



FGM

RESPONDING TO FEMALE GENITAL
MUTILATION IN SCOTLAND

MULTI-AGENCY GUIDANCE

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safer
scotland
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MINISTERIAL FOREWORD



Angela Constance
**Cabinet Secretary for
Communities, Social Security
and Equalities**

Figures from the World Health Organisation tell us that more than 200 million girls and women alive today have been cut (in a procedure which partially or wholly removes or injures their genitalia, for non-medical reasons) in 30 countries in Africa, the Middle East and Asia where Female Genital Mutilation (FGM) is concentratedⁱ. This practice is a physical manifestation of the deep rooted inequality between the sexes; it is an illegal and unacceptable practice which violates the human rights of women and girls.

The Scottish Government is committed to tackling inequality and to preventing and ending all forms of gender based violence, as outlined in Equally Safe: Scotland's strategy for preventing and eradicating violence against women and girls.

There are no quick fixes to tackling FGM and there is no single solution to ending the practice. In Scotland we are taking a collaborative considered approach to the best way to tackling the practice, making sure that what we do helps prevent FGM, provides protection to those at risk, delivers the services that those affected require and through participation gives a voice to communities affected by this practice.

Importantly we need to ensure that those who may be called upon to protect those at risk of FGM, or who may have to respond to the consequences of it are equipped with the relevant information and guidance to understand what is required of them. The complexities associated with FGM, such as why it is done, by whom, and what it signifies, mean that responding appropriately can be challenging.

This guidance provides a framework within which agencies and practitioners can develop and agree processes for working collaboratively and individually to promote the safety and wellbeing of women and girls, and supplements agencies and organisations own policies and procedures on FGM.

It covers; how to identify whether a girl (including an unborn girl) or young woman may be at risk of FGM; how to identify a girl or

i http://www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD.pdf

woman who has undergone FGM; how to protect those at risk and support those already affected; and how to prevent and end FGM.

Recognising the importance of multi-agency working, this guidance is for all services, agencies, organisations and individuals responsible for protecting and promoting the health and welfare of women and girls. This includes, but is not limited to, local authorities, Police Scotland, the NHS and third sector organisations that work with girls and women at risk of or affected by FGM, or deal with its consequences.

It also makes clear that statutory bodies and strategic partnerships such as local authorities, health boards, Police Scotland, Community Planning Partnerships, and integrated joint boards should ensure that their member agencies work together effectively to tackle FGM.

It outlines the issues and presents good practice when dealing with survivors. It sets out how agencies, individually and together, can protect girls and young women from FGM, and how they can respond appropriately to those who have been affected. The best way to make sure that women and girls are protected and supported, now and in the future, is for agencies to work together and with affected communities, to provide a multi-agency response.

Without the dedication of individuals and partners across the statutory, third sectors and from affected communities we would not have been able to develop this comprehensive guidance.

Therefore I would like to take this opportunity to express my thanks to everyone who has contributed. It is their hard work, commitment and their expertise that has delivered a resource which will contribute directly to our work to prevent and eradicate this practice.



Angela Constance
**Cabinet Secretary for Communities
Social Security and Equalities**

1. BACKGROUND

Aims of this guidance

The guidance aims to help with:

- Identifying whether a girl (including before birth) or young woman may be at risk of FGM.
- Identifying whether a girl or woman has undergone FGM.
- Protecting those at risk and responding appropriately to those already affected.
- Working to prevent and end FGM.

Female genital mutilation (FGM) is a form of child abuse and violence against women. The complexities associated with FGM, such as why it is done, by whom, and what it signifies, mean that responding well can be challenging.

The guidance sets out how agencies and frontline staff, individually and together, can protect girls and young women from FGM, and respond to survivors in the right way. It describes 'best practice' and the main elements of a sensitive and suitable response. The best way to make sure that women and girls are protected and supported, sooner rather than later, is for agencies to work together.

Statutory bodies and strategic partnerships such as local authorities, health boards, Police Scotland, Community Planning Partnerships, and integrated boards should ensure that their member agencies work together effectively to respond to FGM.

Good practice also means working closely with, and directly involving, communities affected by FGM. This includes raising awareness, but also supporting communities to end FGM, for example by taking part in developing policy and designing services.

Who it is for

The guidance is for all areas, services, agencies, organisations, practitioners and individualsⁱⁱ responsible for protecting and promoting the health and welfare of women and girls. This includes, but is not limited to, local authorities, Police Scotland, the NHS and third sector organisations which work with girls and women at risk of, or affected by FGM, or which deal with its consequences.

ii Referred to as agencies throughout the guidance for brevity

The Scottish Government is committed to preventing and ending all forms of violence against women, as outlined in **Equally Safe: Scotland's strategy for preventing and eradicating violence against women and girls (2016)**ⁱⁱⁱ. This includes working with statutory and third sector agencies and communities to tackle FGM.

This guidance on FGM provides a framework within which agencies and practitioners can develop and agree processes for working collaboratively and individually to promote the safety and wellbeing of women and girls. It highlights the main responsibilities for agencies and individuals, and promotes a clear and consistent approach across all agencies and areas. It supplements other guidance such as the **National Guidance for Child Protection in Scotland (2014)**^{iv} and agencies' own policies and procedures on FGM.

Principles of the guidance

The principles of the guidance are:

- FGM is illegal in Scotland.
- The safety and welfare of the child is paramount.
- All agencies must act in the interests and the rights of the child as stated in the UN Convention (1989).
- FGM is extremely harmful. Women who have experienced FGM should be treated as survivors of gender-based violence and should be treated with respect and compassion.
- Professional practice means not letting personal fears of being thought 'racist' or 'discriminatory' compromise the duty to provide effective support and protection.
- Professional practice means asking questions, whether or not they cause embarrassment. FGM may be a sensitive subject, but it is also a criminal offence.
- Health, education, police, social work and third sector services must provide accessible, high-quality and sensitive interventions.
- Competent assessments (as outlined in child protection and adult support and protection guidance) should guide professional decisions and plans. These must be sensitive to ethnicity, culture, gender, religion and sexual orientation. They should not stigmatise or make assumptions about the girl or woman affected, or her community.
- FGM is a 'cultural practice' which, like many traditions, is difficult to shift. Ending FGM means working closely and respectfully with families and communities.

iii <http://www.gov.scot/Resource/0049/00498256.pdf>

iv <http://www.gov.scot/Resource/0045/00450733.pdf>

2. INTRODUCTION

Context

FGM is a form of child abuse and violence against women. It is a deeply harmful practice which violates the human rights of girls and women. It can significantly affect their physical, sexual and mental health and wellbeing for life.

The Scottish Government is committed to preventing and ending all forms of violence against women, as outlined in **Equally Safe: Scotland's strategy for preventing and eradicating violence against women and girls (2016)**^v. This includes working with statutory and third sector agencies and communities to tackle FGM.

This guidance on FGM provides a clear and consistent approach across all agencies and areas.

In accordance with the **National Guidance for Child Protection in Scotland (2014)** and **The Children and Young People (Scotland) Act 2014** this guidance defines a child as a person under 18 years of age.

The priority is always to ensure that a vulnerable young person who is, or may be, at risk of FGM is offered support and protection. **The age of the person concerned should not be a barrier to an inter-agency discussion taking place. A response proportionate to the level of risk is essential.**

Getting It Right for Every Child (GIRFEC)^{vi} requires practitioners to meet children and young people's wellbeing needs. This includes agencies working together when necessary.

Agencies should always consider local adult support and protection arrangements. Individuals with a learning disability, cognitive impairment and/or mental health problems are particularly vulnerable to abuse. Agencies should take account of both child protection and adult protection procedures when considering 16- and 17-year-olds.

Scottish Government action on FGM

The safety and wellbeing of women and girls is a key priority for the Scottish Government. Preventing and ending FGM is part of that.

The Scottish Government recognises that communities and individuals affected by FGM must be at the heart of work to

v <http://www.gov.scot/Resource/0049/00498256.pdf>

vi <http://www.gov.scot/Topics/People/Young-People/gettingitright>

change the attitudes and practices behind it. Long-term change requires sustained commitment from all partners.

The Scottish Government is working to prevent FGM, and to improve identification and response. In 2014, it funded the Scottish Refugee Council to research communities affected by FGM in Scotland and models of intervention. The subsequent report **Tackling Female Genital Mutilation in Scotland: a Scottish model of intervention (2014)**^{vii} is informing the national approach.

The Scottish Government published **Scotland's National Action Plan to Prevent and Eradicate Female Genital Mutilation (FGM) 2016-2020**^{viii} setting out actions for the Scottish Government and partners to:

- Prioritise prevention/protection from FGM, provide services and support to those affected, strengthen the law to extend protection to those at risk and to sanction perpetrators.
- Inform those at risk that FGM is illegal in Scotland and a violation of their human rights.
- Work with communities to understand FGM and its impact.
- Support communities to change perceptions, attitudes and behaviour.
- Provide information, guidance and training to the statutory and third sectors.

More information: <http://onescotland.org/equality-themes/gender/female-genital-mutilation-fgm/>

What is FGM?

Definition/types of FGM

The World Health Organization (WHO) defines FGM as 'all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons'.

FGM has no health benefits. It harms girls and women in many ways, and is frequently very traumatic and violent for women and girls.

WHO^{ix} classifies the practice into four types:

- **Clitoridectomy (Type I):** partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).
- **Excision (Type II):** partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are 'the lips' that surround the vagina).
- **Infibulation (Type III):** narrowing of the vaginal opening by creating a covering seal. The seal is formed by cutting and repositioning the inner or outer labia, with or without removal of the clitoris.

vii www.scottishrefugeecouncil.org.uk/assets/9061/FGM_Report_FINAL_A4portrait.pdf

viii <http://www.gov.scot/Resource/0049/00493752.pdf>

ix WHO guidelines on the management of health complications arising from female genital mutilation, 2016: <http://www.who.int/reproductivehealth/topics/fgm/en/>

- **Other (Type IV):** all other harmful procedures to the female genitalia for non-medical purposes, such as pricking, piercing, incising, scraping and cauterising the genital area^x. This includes labia elongation, also referred to as labia stretching or pulling, in which the labia minora are stretched sometimes using sticks, harnesses or weights.

Terminology

Female genital mutilation (FGM) is an internationally-recognised term. It conveys the severe harm it causes to women and girls. However, women affected by FGM may not describe themselves as 'mutilated' and may not recognise the term 'FGM'. Although 'FGM' or 'cutting' are common terms, they are not universally understood because they are English words.

Practitioners and agencies should understand the severe harm which FGM causes but mirror a woman's own description of her experience. For example, she may use other words such as 'cutting' or 'circumcision'. The term 'female circumcision' is unfortunate because it is anatomically incorrect and also misleading.

See Appendix 2 for a list of other terms used and their underlying meaning.

Health consequences of FGM

FGM can have multiple and severe consequences for physical and mental health in the short-term and throughout a woman's life.

Immediate physical health consequences

Immediate physical health consequences include:

- Severe pain.
- Emotional and psychological shock (exacerbated by being subjected to the trauma by loving parents, carers, extended family and friends).
- Haemorrhage.
- Wound infections including Tetanus and blood-borne viruses (including HIV and Hepatitis B and C).
- Urinary retention.
- Injury to adjacent tissues.
- Fracture or dislocation as a result of restraint.
- Damage to other organs.
- Death.

Long-term physical and mental health consequences

Women may experience recurrent sexual, psychological and physiological problems. They are likely to require specialist surgical and psychological interventions during pregnancy and childbirth. WHO data show that, compared to women who have not undergone FGM, those subjected to any type of FGM have increased complications in childbirth, worsening with Type III (infibulation).

x In the event that these procedures are requested for the purpose of female genital cosmetic surgery (FGCS), and the woman is fully autonomous and able to give consent, WHO considers these to be distinct from the lack of consent and the coercion and violence which attend FGM. See 'WHO guidelines on the management of health complications from FGM' 2016 at <http://www.who.int/reproductivehealth/topics/fgm/en/>
In the NHS in Scotland, FGCS is covered by the Adult Exceptional Aesthetic Referral Protocol [http://www.sehd.scot.nhs.uk/mels/CEL2011_27.pdf] and should only be considered for women with a functional impairment confirmed by an appropriate specialist.

Long-term physical health consequences include:

- Chronic vaginal and pelvic infections.
- Difficulties during menstruation.
- Difficulties in passing urine and chronic urine infections.
- Renal impairment and possible renal failure.
- Damage to the reproductive system, including infertility.
- Infibulation cysts, neuromas and keloid scar formation.
- Complications in pregnancy and delay in the second stage of childbirth.
- Maternal or foetal death.
- Increased risk of sexually-transmitted infections.

Long-term mental health implications:

- FGM can be extremely traumatic with lifetime impact. There is increasing awareness of the severe psychological consequences of FGM, which can become evident in mental health problems, drug and alcohol dependency^{xi}. Young women receiving psychological counselling have reported feelings of betrayal by parents, incompleteness, regret and anger^{xii}.
- Research in communities affected by FGM in Africa^{xiii} found that women who have undergone FGM have the same levels of post-traumatic stress disorder (PTSD) as adults who have been subjected to early childhood abuse, and that the majority of the women (80%) suffer from affective (mood) or anxiety disorders.
- The fact that FGM is accepted in her culture and community does not protect a girl or woman from developing PTSD or other psychiatric disorders. Professionals, particularly those in health services, should ensure that girls and women receive mental health support as well as treatment for any physical symptoms or complications.

Communities affected

FGM has been practised across different continents, countries, communities and belief systems for over 5,000 years. This includes Europe, America, Asia, the Middle East and central Africa from the west coast to the Horn of Africa, where it is most concentrated today.

The worldwide movement of people means that FGM is found in communities all over the world, including Europe.

While the exact number is unknown, at least 200 million girls and women in 30 countries have undergone **FGM**^{xiv}. Since certain groups and diaspora communities continue the practice in other countries as well, the total number of girls and women worldwide who have undergone FGM is likely to be higher. The actual figure is not known because there are little reliable data on prevalence in these population groups.

xi Haseena Lockhat (2004) *Female Genital Mutilation: treating the tears*, London: Middlesex University Press

xii Hemmings, J. (2011) *The FGM Initiative Interim Report*, Options UK
<http://www.trustforlondon.org.uk/wp-content/uploads/2013/09/FGM-Interim-Report1.pdf>

xiii Behrendt A, Moritz S. (2005) Posttraumatic stress disorder and memory problems after female genital mutilation. *Am J Psychiatry*. 162:1000-1002.

xiv https://www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD.pdf

Whilst survivors of FGM are found in some communities in Scotland, not all women and girls born in countries or communities where it is practised are affected or at risk. There is no concrete evidence that FGM is actually being practised in Scotland, but neither is there clear evidence that it is not. Prevalence rates vary dramatically both within countries of origin and between them, so it is important not to make any assumptions about women or girls from a particular background or community.

In its report, **Tackling FGM in Scotland: towards a Scottish model of intervention (2014)**^{xv}, the Scottish Refugee Council analysed census, birth register and other data in an attempt to estimate the size and location of communities in Scotland which might be affected by FGM. It found that:

- Around 24,000 men, women and children living in Scotland were born in a country where FGM is practised to some extent.
- There are communities *potentially* affected by FGM in every local authority area, with the largest communities in Glasgow, Aberdeen, Edinburgh and Dundee respectively.
- Between 2001 and 2012, 2,750 girls were born in Scotland to women born in countries where FGM is practised to some extent.

There are no data on ethnicity or other variables which influence the practice of FGM in local communities, so it is not known how many people in those communities are directly affected.

The map in Appendix 3 shows where FGM is most prevalent in Africa and the Middle East. National prevalence rates often mask regional differences. **UNICEF**^{xvi} noted significant variance within countries, with FGM concentrated in specific areas/communities.

When, how and why FGM is practised

The age at which girls undergo FGM varies in different communities – from soon after birth to young adult. FGM is usually performed by older women, for whom it can be a lucrative source of income and prestige. They often perform FGM without medical expertise, anaesthesia or attention to hygiene.

In some communities, health professionals are performing FGM because they think that, if they do it, it will protect women from infection and pain. However, all international groups, including WHO, condemn this^{xvii}.

The practice of FGM is complex. Despite the harm it causes, many women think it is in the best interests of their daughters for reasons of faith, chastity, status, honour, marriageability, belonging, tradition, cleanliness or desirability.

FGM is often linked to sexuality and marriageability and performed to ‘control’ young women’s sexuality. Although both secular and faith communities practise FGM, it is often claimed as a

xv www.scottishrefugeecouncil.org.uk/assets/9061/FGM_Report_FINAL_A4portrait.pdf

xvi Female genital mutilation/cutting: a statistical overview and exploration of the dynamics of change (2013): <http://www.data.unicef.org/resources/female-genital-mutilation-cutting-a-statistical-overview-and-exploration-of-the-dynamics-of-change.html>

xvii WHO (2010) ‘Global Strategy to stop health-care providers from performing female genital mutilation UNAIDS, UNDP, UNFPA, UNICEF, UNHCR, UNIFEM, WHO, FIGO, ICN, IOM, WCPT, WMA, MWIA

religious practice. But no religion condones it and faith leaders have condemned it^{xviii}. In some communities, women who oppose FGM or who try to protect their daughters from it are abused or ostracised, and their daughters shunned or stigmatised.

FGM and the law

FGM is illegal in Scotland. It violates the rights of women and girls and contravenes international, Scots and UK Government law (see Appendix 1 for more information about international, EU and UK Government law).

International law

FGM contravenes human and women's rights under various international treaties. It has been recognised as a form of gender-related persecution under the **1951 Refugee Convention**^{xix} on the grounds of political opinion, membership of a particular social group or religious beliefs, and may, therefore, form the basis of a successful asylum claim. It is mentioned as an example of persecution based on membership of a particular social group in the **EU Qualification Directive**^{xx}. It also constitutes 'serious harm' in the context of the qualification for subsidiary protection within this directive.

The Law in Scotland

The Prohibition of Female Circumcision Act 1985 provides specific legislation to make FGM unlawful in Scotland. **The Prohibition of Female Genital Mutilation (Scotland) Act (2005)**^{xxi} as amended (the 2005 Act) makes it unlawful for a person to carry out specified FGM procedures on another person.

The legislation also makes it an offence for a person to aid, abet, counsel, procure or incite:

- Another person to commit an offence of FGM.
- Another person to carry out FGM on herself or another person who is not a UK national or UK resident to carry out FGM outside of the UK (for example to arrange by telephone from Scotland for their daughter to have an FGM operation carried out abroad by a non UK national or UK resident).

The provisions of the 2005 Act extend to cover actions outwith the UK performed by a UK national or UK resident. It means that a UK national or UK resident would commit an offence under Scots law if they travel to another country and carry out FGM even if FGM is not illegal in that country. It is also an offence for a UK national or UK resident to travel outwith the UK and aid, abet, counsel, procure or incite another person to carry out FGM in that country even if FGM is not illegal in that country.

The penalty on conviction on indictment is up to 14 years' imprisonment.

The 2005 Act allows an approved person to carry out a surgical operation on someone if necessary for the latter's physical or mental health, or on a woman in labour or who has just given birth, for reasons connected with the birth (see Appendix 1).

xviii <http://imamsonline.com/blog/religious-leaders-sign-declaration-on-fgm/>
<http://chiefrabbi.org/the-chief-rabbi-signs-declarations-condemning-female-genital-mutilation-and-forced-marriage/>
<https://www.gov.uk/government/news/faith-and-community-leaders-unite-to-condemn-fgm>
http://huffingtonpost.com/entry/female-genital-mutilation-un-islamic-fgm_n_5523095

xix <http://www.unhcr.org/uk/1951-refugee-convention.html>

xx <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:32004L0083:EN:HTML>

xxi <http://www.legislation.gov.uk/asp/2005/8/contents>

If a child has been a victim of FGM, or is at risk of becoming a victim of FGM, (for example, she lives in the same household as a victim of FGM or as a person who has previously committed an offence involving FGM) then she can be referred to the Reporter to the Children's Hearing. The police, the local authority, health services, schools or by any other person or agency who has concerns about the child can refer her. The court has a specific power to refer affected children if someone has been convicted by that court of an offence which involves FGM.

Local authorities are subject to a particular responsibility under section 60 of **the Children's Hearings (Scotland) Act 2011**^{xxii}. If they think it likely that (i) a child requires protection, guidance, treatment or control, and (ii) that it might be necessary for a compulsory supervision order to be made for the child, then they must make all necessary inquiries into the child's circumstances. If, following those investigations, the local authority thinks that (i) and (ii) apply, then they must make a referral to the Reporter. The police are subject to a similar duty under section 61 of the 2011 Act.

Law in England and Wales

The law on FGM in England and Wales differs from that of Scotland. Reporting within the media, and the publication of English and Welsh guidance, may overlook this distinction, leading to confusion about policy and practice. To clarify: in 2015 the UK Parliament passed the Serious Crime Act which introduced additional provisions on FGM including mandatory reporting, FGM Protection Orders and statutory multi-agency guidance. These requirements apply **only** in England and Wales. There is more information about this and about international law in Appendix 1.

xxii <http://www.legislation.gov.uk/asp/2011/1/contents>

3. POLICY: ALL AGENCIES

Agencies such as the NHS, Police Scotland, education and social work services have a statutory responsibility to protect girls and young women at risk of FGM. They must ensure that policies and procedures are clear; staff are supported and equipped to undertake the duties expected of them; and that there are clear lines of accountability.

Preventing FGM

Although much of this guidance is about identifying risk and responding to harm, the best way to protect girls and women is to prevent and end FGM.

Evidence shows that efforts to prevent and reduce FGM are most successful when the communities affected are actively and directly involved, and supported to be so, as partners. This means that agencies need to work with communities; listen to their concerns; and find solutions and services which are relevant and workable.

In 2016, the Scottish Government published **a national action plan on FGM**^{xxiii}.

Policy and protocol

Agencies should have FGM protocols and pathways for internal communication, responding and referring. They should also develop multi-agency protocols and pathways so that there are consistent approaches and clear expectations across agencies.

Agencies should respond to FGM using existing child and adult protection structures, procedures and policies, including multi-agency arrangements. If FGM is not explicitly included in these, they should add it urgently so that staff know how to respond to a report, suspicion or risk of, or actual FGM.

Policies and procedures should take account of the characteristics of FGM. Risk may escalate or reduce through childhood and adolescence. Partner agencies may need to update one another and review decisions and actions regularly, from a child's birth onwards

Organisational lead/champion

Each organisation should have a designated FGM lead or single point of contact.

xxiii <http://www.gov.scot/Resource/0049/00493752.pdf>

Education

In education, there should be an identified operational lead, with whom the 'designated member' of staff for child protection can consult. They should monitor information to identify when a child in the school or community may be affected. The lead individual should have, or develop, expertise about FGM. They should be able to advise education establishments about identifying and referring a child at risk and how their agency can contribute to risk reduction and the Child's Plan.

Social work

In social work, there should be an identified operational lead who can be contacted for advice or guidance about FGM. The lead individual should have, or develop, expertise about FGM.

Health

In each health board, there should be a clinical lead who is a senior clinician. If the clinician is from mental health services, they should liaise with other clinical services. Health boards should notify other professionals and the community of the name and contact details of the FGM clinical lead, and a named deputy to cover for absences. The clinical lead should have links to the gender-based violence (GBV) operational lead, child protection lead, adult protection lead and others as relevant for individual children and young people.

Data recording and monitoring

Agencies should review data recording and monitoring systems to include FGM where possible.

All agencies should gather, record and collate data about FGM. This is important for understanding the needs of individuals and communities, for commissioning services and for raising awareness. It also helps with identifying risk, intervening promptly, and noticing what is happening within communities.

Health boards should gather anonymised data in order to assess local health and social work needs and to contribute to ISD national data gathering from hospitals, community services and GP practices. It is important for hospital staff to record issues related to FGM on the discharge summary and/or letter to the GP practice, even if FGM is not the reason for attendance. FGM cannot be coded if it is lost in the clinical records. GP practices should use the appropriate 'Read code' for FGM.

Sharing information

Agencies should introduce or strengthen information sharing on FGM so that they can protect women and girls. They should ensure that staff are aware of national guidance and local child protection procedures, and that this includes procedures for sharing information^{xxiv}.

Agencies should make sure that staff know that they:

- Should record any concerns.
- Must share child protection concerns with other key professionals.
- Share information within the context and boundaries of Data Protection Act (DPA).
- Should always share information with the Lead Professional consistent with GIRFEC if a child is involved, or with the adult support and protection lead when relevant.

xxiv <https://ico.org.uk/for-organisations/guide-to-data-protection/principle-6-rights/subject-access-request/>

Staff development and support

Training

Each agency is responsible for ensuring its staff are competent and confident in identifying and responding to FGM.

Each agency must ensure that its staff are competent and able to promote, support and safeguard children's safety and wellbeing. This includes providing training and development; and having communication protocols and clear standards.

Public protection chief officers groups should ensure that multi-agency training is developed to enhance that done by individual agencies.

Different staff groups have different skills, knowledge and responsibilities. Staff from all agencies should be confident about their own roles and how these fit into the wider picture.

All staff should know their agency's policy on FGM, and where they can get information, training and support.

Given the relatively few cases of FGM in Scotland, agencies should make training on FGM a priority. In order to prevent harm to girls, trained professionals need to work closely with families, over time, to assess risk, and intervene if necessary.

Information, training and other materials

The Scottish Government has commissioned information, training and other materials. These include:

- A DVD for training and awareness raising: **Sara's Story**^{xxv}.
- Information leaflets for practitioners.
- Training pack and risk assessment tool for practitioners.
- Scottish Government statement opposing FGM. This statement is for people to show to family or friends, when travelling abroad, to explain that FGM is against the law in Scotland and the UK. It may help them resist pressure from relatives, friends and communities.

These materials are at: <http://onescotland.org/equality-themes/gender/female-genital-mutilation-fgm/>

Service capacity and sustainability

Demand on services may increase as more women come forward, and staff become more skilled in identifying FGM. Migration and population movement may also increase demand for services.

Agencies need to plan for this: both succession planning for the workforce and on-going staff training.

Given the potential for harm, FGM should be embedded within child protection services. It is also important to embed FGM services within existing violence against women/gender-based violence services, given the significant overlaps, for example in dealing with trauma, disclosure, safety and the sensitivity of the issue.

Given the health consequences of FGM, the NHS is likely to be in contact with survivors of FGM and their children. There are different points of entry to the health service where this may be identified. The Scottish Government Health and Social Care Directorate has **issued guidance**^{xxvi} on developing service specifications to meet the needs of survivors.

xxv <http://www.fgmaware.org/>

xxvi [http://www.sehd.scot.nhs.uk/cmo/CMO\(2016\)05.pdf](http://www.sehd.scot.nhs.uk/cmo/CMO(2016)05.pdf)

4. GOOD PRACTICE RESPONSE: ALL PRACTITIONERS

Approach

The multi-agency approach in this guidance is to encourage engagement with families, to find supportive interventions, and to build trust with individuals and communities. Although in some cases parents may be the source of risk to a child, it is important that communities are not marginalised, and that assumptions are not made about parents'/mothers' intentions.

Talking about FGM

FGM is a deeply personal issue. How this is discussed is as important as what is said, and can shape all future interactions with a woman or girl. There are some important things to remember when broaching the subject. These are:

Sensitivity

Asking the right questions in a straightforward and sensitive way is vital for establishing the understanding, information exchange and relationship needed to ensure that a girl or woman, and her family members, receive the care and protection they need.

Women often say they felt distressed and humiliated by the reactions of staff when FGM was revealed. They describe horrified expressions, and inappropriate and insulting questions, and say they felt ashamed and 'abnormal'. If professionals react like this, it can be devastating for women. Word can get back to communities, thus deterring other women from seeking treatment or support and preventing them from getting effective care.

'Sometimes when circumcised women go to the hospital, the nurses call each other to see the circumcised woman. This is an unhappy experience for many women. The nurses ask a lot of questions and they stare^{xxvii}.'

There is a video on **NHS Choices**^{xxviii} in which women who have undergone FGM discuss how they would like professionals to talk to them about it.

xxvii Quote from interviews conducted as part of FORWARD (2009) FGM is always with us: experiences, perceptions and beliefs of women affected by female genital mutilation in London: results from a PEER study

xxviii <http://www.nhs.uk/NHSEngland/AboutNHSservices/sexual-health-services/Pages/fgm-for-professionals.aspx>

'It is embarrassing when men or women (except doctors and nurses) from other ethnic groups ask me about FGM and about what happened to me. I prefer speaking to other women like me who know. I hate being exploited and treated like a spectacle - reminds me of the 'human zoo' - I bet they won't appear in any report.'

Ensuring safety

Practitioners may need to devise a safety plan in case someone sees the woman at or near the department, venue or meeting place. This could include, for example, helping her work out another reason for explaining why she is there.

If a woman/girl insists on having someone else with her, for example a teacher or advocate, practitioners should do all that is reasonable ensure that this person understands the importance of maintaining confidentiality, especially from the family.

Women/girls may need an authorised and accredited interpreter in their dialect (see more on interpreting below).

Good practice when raising the subject of FGM

- ✓✓ If possible, provide a female practitioner if the girl/woman would prefer this
- ✓✓ Understand that the girl/woman may not realise that she has had FGM
- ✓✓ Use simple language
- ✓✓ Do not make assumptions
- ✓✓ Give the girl/woman time to talk
- ✓✓ Listen to what she says
- ✓✓ Create an opportunity for her to disclose, for example, see her on her own, in private
- ✓✓ Be sensitive to the intimate nature of the subject
- ✓✓ Understand she may be loyal to her parents or wider family
- ✓✓ Explain the limits of confidentiality
- ✓✓ Explain that you are asking questions in order to offer support
- ✓✓ Ask straightforward questions such as:
 - 'Have you been closed?'
 - 'Were you circumcised?'
 - 'Were you cut?'
- ✓✓ Be direct. You are asking her whether it happened and what the effects are on her now. You are not asking her to describe what happened in detail because that could re-traumatise her
- ✓✓ If you need to clarify, ask questions such as:
 - 'Does it hurt when you have sex?'
 - 'Does it hurt when you pee?'
 - 'Does it take a long time to pee/does it come out in small amounts?'
 - 'Is it painful when you have your period?'
 - 'Have you had any difficulties in childbirth?'

Good practice when responding

- √ Explain that FGM is illegal and that the law can help a family avoid FGM if/when they have daughters
- √ Explain sensitively the health consequences of FGM
- √ Be non-judgemental (a practitioner should point out the illegality and health risks of FGM, without blaming the girl/woman/her family/community)
- √ Get accurate information about the urgency of the situation if girl/woman is at risk of undergoing FGM, and follow child protection or adult protection procedures
- √ Make and keep a detailed record
- √ If health staff, record FGM in girl/woman's healthcare record, and details of any conversations with her
- √ Stress that the girl/woman can come back to the service/practitioner at another time if she wishes
- √ Offer support, for example counselling, NHS FGM clinics/services
- √ Give out the Scottish Government leaflet: **A statement opposing female genital mutilation**^{xxix}

Good practice in using interpreters

Practitioners may need to arrange for an interpreter. This should be an accredited female interpreter (or male if preferred by the woman). The interpreter should be able to interpret the girl/woman's dialect. The interpreter should know that their role is to translate verbatim and not interpret the message or censor or omit any of the information. Ideally, the interpreter should have had FGM-awareness training.

The interpreter should never be a family member, be known to the individual, or be someone with influence in the girl/woman's community. This is because girls/women may feel embarrassed about discussing sensitive issues. They may be frightened that personal information could be passed on to others in their community and place them in danger. Also, there is a risk that interpreters who are from the family or an individual's community may deliberately mislead staff and/or encourage and even threaten the individual to drop the complaint and comply with the wishes of the family/community.

- √ Check the girl/woman's dialect before arranging an interpreter
- √ Meet the interpreter beforehand to brief her/him
- √ Explain the role of the interpreter to the girl/woman at the beginning of the discussion
- √ If the girl/woman insists on being accompanied, check that she understands the nature of the discussion and the implication of having someone else there
- √ Speak separately to the person accompanying to brief them, particularly about the importance of confidentiality and the dangers of breaching it. There may also be the opportunity to debrief them afterwards

Glasgow Violence Against Women Partnership has published **good practice guidance on interpreting for women who have experienced gender-based violence**^{xxx}.

xxix <http://onescotland.org/wp-content/uploads/2016/11/FGM-Scottish-Government-Statement-2017-1.pdf>

xxx <http://www.womenssupportproject.co.uk/content/news/210,1,351/Goodpracticeguide.html>

'I thank you very much for your kind visit to my home today and the encouragement that I should not be ashamed of being a victim of FGM...I very much look forward to baring it all; the shame, the sorrow of depression, the pain of bearing it all without anyone to confide in, the psychological effects of past and present relationships, the list goes on and on. Most importantly, I hold my heart in mouth at the thought of what could be done to my two innocent under-age daughters if I am forced to take them back home. This thought fills me with fear and trepidation, which gives me sleepless nights.

I do hope I get the much desired solutions and support to put a closure to this emotional and psychological torment.'

(from KWISA)

5. RESPONDING TO GIRLS AT RISK OF, OR WHO HAVE ALREADY UNDERGONE, FGM: ALL AGENCIES

‘Protecting girls at risk of harm through FGM poses specific challenges because the families may give no other cause for concern. There may be an intergenerational element, or husband and wife may have differing views about daughters. The wish to carry out FGM is also not confined to individuals within particular levels of education or social class. The pressure to undertake this procedure may be embedded in family structures. At all times, however, it is important to think the unthinkable, and act with respectful uncertainty.’

(Department of Health, 2003)

Identifying risk

The National Child Protection Guidance for Scotland (2014) defines risk and significant harm:

‘Risk is the **likelihood** or **probability** of a particular outcome given the presence of factors in a child or young person’s life...Risks may be deemed acceptable; they may also be reduced by parents/carers or through the early intervention of universal services. At other times, a number of services may need to respond together as part of a co-ordinated intervention. Only where risks cause, or are likely to cause, **significant harm** to a child would a response under child protection be required. Where a child has already been exposed to actual harm, assessment will mean looking at the extent to which they are at risk of repeated harm and the potential effects of continued exposure over time.’

It can be difficult to identify girls at risk of FGM because, by tradition, different communities perform it at different ages. A girl/woman could be at risk in infancy, early childhood, adolescence, at marriage or first pregnancy. So, while practitioners might identify potential risk to a girl at birth, it may not become an imminent risk until she is (much) older.

Despite the difficulties, **practitioners need to take action to protect girls or women at risk**, consistent with their statutory duties.

Because of the variation in FGM practice, professionals need to share information about what they know or suspect so that action can be taken **if, or when**, the girl is at risk. Agencies may need to instigate child protection measures at birth and leave these in place for up to 18 years.

Practitioners should also ensure that families know that FGM is illegal, and that authorities are actively tackling the issue. This knowledge alone may deter families from having FGM performed on their children, and save girls and women from harm.

Women who experienced physical and/or psychological problems as a result of FGM, and who recognise the association, are less likely to support or carry out FGM on their own children and more likely to support or actively work to end FGM. However, any woman may be pressured by her husband, partner or other family members to allow or arrange for her daughter to undergo FGM. Fathers have legal responsibilities as well as rights and professionals should discuss FGM (the law and health issues) with the girl's father and, if appropriate, other members of the family as well as the mother. If there are identified risks, any approach to the family should be considered as part of an interagency referral discussion (IRD).

Potential risk factors for FGM

There are various factors which indicate that a girl may be at risk of FGM for example:

- The family is from a community in which FGM is practised.
- The girl's mother has experienced FGM.
- The girl has a female sibling/cousin who has experienced FGM.
- Family elders are very influential.
- The family is not well integrated within the UK.

Practitioners need to consider these factors within the girl's overall situation, rather than assuming individual factors to be an indicator of imminent risk. For example, some women who have experienced FGM are opposed to their daughters undergoing it.

Indicators that a girl may be at imminent risk

Indicators that a girl may be at **imminent risk** of FGM include:

- Parents say that they or a relative intends to take the girl out of the country for a prolonged period.
- Girl says she is going on a long holiday to her country of origin, or another country where FGM is common.
- Girl tells a professional that she is to have a 'special procedure' or is to attend a special occasion to 'become a woman'.
- A professional hears FGM coming up in conversation, for example a girl might be talking to her friends about it.
- A girl might ask a teacher or another adult for help.

Indicators that FGM has already been performed

Indicators that FGM has been performed include:

- Girl has difficulty walking, sitting or standing and seems uncomfortable.
- Girl in school leaves the classroom for extended periods because of bladder or menstrual problems; she spends longer in bathroom because of difficulties urinating.
- Girl is absent from school; absences may be prolonged and/or repeated.
- Girl is withdrawn, depressed, shows significant behaviour change and other signs of emotional and psychological distress.

- Girl confides in a professional or asks for help but is not explicit about the problem.
- Girl needs excused from physical education or sport.
- Girl talks about pain or discomfort between her legs.
- Girl is reluctant to undergo medical examination.

Risk assessment

The purpose of risk assessment is to establish the level of risk to a girl/woman in order to inform action taken and/or inform child protection or adult support and protection proceedings. The main points to consider are:

- What risk factors are identified?
- What are the mother's/family's views on FGM?
 - Protective (may be opposed to FGM and determined girl will not have it).

OR

- Non-protective (may not realise health, legal, child protection issues and believe girl should have FGM).
- Undetermined.
- Is there an impending trip to the country of origin? (This significantly increases imminence of risk.)

If there is concern about FGM, practitioners should also consider potential risk to other girls in the wider family/community who may also be a 'child in need of protection'. As FGM can be deeply embedded in family and/or community belief systems, these girls may also be at significant risk of harm.

Because risk can change according to the age of the girl and other circumstances, practitioners who have an ongoing relationship with the girl and/or her family need to be alert to indicators.

The level or extent of risk may change over time. Practitioners should be alert to changes in circumstances which might elevate risk and the need to undertake the risk assessment.

The Department of Health in England has developed a risk assessment framework with factors to consider. This has been amended slightly to reflect the Scottish context and is in Appendix 4.

Responding to risk

The level of involvement with the girl and her family depends on the role and responsibilities of the practitioner or agency. The specific responsibilities of statutory and third sector agencies are set out in **section 6**. These take account of the different settings in which professionals might encounter a girl or woman affected by FGM.

Most practitioners have never knowingly encountered a girl/woman who has undergone FGM. This might change as awareness of FGM increases. So, more experienced social workers and/or public protection police officers or certain health professionals may be best placed to discuss FGM with girls/women and families.

Although many individual practitioners may not be responsible for investigating FGM, they should consider FGM in their assessments and know who to refer any concerns to. If a professional identifies an FGM risk factor, they need to assess the risk, act on the risk assessment and document this.

Any one single factor of potential risk will require the practitioner to initiate a discussion with the woman or parents.

Girls who have undergone FGM

If a practitioner suspects, believes or knows that FGM has been performed on a girl, they should take immediate action to ensure the girl gets medical and other care, and instigate child protection procedures.

Imminent or serious risk of FGM

If a practitioner has information or is concerned that **a girl is at imminent or serious risk of FGM they should make a child protection referral**. Emergency measures may be required to ensure swift action if a girl is at immediate risk or is being taken abroad to have FGM performed.

Adult support and protection procedures should be instigated in cases of vulnerable women who are at serious risk of FGM.

Potential risk of FGM

If a girl/woman is identified as potentially being at risk of FGM but the current situation does not indicate that the risk is imminent or significant, an IRD should take place to ensure that the information is shared appropriately with all relevant agencies. This should ensure that they understand her circumstances, and have an agreed plan for identifying and responding to any future risk.

Practitioners should involve relevant senior colleagues. They may also need to seek the advice and guidance of their professional representative/regulatory organisations.

See Appendix 5 for multi-agency child protection decision-making and action flowcharts.

Information sharing

‘Any reasonable professional concern that a child may be at risk of harm will always over-ride a professional or agency requirement to keep information confidential.’

(s.587, National Guidance for Child Protection in Scotland, 2014)

Practitioners should know the law, policy and practice for sharing personal and/or sensitive information; the limits of confidentiality and consent; and that they can share personal and/or sensitive information.

If practitioners are concerned about a child or young person’s safety or wellbeing, nothing prevents them from sharing information.

If there is a risk to a child or young person’s safety or wellbeing, which may lead to harm, confidential information can be shared under the Data Protection Act 1998.

Not all information is confidential. Confidentiality is not an absolute right.

Any sharing of information should be **relevant, necessary, appropriate and proportionate** and go no further than the minimum necessary to achieve the public interest objective of protecting a child or young person’s safety and wellbeing.

As the level of risk can vary across different age groups, depending on the cultural background of the family, professionals should decide their response on a case-by-case basis, with other agencies involved.

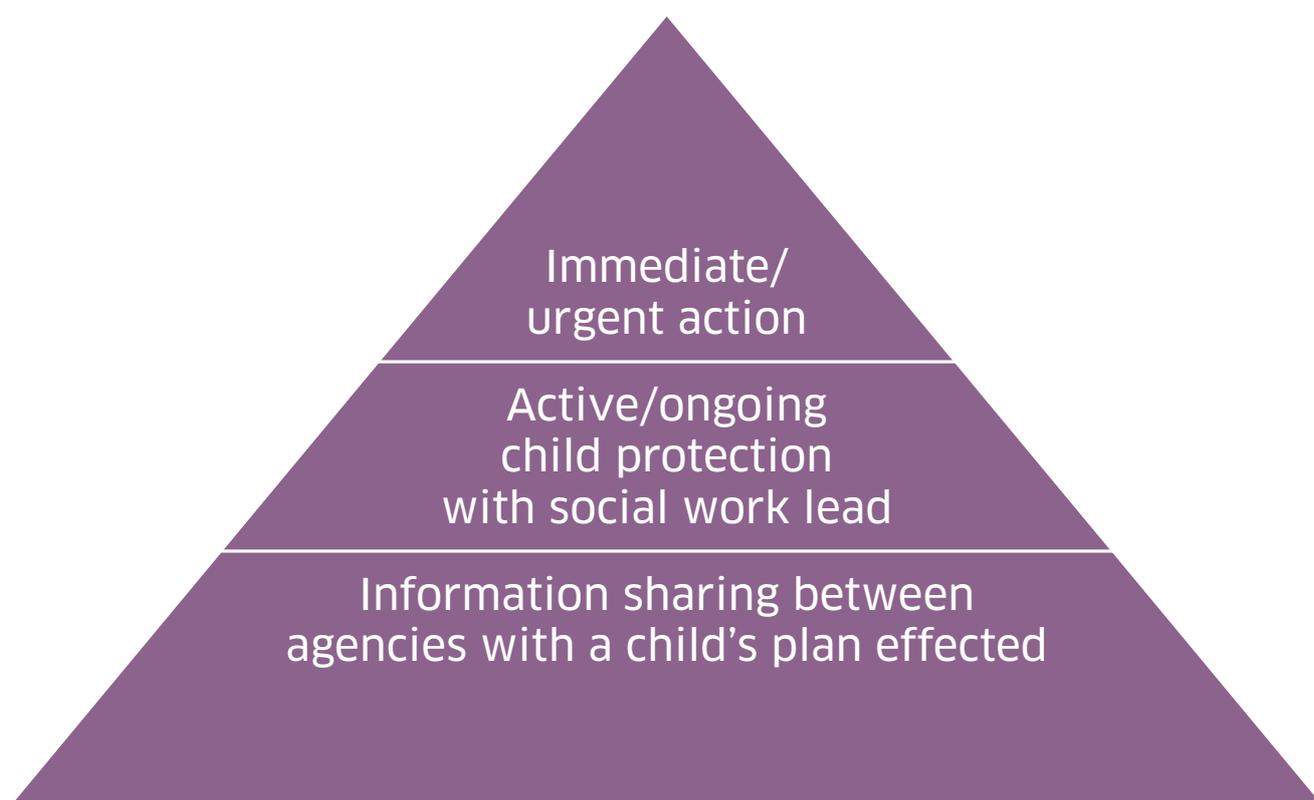
Information sharing with relevant colleagues is vital for informing decisions on the best course of action to protect a girl or woman at risk of FGM. Given the links with other forms of violence against women, however, it is crucial that the safety of women and children is assessed before engaging in discussions with other family members.

Inter-agency discussions

Each area has arrangements for inter-agency discussions at the point of child protection referral in accordance with its own child protection procedures or guidance. In this guidance, these discussions are referred to as the inter-agency referral discussion (IRD). In line with the National Guidance for Child Protection in Scotland (2014), information should be shared, and joint assessment and planning undertaken by relevant police, health and social work staff.

Taking action

Local child protection procedures should indicate the threshold of risk for FGM. Agencies need to work together to protect girls from FGM. This should be a central element of the response. The diagram below shows the three levels of response^{xxxii}:



Any child considered at risk of FGM should have a Child's Plan.

Whilst there is little information about the number of ongoing child protection cases relating to FGM in Scotland, the above diagram shows response types. Sharing information between practitioners and agencies about girls potentially at risk of FGM and about discussions with family members over child protection is vital for all agencies involved. It will inform decisions about the best course of action to protect anyone at risk of FGM.

^{xxxii} Adapted from the Department of Health (2015) Female Genital Mutilation risk and safeguarding: guidance for professionals.

GOOD PRACTICE - EXAMPLE

Woman A had twin daughters at a nursery in Edinburgh. She told the nursery staff she was planning to go back to Sudan for an extended visit for a year. She discussed her visit with a social worker and the nursery. Together they discussed the risks of FGM to her daughters and when she said she was against it, they asked her how she planned to protect her daughters and talked this through with her. Social workers gave her a number and said, if you have any problems in your country you can call the number in the UK and they will call the embassy in Sudan and pick up your family and take them back straight away.

They recommended that she did not go for such a long visit this time. She went to Sudan as planned but only stayed for 2 months. She was scared about going and scared about coming back, she was scared that her mother and granny would do something to her kids saying 'you know in my country if I have a girl and I go outside with my husband, my mum will take my girl and she can do anything because she has looked after them. Because of your religion you have to respect your mum, you can't be rude to her. You just cant'.

When she arrived back in Sudan she told her granny and mum 'you are not allowed to do anything to my daughter because there are a lot of laws in Scotland, maybe they are going to put me in detention'. She told the peer researcher 'I don't want to do this to my daughters, it was done to me and it was very bad for me. But I am sick of the health visitor talking to me about it'. However she feels that the visit went well, she was able to protect her daughters and she has returned for a subsequent visit.

(MY VOICE)

6. RESPONDING TO GIRLS AT RISK OF, OR WHO HAVE ALREADY UNDERGONE, FGM: INDIVIDUAL AGENCIES

1. NHS: guidelines for all healthcare staff

All healthcare workers, including all nurses, midwives and doctors, have a duty of care to girls and women who are at risk of FGM, or who have already had the procedure. The Chief Nursing Officer and Chief Medical Officer for the Scottish Government have written to all healthcare professionals highlighting this obligation and their responsibility to understand and respond to actual and potential FGM^{xxxii}.

Women and girls at risk of, or who have already undergone, FGM may present in various settings such as obstetric and midwifery services, cervical smear screening, sexual and reproductive health clinics, travel clinics, paediatrics, urology, gynaecology, mental health services, A&E, dermatology, out-of-hours primary care services, Scottish Ambulance Service and GP practices.

Treatment depends on the symptoms, the type of FGM, and whether or not the woman is pregnant. FGM is often identified during antenatal care or delivery. Women with gynaecological symptoms such as pelvic or genital pain, incontinence or prolapse, and menstrual dysfunction may need referral to services such as general gynaecology and urogynaecology, or have their care provided in one service if available.

Practitioners should assess a woman/girl holistically and explore her medical, support and protection needs. They should refer to specialist services, including mental health services, as necessary.

Any healthcare worker who obtains information about FGM should record their concerns in the patient's records.

Healthcare workers should routinely share information about any concerns with other main professionals in a girl's life. In practice, this means the girl's health visitor or head teacher/guidance teacher depending on the girl's age, the GP and school nurse (as appropriate).

Risk can only be considered at a particular moment in time.

xxxii [http://www.sehd.scot.nhs.uk/cmo/CMO\(2014\)19.pdf](http://www.sehd.scot.nhs.uk/cmo/CMO(2014)19.pdf)

Healthcare professionals should take the opportunity to continue their discussions about FGM throughout the standard delivery of healthcare. If, for example, a midwife has passed information to a health visitor/GP about a woman who has undergone FGM, the health visitor/GP should discuss this at the next appointment with the woman/child. They could use the relevant section of this guidance to help structure the discussion now and on a continuing basis if required (see FGM risk assessment guidance in Appendix 4).

As part of any discussion with the woman and/or appropriate family members, health practitioners should:

- Clarify that FGM is illegal in Scotland.
- Explain the health consequence of FGM.
- Ensure the woman/family member understands what action, if any, will be taken.
- Ensure the woman/family member understands that information will be shared with colleagues and other agencies as appropriate.
- Provide information and signposting to other services as needed.

Child protection advisers can help to assess the threshold for child protection proceedings, data holding and information sharing across systems and agencies. Healthcare staff should consult with them when deciding on any course of action, and give them details of all risk assessments. This will support action consistent with local child protection procedures.

See flowcharts in Appendix 5.

Maternity staff

Identifying FGM as early as possible is critical to effective maternity care, preventative strategies and protecting girls. The booking appointment/visit is the most suitable time to ask about FGM, during routine taking of a woman's case history. Several health boards undertake routine enquiry of FGM with **all** pregnant women, recognising that it is not possible to identify this through country of origin alone.

However, this might not occur, or a woman might present much later in the pregnancy, or FGM may not become apparent until labour is underway. So, at any stage in the pregnancy, midwives may need to discuss FGM with a woman and assess risk.

If discussion with the woman (and other parent if appropriate), as outlined in Appendix 4, indicates that there is **imminent risk** of FGM following the birth then maternity staff should instigate child protection procedures.

If maternity staff think there **may be risk of FGM** following the birth, they should discuss this with the child protection adviser, the health visitor and the parent(s). An IRD should then be arranged.

If maternity staff have **no concerns** they should record the outcome of the risk assessment in the woman's notes and in the child's public health record.

In all cases, maternity staff must share information with the GP, child protection adviser and health visitor and record this in the woman and the child's health records.

GOOD PRACTICE

In NHS Lothian, from March 2015 110 women have been identified as having experienced FGM. The specialist midwife has met with them to discuss their needs and ensure their care is tailored to these. She also discusses potential risk factors with them. To date only 8 cases have required an Interagency Referral Discussion meeting.

Health visitors

Health visitors are in a unique position to recognise infants and girls at risk of FGM and to take protective action. They are often the only professionals in contact with a family with pre-school children. They generally see pre-school children at routine health surveillance checks and immunisations. Also, health visitors usually contact and visit all families with pre-school children new to an area.

Health visitors are also well placed to collaborate, support and refer as part of a multi-professional team.

Health visitors are responsible for discussing FGM and gathering information if there is no previous discussion or risk assessment on record.

If the child is new-born, maternity service staff should already have gathered sufficient information for assessing risk to the baby. If not, or there is new information, health visitors may need to gather information as if the family were new to the area. Health visitors should be aware that FGM is a 'protected characteristic' in the child health record.

If healthcare staff have already gathered information about a woman who has undergone FGM, health visitors should be able to read what is on record. **Health visitors should copy the information into the child's health records, and provide this for the GP's notes. If there are other girls in the family, then health visitors should copy the information into their notes, and advise the GP of this.**

If there is concern about imminent or significant risk, health visitors should instigate child protection procedures immediately.

If information is incomplete or there are ongoing concerns that a baby girl may be at risk, health visitors should consult the child protection adviser for advice and arrange an IRD. This will enable practitioners to consider collectively information held by police, social work, health and possibly education, and to assess risk. The outcome of any discussions should be recorded.

If there are no indications of risk, the health visitor should be alert to any changes in circumstances that may alter this situation, and be prepared to revisit the risk assessment.

School nurses

School nurses are in a good position to reinforce information about the health consequences of, and the law about, FGM. Specialist school nurses may be most suitable for children over age five, as most families with children of this age will have no contact with other professionals such as social workers and health visitors. Teachers are not expected to have such discussions with parents. FGM-trained school nurses may carry out the required health discussions, participate in risk assessments and share information as appropriate.

(See also under Education.)

GPs, treatment room and practice nurses

GPs, treatment room and practice nurses should be vigilant for health issues such as recurrent urinary tract infection which may indicate that FGM has been performed.

When families ask for vaccinations for foreign travel, practitioners have an opportunity to talk about FGM, the health risks and the law. Discussions could also include forced marriage as these issues are sometimes linked. Practitioners should record what advice or leaflets they give.

(<http://www.gov.scot/Topics/People/Equality/violence-women/FGM/Letter>)

If a woman from a community affected by FGM attends for a cervical smear, this is also an ideal opportunity to talk about FGM and associated health concerns. It is also important to follow up non-attendance for a smear particularly for women who have undergone Type 3 FGM and who are unlikely to attend.

If a professional is concerned about a parent's attitude towards FGM, they should discuss this with a relevant senior colleague and local child protection adviser, and refer if necessary. The outcome of the discussion should be recorded.

GPs are responsible for coding FGM using the appropriate Read or equivalent SNOMED codes. This is **extremely important**, as it is the only way of keeping this information with a patient for life, thereby ensuring that her children can be identified as potentially at risk.

[http://www.sehd.scot.nhs.uk/cmo/CMO\(2014\)19.pdf](http://www.sehd.scot.nhs.uk/cmo/CMO(2014)19.pdf)

GP practices serving **student populations** should be particularly vigilant. In NHS Lothian, for example, postgraduate students from FGM-affected countries have registered with young children who have had, or are at risk of, FGM.

Staff in emergency departments and walk-in centres

Staff in emergency departments and walk-in centres should know the risks associated with FGM so that if girls/women from communities in which FGM is performed attend with urinary tract infections (UTI), menstrual pain, abdominal pain or altered gait, assessment of risk is included in the clinical assessment. Staff should document this. If a girl has undergone FGM, staff should consult with relevant senior staff and the child protection adviser to initiate child protection procedures.

Sexual and reproductive health (SRH) services

Staff in SRH services are ideally placed to enquire about FGM and to refer on if necessary. If a young woman (under 18) has undergone FGM, staff should ascertain where and when this occurred, and arrange an IRD to consider her needs and whether child protection procedures are required. Staff should also check whether there are other girls in the immediate or wider family who are at risk and follow the process outlined at the beginning of this section if they have any concerns.

GOOD PRACTICE

NHS Greater Glasgow and Clyde has an integrated care pathway on FGM. Routine enquiry of FGM is carried out during pregnancy and women referred to the specialist 'Special Needs in Pregnancy Services (SNIPS). A clear protocol and referral process is in place for women seeking revision who are seen at a 'one stop' clinic in Stobhill Hospital. To date 41 revision procedures have been carried out.

Staff in assessment services for asylum seekers and refugees

Some health boards have dedicated services which conduct initial health assessments for asylum seekers and refugees. These assessments include family and personal history (including family trees) to find out whether other family members are in the UK. The assessment (for women) also covers gynaecological issues and history of violence, trauma and/or torture, which should include FGM. Women relocated from abroad through international programmes e.g. from camps in Libya, Europe etc. should also be asked about FGM as part of their health assessment.

Healthcare staff who are conducting such assessments should record whether a woman has undergone FGM and the type, if known. They must also record that they have spoken to the woman to ensure she understands that FGM is illegal in Scotland and given her a leaflet in a language which she can read which explains the risks of FGM, the law and local support services.

Staff should refer a woman to other services if necessary and share relevant information with other health professionals such as the GP and health visitor. If there are female children, staff should consult with a relevant senior colleague, the child protection adviser and the relevant social work team to determine whether an IRD is required.

Guidance documents for health professionals

Child Protection Guidance for Health Professionals (Scottish Government, 2013) (revision of 'The Pink Book'): <http://www.gov.scot/resource/0041/00411543.pdf>

Female Genital Mutilation: caring for patients and safeguarding children (Guidance from the British Medical Association, July 2011):

<https://www.bma.org.uk/-/media/Files/PDFs/.../Ethics/femalegenitalmutilation.pdf>

Royal College of Nursing - FGM educational resource (2006):

https://www2.rcn.org.uk/__data/assets/pdf_file/0010/608914/RCNguidance_FGM_WEB2.pdf

Royal College of Obstetrics and Gynaecology FGM guidelines:

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

RCM, RCN, RCOG, Equality Now, UNITE (2013) *Tackling FGM in the UK: Intercollegiate Recommendations for identifying, recording, and reporting*. London: Royal College of Midwives

<https://www.rcog.org.uk/globalassets/documents/news/tackingfgmuk.pdf>

2. Police Scotland: guidelines for police officers

Reports that a girl or woman has been subject of FGM or concerns that a girl or woman may be at risk of FGM can come to the attention of officers and members of police staff from various sources, including direct reporting by a girl or woman; a named or anonymous member of the public; via statutory agencies such as education; health and local authority social work or 3rd sector advocacy and support services. FGM may also be identified incidentally as part of unrelated duties such as responding to other concerns or when conducting investigations into other crimes or offences.

Children

Initial action in responding to girls at risk of FGM including an unborn child

Details of any disclosure made to a first contact police officer or member of police staff should be carefully noted in the officer's personal notebook or other recording system i.e. STORM incident as soon as practicable. Such a disclosure and any initial interaction with a child should be regarded quite differently from a Joint Investigative Interview. In such circumstances the child should be allowed to provide any voluntary account or information, but, should not be 'interviewed' or questioned in detail about the commission of, or planned commission of FGM as this may undermine the reliability or admissibility of any information in a subsequent interview. The primary consideration must be the immediate safety of the child.

The Prohibition of Female Genital Mutilation (Scotland) Act 2005 makes it illegal to perform or arrange to have FGM carried out in Scotland or abroad. A sentence of 14 years imprisonment can be imposed which highlights the gravity of the offence. FGM should always be seen as a cause of significant harm. As such, when there is information to suggest that a girl has been, is or is likely to be subject of FGM and may be at risk of significant harm, **all officers or members of police staff must immediately signpost to their supervisor and Divisional Public Protection Unit, or if outwith hours, the duty senior CID officer/Duty Inspector, who will be responsible for assessing the level of risk to the child or any other children. This should not be interpreted to mean a child protection joint investigation will commence on every occasion. It will ensure that our interface with partner agencies will reflect common standards of practice, and a shared language and understanding. It will provide a sensitive, proportionate response by specialist officers who are fully conversant with Police Scotland's Child Protection - FGM Standard Operating Procedure, national guidance and local interagency child protection procedures to enable such procedures to be considered and implemented if necessary.**

On all occasions information and intelligence databases must be researched in relation to the child and their family background. The minimum checks to be carried out by Police Scotland are:

- Police National Computer (PNC).
- Police National Database (PND).
- Criminal History System (CHS).
- Scottish Intelligence Database (SID).
- Violent and Sexual Offenders Register (ViSOR).
- Command and Control system.
- Crime Management system.
- Vulnerable Persons Database.

Local inter-agency Child Protection procedures must be invoked for any child who has been subjected to FGM or where there is information that other risk factors are present.

On occasions where there is insufficient information to determine whether child protection procedures should be invoked, and more information is required to inform decision-making, the Divisional PPU or on duty senior CID officer should make an information sharing request to core partners (Social Work, Health and if appropriate Education) to share relevant information in relation to the child or any other child. This may result in an action for the most appropriate partner to engage with the child and her family in an attempt to gain further information. While PPU officers should be in a position to speak with parents/carers about the law and health implications and work collaboratively, the decision about which professional is best place to engage with a child and their family about FGM needs to be carefully considered and should be agreed (and documented) between agencies.

The outcome of family engagement must be shared with Social Work, Health and Police Scotland. If necessary child protection procedures will be instigated. Decisions around investigation i.e. joint or single agency, joint investigative interview and type of medical examination will be made by Social Work and Police in consultation with Health during any subsequent IRD.

Imminent risk of significant harm

In most cases where there are concerns about FGM, these are not associated with imminent risk. However, if a child is about to leave the country; there is information about a fleeing family; clear intent for FGM to be carried out within the UK or any other abusive or negligent behaviour which places a child or unborn baby at immediate risk of significant harm, the Duty Inspector must ensure that effective protection measures are put in place immediately and primary investigation commences in liaison with the Divisional PPU or duty senior CID Officer. Child Protection Procedures will be immediately instigated, during which time consideration will be given to the application for a Child Protection Order or other relevant protection order.

On occasions where the risk is such that it is not practicable for a CPO or other relevant order to be applied for, Section 56 of the Children's Hearing (Scotland) Act 2011 provides for emergency measures, specifically a constable's power to remove a child to a place of safety. Section 59 of the Children's Hearing (Scotland) Act 2011 relates to the obstruction offence.

A child may not be kept in a place of safety under this section for a period of more than 24 hours. Therefore, as soon as practicable after a child is removed under this section, the Principal Reporter **must** be informed. In addition, officers must inform their supervisor and Divisional PPU or on duty senior CID officer immediately powers under Section 59 of the Children's Hearing (Scotland) Act 2011 have been used to instigate child protection procedures.

Adult victims of FGM or adults at risk of FGM

The overarching principles outlined above apply to adult victims of FGM or adults at risk of becoming the victim of FGM. **First responding officers or members of police staff must immediately signpost to their supervisor and Divisional Public Protection Unit, or if outwith hours, the duty senior CID officer, who will be responsible for assessing the level of risk to the adult. This will ensure a sensitive, proportionate response by specialist officers.** While FGM is usually not undertaken for the sexual gratification of another, the circumstances of the act are such that when the victim or potential victim is an adult a Sexual Offences Liaison Officer will be deployed for the purposes of interview and act as a single point of contact.

Support from survivor advocacy services should always be considered prior to any interview taking place.

Officers must consider whether the adult victim or potential victim may have additional needs, such as interpretation services; an appropriate adult if any mental disorder is suspected or if the adult may be an adult at risk as per the **Adult Support and Protection (Scotland) Act 2007**. Any such concerns must be immediately highlighted to the Divisional PPU so that all necessary support can be provided or Adult Support and Protection Procedures instigated.

As above, the primary consideration must be the safety of the victim or potential victim.

Factors to consider

During an investigation into FGM it will be important to establish the timing of the victim and individual family members' entry and exit of the UK, and secure passports; other travel documentation or payment receipts etc. which may be of particular evidential value.

All female members of the household and female relatives of the index case must be considered as being at risk of FGM and included in any risk assessment and safety planning.

For children, families and communities affected by FGM their previous experience of 'authority' figures, including the police, whether abroad or within the UK and Scotland may have been negative or traumatic e.g. asylum seeking communities. This may add barriers to collaborative and meaningful communication in addition to what is a sensitive subject.

If appropriate, a request may be made for an appropriately trained medical professional to conduct a medical examination. It may be in the child's or woman's best interest to have a medical examination for health and wellbeing purposes, without the need for forensic corroborative evidence a crime has not been committed within a country where unlawful. e.g. the FGM was carried out prior to entry into the UK. **In all cases involving children, an experienced paediatrician should be involved in decision-making and arranging medical examinations.**

When a criminal investigation is raised, the interviewing of children and young people must be undertaken in line with the **Scottish Government Guidance on the Joint Investigative Interviewing of Child Witnesses in Scotland 2011**, in order to obtain best evidence.

If any legal action is being considered, early consultation with the Crown Office and Procurator Fiscal Service (COPFS) is important.

Police procedures

On all occasions a restricted VPD Concern Form and SID should be submitted at the point of reporting/referral updated as necessary and, on all occasions, at the conclusion of any investigation. To ensure the integrity and safety of those involved any STORM incident will also be restricted.

A crime report must be raised as soon as there is information that a crime has taken place in line with the Scottish Crime Recording Standards.

Officers should refer to the following documents on the force intranet:

- Child Protection Standard Operating Procedures (SOP).
- Honour Based Violence, Forced Marriage and Female Genital Mutilation SOP.
- **Scottish Government Guidance on the Joint Investigative Interviewing of Child Witnesses in Scotland (2011).**
- **National Guidance for Child Protection in Scotland (2014).**

- **Adult Support and Protection SOP.**
- **Appropriate Adults SOP.**
- **Interpreting and Translating Services SOP.**

Note: the Victim and Witnesses (Scotland) Act 2014 provides for victims of specific crimes to specify a gender preference in relation to an interviewing officer and to gender preference for medical examiner. This does not specifically include FGM, but would be considered best practice.

3. Education: guidelines for teachers and other education staff

The Children and Young People (Scotland) Act 2014 (2014 Act) and the Getting It Right for Every Child approach require practitioners in all services for children and adults to meet children and young people's wellbeing needs, working together if necessary to ensure children and young people reach their full potential.

Education is a universal service. Children and young people spend up to six hours a day in the care of schools and early learning and childcare centres. These services build up strong relationships with children, young people and their parents by creating a positive ethos and culture based on mutual respect and trust.

Children and young people may feel safe at school, and that they can trust education staff. So they may be more likely to confide in them.

Education services can also monitor attendance and physical health. They may notice children and young people at risk (for more on risk see section 5).

The National Guidance for Child Protection in Scotland (2014) states that **FGM should always be seen as a cause of significant harm and local authority child protection procedures should be invoked**. Education staff should work closely with other agencies. The welfare of the child/young person is always the primary concern.

Education staff can ensure a co-ordinated response in accordance with local guidelines on FGM. As with all child protection matters, staff should involve parents/carers unless the latter are the source of risk or harm.

Independent schools will already have child protection procedures in place. The response to suspected FGM should be the same as in a local authority school, that is, that child protection procedures should be followed.

If FGM is suspected, staff should follow child protection procedures and FGM guidelines without delay.

Education staff should know the risk factors and indicators of FGM (see section 5), including children going on extended holidays to areas where FGM is practised and behaviour change on return.

If there are other child protection concerns, these should be part of the risk assessment process. These may include factors such as trafficking or forced marriage.

Schools and early learning and childcare centres should include information on FGM within their annual child protection update. There is more information on the Education Scotland website at: **www.education.gov.scot**

Education staff should raise awareness of FGM and its legal implications with children and young people. For example, health and wellbeing (personal, social, health education) and RME courses could inform children and young people about FGM and its dangers. Education staff should also support children and young people to recognise and realise their rights within the United Nations Convention on the Rights of the Child.

Within Curriculum for Excellence, children and young people are entitled to personal support to enable them to:

- Review their learning and plan for next steps.
- Gain access to learning activities which will meet their needs.
- Plan for opportunities for personal achievement.
- Prepare for changes and choices and be supported through changes and choices.

This is particularly significant for children and young people who have been affected by FGM. All children and young people should have frequent and regular opportunities to discuss their learning with an adult who knows them well and can act as a mentor, helping them to set appropriate goals for the next stages in learning. It is essential that support is provided to remove barriers that may have been caused by FGM or other issues that might restrict their access to the curriculum because of their circumstances, or short or longer term needs.

School nurses

School nurses are in a good position to reinforce information about the health consequences of, and the law about FGM. They can also provide curriculum support.

School nurses, like teachers, may be in a position of trust. Girls/young women (or their friends) may confide in them.

School nurses should be vigilant for health issues in children such as recurrent urinary tract infection which may indicate that FGM has been performed.

If a school nurse has any contact with a family which comes from a country where FGM is practised, they should discuss the risks of FGM; and record the parent's response, the outcome of the discussion, and the leaflets or advice they gave to the parent.

If a school nurse is concerned about a parent's attitude towards FGM, they should take this concern seriously and discuss with a relevant senior colleague and local child protection adviser to consider an IRD.

Colleges and universities

If students are under 18, further educational establishments should follow their existing child protection policies when there is concern about a potential risk of FGM or if a student discloses that she has undergone FGM.

Universities are less likely to encounter girls at risk of FGM but they may become aware that a student is concerned about a younger female relative, for example, or who discloses that she has undergone this herself when younger. They should consider how best to respond in such circumstances, seeking the guidance of appropriate agencies.

4. Children and families social work: guidelines for social work staff

Children and families social work should investigate, initially, under Section 60 of the Children's Hearings (Scotland) Act 2011.

Local authorities have a duty to promote, support and safeguard the wellbeing of all children in need in their area, and, insofar as is consistent with that duty, to promote the upbringing of children by their families by providing a range and level of services appropriate to children's wellbeing needs.

When the local authority receives information which suggests a child may be in need of compulsory measures of supervision, social work services will make enquiries and give the Children's Reporter any information they have about the child. **The role of the registered social worker in statutory interventions: guidance for local authorities (2010)**^{xxxiii} stipulates that, if children are in need of protection and/or in danger of serious exploitation or significant harm, a registered social worker will be accountable for:

- Carrying out enquiries and making recommendations where necessary as to whether or not the child or young person should be the subject of compulsory protection measures.
- Implementing the social work component of a risk management plan and taking appropriate action where there is concern that the Child's Plan is not being actioned and
- Making recommendations to a children's hearing or court as to whether the child should be accommodated away from home.

Children and family social workers also either directly provide, or facilitate access to, a wide range of services to support vulnerable children and families; increase parents' competence and confidence; improve children's day-to-day experiences; and help them recover from the impact of abuse and neglect. For children in need of care and protection, social workers usually act as Lead Professional, co-ordinating services and support as agreed in the Child's Plan.

In fulfilling local authorities' responsibilities to children in need of protection, social work services have various important roles. These include co-ordinating multiagency risk assessments, arranging child protection case conferences, maintaining the Child Protection Register and supervising children on behalf of the Children's Hearing.

Social work response to FGM

Staff should take all notifications of concerns about children seriously. Practitioners responding to these concerns should be aware that even apparently low-level concerns about FGM may point to more serious and significant harm. Practitioners should consider all cases with an open mind and not make any assumptions about whether FGM has, has not, or is likely to occur. Practitioners need to be alert to the possibility of FGM both for girls they already know, and also in cases in which concerns about girls are not stated at the outset, including other female relatives.

Practitioners should acknowledge all concerns, including those that do not require an immediate response, quickly, and indicate when a measured and proportionate response will be made. Practitioners should, in all cases, discuss and record all action taken.

Practitioners should carefully consider including and communicating with the child or young person and their parents; use of an interpreter; which professional should undertake this task and how best to do undertake it. Practitioners should find out if the parents or child have had information about FGM, its harmful effects and the law in Scotland. If not, practitioners should give this to the parents and, if suitable, the child.

xxxiii <http://www.gov.scot/Publications/2010/03/05091627/0>

Before staff decide whether a child protection investigation is required, it is essential that **all relevant services are involved in** an IRD. It is critical that information-gathering involves **all other key services**, including education, health, police, third sector and adult services. Staff should check agency records, any previous agency involvement or any known relevant medical history, including that relating to parents/carers.

Practitioners should consult with the social work lead for FGM.

Staff should then decide whether to progress concerns under child protection procedures. They should also consider how a girl's wellbeing needs can be met, and whether a Child's Plan is required.

If a girl is at immediate risk of harm

If a child protection response is required, staff should initiate an IRD. This may be face-to-face.

Practitioners must always balance the need to gather information against the need to take any immediate protective action. At this stage, information gathered may only be enough to inform an **initial** assessment of the risk to the girl(s). On the basis of the assessment of risk, social work, health and police need to decide whether to take any immediate action to protect the child and any others in the family or wider community. If the IRD decides that the girl is in immediate danger of FGM, and parents cannot satisfactorily guarantee that they will not proceed with it, then practitioners should seek a Child Protection Order (or other agreed emergency measures).

Practitioners should try to work with parents on a voluntary basis to prevent harm to any girl. The investigation must consider every possible way of achieving parental co-operation. If there is no agreement with parents, the priority is to protect the girl. The primary focus is to prevent the girl undergoing any form of FGM, rather than removing her from the family.

If necessary, staff should consider referring the child to the Reporter to the Children's Hearing, convening a child protection case conference or whether emergency measures are needed.

If a girl has already undergone FGM

If a child has already undergone FGM, there must be an IRD to consider how, where and when the procedure took place and the implications of this.

The IRD needs to decide whether to continue enquiries or assess the need for support services. If considering legal action, practitioners must seek legal advice from local authority solicitors.

A child protection case conference is not usually needed for a girl who has already undergone FGM, nor her name listed on the Child Protection Register unless she is still at risk of significant harm or neglect. However, practitioners should offer counselling and medical help suitable for the girl's age.

A child protection case conference is only necessary if there are unresolved child protection issues after the initial investigation and assessment are complete.

Practitioners should also consider the needs of any other girls at risk in the wider family.

5. Third sector organisations: guidelines for staff

Third sector organisations provide many services for children and young people. This includes nurseries, residential care, pre-school play groups, parenting and family support, youth work and other youth services, befriending, counselling, respite care, foster care, adoption, through-care and after-care, advocacy, helplines and education.

Public bodies, such as local authorities, may commission third sector organisations to provide direct services. If a third sector organisation is under contract to a public body, and providing a service on its behalf, it is under the duty of the public body.

Many third sector organisations have direct and indirect contact with children, young people and parents, even if this is not their principal activity. Providers of services to adults, for example for housing/tenancy support, mental health, disability, drug and alcohol problems, may become concerned about girls in a family, without having seen them. Anyone who is concerned about a child or young person's wellbeing should share that information with the appropriate service. If there are concerns that a girl may be at risk of significant harm, they should share that information in accordance with child protection procedures, and **National Guidance for Child Protection in Scotland (2014)**^{xxxiv}.

If a staff member (whether paid or voluntary) is working with a family, they should consider raising FGM when talking about, for example, life in Scotland, health, parenting or child protection. Staff should not assume that the individual, a family or community is affected by, or supports the practice of, FGM.

Identifying and responding to risk

If a staff member is concerned that a girl could be at risk, because of the indicators, they should talk to the family/parent about the risks and where to get help/support. They should give them information about the law in Scotland. If the family is intending to visit family/friends they could give them the **Scottish Government leaflet 'A statement opposing female genital mutilation'**^{xxxv}.

Staff should consult their supervisor/manager.

Staff should assess immediate risk to the child. If they identify **immediate or serious risk**, they should follow their organisation's child protection procedures and refer to social work or police.

If there is **no immediate** risk, but there are potential risk indicators, the staff member should discuss, with the family, how to protect the girl. This includes whether family/parent(s) need ongoing support to protect the girl and any other girls in the family. Staff should record their actions. If there are several risk factors it may be more appropriate to instigate child protection procedures.

If a girl has already undergone FGM

Staff should instigate child protection procedures immediately.

xxxiv <http://www.gov.scot/Resource/0045/00450733.pdf>

xxxv <http://www.gov.scot/Resource/0047/00474491.pdf>

7. RESPONDING TO WOMEN WHO HAVE EXPERIENCED FGM

All agencies

There is **no requirement** to automatically refer adult women (i.e. over age of 18) with FGM to adult social services or the police.

If a woman discloses FGM, it may be the first time she has discussed it with anyone. Practitioners must not automatically refer her to the police as their first response. They should conduct an initial risk assessment, including whether there are others in the family who are at risk of, or affected by, FGM.

If a woman is pregnant and/or has daughters, practitioners must consider their welfare as well as that of other girls in the extended family, since they may be at risk. Action should be taken in accordance with the guidance in section 6.

A woman may disclose that she has adult daughter(s) over 18 who have already undergone FGM. Even if the daughter(s) do not want to involve the police, it is important to establish when and where the FGM was performed, and whether there are other girls in the wider family.

If a family has decided against FGM on a UK-born girl, practitioners should try to find out whether this is because of a change in attitude, fear of prosecution, lack of opportunity or some other reason. Women tend to be more influential in preventing FGM when they are away from their country of origin. It may be that they would benefit from ongoing support to prevent any future attempts to carry out FGM on their daughters.

Given the long-term impact of FGM, professionals should ensure that women affected get proper support to meet their health and wellbeing needs. Professionals must respect the wishes of women.

Support might include:

- Referral/signposting to health services such as psychological/ psychosexual; sexual health; physical health such as gynaecology.
- Referral to specialist services for peer or community support.
- Discussing options to report FGM as victim of a crime.
- Giving information about FGM and the law in Scotland.

If a woman is of childbearing age, she may need support at a later date to protect her children.

NHS response: healthcare staff

Given the adverse mental, physical and sexual health consequences of FGM, the NHS is vital in helping women and girls into services. Women may present in settings such as obstetric and midwifery services, cervical smear screening, sexual and reproductive health clinics, travel clinics, paediatrics, urology, gynaecology, mental health services, A&E, dermatology, out-of-hours primary care services, Scottish Ambulance Service and GP practices.

Treatment depends on the symptoms, type of FGM, and whether or not the woman is pregnant. FGM is often identified during antenatal care or delivery. Women with gynaecological symptoms such as pelvic or genital pain, incontinence and menstrual dysfunction may need referral to gynaecological services such as general gynaecology and urogynaecology or be managed in a single service that may provide all care needed.

Healthcare staff should provide or help women into services such as:

- Psychosexual services.
- Mental health services.
- Maternity services.
- Gynaecology services including general gynaecology and urogynaecology.
- Advocacy/patient support.
- Child protection services.
- De-infibulation as in-patient and out-patient.
- Local community FGM support services.

Healthcare staff should:

- Understand that a woman may not be aware she has had FGM (particularly if it was performed when she was very young).
- Be realistic about options available to women.
- Check what services can do for a woman before referring her.

Staff must never perform FGM or re-infibulate a woman.

Staff should follow professional guidance as well as consult their senior colleague and/or follow child protection procedures or adult support and protection procedures as appropriate.

See Royal College of Obstetricians and Gynaecologists guidelines:

<https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg53/>

Clinical response

Healthcare staff should use an assessment checklist to ensure consistency and that critical aspects are covered (see Appendix 4).

Staff should document referrals to specialist care in clinical records and inform the GP practice of any interventions, transfer of care, outpatient follow up and discharge. To enable the coders to code FGM in a hospital setting, FGM should be recorded in the discharge summary or any communication to the GP (for example from an out-patient attendance) even if the attendance was not related to FGM at that visit. ([http://www.sehd.scot.nhs.uk/cmo/CMO\(2014\)19.pdf](http://www.sehd.scot.nhs.uk/cmo/CMO(2014)19.pdf))

The key elements of the clinical response are:

- Medical examinations.
 - As most girls and women will require a genital assessment, a chaperone is needed. Staff should explain the reason for the examination; who will do it; why there is a chaperone; and anything else that will help to reassure the woman. They should do this in a sensitive manner, before the woman undresses (ref to GMC chaperone guidance: www.gmc-uk.org/guidance/ethical_guidance/21168.asp).
 - Staff should avoid unnecessary and repeated examinations.
- De-infibulation.
 - All health boards must offer a de-infibulation service, whether provided by the board or by referral elsewhere. The referral pathway for de-infibulation should be clear. De-infibulation may not be appropriate in all cases. Staff should discuss options for surgical intervention with the woman. This should include telling her about the benefits and risks.
 - Most de-infibulations should be performed under local anaesthetic in an outpatient setting. Some women with extensive genital scarring or who are very distressed during examination need de-infibulation under a general or spinal anaesthetic. This will usually require a day case hospital admission. See service specification: [http://www.sehd.scot.nhs.uk/cmo/CMO\(2016\)05.pdf](http://www.sehd.scot.nhs.uk/cmo/CMO(2016)05.pdf)
- Mental health.
 - Staff should refer women and girls with mental health difficulties including anxiety, depression, PTSD and complex PTSD to the appropriate trauma-informed or trauma specialist mental health service.
- Documentation.
 - All consultations must include discussion about the legal status of FGM. Staff must document this discussion in the notes in the agreed template.

8. RESOURCES

Video on NHS Choices where women who have had FGM discuss how they would like to see professionals hold sensitive conversations about FGM:

<https://www.gov.uk/government/publications/fgm-video-resources-for-healthcare-professionals>

Scottish Government Statement

Scottish Government statement opposing FGM, outlining the law and where to get help in Scotland or whilst abroad.

<https://www.fgmaware.org/community-use.html>

Scottish Government - One Scotland Website

<http://onescotland.org/equality-themes/gender/female-genital-mutilation-fgm/>

Chief Medical Officer/Chief Nursing Officer letter 2016: guidance for service specification and standards for healthcare to prevent FGM, and respond to the needs of survivors

<https://beta.gov.scot/publications/fgm-guidance/>

Chief Medical Officer/Chief Nursing Officer letter 2015: additional resources available for services for people who have experienced, or are at risk of

<https://beta.gov.scot/publications/fgm-additional-resources-for-health-professionals-letter/>

FGM Awareness Raising Postcard

<https://beta.gov.scot/publications/female-genital-mutilation-fgm-awareness-raising-postcard/>

This postcard's message is that FGM has no health benefits and is illegal.

Sara's Story

<https://www.fgmaware.org/>

A short animated film which has been developed in consultation with women survivors of FGM, and experienced practitioners.

World Health Organisation (WHO) Fact Sheet on FGM

<http://www.who.int/mediacentre/factsheets/fs241/en/>

Scottish Legislation on FGM

<http://www.gov.scot/Topics/People/Equality/violence-women/MinorityEthnicIssuesPages/FemaleGenitalMutilation>

National Training Resources website

<http://www.womenssupportproject.co.uk/vawtraining/content/femalegenitalmutilation/277,234/>

APPENDIX 1: THE LAW – INTERNATIONAL, EU, ENGLAND AND WALES

International and EU Law

FGM violates a number of fundamental rights protected under international law, such as the right to physical and mental integrity; freedom from violence; the highest attainable standard of health; freedom from discrimination on the basis of sex; freedom from torture, cruel, inhuman and degrading treatment; and life, when the procedure results in death. These rights are protected in the **International Covenant on Civil and Political Rights (ICCPR)**, **International Covenant on Economic, Social and Cultural Rights (ICESCR)**, **Convention Against Torture (CAT)**, **Convention on the Elimination of Discrimination Against Women (CEDAW)** **Convention on the Rights of the Child (CRC)**, as well as regional human rights instruments including the **European Convention of Human Rights**. FGM constitutes a form of gender-related persecution under the **1951 Refugee Convention** that can be related to the grounds of political opinion, membership of a particular social group or religious beliefs. FGM is mentioned as an example of persecution based on membership of a particular social group in the EU Qualification Directive

In April 2017 the UK ratified the **Council of Europe Convention on preventing and combating violence against women and domestic violence** (the Istanbul Convention), which includes FGM.

A useful overview of international law on FGM, and the number of treaties to which it runs contrary, is on the following UN sites:

<http://www.unfpa.org/resources/female-genital-mutilation-fgm-frequently-asked-questions>

http://www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf#

Legislation in England and Wales

The **Serious Crime Act 2015**^{xxxvi} contains six FGM-related legislative provisions for England and Wales as set out below. **NB Only the first provision applies to Scotland:**

1. Part 5 Section 70 - Offence of female genital mutilation: extra-territorial acts. The Scottish Government collaborated with the Westminster Government to close a loophole in the law in the Prohibition of Female Genital Mutilation (Scotland) Act 2005 (by means of an LCM) to extend the reach of the extra-territorial offences in that Act to habitual (as well as permanent) UK residents. This provision commenced in Scotland on 03 May 2015
2. Lifelong Anonymity of Victims: Part 5 Section 71 4a
3. Failing to Protect a Girl at Risk of FGM: Part 5 Section 72 3a
4. FGM Protection Orders: Part 5 Section 73 5a
5. Mandatory Reporting of FGM: Part 5 Section 74 5b
6. Placing multi-agency guidance onto a statutory footing: Part 5 Section 75 5c

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

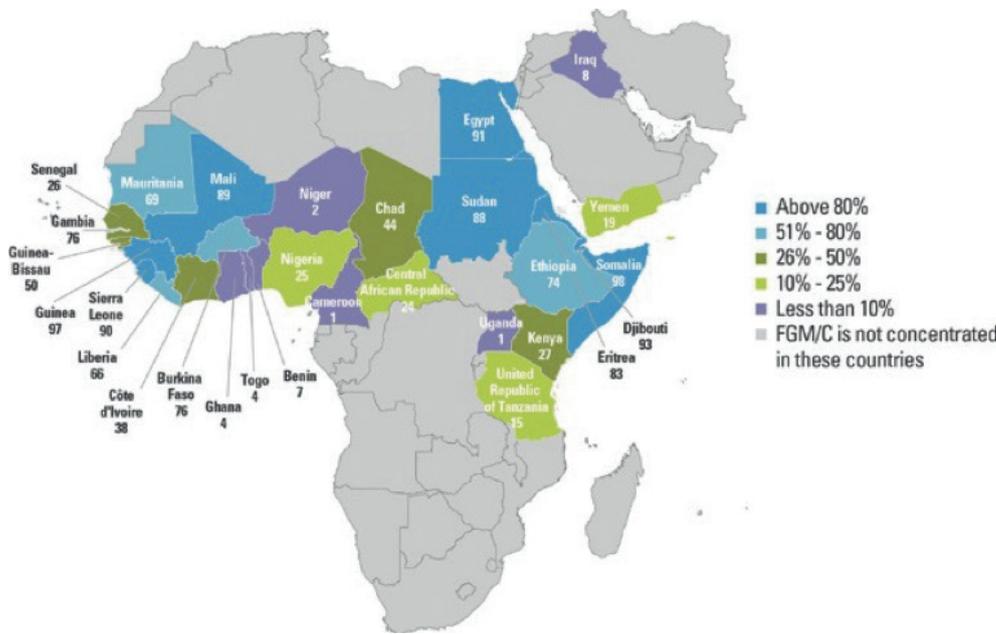
APPENDIX 2: TRADITIONAL AND LOCAL TERMS FOR FGM

Country	Term used for	Language	Meaning
EGYPT	Thara	Arabic	Deriving from the Arabic word 'tahar' meaning to clean/purify
	Khitan	Arabic	Circumcision - used for both FGM and male circumcision
	Khifad	Arabic	Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)
ETHIOPIA	Megrez	Amharic	Circumcision/cutting
	Absum	Harrari	Name giving ritual
ERITREA	Mekhnishab	Tigreña	Circumcision/cutting
KENYA	Kutairi	Swahili	Circumcision - used for both FGM and male circumcision
	Kutairi was ichana	Swahili	Circumcision of girls
NIGERIA	Ibi/Ugwu	Igbo	The act of cutting - used for both FGM and male circumcision
	Sunna	Mandingo	Religious tradition/obligation - for Muslims
SIERRA LEONE	Sunna	Soussou	Religious tradition/obligation - for Muslims
	Bondo	Temenee/ Mandingo/ Limba	Integral part of an initiation rite into adulthood - for non-Muslims
	Bondo/Sonde	Mendee	Integral part of an initiation rite into adulthood - for non-Muslims
SOMALIA	Gudiniin	Somali	Circumcision used for both FGM and male circumcision
	Halalays	Somali	Deriving from the Arabic word 'halal' i.e. 'sanctioned' - implies purity. Used by Northern & Arabic speaking Somalis.
	Qodiin	Somali	Stitching/tightening/sewing refers to infibulation

Country	Term used for	Language	Meaning
SUDAN	Khifad	Arabic	Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)
	Tahoor	Arabic	Deriving from the Arabic word 'tahar' meaning to purify
CHAD - the Sara subgroup	Bagne		Used by the Sara Madjingaye
	Gadja		Adapted from 'ganza' used in the Central African Republic
GUINEA-BISSAU	Fanadu di Mindjer	Kriolu	'Circumcision of girls'
GAMBIA	Niaka	Mandinka	Literally to 'cut/weed clean'
	Kuyango	Mandinka	Meaning 'the affair' but also the name for the shed built for initiates
	Musolula Karoola	Mandinka	Meaning 'the women's side'/'that which concerns women'

APPENDIX 3: COUNTRIES WHERE FGM IS PRACTISED

FGM/C is concentrated in a swathe of countries from the Atlantic coast to the Horn of Africa



FGM has also been documented in communities including:

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

Percentage of girls and women aged 15 to 49 years who have undergone FGM/C

Note: In Liberia, girls and women who have heard of the Sande society were asked whether they were members; this provides indirect information on FGM/C since it is performed during initiation into the society.

Source: UNICEF global databases, 2014, based on DHS, MICS and other nationally representative surveys, 2004-2013. <http://www.data.unicef.org/child-protection/fgmc>

APPENDIX 4: FGM RISK ASSESSMENT GUIDANCE

Introduction

The aim is to help make an initial assessment of risk, and then support the ongoing assessment of women and children who come from FGM affected communities (using parts 1 to 3).

Introductory questions:

- (1) Do you or your partner come from a community where cutting or circumcision is practised?
(See appendix 3 for map. Please remember you might need to consider that this relates to their parent's' country of origin).
- (2) Have you been cut? It may be appropriate to use other terms or phrases.

If you answer YES to questions (1) or (2) please complete one of the risk templates.

PART ONE: For an adult woman (18 years or over)

(a) PREGNANT WOMAN: ask the introductory questions.

If the answer is YES to either question, use part 1(a) to support your discussions.

(b) NON-PREGNANT WOMAN where you suspect FGM.

For example, if a woman presents with physical symptoms or emotional behaviour that triggers a concern (such as frequent urinary tract infections, severe menstrual pain, infertility, symptoms of PTSD such as depression, anxiety, flashbacks or reluctance to have genital examination, see part 5); or if FGM is discovered through the standard giving of healthcare (for example when placing a urinary catheter, carrying out a smear test and so on), ask the introductory questions.

If the answer is YES to either question, use part 1(b) to support your discussions.

PART TWO: For a girl (under 18 years)

Ask the introductory questions (see above) to either the child directly or the parent or legal guardian depending upon the situation.

If the answer to either question is yes OR you suspect that the child **might be at risk of FGM**, use part 2 to support your discussions.

PART THREE: For a girl (under 18 years)

Ask the introductory questions (see above) to either the child directly or the parent or legal guardian depending upon the situation.

If the answer to either question is yes OR you suspect that the child **has had FGM** (see part 5), use part 3 to support your discussions.

In all circumstances:

- The woman and family must be informed of the law in the UK and the health consequences of practising FGM.
- Ensure all discussions are approached with due sensitivity and are non-judgemental.

- Any action must meet all statutory and professional responsibilities for child protection, and be in line with local processes and arrangements.
- Using this guidance does not replace the need for professional judgement in about the circumstances presented.

Guidance

The framework is designed to support practitioners to identify and consider risks for female genital mutilation, and to support the discussion with her and family members.

It should be used to help assess whether a woman is either at risk of harm of FGM or has had FGM, and whether she has children who are potentially at risk of FGM, or if there are other children in the family/close friends who might be at risk.

When asking questions based on this guide, if any answer gives you cause for concern, you should continue the discussion, and consider asking other related questions to explore this concern. Please remember that you must record either the assessment or the information obtained in the woman's record. The templates also require that you record when, by whom and at what point in the care pathway this has been completed.

Having used the guide, you will need to decide:

- Do you need to make a referral through your local child protection processes, and is that an urgent or standard referral?
- Do you need to seek help from your local child protection lead or other professional support before making a decision?
- If you do not believe the risk has altered since your last contact with the family, or if the risk is not at the point where you need to refer to an external body, then you must ensure you record and share information about your decision accordingly.

You should refer a girl or young women under 18 who is discovered to have had FGM through your local child protection procedures during normal working hours if there is no imminent or urgent risk identified.

You should make an URGENT referral, out of normal hours if necessary, if a girl or young woman shows signs of very recently having undergone FGM. This may allow the police to collect physical evidence.

You should also make an URGENT referral if you believe that there are plans to travel abroad which mean there is a risk that a girl is imminently likely to undergo FGM if allowed to leave your care.

In urgent cases, social work and the police will consider what action to take.

Part One (a): PREGNANT WOMEN

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

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

Indicator	Yes	No	Details
CONSIDER RISK			
Woman comes from a community known to practice FGM			
Woman has undergone FGM herself			
Husband/partner comes from a community known to practice FGM			
A female family elder is involved/will be involved in care of children/unborn child or is influential in the family			
Woman/family has limited integration in UK community			
Woman and/or husband/partner have limited/ no understanding of harm of FGM or UK law			
Woman's nieces of siblings and/or in-laws have undergone FGM			
Woman has failed to attend follow-up appointment with an FGM clinic/FGM			
Woman's husband/partner/other family member are very dominant in the family and have not been present during consultations with the woman			
Woman is reluctant to undergo genital examination			
SIGNIFICANT OR IMMEDIATE RISK			
Woman already has daughters who have undergone FGM			
Woman requesting reinfibulation following childbirth			
Woman is considered to be a vulnerable adult and therefore issues of mental capacity and consent should be considered if she is found to have FGM			
Woman says that FGM is integral to cultural or religious identity			
Family are already known to social work services – if known, and you have identified FGM within a family, you must share this information with social services			

Please remember: any child under 18 who has undergone FGM should be referred to social services.

ACTION

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

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

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

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

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

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

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

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

Indicator	Yes	No	Details
CONSIDER RISK			
Woman already has daughters who have undergone FGM - who are over 18 years of age			
Husband/partner comes from a community known to practice FGM			
Grandmother (maternal or paternal) is influential in family or female family elder is involved in care of children			
Woman and family have limited integration in UK community			
Woman's husband/partner/other family member may be very dominant in the family and have not been present during consultations with the woman			
Woman/family have limited/no understanding of harm of FGM or UK law			
Woman's nieces (by sibling or in-laws) have undergone FGM Please note:- if they are under 18 years you have a professional duty of care to refer to social work			
Woman has failed to attend follow-up appointment with an FGM clinic/FGM			
Family are already known to social services - if known, and you have identified FGM within a family, you must share this information with social services			
SIGNIFICANT OR IMMEDIATE RISK			
Woman/family believe FGM is integral to cultural or religious identity			
Woman already has daughters who have undergone FGM - who are under 18 years of age			
Woman is considered to be a vulnerable adult and therefore issues of mental capacity and consent should be triggered if she is found to have FGM			

Please remember: any child under 18 who has undergone FGM should be referred to social work.

ACTION

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

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

Significant or Immediate risk - if you identify one or more serious or immediate risks, or the other risks are, by your judgement, sufficient to be considered serious, you should look to refer to Social Work/Police in accordance with your local child protection procedures.

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

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

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

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

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

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

ACTION

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

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

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

If the risk of harm is imminent, emergency measures may be required and any action taken must reflect the required urgency. NHS staff in all cases:-

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

ACTION
<p>Ask more questions – if one indicator leads to a potential area of concern, continue the discussion in this area.</p> <p>Consider risk – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/designated child protection lead.</p> <p>Significant or Immediate risk – if you identify one or more serious or immediate risks, or the other risks are, by your judgement, sufficient to be considered serious, you should look to refer to Social Work/Police in accordance with your local child protection procedures.</p> <p>If the risk of harm is imminent, emergency measures may be required and any action taken must reflect the required urgency. NHS staff in all cases:-</p> <ul style="list-style-type: none"> • Share information of any identified risk with the patient's GP • Document in notes • Discuss the health complications of FGM and the law in the UK

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

Please remember: any child under 18 who has undergone FGM should be referred to social services.

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

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

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

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

Please remember: any child under 18 who has undergone FGM should be referred to social services.

ACTION

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

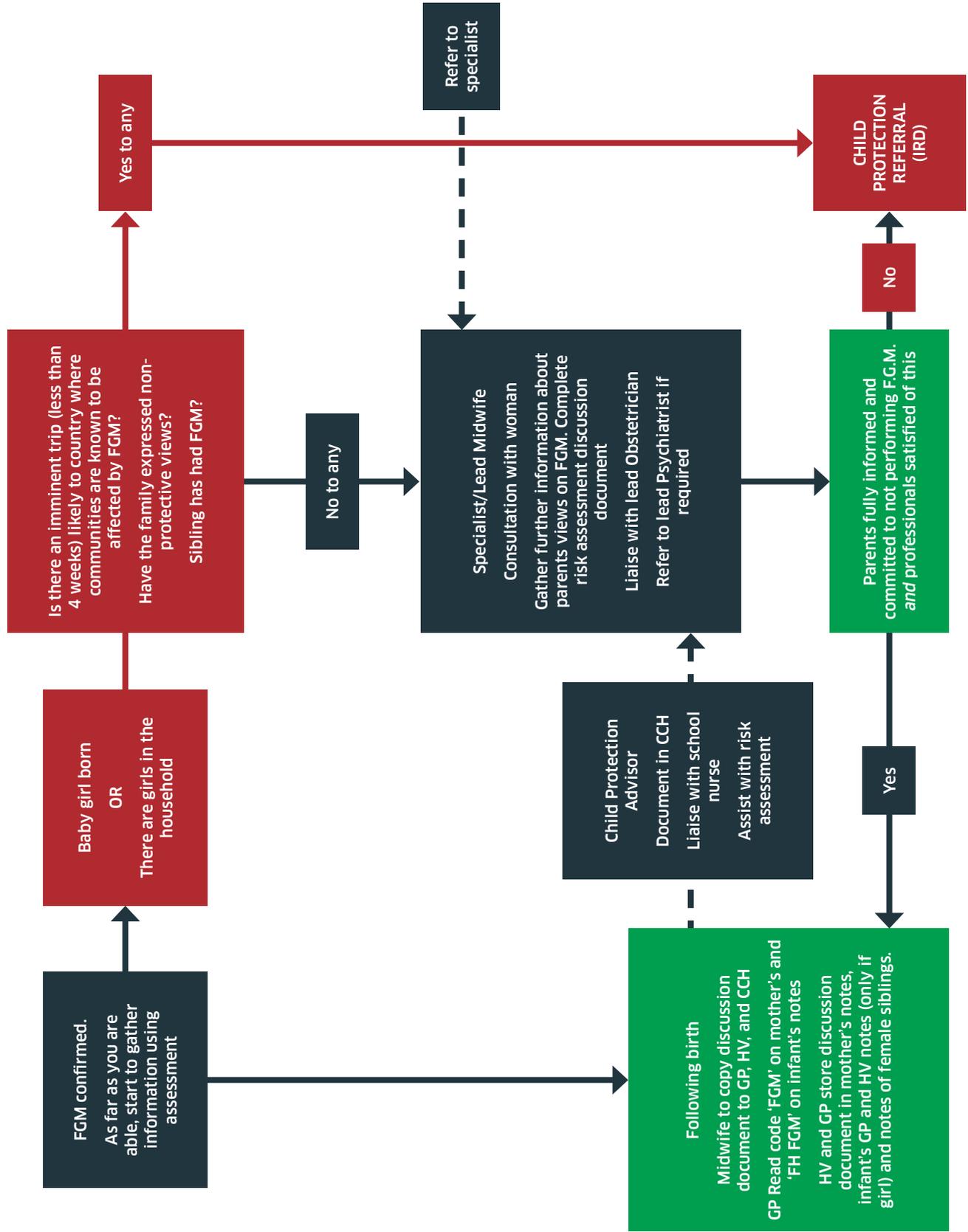
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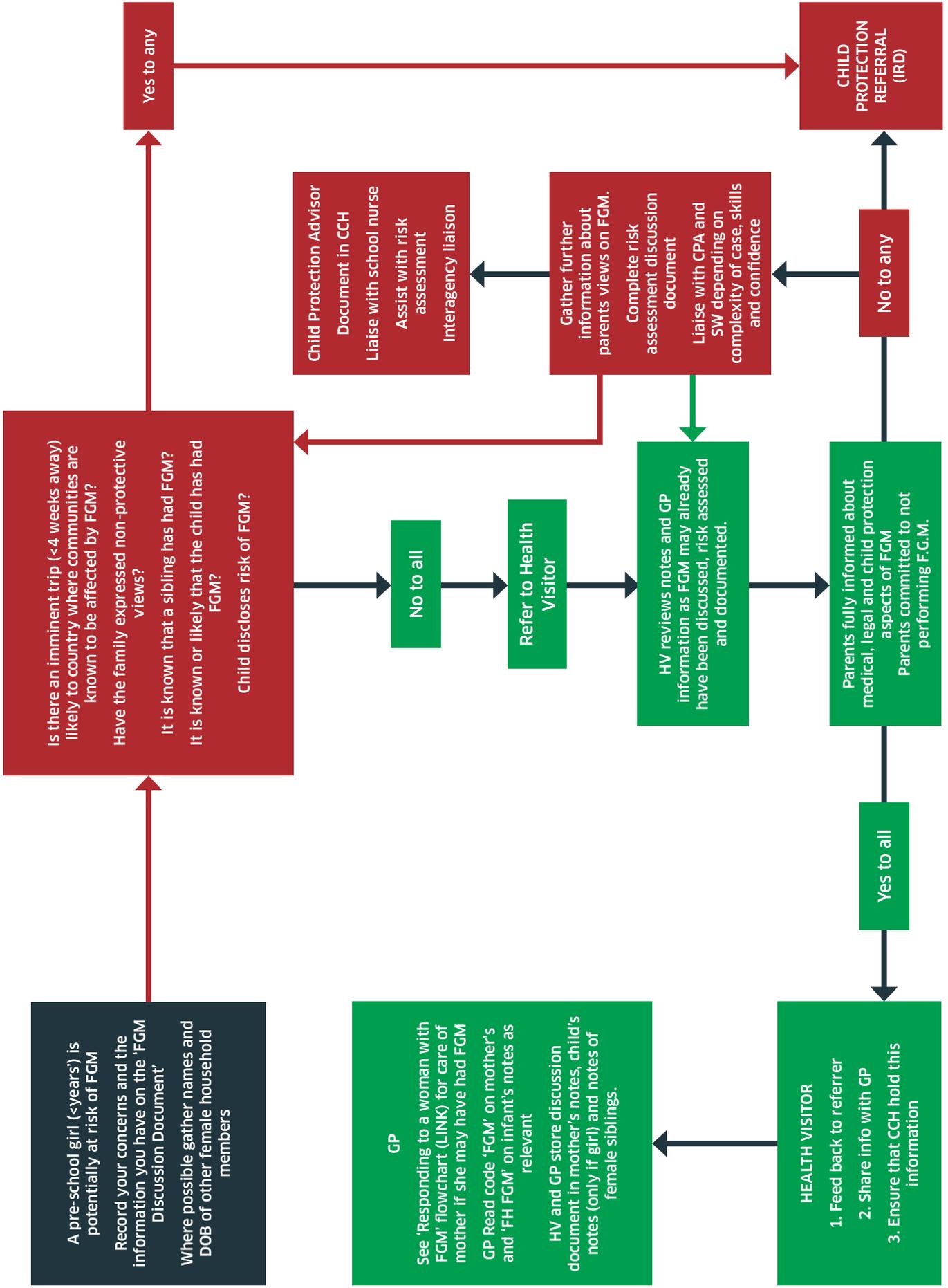
If the risk of harm is imminent, emergency measures may be required and any action taken must reflect the required urgency. NHS staff in all cases:-

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

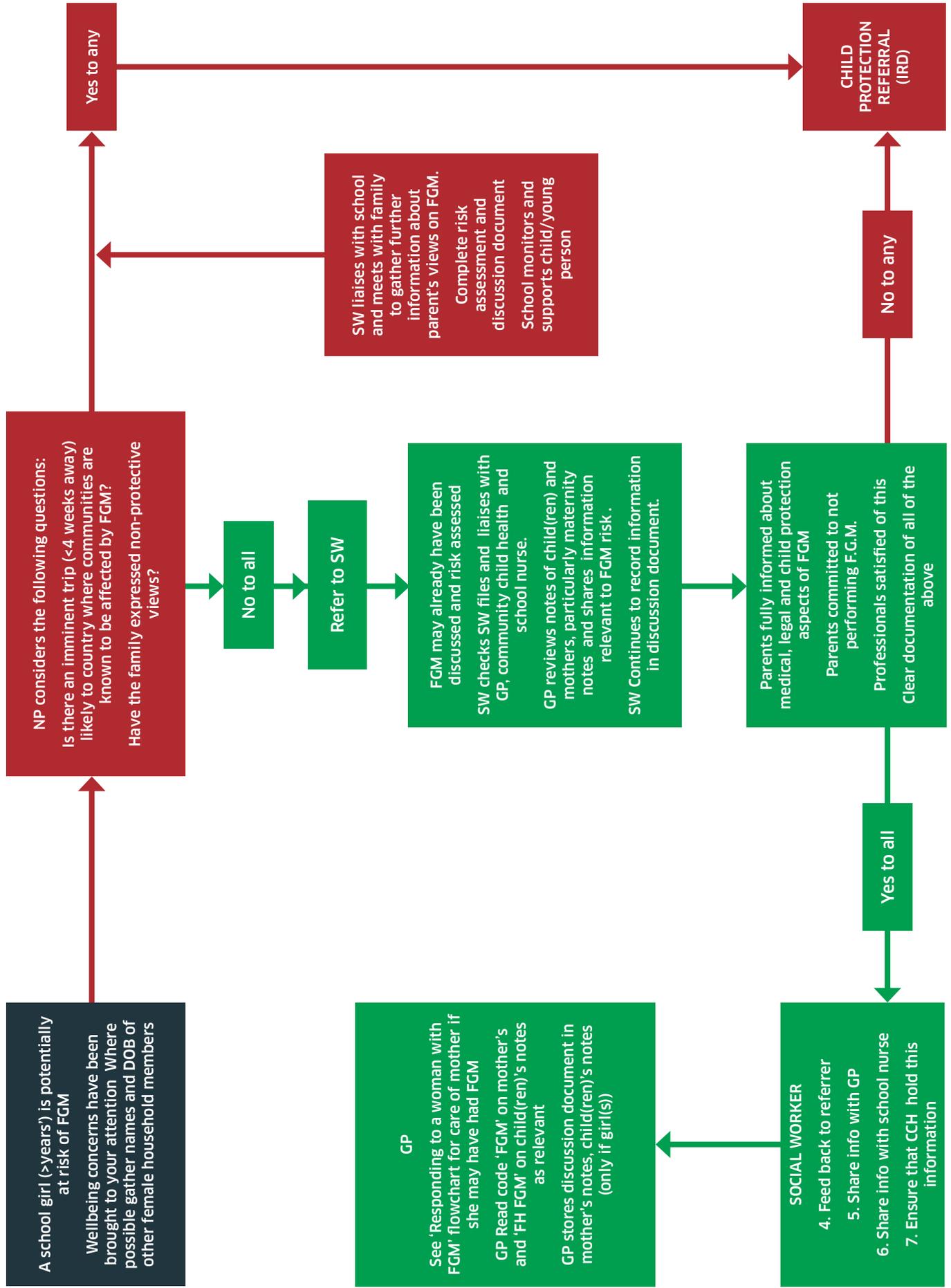
Baby born to mother who has had FGM, not previously known to health services



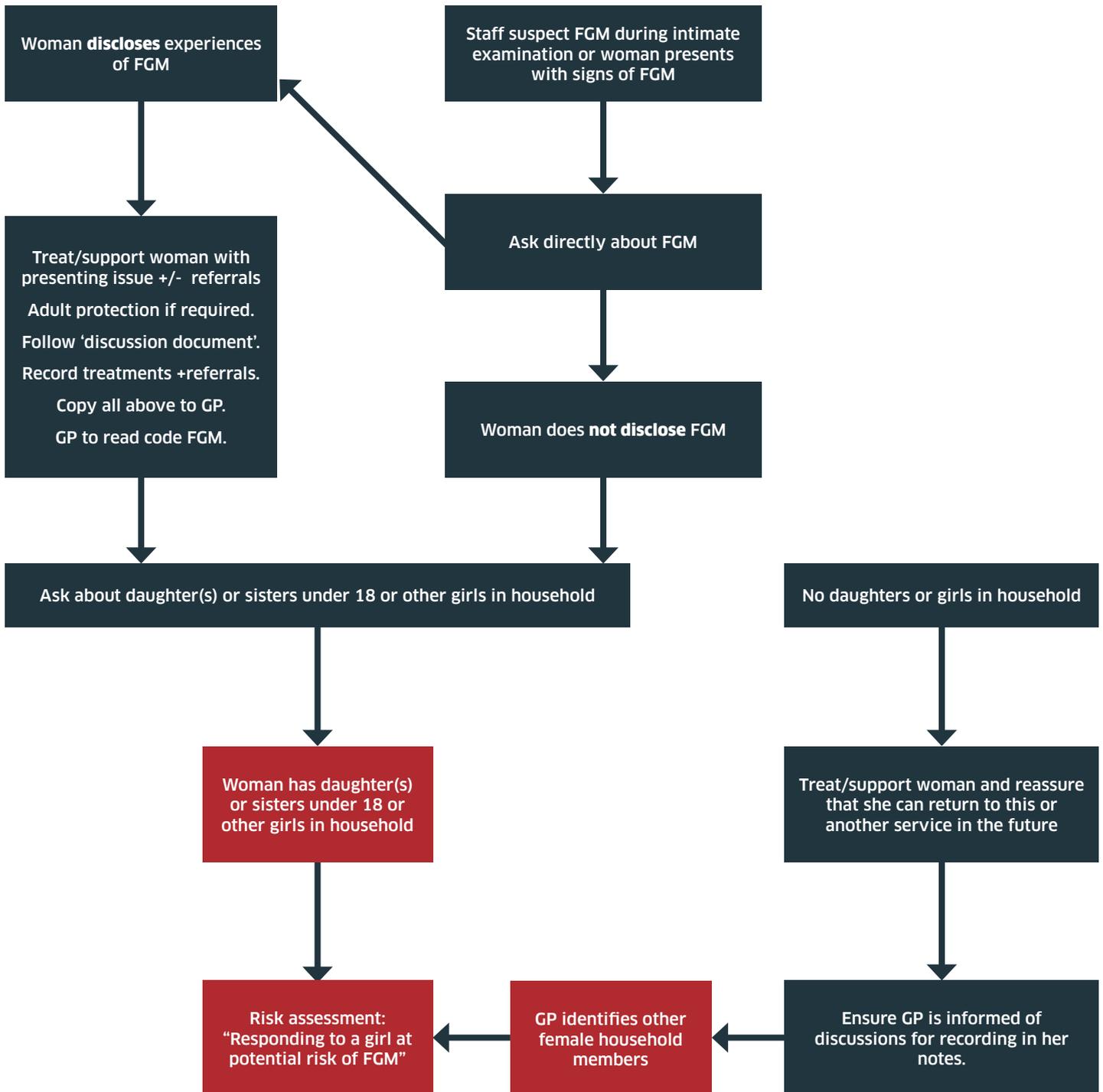
Concerns about pre-school girl who may be at risk of FGM



Concerns about school girl (>5 years) who may be at risk of FGM



Responding to a Woman with (possible) FGM



ORGANISATIONS AND USEFUL CONTACTS

Foreign and Commonwealth Office Forced Marriage Unit

The Forced Marriage Unit is a single point of confidential advice and assistance for those at risk of being forced into marriage overseas.

Tel: 020 7008 0151

From overseas: +44 (0)20 7008 0151

Opening hours: Monday to Friday, 9am to 5pm

Out of hours: 020 7008 1500 (ask for the Global Response Centre)

Email: fmu@fco.gov.uk

Website: www.fco.gov.uk/forcedmarriage

National Domestic Abuse and Forced Marriage Help Line

Tel: 0800 0271234

Support is available 24/7

Stonewall Scotland

Campaign for equality and justice for gay, lesbian, bisexual and transgender (LGBT) people living in Scotland.

Tel: 0131 474 8019

Email: info@stonewallscotland.org

Shakti Women's Aid

Shakti offers support and information to all black minority ethnic women, children and young people who are experiencing or fleeing domestic abuse, forced marriage and other honour based violence issues. They also have refuge accommodation.

Tel: 0131 475 2399

Opening hours: Monday to Friday, 10am to 5pm

Website: www.shaktiedinburgh.co.uk

Saheliya

Saheliya is an organisation, which provides a safe and confidential service that supports the mental health and well being of Black and Minority Ethnic women in Edinburgh and Glasgow. Services include counselling, support, befriending and advocacy.

Website: www.saheliya.co.uk

Edinburgh office: 125 McDonald Road, Edinburgh, EH7 4NW

Tel: 0131 556 9302

Email: info@saheliya.co.uk

Opening hours: Monday to Friday, 9am to 5pm

Glasgow office: St Rollox House, 130 Springburn Rd, Glasgow G21 1YL

Tel: 0141 552 6540

Email: admin.glasgow@saheliya.co.uk

Opening hours: Monday to Friday, 9am to 5pm

Amina Muslim Women's Resource Centre

Amina works with mainstream agencies to establish the barriers that prevent Muslim women from accessing services and participating in society. They provide direct helping services and community development to Muslim women. There are offices in Glasgow, Edinburgh and Dundee

Free phone helpline number: 0808 801 0301

Email: info@mwrc.or.uk

Glasgow: Citywall House, 21 Eastwood Ave, G41 3NS

Tel: 0141 212 8470

Edinburgh: Greyfriars Charteris Centre, 138/140 The Pleasance, EH8 9RR

Tel: 0131 662 6850

Dundee: 1/3, 6 Whitehall Crescent, DD1 4AU

Tel: 01382 787 450

Website: www.mwrc.org.uk

Beyond the Veil

Beyond the Veil educate and inform the public to clear misconceptions and myths surrounding Islam.

Address: c/o 1 House O'Hill Road, Edinburgh, EH4 2AJ

Email: nasim.azad69@yahoo.co.uk

Iranian and Kurdish Women's Rights Organisation

The Iranian and Kurdish Women's Rights Organisation provide advice; support, advocacy and referral in Arabic, Kurdish and Farsi to help women, girls and men escape the dangers of "honour" killing, forced marriage and domestic abuse.

Tel: 0207 920 6460

Opening hours: Monday to Friday 9:30am and 5:30pm

Email: ikwro@yahoo.co.uk

Scottish Women's Aid

Address: 2nd Floor, 132 Rose Street, Edinburgh EH2 3JD

Tel: 0131 226 6606

Fax: 0131 226 2996

Email: contact@scottishwomensaid.org.uk

Hemat Gryffe Women's Aid

(Glasgow based)

Hemat Gryffe provides support, advice and temporary accommodation to women and children from the BME community who experience domestic abuse or forced marriage.

Tel: 0141 353 0859

Opening hours: Monday to Friday, 9am to 5pm

Email: hemat.gryffe@ntlbusiness.com

Rape Crisis (Scotland)

Rape Crisis Scotland (RCS) is the national office for the rape crisis movement in Scotland. The Rape Crisis Scotland National Helpline provides crisis support for anyone in Scotland affected by sexual violence at any time in their lives.

Address: 46 Bath Street, Glasgow, G2 1HG

Tel: 0141 331 4180

Fax and Minicom: 0141 332 2168

Email: info@rapecrisisscotland.org.uk

Rape Crisis Scotland Helpline: 08088 01 03 02 (free number) everyday, 6pm to midnight.

UK Human Trafficking Centre

Address: PO Box 4107, Sheffield, South Yorkshire S1 9DQ

Tel: 01142 523 891

Email: info@ukhtc.org

Karma Nirvana

Karma Nirvana - honour crimes and forced marriages

Address: PO Box 148, Leeds LS13 9DB

Honour Network Helpline: 0800 5999 247

Website: <http://www.karmanirvana.org.uk/>

Bright Choices

Bright Choices is a partnership between Sacro, the Edinburgh and Lothian Regional Equality Council (ELREC) and the Multi-Cultural Family Base (MCFB). Bright Choices provide range of services to individuals and families who are affected by Honour Abuse and Honour-Based Violence (HBV).

Address: Sacro National Office, 29 Albany Street, Edinburgh, EH1 3QN

Tel: 0131 622 7500.

Email: brightchoices@sacro.org.uk

To send a secure referral directly to Bright Choices brightchoices@sacrosecure.org.uk.cjism.net

Please note this address will only accept email sent from another secure address

Website: <http://www.sacro.org.uk/services/criminal-justice/bright-choices>

KWISA - Kenyan Women in Scotland Association

KWISA provide support and information for African women on FGM and other harmful traditional practices.

Address: Hayweight House, 23 Lauriston Street, Edinburgh, United Kingdom

Tel: 0131 281 7347

Email: kenyanwomeninscotland@gmail.com

Waverly Care - My Voice

My Voice is a research project that is working with communities in Scotland affected by Female Genital Mutilation (FGM). The project empowers communities to challenge and prevent FGM while supporting the development of culturally sensitive support services for individuals affected.

Address: 3 Mansfield Place, Edinburgh EH3 6NB

Tel: 0131 558 1425 / 07713 304029

Email: contact@waverleycare.org

Website: http://www.waverleycare.org/waverley_care/my-voice-fgm-project/

MORE INFORMATION AND SUPPORT

Scottish Government - One Scotland Website

<http://onescotland.org/equality-themes/gender/female-genital-mutilation-fgm/>

FORWARD

UK organisation raising awareness of FGM and campaigning against its practice. Also provides support

<http://forwarduk.org.uk/>

Daughters of Eve

Provides support to those with experience of FGM

<http://www.dofeve.org/>



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