain. Proper anaesthesia is rarely used and, when used, is not always effective. The healing period is also painful. Type III FGM is a more extensive procedure of longer duration, hence the intensity and duration of pain may be more severe. The healing period is also prolonged and intensified accordingly.

Excessive bleeding: (haemorrhage) can result if the clitoral artery or other blood vessel is cut during the procedure.

Shock: can be caused by pain, infection and/or haemorrhage.

Genital tissue swelling: due to inflammatory response or local infection.

Infections: may spread after the use of contaminated instruments (e.g. use of same instruments in multiple genital mutilation operations), and during the healing period.

Human immunodeficiency virus (HIV): the direct association between FGM and HIV remains unconfirmed, although the cutting of genital tissues with the same surgical instrument without sterilization could increase the risk for transmission of HIV between girls who undergo female genital mutilation together.

Urination problems: these may include urinary retention and pain passing urine. This may be due to tissue swelling, pain or injury to the urethra.

Impaired wound healing: can lead to pain, infections and abnormal scarring

Death: can be caused by infections, including tetanus and haemorrhage that can lead to shock.

Psychological consequences include:

The pain, shock and the use of physical force by those performing the procedure are mentioned as reasons why many women describe FGM as a traumatic event.

Long-term health risks from Types I, II and III (occurring at any time during life)

Pain: due to tissue damage and scarring that may result in trapped or unprotected nerve endings.

Infections:

Chronic genital infections: with consequent chronic pain, and vaginal discharge and itching. Cysts, abscesses and genital ulcers may also appear.

Chronic reproductive tract infections: May cause chronic back and pelvic pain.

Urinary tract infections: If not treated, such infections can ascend to the kidneys, potentially resulting in renal failure, septicaemia and death. An increased risk for repeated urinary tract infections is well documented in both girls and adult women.

Painful urination: due to obstruction of the urethra and recurrent urinary tract infections.

Menstrual problems: result from the obstruction of the vaginal opening. This may lead to painful menstruation (dysmenorrhea), irregular menses and difficulty in passing menstrual blood, particularly among women with Type III FGM.

Keloids: there have been reports of excessive scar tissue formation at the site of the cutting.

Human immunodeficiency virus (HIV): given that the transmission of HIV is facilitated through trauma of the vaginal epithelium which allows the direct introduction of the virus, it is reasonable to presume that the risk of HIV transmission may be increased due to increased risk for bleeding during intercourse, as a result of FGM.

Female sexual health: removal of, or damage to highly sensitive genital tissue, especially the clitoris, may affect sexual sensitivity and lead to sexual problems, such as decreased sexual desire and pleasure, pain during sex, difficulty during penetration, decreased lubrication during intercourse, reduced frequency or absence of orgasm (anorgasmia). Scar formation, pain and traumatic memories associated with the procedure can also lead to such problems.

Obstetric complications: FGM is associated with an increased risk of Caesarean section, post-partum haemorrhage, recourse to episiotomy, difficult labour, obstetric tears/lacerations, instrumental delivery, prolonged labour, and extended maternal hospital stay. The risks increase with the severity of FGM.

Obstetric fistula: a direct association between FGM and obstetric fistula has not been established. However, given the causal relationship between prolonged and obstructed labour and fistula, and the fact that FGM is also associated with

prolonged and obstructed labour it is reasonable to presume that both conditions could be linked in women living with FGM.

Perinatal risks: obstetric complications can result in a higher incidence of infant resuscitation at delivery and intrapartum stillbirth and neonatal death.

Psychological consequences:

Some studies have shown an increased likelihood of post-traumatic stress disorder (PTSD), anxiety disorders and depression. The cultural significance of FGM might not protect against psychological complications.

Appendix 4

The Law relating to FGM

FGM is illegal in the UK. It has been a criminal offence since 1985. In 2003 it also became a criminal offence for UK nationals or permanent UK residents to take their child abroad to have female genital mutilation. The Serious Crime Act 2015 amended the Female Genital Mutilation Act to include FGM protection orders (FGMPOs).

It is an offence to:

- perform FGM (including taking a child abroad for FGM)
- help a girl perform FGM on herself in or outside the UK
- help anyone perform FGM in the UK
- help anyone perform FGM outside the UK on a UK national or resident
- fail to protect a girl for whom you are responsible from FGM

Anyone who performs FGM can face up to 14 years in prison. Anyone found guilty of failing to protect a girl from FGM can face up to seven years in prison.

Female Genital Mutilation Act 2003 as amended by the Serious Crime Act 2015

Protection orders
Section 73 of the Serious Crime Act 2015 provides for an FGM protection order to be applied for. It is a civil measure which can be applied for through a family court. The FGM protection order offers the means of protecting actual or potential victims from FGM under the civil law.

Breach of an FGM protection order is a criminal offence carrying a sentence of up to 5 years in prison. As an alternative to criminal prosecution, a breach could be dealt with in the family court as a contempt of court, carrying a maximum of 2 years' imprisonment.

Applications for an order can be made by:

- the person who is to be protected by the order
- a relevant third party (such as the local authority)
- any other person with the permission of the court (for example, teachers, health care professionals, police, family member).

FGM protection orders are unique to each case and contain legally binding conditions, prohibitions and restrictions to protect the person at risk of FGM. These may include:

- confiscating passports or travel documents of the girl at risk and/or family members or other named individuals to prevent girls from being taken abroad
- ordering that family members or other named individuals should not aid another person in any way to commit or attempt to commit an FGM offence, such as prohibiting bringing a “cutter” to the UK for the purpose of committing FGM.

The court can make an order in an emergency so that protection is in place straightaway. FGM protection orders came into force on 17 July 2015 and apply to England, Northern Ireland and Wales.

Mandatory Reporting of FGM

Section 74 of the Serious Crime Act 2015 amended the Female Genital Mutilation Act 2003 to introduce the legal duty for regulated health and social care professionals and teachers to make a report to the police if:

- they are informed by a girl under the age of 18 that she has undergone an act of FGM

Or

- they observe physical signs that an act of FGM may have been carried out on a girl under the age of 18.

For details on what is required of professionals, see Mandatory reporting of female genital mutilation: procedural information (Home Office, 2015) in the guidance section below.

Reports of FGM should be made when FGM is either visually noted, or there is a disclosure. The reports should contain the following information:

The name, age/date of birth, and address of the service user concerned.

The details of the referrer i.e. your details, including name, contact details (work telephone number and e-mail address) and times when you will be available to be called back, role and place of work.

Making a report

It is recommended that the report is made orally by calling 101, the single non-emergency number. When 101 are called, the system will determine the location of the caller and connect to the police force covering that area. A recorded message is then heard, announcing the police force that the caller is being connected to. The caller will then be given a choice of which force to be connected to – if the call

relates to a report outside the force area which you are calling from, you can ask to be directed to that force.

Appendix 5

Brent

Data from April 2016 – March 2017, for the London Borough of Brent indicates the following statistical information:

Caution needs to be taken when making comparisons with historic data. It became mandatory for all acute trusts to collect and submit to the FGM Enhanced Dataset from 1 July 2015 and for all mental health trusts and GP practices, from 1 October 2015. Therefore only partial information is available from July 2015.

Of the newly recorded cases from April 2016-March 2017, the referring organisation was as follows:

Not recorded = 40 cases (17%)

Not stated = 10 cases (2%)

General practice = 105 cases (45%)

NHS organisations = 55 cases (24%)

Self referral = 10 cases (4%)

Other = 10 cases (4%)

Types of FGM reported:

* indicates the number is between 0-4

Not recorded * (number between 0-4)

Type unknown = 85 cases (37%)

Type 1 = 50 cases (22%)

Type 2 = 30 cases (13%)

Type 3 = 55 cases (24%)

Type 4 * (number between 0-4)

History of FGM type 3 = 5 cases

FGM type 3 re-infibulation identified * (number between 0-4)

Age at attendance for FGM

Unknown *

Under 10 *

10-17 *

18-24 = 25 cases (11%)

25-29 = 65 cases (28%)

30-34 = 70 cases (30%)

25-39 = 40 cases (17%)

40-44 = 20 cases (9%)

45-49 = 5 cases (2%)

50+ *

Age at which FGM was carried out

Not recorded = 70 cases (30%)

Not stated = 5 cases (2%)

Under 1 *

1-4 = 35 cases (15%)

5-9 = 85 cases (37%)

10-14 = 25 cases (11%)

15-17 *

18+ = 10 cases (4%)

FGM identification method

Not recorded =50 cases

Self report=135 cases

On examination=20 cases

Other clinician * (between 0-4 cases)

Other = 20 cases

Country of birth of woman

Not recorded = 50

Not stated or unknown = 45

Eastern Africa = 115

Northern Africa = 10

Western Africa *

Rest of Africa *

Western Asia *

Rest of world *

Country of origin

Not recorded = 50

Not stated or unknown = 60

Eastern Africa = 100

Northern Africa = 10

Western Africa *

Rest of Africa *

The United Kingdom *

Western Asia *

Rest of Asia *

Rest of world *

Country where FGM was undertaken

Not recorded = 55

Not stated or unknown = 105

Eastern Africa = 60

Northern Africa = 5

Western Africa *

Rest of Africa *

The United Kingdom *

Western Asia *

Rest of Asia *

Rest of world *

For FGM attendees:

Treatment provided by:

Obstetrics = 10 cases

Gynaecology = 10 cases

Midwifery services = 185

Not recorded 405 cases

Paediatric specialities = 10 cases

Other *

Rates of de-infibulation

Not recorded = 420 cases

Yes *

No = 200 cases

Advised on health implications of FGM

Not recorded = 395 cases

Unknown = 30 cases

Yes = 190

No *

Advised on illegality of FGM

Not recorded = 395

Unknown = 25

Yes = 195

No *

Appendix 6

Imperial College Healthcare

Female Genital Mutilation (FGM) Clinics

All clinics are staffed by female-only midwives.

We have specialist health advocates who speak Somali and Arabic and access to counselling support. The midwives who run the clinics are specialists who have years of experience in helping and caring for women with FGM. There is an interpreter present at all clinics, as well as an advocate, a counsellor and a social worker.

Clinic 1 – A clinic for women who are not pregnant

Address

Queen Charlotte's & Chelsea Hospital FGM clinic
Gynaecology outpatients
Ground floor
Queen Charlotte's & Chelsea Hospital
Du Cane Road
London W12 0HS

Hours

09.00 to 12.00 on alternating Fridays.

Contact information

Phone: Juliet Albert 077 3097 0738
Phone: Deqa Dirie 075 5789 4186
Email: FGMservice.gynaeICHT@imperial.nhs.uk

Clinic 2 – For pregnant women booked to have their baby at Queen Charlotte's & Chelsea Hospital

Address

Queen Charlotte's & Chelsea FGM clinic
Ground Floor
Queen Charlotte's & Chelsea Hospital
Du Cane Road
London W12 0HS

Hours

09.00 to 12.00 on alternating Fridays.

Contact information

Phone: Juliet Albert 077 3097 0738
Phone: Deqa Dirie 075 5789 4186

Clinic 3 – For pregnant women booked to have their baby at St Mary's Hospital

Address

St Mary's Hospital FGM clinic
Maternity day assessment unit
St Mary's Hospital
Praed Street
London W2 1NY

Hours

Every Tuesday.

Contact information

Phone: Zuriash Amare 020 3312 1060 or 020 3312 1730

(Foundation for Women's Health Research and Development) is committed to gender equality and safeguarding the rights of African girls and women.

London Northwest Healthcare Trust (LNWHT)

FGM Services

The London North West Healthcare NHS Trust delivers FGM services to all women who access our services. The Trust covers 3 boroughs Ealing, Brent and Harrow

The LNWHT FGM services are provided by the Women's' and Children's Services within LNWHT

There are 2 clinics, one at Central Middlesex Hospital and the other on the Northwick Park Hospital site

Open: Friday from 08:30am – 16:30pm

- Central Middlesex Hospital, Acton Lane, Park Royal, NW10 7NS Antenatal Clinic

Telephone 0208 963 7180

- Northwick Park Hospital, Watford Road, Harrow, Middlesex, HA1 3UJ Antenatal Clinic

Telephone 0208 869 2870

Daughters of Eve offer the following services accessed by Brent women

African Well Women's Clinic - Antenatal Clinic

Central Middlesex Hospital, Acton Lane, Park Royal, London, NW10 7NS

Tel: 0208 963 7177 or 0208 965 5733

Open: Friday, 9am – 12pm

Contact: Kamal Shehata Iskander

African Well Women's Clinic - Antenatal Clinic

Northwick Park & St. Mark's Hospital, Watford Rd.

Harrow, Middlesex, HA1 3UJ

Tel: 0208 869 2870

Open: Friday, 9am – 5pm

Contact: Jeanette Carlsson

FORWARD http://forwarduk.org.uk/

We are a leading African diaspora women's campaign and support organisation. We work through partnerships in the UK, Europe and Africa to transform lives, tackling discriminatory practices that affect the dignity and wellbeing of girls and women. Our focus is on female genital mutilation (FGM), child marriage and obstetric fistula.

Information from the FORWARD community programme

FORWARD have engaged in Brent by providing parent sessions and 1:1 support to women and professionals and have held coffee mornings and community events in Brent. We recognise that there is a need for more communities to engage with services on FGM and in the next year we would like to be more active in the borough.