Female Genital Mutilation
Identification, Support and Prevention Strategy

A partnership approach to tackling FGM in Wandsworth

www.wandsworthfgm.org.uk
**Prepared by:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position and Organization</th>
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</thead>
<tbody>
<tr>
<td>Gabriel Agboado</td>
<td>Public Health Principal, Wandsworth Council Public Health Department</td>
</tr>
<tr>
<td>Bryony Dobson</td>
<td>Public Health Practitioner Children &amp; Young People, Wandsworth Council Public Health Department</td>
</tr>
<tr>
<td>Stewart Low</td>
<td>Head of Community Safety, Wandsworth Community Safety Department</td>
</tr>
</tbody>
</table>

**Members of the Wandsworth Female Genital Mutilation (FGM) Prevention Strategy Development Group:**

**Health and Social Care representatives**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position and Organization</th>
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<tbody>
<tr>
<td>Gabriel Agboado</td>
<td>Public Health Principal, Wandsworth Council Public Health Department (Chair)</td>
</tr>
<tr>
<td>Ileen Ashitey</td>
<td>Designated Nurse Safeguarding Children, Wandsworth Clinical Commissioning Group</td>
</tr>
<tr>
<td>Jacquelyn Burke</td>
<td>Head of Safeguarding Standards Unit-Policy &amp; Development, Wandsworth Children's Services</td>
</tr>
<tr>
<td>Bryony Dobson</td>
<td>Public Health Practitioner Children &amp; Young People, Wandsworth Council Public Health Department</td>
</tr>
<tr>
<td>Denise Henry</td>
<td>Perennial Midwife, St George’s Health Care NHS Trust</td>
</tr>
<tr>
<td>Jenny Iliff</td>
<td>Domestic Violence Co-Ordinator, Wandsworth Community Safety Department</td>
</tr>
<tr>
<td>Lorraine King</td>
<td>PSHEe and Healthy Schools Development Officer, Children's Services</td>
</tr>
<tr>
<td>Winnie Lacey</td>
<td>Multi-agency Training Manager, Children's Services</td>
</tr>
<tr>
<td>Stewart Low</td>
<td>Head of Community Safety, Wandsworth Community Safety Department</td>
</tr>
<tr>
<td>Stella Macaulay</td>
<td>Principal Education Welfare Officer, Children's Services</td>
</tr>
<tr>
<td>Helen Morgan</td>
<td>Named GP for Child Safeguarding Wandsworth</td>
</tr>
<tr>
<td>Fiona Mulvaney</td>
<td>Community Partnership Officer, Wandsworth Children's Services</td>
</tr>
<tr>
<td>Vicky Pigott</td>
<td>Senior Health Visitor, Roehampton Children Centre, St George’s Health Care NHS Trust</td>
</tr>
<tr>
<td>Anne Varvill</td>
<td>Practice Nurse, Mayfield Surgery, Roehampton</td>
</tr>
<tr>
<td>Rebecca Wilbond</td>
<td>Safeguarding Midwife and Link Midwife for Domestic Violence, Kingston Hospital NHS Foundation Trust</td>
</tr>
</tbody>
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**Metropolitant Police representatives**

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<tr>
<th>Name</th>
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<tr>
<td>Joanne Belton</td>
<td>Detective Inspector, Child Abuse Investigation Team, Wandsworth</td>
</tr>
<tr>
<td>James Foley</td>
<td>DCI (Public Protection), Wandsworth Borough</td>
</tr>
<tr>
<td>Elaine Westerman</td>
<td>Sexual Offences, Exploitation &amp; Child Abuse Command</td>
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**Wandsworth School representative**

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<th>Name</th>
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<tr>
<td>Cath Brookes</td>
<td>Deputy Principal, Burntwood School, Wandsworth</td>
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**Community representatives**

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<th>Name</th>
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<tr>
<td>Hodan Abdi</td>
<td>Somali Community Representative</td>
</tr>
<tr>
<td>Ayan Yusuf</td>
<td>Somali Community Representative from the Association of Somali Women and Children (ASWAC)</td>
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**The following provided information and/or guidance to the group:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position and Organization</th>
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<tr>
<td>Houda Al Sharifi</td>
<td>Director of Public Health, Wandsworth Council Public Health Department</td>
</tr>
<tr>
<td>John Hall</td>
<td>Senior Parliamentary Assistant to Jane Ellison MP</td>
</tr>
<tr>
<td>Toks Okeniyi</td>
<td>FORWARD, Head of UK Programmes</td>
</tr>
</tbody>
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| Publication date       | 14th April 2014                                                      |
| Review date            | To be confirmed                                                      |
# Table of Contents

1. **Introduction** .................................................................................................................................................................................. 3
   1.1 **Definition** .................................................................................................................................................................................. 3
   1.2 **Prevalence of FGM** ...................................................................................................................................................................... 3
   1.3 **Consequences of FGM** ............................................................................................................................................................... 5

2. **National policy context and Legislative framework** ............................................................................................................ 5
   2.1 **National Policy documents for professionals** ......................................................................................................................... 5
   2.2 **Legal framework on FGM** ............................................................................................................................................................ 5
   2.3 **Best practice recommendation** .................................................................................................................................................. 6

3. **FGM in Wandsworth** ...................................................................................................................................................................... 7
   3.1 **Scale of the problem in Wandsworth** ........................................................................................................................................ 7
   3.2 **Local practice-related issues identified** ...................................................................................................................................... 8

4. **What we want to achieve – Our Aim** ........................................................................................................................................... 8

5. **How we will achieve our aim** .......................................................................................................................................................... 9
   5.1 **Partner agencies** ........................................................................................................................................................................... 9
   5.2 **Measures of success** .................................................................................................................................................................... 10
   5.3 **Developments at regional and national levels** .......................................................................................................................... 10
   5.4 **Potential barriers to success** ....................................................................................................................................................... 11

6. **Communicating the strategy to all stakeholders** ....................................................................................................................... 12

7. **The action plan** ............................................................................................................................................................................. 14

8. **Appendices** .................................................................................................................................................................................... 19
   8.1 **Appendix 1: Map of Prevalence of FGM** .............................................................................................................................. 19
   8.2 **Appendix 2: Detailed WHO classification of FGM** .................................................................................................................. 20
   8.3 **Appendix 3: Glossary of terms used in various practising and affected communities** ......................................................... 20

9. **References** .................................................................................................................................................................................... 21
1 Introduction

Female Genital Mutilation (FGM) is a violation of a girl’s rights as a child and her entitlement to her bodily integrity. FGM is not simply an exotic or ‘cultural’ ritual that girls need to undergo, but a practice which has intolerable long-term physical and emotional consequences for the survivors. FGM causes death, disability, physical and psychological harm for millions of women every year worldwide\(^1\), as in many instances it is done under non-sterile conditions and with no anaesthesia.

FGM in England has been proscribed since 1985, and in 2003 the Female Genital Mutilation Act increased the penalty for aiding, abetting or counselling to procure FGM to 14 years imprisonment. However, despite this no prosecution has been made under the law to date, as FGM is a hidden practice and is difficult to detect. Although FGM is incorporated into child protection, at present data collection on the prevalence of FGM has been limited and this has made it difficult for professionals and other stakeholders to know the true extent of the problem both at national and local levels.

Most recently FGM has become a priority public health issue. A national report launched on the 1\(^{\text{st}}\) of November 2013 made recommendations for tackling FGM in the United Kingdom (UK).\(^1\) This strategy describes Wandsworth’s intended multi-agency approach to tackling FGM.

1.1 Definition

The World Health Organisation (WHO) defines FGM as:

*Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons (WHO, UNICEF, UNFPA, 1997).*\(^2\)

Female genital mutilation is classified into four major types.\(^2\)

- **Type 1** — Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
- **Type 2** — Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).
- **Type 3** — Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
- **Type 4** — All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.

See Appendix 2: Detailed WHO classification of FGM for the full WHO classification.

1.2 Prevalence of FGM

According to the UNICEF’s 2013 Statistical Survey, globally, 100 to 140 million women and girls have undergone FGM, and a further 3 million girls undergo FGM every year in Africa.\(^3\) Most females affected live in 28 African countries, while some are from parts of the Middle East and Asia, with national FGM prevalence rates varying from as low as 1% to 90% or more. The highest prevalence rates, of 90% or more, are found in Somalia, Sudan, Djibouti, Egypt, Guinea and Sierra Leone, where little difference in trends in prevalence is found by age group (Figure 1). In the UNICEF Survey,\(^3\) FGM was conducted on girls under 5 years of age in half of the countries surveyed. In the rest of the countries, it was done between the ages of 5 to 14 years.
Figure 1: Prevalence of FGM in some FGM-practising countries (UNICEF, 2013)³

Due to in international migration, the practice has spread to many other countries including the UK and other parts of Europe which host migrants from these countries. Consequently some of those affected by FGM may be British citizens born to parents from FGM practising communities or girls resident in the UK who were born in countries that practice FGM and may include immigrants, refugees, asylum seekers, overseas students or the wives of overseas students.⁴ The full extent of the problem in UK is not known, but in 2001 it was estimated that 66,000 residents in England and Wales had undergone FGM and over 23,000 under the age of 15 from African communities are at risk or may have undergone FGM.⁵
1.3 Consequences of FGM

The WHO has identified complications associated FGM. These are listed in Table 1.

<table>
<thead>
<tr>
<th>Immediate and short term complications</th>
<th>Long-term complications</th>
</tr>
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<tbody>
<tr>
<td>Severe pain during the procedure and healing</td>
<td>Chronic pain due to trapped or unprotected nerve endings</td>
</tr>
<tr>
<td>Shock can be caused by pain and/or haemorrhage</td>
<td>Infections particularly of the reproductive and urinary tracts</td>
</tr>
<tr>
<td>Excessive bleeding (haemorrhage) and septic shock have been documented</td>
<td>Keloid which is excessive scar tissue formed at the site of the cutting</td>
</tr>
<tr>
<td>Difficulty in passing urine, and also passing of faeces, can occur due to swelling, oedema and pain</td>
<td>Increased risk of HIV infection and transmission in adulthood due to an increased risk for bleeding during intercourse</td>
</tr>
<tr>
<td>Infections may spread after the use of contaminated instruments and during the healing period</td>
<td>Impaired quality of sexual life due to reduced sexual sensitivity, pain during sex, scar formation, and pain and traumatic memories associated with the procedure</td>
</tr>
<tr>
<td>Human immunodeficiency virus (HIV) due to the use of the same surgical instrument without sterilization</td>
<td>Menstrual problems</td>
</tr>
<tr>
<td>Death can be caused by haemorrhage or infections, including tetanus and shock</td>
<td>Birth complications such as prolonged labour, recourse to caesarean section, postpartum haemorrhage, tearing and recourse to episiotomies</td>
</tr>
<tr>
<td>Psychological consequences due to the pain, shock and the use of physical force by those performing the procedure</td>
<td>Danger to the new-born with higher death rates and reduced Apgar scores</td>
</tr>
<tr>
<td>Unintended labia fusion following Type 2 FGM</td>
<td>Psychological consequences such as fear of sexual intercourse, post-traumatic stress disorder, anxiety, depression and memory loss</td>
</tr>
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</table>

2 National policy context and Legislative framework

2.1 National Policy documents for professionals

- Royal College of Nursing Female genital mutilation (2006).
- Female Genital Mutilation and its Management (2009).
- Female Genital Mutilation: Caring for patients and safeguarding children (2011).
- Protecting Children and young people: the responsibilities of all doctors (2012).

2.2 Legal framework on FGM

The United Kingdom is a signatory to two key international Conventions: the UN Convention on the Rights of the Child (CRC) and the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). Article 24 of the CRC calls for the prohibition of all traditional practices that are prejudicial to the health and wellbeing of children across the globe.
FGM is illegal in England, Wales and Northern Ireland under the Female Genital Mutilation Act 2003 and in Scotland under the Prohibition of Female Genital Mutilation Act 2005. Both Acts make it an offence for any person:

a) to excise, infibulate or otherwise mutilate the whole or any part of a person’s labia majora, labia minora or clitoris; or
b) to aid, abet, counsel or procure the performance by another person of any of those acts on that other person’s own body, or
c) to aid, abet, counsel or procure a person to excise, infibulate or otherwise mutilate the whole or any part of her own labia majora, labia minora or clitoris.

The FGM Act (2003) also makes it an offense for anyone to assist a non-UK person to mutilate a girl’s genitalia abroad, including in countries where the practice may be legal. For instance, parents who procure FGM for their daughters outside the UK would be committing a criminal offence, even if they have not carried out the procedure themselves.

It is an offence for a trained medical practitioner to perform any surgical procedure for FGM or to re-infibulate a girl or woman. However there is no offence for an approved person to perform a surgical procedure where necessary for a girl or woman’s physical or mental health (e.g. for gender reassignment, cosmetic surgery resulting from perceived abnormality, and operations to remove malignant tumours), or during childbirth.

These Acts carry a maximum penalty of 14 years imprisonment.

2.3 Best practice recommendation
The UK Intercollegiate report, launched on the 1st of November 2013, made the following recommendations for tackling FGM in the UK:

1. Treat FGM as child abuse.
2. Document and collect information on FGM.
3. Share information on FGM systematically.
4. Empower frontline professionals to ensure prevention and protection of girls at risk of FGM, and provide quality care for girls/women who suffer complications of FGM.
5. Identify girls at risk and refer them as part of child safeguarding obligations.
6. Report cases of FGM – all girls and women presenting with FGM must be considered potential victims of crime and should be referred to the police and support services.
7. Hold frontline professionals accountable.
8. Empower and support affected girls and young women - both those at risk and survivors.
9. Implement FGM awareness campaigns.
## 3 FGM in Wandsworth

### 3.1 Scale of the problem in Wandsworth

We do not have a complete understanding of the extent of FGM practiced locally but information gleaned from maternity services serving Wandsworth (St. George’s Hospital, Chelsea and Westminster [C&W] Hospital, and Kingston Hospital) shows that about 1,044 women with FGM have come into contact with these services between 2007 and 2013 (937 for St George’s Hospital, 19 for C&W Hospital, 4 for Kingston Hospital). Figure 2 shows the trend in women presenting with FGM in some of the maternity services serving Wandsworth. These figures exclude significant numbers who might have been seen in GP practices, and Genito-Urinary and Family Planning clinics. Though Figure 2 suggests a declining trend, the actual trend may be different as the data presented is not complete.

Figure 2: Trend for the number of FGM cases seen at St George’s Hospital (2007-2012)

The majority of women were registered with GPs in Wandle Locality (Figure 3). It must be noted that the distribution may not be reflective of the actual problem as the majority of the data was from St George’s, which is nearest to Wandle residents while women from other areas with “high risk” communities may go to other hospitals outside Wandsworth.

Figure 3: Distribution of FGM by GP Locality (St Georges and C&W)

The vast majority (about 73%) of the women were born in Somalia. The data also indicated a few were UK-born, raising the prospect of FGM being practised amongst the resident population.

* Data for Chelsea and Westminster and Kingston are for patients registered with Wandsworth GPs
3.2 Local practice-related issues identified

Wandsworth has established a multi-agency FGM Steering Group which identified the following issues relating to FGM prevention in the borough:

- Lack of awareness among health professionals, social care professionals and teachers on FGM issues
- Lack of awareness among communities on FGM issues
- There are no consistent risk assessment tools available for use by key frontline professionals
- There are no consistent approaches to case identification and management
- There are no systems for consistently documenting and reporting FGM cases
- There is a need to empower communities to ensure they are able to take action to prevent FGM
- Inadequate capacity within services to manage FGM and raise awareness
- There is a need to learn from the experience of areas implementing “good practice” programmes

4 What we want to achieve – Our Aim

Our aim is to eliminate the risk of girls and women experiencing FGM in Wandsworth. We will achieve this goal by implementing best practice recommendations underpinned by the following principles:

- The safety and welfare of the child is paramount
- All agencies will act in the interest of the Rights of the Child as stated in the UN Convention (1989)
- FGM is illegal and is prohibited by the Female Genital Mutilation Act 2003 and Prohibition of Female Genital Mutilation (Scotland) Act 2005
- FGM causes significant harm both in the short and long term and constitutes physical and emotional abuse to children
- All decisions or plans for the child/ren should be based on good quality assessments and be sensitive to the issues of race, culture, gender, religion and sexuality, and avoid as far as possible, stigmatising the child or the practising community
- Accessible, acceptable and sensitive Health, Education, Police, Children’s Social Care and Voluntary Sector services must underpin this procedure
- All agencies should work in partnership with members of local communities, to empower individuals and groups to develop support networks and education programmes
5 How we will achieve our aim

We will achieve the singular aim of eliminating FGM risk by:

1. Establishing a multi-agency partnership including the statutory and voluntary sector to tackle FGM
2. Empower frontline professionals by equipping them with the necessary knowledge and skills to identify and appropriately manage FGM and raise awareness
3. Raising awareness among professionals and communities about FGM
4. Establishing an accountability framework for professionals in managing FGM
5. Establishing effective arrangements for data recording, analysis and sharing among partners
6. Empowering communities to take action to prevent FGM
7. Strengthening capacity within partner agencies to effectively address FGM-related issues and making FGM everyone’s business
8. Working with regional and national agencies to ensure consistency in approach
9. Learning from the experience of areas implementing “good practice” programmes on FGM
10. Monitoring progress on reducing the risk of FGM in the population

The Action Plan in Section 7 of this document sets out how these objectives would be met. The implementation of the Action Plan would be lead by Wandsworth Council Community Safety Department, which would be accountable to the Health and Wellbeing Board through the Wandsworth Safeguarding Children’s Board (WSCB).

5.1 Partner agencies

- Local Authority (Public Health, Community Safety, Workforce Development, Safeguarding, Education and Social Services, Housing Department and Children Centres)
- Wandsworth Clinical Commissioning Group (CCG)
- GPs Practices in Wandsworth
- St George’s Healthcare NHS Trust
  - Community Services Wandsworth (Health Visiting and School Nursing Services)
  - Maternity services and A&E
- Other Acute Trusts serving Wandsworth
  - Maternity Services
  - GUM Services
  - Family Planning Services
- Walk-In Centres
- Out-of-Hours Service
- Schools (maintained, academies, free schools and Pupil Referral Units), colleges and universities in Wandsworth
- The Metropolitan Police
- Community groups in the “high risk” communities
- Places of worship in Wandsworth
- FORWARD, AFRUCA and other 3rd sector organisations (e.g. The Katherine Low Settlement)
- Early Years settings (e.g. day nurseries, child minders) in Wandsworth
- Out of school care providers and youth services in Wandsworth
5.2 Measures of success
Due to the nature of FGM, initial indications of success would likely be increasing numbers coming to the attention of relevant agencies in the immediate short term. Other tangible measures of success would be effective inter-agency working to address FGM, effective record keeping on FGM, increased awareness among health and social care professionals, teachers and communities, and the establishment of active community organisations against FGM.

5.3 Developments at regional and national levels
In setting out this strategy, the team is aware there are developments at national and London level in relation to FGM. In order not to duplicate actions, the team will be sure to align the local Strategy and Guidelines to national and regional guidance, whilst adopting interim measures to safeguard children.

Some of the relevant developments are:
- Data collection: With effect from 1st April 2014, it is mandatory for all acute hospitals to record women presenting with FGM. The ISB 1610 FGM Prevalence Dataset requires organisations to record and collect information about the prevalence of FGM within the patient population as treated by the NHS in England. Hospitals are to record:
  - if a patient has had FGM
  - if there is a family history of FGM
  - if an FGM-related procedure has been carried out on a woman (deinfibulation)

The requirement to submit the FGM Prevalence Dataset is mandatory for all Acute (Foundation and non-Foundation) Trusts, including A&E departments, however other organisations (which may include GPs) may wish to support the standard and provide an FGM Prevalence Dataset centrally.

This is the first stage of a wider ranging programme of work in development to improve the way in which the NHS will respond to the health needs of girls and women who have suffered FGM and actively support prevention.

- Inquiry: The Home Affairs Select Committee announced on 18th December 2013 a new enquiry into FGM in a press release. Though no date has been communicated relating to when this would conclude, the enquiry would consider the following:
  - Effectiveness of existing legislative framework on FGM
  - Groups in the UK most at risk of FGM and the barriers to identification and intervention
  - The roles of the police, health, education and social care professionals, and the third sector, and how multi-agency co-operation could be improved
  - Systems for collecting and sharing information on FGM and how they could be improved
  - Effectiveness of existing efforts to raise awareness of FGM
  - Improving available support and services for women and girls in the UK who have suffered FGM

- Revision of the London Safeguarding Guideline: “Safeguarding children at risk of abuse through female genital mutilation” document produced by London Safeguarding Children Board was published in 2007. This is being revised and the relevant contents would be adopted by Wandsworth Council. No date has yet been communicated relating to completion of the revision.
5.4 Potential barriers to success

Table 2 shows some of the potential barriers to successful implementation of the strategy and suggested actions to mitigate their impact. These should be considered in its implementation.

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<tr>
<th>Potential barrier</th>
<th>Actions to overcome barriers</th>
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| Inability to effectively engage communities due to:                             | • Establishing clear communication links with the communities from the onset to gain their confidence in the process  
• Being sensitive to the needs of the communities but ensuring a clear message on FGM is communicated  
• Communicating the range of support available to survivors, child protection issues involved, the legal requirements and when prosecution may be required  
• Establishing a support network for volunteers through charities  
• Training of selected community members as Community Champions to engage with their communities and deliver the aims of the agenda in a way that is understood by all |
| Some communities feeling unfairly targeted and as a result disengaging with any  | • Ensure interventions are universal to all segments of the population  
• Targeted intervention should be discussed with communities before implementation  
• Share information in an impartial manner  
• Training of Community Champions from all communities represented within Wandsworth, who in turn will work with members of all communities within the borough |
| process                                                                         |                                                                                                                     |
| Lack of funding to adequately support interventions                             | • FGM prevention activities should be mainstreamed into other activities related to violence against women and girls  
• Work Source funding from Governmental and non-governmental sources in collaboration with local and national charities                                                                                                                                                                                                                                                                  |
| Lack of sustainability of community volunteer schemes                           | • Incorporating a reward/salary into such schemes  
• Contracting a charity to manage the volunteer scheme(s)                                                                                                                                                                                                                                                                                                                                 |
| Not having a volunteer squad that has community credibility                     | • Vetting volunteers with support from charities linked to the communities during recruitment  
• Ensuring training for volunteers address how they comport themselves in the communities                                                                                                                                                                                                                                                                                                         |
| Inadequate systems for managing data flow and monitoring                        | • Follow national guidance on data management and monitoring                                                                                                                                                                                                                                                                                                                                 |
| Inadequate local services (e.g. counselling, de-infibulation) to manage potential | • Consideration should be given to service development issues especially in staff training and funding of interventions to reverse/ameliorate the affects of FGM survivors  
• Development of a holistic FGM service at St George’s hospital to be inclusive of all services for support of survivors of FGM (e.g. counselling, de-infibulation)                                                                                                                                                                                                 |
| influx of cases                                                                  |                                                                                                                     |
| Lack of clarity about professional responsibilities relating to FGM             | • Clarification of roles through the FGM Steering Group and Children Safeguarding Board                                                                                                                                                                                                                                                                                                                                                                    |
| Failure to co-ordinate FGM prevention activities                               | • Establish a co-ordinator role within Community Safety to co-ordinate FGM prevention activities in the borough and maintain working relationships with governmental, voluntary and community groups                                                                                                                                                                                                                                                                   |
| Negative impact on access to health services e.g. cervical screening, sexual     | • Train staff to sensitively handle FGM issues  
• Provide counselling for affected individuals and families  
• Pro-actively engage with affected communities through Community Champion scheme |
| and reproductive health services                                                |                                                                                                                     |
6 Communicating the strategy to all stakeholders

The Strategy with the Action Plan has been formally approved by the WSCB on the 14th April 2014 and is to be disseminated to all stakeholders. The WSCB will ensure that monitoring of the strategy is included in the WSCB monitoring framework, and that reviews of the FGM Strategy document will be conducted and updated as and when necessary. A list of all stakeholders and the method of communicating the Strategy are in Table 3 below.

Table 3: Strategy communication plan

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<thead>
<tr>
<th>Stakeholder</th>
<th>Method</th>
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| All stakeholders | • The FGM Strategy has been finalised and approved by the WSCB, an electronic copy of which would be sent to all stakeholders  
• Organise a multi-agency forum on the FGM strategy for frontline staff and members of the community  
• A link to the FGM Strategy and Guidelines would be provided in all multi-agency and single-agency Safeguarding training, as well as on the Wandsworth Council website  
• Information advertised in Brightside Magazine  
• Information placed of social media (e.g. twitter)  
• Training on the roles and responsibilities of each frontline staff will be undertaken to raise awareness and enable staff to engage girls and women who potentially are “at risk” and to know the correct methods of recording and pathways of referral/reporting |
| Wandsworth Council Elected members | • A paper to the Children’s Overview and Scrutiny Committee on the FGM Strategy would be submitted |
| Wandsworth Health and Wellbeing Board | • A presentation would be given to the Board |
| WSCB | • All the documents would be included in the resource materials for staff on the Wandsworth Safeguarding Children and Young People website. |
| Wandsworth CCG | • A presentation would be given at the CCG management team meeting. Electronic copies to be placed on CCG website |
| Departments in Wandsworth Council | • Electronic copies sent to all managers in the Departments of Education and Social Services, Children Services, and the Safeguarding leads.  
• Electronic copies of all strategy-related documents would be put on Wandsworth Council Website, Family Information Service (FIS) and Little Feet website |
| Children’s Health and Clinical Reference Group | • A presentation would be given at the CHOCRG quarterly meeting. |
| South West London Maternity Network | • A presentation would be given at the quarterly meeting, and circulation of electronic copies to members |
| GP practices | • Electronic copies would be e-mailed to all practices  
• Posters and information leaflets would be distributed to all practices |
| Children’s Centres | • Electronic copies would be e-mailed to all Children’s Centres through the Head of Early Years.  
• Posters and information leaflets would be distributed all centres |
<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child minders</td>
<td>• Information leaflets summarising the main points of the strategy and posters would be distributed</td>
</tr>
</tbody>
</table>
| Day nurseries                                                               | • Electronic copies would be sent to all managers  
• Information leaflets summarising the main points of the strategy and posters would be distributed |
| Out of school care providers and youth services in Wandsworth               | • Electronic copies would be sent to all managers  
• Information leaflets summarising the main points of the strategy and posters would be distributed |
| St George’s Healthcare NHS Trust  
• CSW (Health visiting & school nursing)  
• Maternity and A&E Department                                             | • Electronic copies would be sent to all managers  
• Information leaflets summarising the main points of the strategy and posters would be distributed |
| Walk-In Centres and Out-of-Hours Service                                   | • Electronic copies would be sent to all managers  
• Information leaflets summarising the main points of the strategy and posters would be distributed |
| Schools, colleges and universities in Wandsworth, both state and independent | • Electronic copies would be sent to all heads of schools  
• Information leaflets summarising the main points of the strategy and posters would be distributed |
| Metropolitan Police                                                         | • Electronic copy would be sent to the Metropolitan Police                                                                            |
| Community groups in the “high risk” communities                            | • Information leaflets summarising the main points of the strategy and posters would be distributed                                  |
| Places of worship in Wandsworth                                             | • Leaders of faith groups would be approached to become Community Champions against FGM, they would be engaged to be key leaders in bringing about change within their communities  
• A presentation would be given to gatherings, if requested  
• Information leaflets summarising the main points of the strategy and posters would be distributed |
| Voluntary sector organisation                                               | • Information leaflets summarising the main points of the strategy and posters would be distributed                                  |
### 7 The action plan

<table>
<thead>
<tr>
<th>Objective</th>
<th>Actions Undertaken</th>
<th>Status</th>
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<tbody>
<tr>
<td>1. Establish a multi-agency FGM Steering Group</td>
<td>Members of the public and voluntary sector, local authority, national government and the community were identified and invited to join the FGM Steering Group. Three meetings have been held thus far and the FGM Strategic group formed to develop the FGM Strategy and Guidelines</td>
<td>Done</td>
</tr>
</tbody>
</table>
| 2. Empower frontline professionals | Equip frontline staff with the knowledge and skills to identify and appropriately manage FGM  
  - This has been done by developing a risk assessment tool which will be distributed among all frontline staff. GPs have received the tool thus far | In Progress  
  - GPs received  
  - Printing in progress to disseminated to all frontline staff |
| | The FGM Strategy and Guidelines has been developed and signed off by the WSCB  
  - Pathways have been developed for each workforce and are to be embedded in Safeguarding training | Done |
| | Commission training on FGM for all frontline professionals  
  - The first training session was delivered 23rd January 2014 in collaboration with FORWARD | In Progress |
| | Incorporate FGM in Safeguarding training/update as a mandatory element for key professionals  
  - Further training will be embedded in Safeguarding training and any forums to raise awareness of roles and responsibilities, the correct way to record and report on FGM  
  - Meeting held with all safeguarding leads for each workforce to discuss incorporating a FGM module in the mandated training, and what information/message is to be delivered | In Progress  
  - Consultation with Safeguarding training leads to embed FGM training for all single-agency and multi-agency training – this has been agreed and a standardised training package will be sent to all trainers  
  - FORWARD will be contacted for training should it be requested |
| 3. Raise awareness among professionals, educational settings, and health care practices about FGM | Development of FGM awareness materials  
  - Work has been done with all stakeholders to develop FGM awareness materials (leaflets, banners etc.) for all frontline professionals  
  - Materials have been purchased from FORWARD for distribution at any event Public Health is invited to  
  - DVDs from NSPCC and other campaigns have been sourced for use in FGM training and raising awareness | Done |
| | Prepare for School Holidays  
  - In preparation a FGM School Pack will be sent to all schools with a covering letter stating the need to raise awareness amongst teachers, educate the girls and be vigilant in identifying a girl at risk  
  - PSHE leads, SENCOs, Child Protection Officers and teachers will be invited to a FGM training – TBC | In Progress  
  - Meeting held with Lorraine King to discuss how to distribute this information, packs are being developed and will be sent out by 4th July 2014 |
| | Work within Children Centres and other educational settings (college, home-schooled)  
  - In preparation for the summer term a pack will be delivered to all places of education to raise awareness | In Progress  
  - Information packs being developed to be posted |
<table>
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<tr>
<th>Objective</th>
<th>Action</th>
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<tbody>
<tr>
<td>Incorporate FGM awareness into PSHE education training for schools and the School Nursing Service</td>
<td>• FGM awareness has been included in the School Nursing Services Contract • Training of PSHEe leads to be done at the quarterly PSHEe Network meeting • Give schools an example of a Silver Healthy Schools Action Plan with FGM included, to encourage schools to include FGM</td>
<td>In Progress</td>
</tr>
<tr>
<td>Raise the profile of FGM by including it in the Wandsworth JSNA</td>
<td>• FGM has been included in the JSNA and will be updated accordingly</td>
<td>Done</td>
</tr>
<tr>
<td>Observe the International Day of Zero Tolerance to FGM on 6th February each year</td>
<td>• 6th February 2014 the screening of the video <em>The Cruel Cut</em> was hosted at Wandsworth Council to which members of the community, Public Health Department, Council and frontline staff attended • Members of the community were identified to train as Community Champions • Materials raising awareness to FGM and the risk identification poster were distributed to GP practices, schools and children centres</td>
<td>Done</td>
</tr>
<tr>
<td>4. Raise awareness among communities about FGM</td>
<td>Develop materials with versions translated into languages of the most affected communities • To work with FORWARD to develop FGM awareness materials in different languages • An advert was placed in Brightside Magazine (February edition) • Information on FGM is on Wandsworth Little Feet and Family Information Service websites • Love Productions has been contacted to request the movie <em>The Cruel Cut</em> to be dubbed into languages of the most affected communities – the use of visual media is very important • To develop an advert for Somali TV channels, or arrange for a talk show • Wandsworth FGM website to be developed</td>
<td>In Progress • Continue to liaise with the community representatives to develop ways in which to communicate with the communities information regarding FGM • Work has been done on establishing the Wandsworth FGM website</td>
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<tr>
<td>Community Champions to work within their own communities</td>
<td>• Once trained the Community Champions will work with Public Health and KLS to raise awareness within their own communities</td>
<td>In Progress • Training to commence in September 2014</td>
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<tr>
<td>5. Establish effective arrangements for data recording, analysis and sharing among partners</td>
<td>Work with GPs to identify templates and a code for recording FGM in line with national guidance • Templates and codes for EMIS have been identified and circulated to all GP practices • Further work will be required to follow up on the implementation • Ensure all methods of recording and reporting are in line with national guidance</td>
<td>In Progress • HM, AT and BD discussed codes to be placed on EMIS and ensure in line with national recording – to be launched October 2014</td>
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</table>
| Ensure FGM status on clients’ records is transferred when clients change practice | • Data on FGM status is to be transferred with clients moving out of the practice • AT to ensure the codes are transferrable between practices | In Progress • Decisions on codes have been made • Final agreement to be based on national guidance • Engage GPs, Practice Nurses, Health Visitors and
### Actions Undertaken

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<tbody>
<tr>
<td>Ensure FGM risk status on children records is transferred when children move out of area</td>
<td>• Data on FGM status transferred with children moving out of the area – EMIS will have transferrable codes</td>
<td>School Nurses in training on the importance of this action</td>
</tr>
<tr>
<td>Identify a coding system for Child Health Information System in line with national guidance</td>
<td>• This is underway and the final agreement will be based on national guidance • St George’s IT services and others have been consulted</td>
<td>In Progress</td>
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<tr>
<td>Ensure maternity contracts have a requirement for service providers to consistently document FGM status of the mother and the risk status of the child, and ensure such records are passed on to relevant stakeholders (e.g. GPs, health visitors) when clients are discharged from their service.</td>
<td>• Presentation to be given to the SWL Maternity Network 9th April 2014 • Local processes will be adopted in the interim of a national guidance, but will be updated accordingly • New patient forms include a question to all mothers on FGM status • The importance of recording FGM status of the mother on the mother’s record and the child’s record to and this information passed on to the GP and Health Visitor to be encouraged during training</td>
<td>In Progress • National guidance released on 4th April 2014 mandates that All women are asked if they have FGM during ante-natal contacts</td>
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<td>Ensure FGM status is recorded on discharge summaries between Maternity Services and Health Visiting service and GP practices</td>
<td>• FGM status routinely handed over to partner agencies in discharge summaries • Denise Henry has ensured St George’s Maternity services have this on their forms</td>
<td>In Progress • That all information regarding FGM is recorded on the discharge summary to go to GPs and Health Visitors</td>
</tr>
<tr>
<td>Establish a case reporting/notification system for FGM to include who should be the first point of contact (Police or Children’s Social Care) for frontline professionals.</td>
<td>• Through consultation with the relevant stakeholders an interim guidance has been developed and following the WSCB will be disseminated across all frontline professions • The local guidelines will be updated accordingly to national guidance</td>
<td>In Progress • Discussions have been has with Children Services and Safeguarding as to whether MASH is the first point of call – decision to be updated on all documents</td>
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<tr>
<td>Work with the Professional Centre and Schools to collect demographic data on pupils within schools to: 1. Create a baseline summary of the number of girls “at risk” within the borough 2. Explore how schools can use the data to create a universal and targeted approach to FGM priorities 3. Incorporate recording of ethnic groups (based on the list of priority countries) in the annual school census</td>
<td>• Discussions are underway and data is being collected by the BMA and PSHE leads in schools to be submitted to Public Health (Bunty Dames) • To be embedded with Laurence Gibson’s team in the Public Health Department</td>
<td>In Progress</td>
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<tr>
<td>Establish FGM support groups in communities at risk of FGM</td>
<td>• Meetings with the community groups have started, during which time issues such as the law, raising awareness and posters development have been broached</td>
<td>Done • A continual action</td>
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6. Empower communities to take action to
### Actions Undertaken

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<tr>
<th>Objective</th>
<th>Action</th>
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<tr>
<td>prevent FGM</td>
<td>Establish and support the community Champions scheme for FGM prevention in collaboration with FORWARD</td>
<td>In Progress • Meeting with KLS and FORWARD has been held to establish the roles of each stakeholder • Members of the community are being identified • Training will commence in September 2014</td>
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<td></td>
<td>• Members of the community have been identified to train as Community Champions</td>
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<td>• A bid was secured from the Home Office for funding in a collaboration with the Katherine Low Settlement (KLS) and FORWARD to train a community members as Community Champions who will form a team that will work within the communities to raise awareness, provide support and end FGM. This team will be managed by the KLS, and they will be advocates against FGM</td>
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<td>Working with other Boroughs</td>
<td>• Wandsworth Public Health has been contacted by other Boroughs for use of the Strategy and Guidelines in developing their own (e.g. Sutton and Merton) • Wandsworth Public Health has been contacted to work collaboratively in helping other Boroughs understand the challenges faced and working with all stakeholders (e.g. Coventry)</td>
<td>In Progress • Permission given to Sutton and Merton to use the FGM Strategy and Guidelines to write their own • 9th July 2014 BD and AY to go to Coventry to present Wandsworth FGM Strategy</td>
</tr>
<tr>
<td>7. Ensure consistency in approaches to tackling FGM</td>
<td>Participation in regional and national forums on FGM • Members of the FGM Strategy group attend various forums on FGM (Stewart Low, Anne Varvill, The Metropolitan Police representation and others)</td>
<td>Done A continual action</td>
</tr>
<tr>
<td>8. Monitoring the implementation of the action plan</td>
<td>Establish the FGM Steering group to coordinate interventions to reduce FGM and monitor progress of the action plan implementation • To be monitored on an annual basis by the Department of Public Health, Community Safety and the WSCB</td>
<td>Done A continual action</td>
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### Actions Still to be Undertaken

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<tr>
<th>Objective</th>
<th>Action</th>
<th>By whom</th>
<th>Outcome</th>
<th>By when</th>
<th>Progress</th>
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<tbody>
<tr>
<td>1. Raise awareness among professionals about FGM</td>
<td>Work with FORWARD to organise an FGM “Conference” to raise awareness among frontline professionals</td>
<td>Stewart Low Jenny Iliff Vicky Pigott Denise Henry</td>
<td>Violence Against Women and Girls (VAWG) Forum on FGM delivered Increased FGM awareness among</td>
<td>Summer 2014 (before the school summer break)</td>
<td>Plan will be developed by August 2014</td>
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<tr>
<td>2. Raise awareness among communities about FGM</td>
<td>Commission the development and screening of FGM adverts in GP Practices</td>
<td>Bryony Dobson Stewart Low Hodan Abdi and Ayan Yusuf</td>
<td>Increased FGM awareness among communities</td>
<td>July 2014</td>
<td>• Funding for this to be discussed June 2014 • On-going</td>
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<tr>
<td><strong>3. Establish effective arrangements for data recording, analysis and sharing among partners</strong></td>
<td>Develop an agreed information gathering and sharing protocol on FGM among key stakeholders.</td>
<td>Jacquie Burke</td>
<td>Data sharing protocol agreed among partner agencies</td>
<td>September 2014</td>
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<td><strong>4. Strengthen capacity within partner agencies to effectively address FGM-related issues and making FGM everyone’s business</strong></td>
<td>Commission training on FGM management for all frontline staff e.g. care pathways, counselling, and FGM legislation.</td>
<td>Fiona Wallace, Ileen Ashitey, Winnie Lacey</td>
<td>Staff equipped with requisite skills to appropriately manage FGM cases</td>
<td>September 2014</td>
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<td></td>
<td>Develop counselling and support services with provider organisations</td>
<td>Denise Henry, Jenny Iliff, Jenny Giles</td>
<td>Effective counselling and support services provided for FGM victims and those at risk of FGM</td>
<td>TBC</td>
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<td><strong>5. Learn from the experience of areas implementing “good practice” programme on FGM</strong></td>
<td>A team to visit areas with “good practice” programmes (e.g. Bristol)</td>
<td>Jenny Iliff, Ileen Ashitey</td>
<td>Visit/s made to good practice programmes</td>
<td>June 2014</td>
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<td>Tentative time established</td>
<td>Awaiting details</td>
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<tr>
<td><strong>6. Ensure consistency in approaches to tackling FGM</strong></td>
<td>Adopt revised London Safeguarding Procedures for FGM when completed</td>
<td>FGM Steering Group</td>
<td>When completed</td>
<td>TBC</td>
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<td></td>
<td>Implement relevant national protocols on FGM including data coding and sharing</td>
<td>FGM Steering Group in collaboration with partner agencies</td>
<td>When developed</td>
<td>TBC</td>
<td></td>
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<tr>
<td><strong>7. Monitoring the implementation of the action plan</strong></td>
<td>Ensure the FGM steering group is accountable to WSCB</td>
<td>Stewart Low, WSCB</td>
<td>TBC</td>
<td>14th April 2014 presented to the WSCB Report back to WSCB quarterly</td>
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**Key Points:**
- Jacque Burke to disseminate existing information sharing protocol
- Agreement is required by all stakeholders on the information sharing protocol
- To be delivered through multi-agency training to equip staff of all partners
- To be discussed with CCG and other stakeholders
- To be included in the Opal Clinic
- Tentative time established
- Awaiting details
- 14th April 2014 presented to the WSCB Report back to WSCB quarterly
8 Appendices

8.1 Appendix 1: Map of Prevalence of FGM

Figure 4: Prevalence of FGM in Africa and Middle East

Source: UNICEF (2013)
8.2 Appendix 2: Detailed WHO classification of FGM

- **Type 1** — Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
  - When it is important to distinguish between the major variations of Type I mutilation, the following subdivisions are proposed:
    - Type Ia, removal of the clitoral hood or prepuce only;
    - Type Ib, removal of the clitoris with the prepuce.

- **Type 2** — Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).
  - When it is important to distinguish between the major variations that have been documented, the following subdivisions are proposed:
    - Type 2a, removal of the labia minora only
    - Type 2b, partial or total removal of the clitoris and the labia minora
    - Type 2c, partial or total removal of the clitoris, the labia minora and the labia majora.

- **Type 3** — Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
  - Type 3a, removal and apposition of the labia minora
  - Type 3b, removal and apposition of the labia majora.

- **Type 4** — All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.

8.3 Appendix 3: Glossary of terms used in various practising and affected communities

Egypt: “Thara” & in Sudan “Tahoor” are derived from the Arabic “Tahar” meaning to clean or purify.

Nigeria & Sierra Leone both use the word “Sunna” which means a religious tradition / obligation for Muslims.

Many other communities in Sierra Leone have words in their own languages meaning that it is an integral part of an initiation rite into adulthood for non-Muslims.

Somalia: “Halalays”, derived from the Arabic “Halal”, i.e. sanctioned, implies purity.

Gambia: “Niaka” – “to cut /weed clean”; “Kuyango” – the name for the shed built for initiates; “Musolula” – “the women’s side” – that which concerns women.

Most countries also use the same word to describe both FGM and male circumcision E.g.: “Gudiniin” in Somali. 

9 References


