FGM

(Female Genital Mutilation)

Practice Guidance & Resource Pack

Version 5

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Contents

Principles of Practice

The following principles should be adopted by all agencies in relation to identifying and responding to girls (and unborn girls) and women at risk of, or who have experienced FGM, and their parent(s):

- The safety and welfare of the child is paramount.
- All agencies act in the interests of the rights of the child as stated in the UN Convention (1989).
- FGM is illegal in the UK (for more information, see Section 2.3).
- FGM is not a matter that can be left to be decided by personal preference – it is an extremely harmful practice. Professionals should not let fears of being branded 'racist' or 'discriminatory' weaken the protection and support required by vulnerable girls and women.
- Accessible, acceptable and sensitive health, education, police, social care and voluntary sector services must underpin interventions.
- It is acknowledged that some FGM practicing families do not see it as an act of abuse (for more information, see Section 2.8). However, FGM is child abuse and has severe significant physical and mental health consequences both in the short and long term, and as such must never be excused, accepted or condoned.
- As an often embedded 'cultural practice', engagement with families and communities will be required to achieve a long-term abandonment and eradication of FGM.
- All decisions or plans should be based on good quality assessments (using, for example, the Common Assessment Framework in England and the Framework for the Assessment of Children in Need and their Families in Wales) and be sensitive to the issues of race, culture, gender, religion and sexuality; and should avoid stigmatising the girl or woman affected, and the practicing community, as far as possible given the other principles above.

Please also refer to Chapter Four of the HM Government Multi-Agency Practice Guidelines: Female Genital Mutilation (good practice to follow in all cases).

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/380125/MultiAgencyPracticeGuidelinesNov14.pdf

1. What is Female Genital Mutilation?

FGM comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. It has no health benefits and harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue, and hence interferes with the natural function of girls' and women's bodies. The practice causes severe pain and has several immediate and long- term health consequences, including difficulties in childbirth also causing dangers to the child.

FGM is known by a number of names including 'female genital cutting', 'female circumcision' or 'initiation'. The term female circumcision suggests that the practice is similar to male circumcision but it bears no resemblance to male circumcision, has serious health consequences and no medical benefits'.

FGM is also linked to domestic abuse, particularly in relation to 'honour based violence'. Please see the links to other documents at the end of this document for further information and links to other T&W Local Safeguarding Children Board Procedures.

2. Types of Female Genital Mutilation

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

***Type 1 - Clitoridectomy*:** partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).

***Type 2 - Excision*:** partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are the 'lips' that surround the vagina).

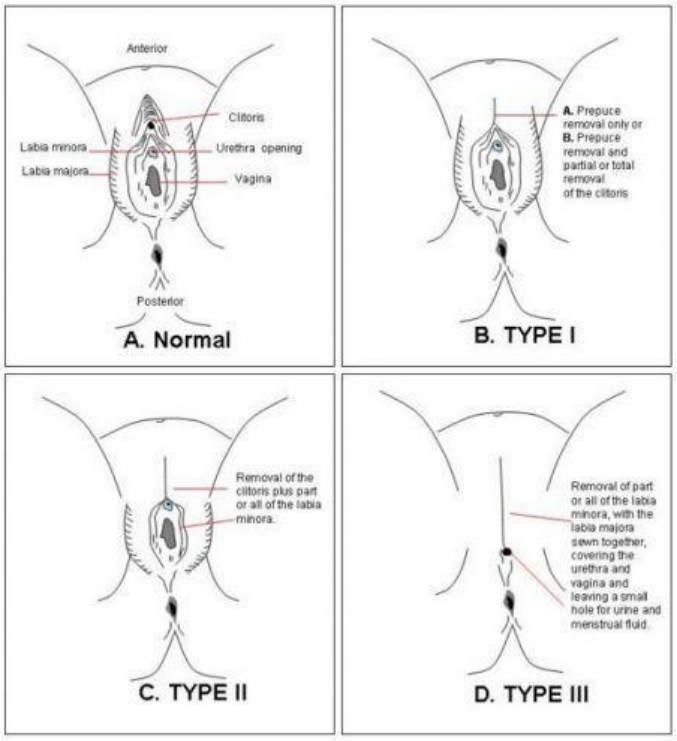
***Type 3 - Infibulation*:** narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.

***Type 4 - Other*:** all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterising the genital area.

The age at which girls undergo FGM varies enormously according to the community. The procedure may be carried out when the girl is newborn, during childhood or

adolescence, just before marriage or during the first pregnancy. However, the majority of cases of FGM are thought to take place between the ages of 5 and 8 and therefore girls within that age bracket are at a higher risk**.**

The following diagrams illustrate the differences in FGM types:



3. Prevalence

FGM is deeply rooted in tradition widely practiced among specific ethnic populations in Africa and parts of the Middle East and Asia. Data from Somalia, Guinea, Djibouti, Sierra Leone, Egypt, Sudan, Eritrea and Mali show a prevalence of over 80% but it is also widely practiced in other African countries. However, FGM has been found in communities in Iraq, Israel, Oman, the United Arab Emirates, the Occupied Palestinian Territories, India, Indonesia, Malaysia and Pakistan.

The World Health Organisation (WHO) 2010 estimates that between 100 and 140 million girls and women have been subjected to FGM and that around 3 million girls undergo some form of the procedure each year in Africa alone.

FGM's prevalence in the UK is difficult to estimate due to its hidden nature.

However, a recent study[1] estimated that: approximately 60,000 girls aged 0-14 were born in England and Wales to mothers who had undergone FGM; approximately 103,000 women aged 15-49 and approximately 24,000 women aged 50 and over who have migrated to England and Wales are living with the consequences of FGM; also, approximately 10,000 girls aged under 15 who have migrated to England and Wales are likely to have undergone FGM.

It is possible that, due to population growth and immigration from practising countries since 2001, FGM is significantly more prevalent than these figures suggest. There is likely to be an uneven distribution of cases of FGM around the country, with more occurring in those areas of the UK with larger communities from the practising countries - found by the same study to be London, Cardiff, Manchester, Sheffield, Northampton, Birmingham, Oxford, Crawley, Reading, Slough and Milton Keynes. However, all areas, local authorities and professionals must be aware of and actively prevent and tackle FGM.

4. Why Is FGM performed?

FGM is often seen as a natural and beneficial practice carried out by a loving family who believe that it is in the girl's or woman's best interests. This also limits a girl's incentive to come forward to raise concerns or talk openly about FGM - reinforcing the need for all professionals to be aware of the issues and risks of FGM. It is because of these beliefs that girls and women who have not undergone FGM can be considered by practising communities to be unsuitable for marriage.

A number of factors have been identified:

a. To maintain cultural identity
b. Religion; in the mistaken belief that it is a religious requirement
c. Social acceptance especially for marriage
d. Preservation of virginity/chastity
e. Increasing sexual pleasure for the male
f. Men's control of female reproductive functions
g. Hygiene and cleanliness
h. Family honour
i. Fear of social exclusion

Despite the harm it causes, many women from FGM practising communities consider FGM normal to protect their 'cultural identity'. As a result of the belief

[1] Macfarlane A, Dorkenoo E. Female Genital Mutilation in England and Wales: Updated statistical estimates of the numbers of affected women living in England and Wales and girls at risk. Interim report on provisional estimates. London: City University London and Equality Now, 2014.

systems of the cultural groups who practise FGM, many women who have undergone FGM believe they appear more attractive than women who have not undergone FGM. Women who have attempted to resist exposing their daughters to FGM report that they and their families were ostracised by their community and told that nobody would want to marry their daughters. In some cases where women are deemed to have shamed the family honour, they have been subjected to 'honour' based abuse.

Although FGM is practised by secular communities, it is most often claimed to be carried out in accordance with religious beliefs. However, FGM predates Christianity, Islam and Judaism, and the Bible, Koran, Torah and other religious texts do not advocate or justify FGM.

5. At What Age is FGM Performed?

The age at which girls undergo FGM varies enormously according to the community. The procedure may be carried out when the girl is newborn, during childhood or adolescence, at marriage or during the first pregnancy. However, the majority of cases of FGM are thought to take place between the ages of 5 and 8 and therefore girls within that age bracket are at a higher risk.

It is believed that FGM happens to British girls in the UK as well as overseas (often in the family's country of origin). Girls of school age who are subjected to FGM overseas are thought to be taken abroad at the start of the school holidays, particularly in the summer holidays, in order for there to be sufficient time for her to recover before returning to her studies.

6. Who performs FGM?

The practice of female genital mutilation is often perpetrated by an older woman in the practicing community and can be a way of her gaining prestige and making a good income. It may be possible that families will practise FGM in the UK when a female family elder is around, particularly when she is visiting from a country of origin.

It is often performed with crude blunt instruments such as un-sterilised household knives or razor blades but broken glass and stones are also used and often without anaesthetic. The more affluent may have the procedure performed in a health care facility by qualified health personnel. Neither of these practices are acceptable.

7. Effects of FGM

FGM can cause both short term and long term complications. Some of these are as a result of the procedure being performed in unhygienic circumstances.

Short-term implications:

- Severe pain
- Shock-both emotional and psychological as well as medical
- Haemorrhage
- Wound infection including tetanus and blood borne viruses such as HIV and Hepatitis B and C
- Damage to organs around clitoris and labia
- Urine retention
- Fracture of bones or dislocation of joints as a result of restraint
- Damage to other organs
- Death

Long-term implications can entail:

- Damage to the reproductive system including infertility
- Chronic vaginal and pelvic infections
- Cysts and abscesses
- Complications in pregnancy and child birth, including death
- Psychological damage
- Painful sexual intercourse
- Sexual dysfunction
- Difficulties in menstruation
- Difficulties in passing urine and chronic urine infections
- Renal impairment and possible renal failure
- Increased risk of HIV and other sexually transmitted infections

There is increasing awareness of the severe psychological consequences of FGM which can be life long. There is evidence to suggest that girls having undergone FGM suffer from post traumatic stress disorder with flash backs and many suffer from anxiety and mood disorder. The feeling of betrayal, incompleteness, anger and regret are themes reported by young women undergoing counselling.

8. Identifying girls at risk of FGM

A girl from a practicing community may be at risk of FGM but it cannot be assumed that all families from practicing communities will want their females to undergo FGM.

The risk of FGM to an individual is greater when the community is less well integrated into British society, when their own mother or sister has been the subject of FGM or when they have been withdrawn from Personal, Social and Health Education or Personal and Social Education lessons at school. The withdrawal from such lessons may be the parents' way of keeping the girl uninformed of her rights and her own body.

A girl may be taken out of the country for a holiday for the procedure to be carried out abroad with time for recovery, but there is also evidence that FGM is carried out in the UK. The summer holiday is a peak period for cases of forced marriage and female genital mutilation. Schools, at this time in particular, and LAs are encouraged to be alert to the signs of potential abuse.

Alerts to imminent FGM may include:

- A visiting female elder being in the UK from the country of origin
- A professional hearing reference to FGM e.g. hearing someone talking about a 'special procedure'
- A disclosure or request for help if the girl is aware or suspects she is at risk
- Parents taking the child out of the country for a prolonged period
- The girl talking about a long holiday to one of the countries where FGM is practiced

FGM may already have taken place but it is important that this is recognised so that help can be offered to the girl, other family members at risk can be safeguarded and so that a criminal investigation can be carried out.

Indications that FGM has already been carried out may be suspected if:

- A girl seems to have difficulty walking, sitting or standing
- A girl spends longer then normal in the bathroom/toilet due to difficulties urinating
- A girl spends long periods away from the classroom with bladder or menstrual problems
- A girl misses a lot of time off school or college

- A girl has a change in behaviour
- A girl being unduly reluctant to have a normal medical examination
- A girl confides in someone or may ask for help but not be explicit due to fear or embarrassment

9. Legal Context - FGM is illegal in the UK!!!

The Female Genital Mutilation Act 2003 applies to England, Wales and Northern Ireland and a person, whatever their nationality or residence status, is guilty of an offence under this Act if they excise, infibulate or otherwise mutilate the whole or any part of a girl's or woman's labia majora, labia minora or clitoris within the UK.

Necessary operations by a registered medical practitioner or midwife for medical reasons or related to child birth are specific exclusions under the Act.

It is also an offence to assist a girl or woman in mutilating her own genitalia

Under the 2003 Act, it is an offence for a UK national to assist in FGM abroad and for a girl to be taken abroad for FGM to take place.

Anyone found guilty under the 2003 Act will be liable to a maximum penalty fine or up to 14 years imprisonment or both.

FGM is a human rights issue (Article 3 of the European Convention on Human Rights and the 1989 United Nations Convention on the Right of the Child, Part 1, Article 37).

10. Responding to FGM

Girls and young women at risk of FGM need to be safeguarded. Anyone who has information that a child is potentially or actually at risk of significant harm is required to inform Children's Social Care or the Police (Children Act 1989; consolidated by s10 Children Act 2004 which places a duty on all key agencies to co-operate to improve the well-being of children and young people). Children's Social Care services will then assess the risk to the child under a section 47 investigation.

Staff in education settings/obstetrics and midwifery services need to be aware of the potential risk to girls and women from communities known to practice FGM.

Professionals need to be aware of the sensitive and complex nature of FGM. Often

the family does not see FGM as an act of abuse and in all other ways provide a loving environment. Removal of the girl from the family home may not be appropriate.

Each case needs to be responded to depending on the particular circumstances and level of danger at the time.

If an individual has undergone FGM, professionals must consider whether other girls are at risk.

When talking about FGM professionals, it is good practice to:

a) **Ensure a female professional is available if the girl prefers**
b) **Make no assumptions**
c) **Be sensitive to the fact that the girl may still be loyal to her family**
d) **Be non judgmental and stick to facts e.g. the legal position and health implications**
e) **Gain accurate information and keep accurate records**
f) **Use simple, non loaded and value neutral terminology**
g) **Ask direct questions to avoid confusion**

If an interpreter is required, they must not be a family member nor have any influence in the girl's community.

Females may be frightened about contact with statutory agencies for a variety of reasons including being in breach of immigration rules. However, the female may need medical treatment of may be the victim of a crime. The situation should be handled sensitively and may need agreement between the police and UK Border Agency officials.

Females may also find it difficult to disclose FGM because of fear of the consequences for the family, including being taken to court.

If a medical examination is required, this should be carried out by an appropriately trained person and should be carried out under safeguarding procedures by SARC (West Road, Wellington, TF1 2BB).

Professionals may feel uncomfortable about disclosing information about FGM, but law and policy allow for disclosure when it is in the public interest or where a crime may have been committed. Professionals should follow appropriate guidance regarding confidentiality and disclosure, e.g. Information Sharing Guidance for

Practitioners (2008) Nursing and Midwifery Council's advice on confidentiality (2009), General Medical Council guidance (2009), Local Safeguarding Children Boards' policy and procedures.

Professionals need to be aware that an individual may be at risk of both FGM and forced marriage. The national and local guidance on forced marriage should be consulted.

11. Clinical issues and procedures

Women and girls who have suffered mutilation may be very reluctant to agree to a vaginal or rectal examination, and may refuse routine cervical smears and/or infection screening. It may be impossible to perform a vaginal examination at all, and be very difficult or impossible to pass a urinary catheter.

Nurses and midwives need to deal with this in a sensitive manner, and be prepared sufficiently that they do not exhibit signs of shock, confusion, horror or revulsion on seeing the genitalia. Even though sensitivity is needed, it is very important to ask women whether they have been 'cut' or 'circumcised'. Some seek help because they wish to have the FGM reversed before marrying, or may be experiencing problems conceiving because of difficulties with penetration. These women and girls need to be referred to appropriate clinics (See page 15 for details of specialist groups /advice & support).

12. Legal Interventions

Working Together to Safeguard Children (2013) states:

"If at any time it is considered that the child may be a child in need as defined in the Children Act 1989, or that the child has suffered significant harm or is likely to do so, a referral should be made immediately to local authority children's social care. This referral can be made by any professional."

FGM is recognised as significant harm.

Professionals should intervene to safeguard girls who may be at risk of FGM or has been affected by it. This is by using the relevant existing statutory procedures. There may be a joint investigation which would be handled in line with the Safeguarding Board procedures and Working Together to Safeguard Children (2013).

The police may use their protection powers under section 46 of the Children Act 1989 where there is reasonable cause to believe that a child or young person

under 18 years is at risk of significant harm. Children's social care would be informed by the police and initiate child protection enquiries.

Emergency Protection Order (EPO) can be applied for by anyone but in general is by children's social care. An EPO authorises the applicant to remove the girl and keep her in safe accommodation. It lasts for 8 days but can be renewed for up to a further 7 days.

Care Orders and Supervision Orders - Children's social care may need to consider whether the circumstances constitute likely significant harm to justify initiating care proceedings. The court will decide whether the threshold has been reached and which order is most appropriate depending on the circumstances and the age of the child or young person (Children Act 1989 section 31).

Under the Children Act 1989, local authorities can apply to the courts for various orders to prevent a child being taken abroad for FGM.

A Prohibitive Steps Order (Children Act 1989, Section 8) can be sought to prevent parents or carers from carrying out a particular act without the consent of the court.

13. Community Education

Cities such London, Liverpool, Birmingham, Sheffield and Cardiff have substantial populations from the countries where FGM is widely practiced. However it is important to note that FGM is not necessarily confined to these areas.

Practicing communities where FGM is deeply embedded in the culture may resent the imposition of liberal western values on them. Professionals nonetheless must be aware that FGM can be very harmful and is not a matter that can be left to personal preference or culture.

It is important however, that any community education is sensitive to the cultural norms and pressures applied to parents and children. Professionals involved will have to be aware of language and terminology. Consideration should be given to the production of leaflets in specific languages in order to help with this process.

Any child protection policy adopted will need to be effective within the community to which it is targeted and therefore liaison with community members to work with agencies around education will need to be put in place.

14. Support

Families involved may need to be referred to appropriate counselling services, to deal with any psychological conflicts that may arise.

It is imperative for agencies to recognise that many families, who are considering perpetrating this practice, have a considerable cultural dilemma. Families should be warned that this is an illegal practice in this country and that they are liable to prosecution if they proceed. This can take away the decision from the family and therefore reduce criticism from within their own community.

Further support may be needed for those families where FGM is suspected (refer to page 15).

15. Links with Domestic Abuse & Honour-Based Violence (HBV)

Definition of Honour-Based Violence (HBV)

The terms 'honour crime', 'izzat' or 'honour-based violence' embrace a variety of crimes of violence (mainly but not exclusively against women), including assault, imprisonment and murder where the person is being punished by their family or community. They are being punished for actually, or allegedly, undermining the family or community believes to be the correct code of behaviour. In transgressing against this correct code of behaviour, the person shows that they have not been properly controlled to conform by their family and this is to the 'shame' or 'dishonour' of the family.

Forced marriage and honour-based violence are human rights abuses and fall within the Government's definition of domestic violence. Forced marriage is defined as a marriage conducted without the full consent of both parties and where duress is a factor. There is a clear distinction between forced marriage and an arranged marriage. In arranged marriages, the families may take a leading role in arranging the marriage, but the choice whether or not to accept remains with the prospective spouses. In a forced marriage, one or both spouses do not consent to the marriage. The young person could be facing physical, psychological, sexual, financial or emotional abuse to pressure them into accepting the marriage.

Links to Female Genital Mutilation and Forced Marriage

'Honour-based' violence can include the following issues:

j. Forced marriage (FM)
k. Female genital mutilation (FGM)
l. Honour killings (murder)
m. Domestic imprisonment
n. Dowry-related abuse

As a result, FGM and FM are types of abuse that fall into the category of HBV. For further information please refer to section 'Useful Documents'.

16. Raising Awareness

Training with regard to the recognition of female genital mutilation may be needed. Sensitivity in managing the patients, referral facilities for reversal surgery, pre-birth examination and information gathering would have to contain awareness that women may not recognise female genital mutilation as surgery and indeed may not consider it abnormal. It is important that enquiries are made as early as possible in pregnancy in order to identify infibulated women and refer them for a medical opinion. Similarly it is important to stress that re-infibulation is illegal.

There will be issues for all staff involved regarding training and case management including cultural sensitivity issues.

There is a clear need to build up relationships with families to overcome the initial hostility which intervention generates. There is also a need to emphasise the positive aspects of the family's culture, since for many FGM is usually practised out of a positive regard for a woman's future status within her community.

Workers who are dealing with these issues will need specific support because it may be that if they are members of a similar community to the families they are working with, they may be seen as outsiders and treated with particular hostility.

Health Visitors and School Nurses will need to have an a awareness of the problem, both from the point of view of offering initial support and signposting to counselling services and also for raising awareness in health education programmes.

17. Specialist groups which can provide advice & support:

For an up to date list of FGM Clinics, please click the link below and then go to 'Download a list of all available clinics'.

http://www.nhs.uk/NHSEngland/AboutNHSservices/sexual-health-services/Pages/fgm-healthservices-for-women.aspx

18. Organisations working on issues on or around FGM

POLICE SERVICE

Metropolitan Police Service / Project Azure 020 7161 2888

UK GOVERNMENT

https://www.gov.uk/female-genital-mutilation

HELPLINES

National Society for the Prevention of Cruelty to Children (NSPCC) FGM Helpline
24 –hour Helpline. Free phone 0800 028 3550 www.nspcc.org.uk/fgm

Black Association of Women Step Out (BAWSO)
24-hour Helpline: 0800 731 8147 www.bawso.org.uk

ChildLine
24-hour Helpline for children: 0800 1111 www.childline.org.uk

National Domestic Violence Helpline
24-hour Helpline: 0808 2000 247
www.nationaldomesticviolencehelpline.org.uk

NSPCC British Sign Language Helpline for deaf or hard-of-hearing callers
ISDN videophone: 020 8463 1148 Webcam: nspcc.signvideo.tv (available Monday – Friday, 9am – 5pm, in English language only) Text: 0800 056 0566

OTHER ORGANISATIONS

28 Too Many
http://28toomany.org/

Africans Unite Against Child Abuse (AFRUCA)
http://www.afruca.org/

Agency for Culture and Change Management UK (ACCM UK)
http://www.accmuk.com/

Birmingham & Solihull Women's Aid
http://bswaid.org/

Foundation for Women's Health Research & Development (FORWARD)
http://www.forwarduk.org.uk/

Halo Project
http://www.haloproject.org.uk/

Manor Gardens Health Advocacy Project
http://www.manorgardenscentre.org/

The Lily Project
www.visioncornwall.com

The Maya Centre
www.mayacentre.org.uk.

For more organisations and local services, please visit
https://www.gov.uk/female-genital-mutilation

The government's FGM unit can offer advice and support to local areas who would like to strengthen or develop their work on tackling FGM.

To contact the FGM unit, please email FGMEnquiries@homeoffice.gsi.gov.uk

More information on the role of the FGM unit can be found at:
https://www.gov.uk/government/collections/ female-genital-mutilation

19. Conclusion

Female genital mutilation is not a race or a religious issue; it is a safeguarding issue which will need to be managed consistently. All staff involved in the safeguarding of children must recognise this.

The practice of female genital mutilation tends to run in families and therefore if one family member is identified as being at risk of undergoing FGM or has undergone FGM, risks to other female family members must be recognised.

Any concerns regarding female genital mutilation must be acted upon in accordance with local policy and guidance. The referrer however, must feel reassured that a sensitive strategy will follow, including the sensitive management of any subsequent investigation and child protection conference.

20. References

HM Government, *Multi-Agency Practice Guidelines: Female Genital Mutilation*, 2011 World Health Organisation, *Female Genital Mutilation, Fact Sheet No 241*, 2010

Multi-Agency Practice Guidelines: Female Genital Mutilation – Home Office, July 2014.

21. Useful resources

GUIDANCE AND GUIDELINES FOR PROFESSIONALS

The following list is not designed to be an exhaustive list of all applicable publications. Professionals should consult the relevant professional bodies and agencies for the up to date guidance.

- All Wales Child Protection Procedures Review Group (2005) All Wales ACPC Female Genital Mutilation Protocol 2005;
- Association of Chief Police Officers (2005) Guidance on Investigating Child Abuse and Safeguarding Children;
- Department for Children, Schools and Families (2010) Working Together to
- Safeguard Children: A Guide to Inter-Agency Working to Safeguard and Promote the Welfare of Children;
- British Medical Association (2006) Female Genital Mutilation – Caring for Patients and Child Protection;
- General Medical Council (2006) Raising Concerns about Patient Safety;
- General Medical Council (2007) 0–18 Years: Guidance for All Doctors;
- General Medical Council (2008) Consent: Patients and Doctors Making Decisions Together;
- General Medical Council (2009) Confidentiality;
- HM Government (2006) What To Do If You Are Worried A Child Is Being Abused;
- HM Government (2009) Multi-Agency Practice Guidelines: Handling Cases of Forced Marriage;
- HM Government (2010) Call to End Violence against Women and Girls;
- Standardisation Committee for Care Information (2014) Female Genital Mutilation Prevalence Dataset;
- Nursing and Midwifery Council (2008) The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives;
- Royal College of Midwives, Royal College of Nursing, Royal College of Obstetricians and Gynaecologists, Equality Now, UNITE (2013);
- Intercollegiate Guidelines Tackling FGM in the UK - Intercollegiate recommendations for identifying, recording and reporting. (2013);
- Royal College of Midwives (2011) RCM Position Statement: Female Genital Mutilation;
- Royal College of Midwives (2011) Guidance for Midwives;

- Royal College of Nursing (2006) Female Genital Mutilation – An RCN Educational Resource for Nursing and Midwifery Staff;
- Royal College of Obstetricians and Gynaecologists (2009) Green-top Guideline No. 53 – Female Genital Mutilation and its Management;
- Welsh Assembly Government (2004) Safeguarding Children: Working Together to Safeguard Children Under the Children Act 2004.

The FGM National Clinical Group has produced an educational DVD which clearly instructs and shows doctors, midwives and nurses how to undertake de-infibulation. This can be ordered from the group's website: **www.fgmnationalgroup.org**

An NHS Choices FGM page containing information and support for frontline professionals and members of the public who are concerned about the practice and are seeking advice. (**www.nhs.uk/fgm**)

A Department of Health DVD about FGM can be also ordered by emailing
fgm@dh.gsi.gov.uk

Information about the government's strategy to eradicate violence against women and girls can be found at **https://www.gov.uk/government/ policies/ending-violence-against-women-andgirls-in-the-uk**

Information from the Department for Education about safeguarding children can be found at

https://www.gov.uk/childrens-services/ safeguarding-children

The Female Genital Mutilation Prevalence Dataset is a monthly return of aggregated patient data generated by acute hospital providers in England. The Female Genital Mutilation (FGM) Prevalence Dataset Information Standard (ISB1610) was published on 1 April 2014, with the first monthly return submitted in May 2014. It was mandated as a monthly return from 1 September 2014 and collects a count of incidence of patients with FGM identified in acute care Trusts. The FGM Prevalence Dataset is an initial aggregate dataset to be collected until the end of March 2015. An enhanced dataset is planned for April 2015. http://www.hscic.gov.uk/fgm