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Prevalence of Female Genital Cutting/Mutilation in the UK

What can official data tell us?



Saffron Karlsen, Janet Howard, Natasha Carver,
Magda Mogilnicka and Christina Pantazis

Prevalence of Female Genital Cutting/Mutilation in the UK.

What can the official data tell us?

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*“Even though, as a community, we want to move away from this practice,
[we are] slapped across the face with it- [...] Even if communities stop practicing it,
they will still be stigmatised and labelled by it.
It undermines the progress that we’ve made.”*

(Karlsen et al 2019)

January 2021

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A note on logos:

The University of Bristol is currently undertaking a review of its relationships with those who historically profited from the enslavement of Africans and the ways these are represented, including in its logo. While this is on-going, some staff and students are choosing to draw attention to the problems of existing approaches by using an additional badge. This badge was developed by the DecoloniseUoB group and references street artist Banksy's depiction of the toppling of the statue of Edward Colston, a prominent trader in enslaved Africans, by members of the public in Bristol on 7 June 2020. For more details of this initiative, please see @decoloniseUoB on Twitter

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Executive Summary

Introduction

According to the World Health Organisation (WHO), Female Genital Cutting/Mutilation (FGC/M)¹ includes “all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons”.^{2,3} Politicians and media sources have repeatedly stated that ‘tens of thousands of girls’ living in the UK are at risk of FGC/M.⁴⁻⁶ This report examines direct and indirect approaches currently adopted to establish the scale of FGC/M prevalence and risk among the UK resident population, upon which such claims may be based. The evidence indicates that the on-going risk of FGC/M to girls born and/or resident in the UK is far below that suggested. We also identify a number of problems with these data, and their use as a means by which to estimate levels of FGC/M risk. Recommendations are made regarding ways to improve these resources, and to develop a more accurate picture of the current scale of risk among the UK resident population from which to enable more effective and appropriate policy and practice.

Direct estimates of FGC/M prevalence and risk in the UK

No national survey has been conducted to establish FGC/M prevalence in the UK. However, relevant evidence is collected by several governmental departments, although each according to their own agenda. We consider here the potential to make direct estimates of FGC/M prevalence via:

- the Home Office’s mandatory reporting system for health care professionals, social workers and teachers, which was introduced in 2015;
- the data relating to criminal justice activity available via the Home Office and Ministry of Justice;
- information on FGC/M-related referrals and assessments held by the Department for Education;
- the Department of Health’s FGM Information Sharing System and FGM Enhanced Dataset; and
- published academic research.

1. Mandatory reporting data reported publicly or held by the Home Office, Ministry of Justice and Department for Education.

Anyone in the UK who has information that a child is at risk of significant harm, including from FGC/M, is required to inform social care or the police. National figures for this mandatory reporting are not publicly available, with FGC/M cases handled by each of the 43 police forces separately. There is some evidence that reports of FGC/M have increased over time - from 137 in 2014 to 647 in 2016 - but no detail regarding the nature of these reports, or whether or how police forces responded to them.⁷

Data available from the Crown Prosecution Service (CPS) reports 36 referrals of alleged FGC/M between 2010 and March 2019, of which 33 did not proceed to charge with the rest acquitted.⁸ There was one conviction from two further prosecutions in 2019.⁹ There were 584 FGM Protection Orders (FGMPOs) made between their introduction in July 2015 and the end of March 2020.¹⁰ Available evidence (up to March 2019) suggests that there have been no prosecutions for breach of a FGMPO.¹¹

The responses to a series of requests for information relating to FGC/M made in April 2019 under the Freedom of Information Act 2000 made to the Ministry of Justice (MoJ), the Home Office and the Department for Education were generally disappointing. We were informed that any relevant information held by the MoJ was not held centrally, nor electronically. As such, they were unable to provide any information beyond identifying those

Family Courts involved in making disposals of FGMPOs.

Some information was available from the Home Office regarding the outcomes of crime recorded by the police in England and Wales for offences against the FGM Act 2003, breach of a FGMPO and failure to protect a child from risk of FGC/M. Overall, the data demonstrates that the police record very few crimes related to FGC/M and very few of these are prosecuted through the courts. The figures received indicate a total of 173 alleged offences under the FGM Act 2003, 28 incidents of alleged failure to protect a child from risk of FGC/M between 2009 and 2018, and three alleged breaches of an FGMPO, all of which were reported in 2018. It is important to note that these data are police-recorded offences, not confirmed convictions. Only two of the alleged offences under the FGM Act 2003 and none of alleged failures to protect a child from risk of FGC/M resulted in a charge or summons. None of those proceeding to charge were found guilty. Twenty-four alleged offences under the FGM Act 2003, four cases of alleged failure to protect a child from risk of FGC/M and three alleged breaches of an FGMPO remained under investigation when the data were provided. Importantly, these data do not record the date when the alleged offence took place. As such, recent reports may describe historical incidents. It is therefore difficult to use these data to deduce the prevalence of FGC/M in the UK.

Between 1 April 2016 (when records began) and 31 March 2018, 1910 referrals to children's social care were recorded with FGC/M identified as a risk factor at the end of the assessment. There is no explanation regarding what circumstances

might lead to a child being considered at risk of FGC/M.

In summary, while there is some information here which might be used to indicate levels of concern (e.g. referrals and allegations of FGC/M), there is insufficient information from which to determine the actual scale of FGC/M presence or risk within the UK. But, there is little to suggest that this affects ‘tens of thousands of girls’. The vast majority of referrals fail to proceed to charge, or conviction. Of concern is the lack of evidence from which to determine whether correct procedures are being followed in these cases, particularly given their sensitivity and the documented traumatic implications when things go wrong.¹²⁻¹⁵ It is shocking that arrangements for the collection and storage of this important information are so haphazard. The development of more comprehensive, electronic and centrally-held registers, for this and other forms of child abuse, must be a priority.

2. The FGM Information Sharing System and FGM Enhanced Dataset

The FGM Information Sharing System¹⁶ (FGM-IS) was launched by the Department of Health and NHS England in July 2014. Any female infant born in England into a family with a history of FGC/M (on either parents’ side) has a flag attached to her summary care record which remains until she is 18 years old. Little information is released regarding the number of cases identified using this approach, and according to what criteria. As such, these data cannot be used to assess FGC/M prevalence or risk.

The so called “FGM Enhanced Dataset” collects data on FGC/M within the patient population from NHS trusts and GP practices in England.^{17,18} Mandatory data collection and submission for all acute trusts was established on 1 July 2015 and for all mental health trusts and GP practices from 1 October 2015. Cases documented and submitted include: any patient receiving treatment related to FGC/M; when there is a change in a woman’s FGC/M type; when FGC/M is identified in any other way by a medical professional, including by self-report; or when a woman with FGC/M gives birth to a girl.

There are a number of significant problems affecting these data. Until March 2020, only 2.5% of GP practices and 62.7% of NHS Trusts had submitted any information to the dataset. Even where data is submitted, its incompleteness significantly limits the value. Only 22% of the individual women recorded on the FGM Enhanced Dataset in 19/20 have comprehensive data regarding their FGC/M type, age and place when undertaken. Information on nil returns is not collected and the database does not record those women who are asked and who do not have FGC/M (or who do not have daughters with FGC/M). There are also concerns with the accuracy of these reports, and the reliance of self-reported FGC/M status.

The data suppression methods used on the FGM Enhanced Dataset to prevent individuals being identified limit our ability to identify the exact number of individuals affected and develop estimates of prevalence and risk. The impact of these methods is particularly problematic when the number of cases is small, where a total of 15 could represent anywhere between 3

and 21 actual individuals. Even if we had reasonable indication of those who have had FGC/M, then, it is difficult to understand these data as a proportion of the wider population.

Between April 2015 and March 2020 24,420 individual women and girls were identified through the FGM Enhanced Dataset as having had FGC/M at some point in their lives. Less than 2% of all attendances for FGC/M-related issues in any given year involve those aged under 18. Given that any women/girl can have multiple attendances, the actual number of girls affected may be far fewer. However, it is unclear whether this reflects the reality, or whether some girls who have undergone FGC/M have not yet had medical needs to bring them into contact with these reporting systems, given that the vast majority of the cases identified are in adult women accessing maternity services.

Where information was available, fewer than 5% of the incidents of FGC/M recorded on the FGM Enhanced Dataset since 2015 took place in the UK. Of the 425¹⁹ women/girls recorded on the FGM Enhanced Dataset as having had FGC/M in the UK, all those recorded between April 2015 and March 2017, 82% of those recorded between April 2017 and March 2019 and 92% of those recorded between

April 2019 and March 2020 were aged 18 or over at the time of the incident. This may correspond to as few as eight girls in total who had FGC/M while UK resident and aged under 18 since these records began.

Moreover, since April 2017, over 80% of FGC/M cases recorded among those born in, or having experiences of FGC/M, in the UK, are type 4, which includes less mutilating forms. Around three-quarters of incidents of FGC/M type 4 recorded on the FGM Enhanced Dataset involved genital piercing. The number of women/girls recorded as experiencing FGC/M types 1, 2 or 3 in the UK may be as few as one or two.

3. Academic research and other sources

Academic evidence on cases of FGC/M in the UK among children also indicate that the numbers of girls experiencing FGC/M in the UK are low, with the majority having the procedure performed before they migrate to the UK. Studies of children in other European or Western countries reveal a similar trend.

Indirect methods for estimating FGC/M prevalence and risk among women in the UK

All estimates of FGC/M prevalence produced for the UK population to date have used an indirect extrapolation approach, using census data and prevalence estimates for countries from which people migrate to the UK - often using data from Demographic Health Surveys (DHS)²⁰ or the Multiple Indicator Cluster Survey (MICS) – as a basis from which to assess level of risk in the UK.²¹ The reliability of these figures for establishing prevalence rates even in high FGC/M-prevalence countries has been queried. But, there is now considerable evidence that the likelihood of undergoing FGC/M is lower among those who are born in or who have moved to low FGC/M prevalence countries compared with those living in high prevalence countries, particularly when they moved at very young ages and even where their mother has experienced FGC/M themselves. The application of this extrapolation approach to low FGC/M-prevalence settings is therefore particularly problematic.

The impact of attitudinal changes on the risk of undergoing FGC/M cannot be quantified in a way that can be applied in numerical estimates at a population level.²²⁻²³ As such, we need to adopt new approaches to recognising these risks. The European Institute for Gender Equality (EIGE) have developed a methodology incorporating quantitative and qualitative components which allows for some exploration of the difference in attitude towards FGC/M by practising communities post-migration.²⁴ While their approach does seek to calculate the number of girls at risk, which we would not recommend, it also offers valuable insights for those seeking to better understand the changing prevalence of FGC/M over time or in different social contexts. This may enable a more effective means of identifying and responding to any FGC/M risk in society. Data collection approaches which directly engage with the individuals potentially affected – young people born and living in the UK – would appear to be a much more valuable approach than trying to establish present levels of risk using historical experiences which are increasingly irrelevant to Britain today.

Recommendations

Our research in this area, presented in this report and in Karlsen et al,^{13,14} has identified a number of persistent issues with current approaches to FGM-safeguarding and the collection of data associated with these policies which must be addressed.

- The need to establish the prevalence and risk of FGC/M among the UK-resident population cannot be achieved effectively using any of the methods examined here. It can only be achieved by working in partnership with those with heritage in FGC/M-affected communities to develop research which explores the attitudes, knowledge and practices of those living in the UK today.
- Data collection approaches must directly engage with the individuals potentially affected – young people born and living in the UK – e.g. through an anonymous survey. This will establish present levels of risk far more effectively than using historical experiences which are increasingly irrelevant to Britain today.
- Following the recommendations of the Lammy Review,²⁶ we need more consistent, comprehensive, centralised and electronic approaches to the collection and presentation of data which maintain the highest standards of methodological rigor, to ensure services can properly meet the needs of their users. Ethnicity must be consistently recorded by all public services as well as full details of the identification, outcomes, process and consequences associated with each reported offence and pertinent details from which to determine the support provided to the victims and alleged perpetrators. These data must be regularly subjected to rigorous analysis to identify and respond to problematic practices. These data are not appropriate for establishing FGC/M prevalence in the UK. However, without more effectively establishing the number of cases of FGC/M being brought to the attention of statutory services and responses to them, it is impossible to evaluate the effectiveness of these approaches or identify ways to improve them.
- The failure to collect nil reports and negative responses (e.g. among those without experience of FGC/M) and information on deaths/outmigration of those with FGC/M as part of the FGM Enhanced Dataset has produced serious impediments to its value as a means of establishing need for services, as well as FGC/M prevalence.
- Information to explain the current low response rates to the FGM Enhanced Dataset is needed, in general and in terms of the submission of non-mandatory information. Establishing whether this reflects time constraints on health professionals, language barriers, or a reluctance among health professionals to ask these questions or among patients to answer them is imperative in order to identify opportunities to improve these approaches.
- All authorities involved in FGM-safeguarding – including those working in healthcare, education, social services and the police – must ensure that all engagement is sensitive, appropriate and proportional.

- Where risk assessment tools are used, these must be used consistently and based on reliable, validated methodologies considered appropriate by service users and their families, particularly in light of evidence of the potentially traumatic impact of current approaches associated with self-reported FGC/M experience.^{13,14}
- There is also a need to respond to the evidence regarding the traumatising effects of some approaches to adopted to the collection of data for the FGM Enhanced Dataset. In Karlsen et al,^{13,14} medical staff were perceived to prioritise extracting this information over and above their health needs and without consideration of their trauma in connection with their past experiences of FGC/M. This undermined participants' trust in health providers and encouraged a reluctance to seek care.
- Health providers have also expressed concerns regarding the impact of the

mandatory reporting mechanisms related to the FGM Enhanced Dataset, an “unnecessary and misguided...policy that wrecks the basic medical promise of confidentiality” which “underpins the doctor-patient relationship”.²⁵ Such approaches, regarding both the nature of questioning and mandatory reporting, are contrary to responses to other forms of abuse.

It is clear that current policy and practice relating to FGC/M in the UK is based on a number of incorrect assumptions, which have developed from misguided use of the available data and a lack of attention to the problems which affect its use. There is a clear need to protect children at risk. But there is no evidence from any of the sources examined here to justify the over-zealous and often heavy-handed approaches to FGM safeguarding currently undertaken in the UK, or the negative outcomes for individual children, their parents and families and their communities which often accompany them.

Executive Summary - References and Notes

1. Whilst the term ‘female genital mutilation’ (FGM) is frequently used in policy and practice arenas, it is controversial for at least two reasons. First, it is applied to a wide range of procedures, some of which are not mutilating. Second, it typically excludes other procedures which are genitally mutilating, such as forms of cosmetic surgery and male circumcision. For more detailed discussion of this, see Shahvisi, A and Earp, BD (2019) *The law and ethics of female genital cutting*. In: Creighton, Sarah M and Liao, Lih-Mei (eds.) *Female genital cosmetic surgery: solution to what problem?* Cambridge University Press, pp. 58-71. The term is commonly used in relation to statutory processes relating to FGM-safeguarding. However, academic opinion is more diverse with some scholars preferring the term, female genital cutting (FGC) (Shahvisi & Earp 2019).
2. <https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation>
3. The WHO definition of FGM includes a range of procedures including: clitoridectomy – the partial removal of the clitoris or prepuce (type 1); excision - the partial removal of the clitoris and labia minora (type 2); infibulation – the narrowing of the vaginal opening (type 3) and; any female genital piercing, pricking, incising, cauterising or scraping for non-medical reasons (type 4). Type 4 therefore includes procedures which might not be associated with long-term tissue damage. FGM mandatory reporting duty in the UK includes female genital piercing, tattooing and other procedures which are medically unnecessary. WHO definitions of Type 1 and 2 also mention ‘total’ clitoral removal, but this relies on anatomically incorrect understandings of the nature of the clitoris. (For further discussion, see Abdulcadir, J., Botsikas, D., Bolmont, M., *et al.* 2016. Sexual Anatomy and Function in Women With and Without Genital Mutilation: A Cross-Sectional Study. *J Sex Med*;13(2):226-37).
4. Home Affairs Select Committee 2016-17. Female Genital Mutilation: Abuse Unchecked’ – Ninth Report of Session, at <https://publications.parliament.uk/pa/cm201617/cmselect/cmhaff/390/390.pdf>
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17. NHS Digital, SCCI2026: Female Genital Mutilation Enhanced Dataset, updated at <https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/scci2026-female-genital-mutilation-enhanced-dataset>
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19. Note that data suppression techniques mean this is likely to be an over-estimate of the actual number of cases.
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1. Introduction

According to the World Health Organisation (WHO), Female Genital Cutting/Mutilation (FGC/M)¹ includes “all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons”.^{2,3} While FGC/M predominantly affects populations from certain African, Asian and Middle Eastern societies, it is described as a ‘global concern’.⁴ In 2015, United Nations members agreed a target for its elimination by 2030 as part of its Sustainable Development Goals.^{4,5} Politicians and media sources have repeatedly stated that ‘tens of thousands of girls’ living in the UK are at risk of FGC/M.⁶⁻⁸ The aim of this study is to determine the evidence on which such claims are made.

Across Europe, policy responses to FGC/M have tended toward criminalisation and enforcement.^{9,10} In the UK, specific legislation against FGC/M has been in place since the Prohibition of Female Circumcision Act 1985, which was replaced by the Female Genital Mutilation Act 2003 in England and Wales and the Prohibition of Female Genital Mutilation (Scotland) Act 2005 in Scotland. Concerns regarding the lack of prosecutions under these Acts¹¹ led to the development of a further range of legislation and policies which fall under the umbrella term ‘FGM-safeguarding’, largely implemented through the Serious Crimes Act 2015, although the requirements vary by devolved nation.¹² These included mandatory reporting to police by state professionals (e.g. school staff, health practitioners) of any identified cases of FGC/M involving girls under 18 and FGM

Protection Orders (FGMPOs) which enable the local authority or another relevant person to ask a judge to impose protective measures, such as withholding passports of those considered potential victims of FGC/M abroad.¹²

It is also recognised, by care providers and policymakers, that those living with, or at risk of, FGC/M need to be provided with sensitive and compassionate health and other care.¹³ To understand the level of demand for this care, accurate data on the prevalence of FGC/M in the UK-based population is required.¹³ To these ends, procedures have been introduced to monitor rates and risk of FGC/M in general practice and mental health and acute trusts in England.¹⁴ Similar systems are currently being established in Scotland. But despite the aims for positive care underpinning these monitoring systems, evidence indicates that current approaches to FGM-safeguarding – in the UK and elsewhere in Europe – may instead work to stigmatise rather than support, directly weakening trust in public institutions such as the police and health services.¹⁵⁻¹⁸ The explanations for what have come to be experienced by individuals and communities as ‘heavy-handed’ FGM-safeguarding approaches are poorly understood. Research into the perceptions of policy-makers and health professionals on approaches to FGM-safeguarding is scant. However, people with heritage in FGC/M-affected groups describe concerns that current practices are driven by inaccurate perceptions regarding the scale of FGC/M in the UK, due to a reliance on statistics from high-FGC/M prevalence countries which

produce an exaggerated sense of the risk to those resident elsewhere.¹⁶

There is mounting evidence that the scale of FGC/M risk to those based in the UK and other traditionally low FGC/M-prevalence countries to which people migrate is significantly lower than is presumed.¹⁹⁻³⁹

There is an urgent need to review the way in which data from high FGC/M prevalence countries are being used in low FGC/M prevalence countries, and their capacity to produce reliable prevalence estimates. However, to date, the attention given to this issue has been limited.

This report examines several approaches currently adopted to establish the scale of FGC/M prevalence and risk among the UK resident population and the data they produce. A key finding of this investigation is that existing evidence, corroborated across multiple sources, suggests that the number of cases of FGC/M experienced by people aged under the age of 18, in the UK, is low. It suggests that the on-going risk to girls born and/or resident in the UK could be even lower, far below that reported by the Government and media.⁶⁻⁸ This research suggests that evidence related to FGC/M as it is currently produced is not an appropriate means by which to estimate levels of risk to the UK. We make recommendations regarding ways to improve these resources, and to develop a more accurate appreciation of the current scale of risk among the UK resident population from which to develop more effective and appropriate policy and practice.

Section 1:
Direct estimates of FGC/M risk and
prevalence in the UK

2. Direct estimates of FGC/M risk and prevalence in the UK

No national survey has been conducted to establish FGC/M prevalence in the UK. Instead, evidence is gathered from data collected by several different governmental departments, each with their own agenda. The following subsections provide a summary of the purpose and type of data collected within each sector, and an evaluation of the utility of the data for estimating FGC/M prevalence and risk. First, we consider the data available via the Home Office's mandatory reporting system for health care professionals, social workers and teachers, which was introduced in 2015. This subsection also examines the available data relating to criminal justice activity available via the Home Office and Ministry of Justice as well as information on FGC/M-related referrals and assessments held by the Department of Education. The next sections explore the outcomes of attempts by the Department of Health to improve the health sector's response to FGC/M in England, organised under the National FGM Prevention Programme. These include the publication of FGM-safeguarding guidance, the establishment of the FGM Information Sharing System and the introduction, in 2014, of the FGM Enhanced Dataset. We also consider the evidence presented in academic papers on this topic.

Some approaches to FGC/M monitoring vary between England, Wales, Scotland and Northern Ireland. In Scotland, systems to enable national reporting and monitoring of FGC/M prevalence are currently being developed as part of the National Action Plan to Prevent and Eradicate FGM, to be completed in 2020.⁴⁰ In England,^{41,42} Wales^{43,44} and Northern Ireland,⁴⁵ FGC/M monitoring includes mandatory reporting and recording in healthcare, mandatory reporting in education, social services and policing and FGM protection orders in family and civil courts. In Scotland⁴⁶ FGC/M monitoring approaches are currently being developed, although there is provision for mandatory recording through the Child's Plan in healthcare and the national police register. FGM Protection Orders are also being introduced.

2.1. FGC/M mandatory reporting

Under section 47 of the Children Act 1989, anyone in the UK who has information that a child is potentially or actually at risk of significant harm is required to inform social care or the police. The Serious Crime Act 2015 introduced additional mandatory reporting requirements for health professionals and others specifically regarding FGC/M. Professionals are required to notify the police if they discover in the course of their work that an act of FGC/M appears to have been carried out on a girl under 18 years of age.

National figures for mandatory reporting are not publicly available. FGC/M cases are handled by each of the 43 police forces separately. In 2018 the Iranian and Kurdish Women's Rights Organisation made requests under the Freedom of Information Act (FOIA) 2000 to all police forces to try to establish the nature of this evidence. This indicated a 'nearly fivefold increase in reports of alleged FGM to police forces in the UK...[up] from 137 in 2014 to 647 in 2016'.⁴⁷ However, no further detail was provided regarding the nature of these reports, or whether or how police forces responded to them.

Data available from the Crown Prosecution Service (CPS) reports 36 referrals of alleged FGC/M between 2010 and March 2019, of which 33 did not proceed to charge. All of the remaining cases were charged for FGC/M-related offences or child cruelty and subsequently acquitted.⁴⁸ The 2019 report details two defendants prosecuted for FGC/M in 2019, one of whom was acquitted and the other convicted.⁴⁹ It also states that 'The CPS does not collate formal statistics in relation to FGC/M. We work

with the police to seek early referrals of cases, ranging from early discussions, requests for early investigative advice to charging decisions.'⁵⁰ This lack of data is problematic for understanding the scale of FGC/M in the UK. Information available on Hansard indicates that no prosecutions were brought under the 1985 Prohibition of Female Circumcision Act.⁵¹ Hansard entries also confirm that there had been no prosecutions brought under 2003 Female Genital Mutilation Act by 10 March 2014.^{52,53}

FGM Protection Orders (FGMPOs) were introduced for England, Wales and Northern Ireland through the Serious Crime Act in July 2015. Similar civil remedies are currently being developed in Scotland. These enable the family courts to impose a number of restrictions including taking action to prevent travel where there is a perceived risk of FGC/M occurring to British citizens abroad, such as through surrendering passports. Statistics on FGMPOs are publicly available as part of the Family Courts Statistics Quarterly series at <https://www.gov.uk/government/collections/family-court-statistics-quarterly>.

According to the Family Court Statistics Quarterly, 584 FGMPOs were made between their introduction in July 2015 and the end of March 2020.⁵⁴ According to the 2019 report from the CPS, there have been no prosecutions for breach of a FGMPO.⁴²

The National FGM Centre reports that it had 450 case referrals of adults or children between September 2015 – March 2019 from Local Authorities in East England and

London and 14 from other Local Authorities in England and Wales. They have supported the application of 28 FGMPOs over this period.⁵⁵ No information is provided regarding whether there have been referrals made since this time.

On 29 April 2019, we made an FOIA 2000 request to the Ministry of Justice (MoJ) for information regarding the number of people charged under the 1985 Prohibition of Female Circumcision Act, the 2003 Female Genital Mutilation Act or the 2015 Serious Crimes Act, Part 5 in relation to FGC/M (in any capacity, including failure to report). We specifically sought information relating to the indictment, to which part of the Act it applied, when and where the charge was brought and the outcome, for the child and their siblings. We also asked for information on the ethnicity and/or home language of the victim and their family and whether an interpreter was used with any party and with what language. We also sought a percentage breakdown of the total number of FGMPOs, by court/geographical location, in relation to both cases started and disposed and including the ethnicity of the alleged victim and/or their home language, the number of interpreters required for proceedings and in which languages. We requested information on the outcomes of disposed cases: any resulting action (or not) and the number of protection orders which were granted. We also sought information regarding specific cases involving the prosecution of people for FGC/M-related offences brought under s.1 of the 1933 Children and Young Person's Act or any legislation other than the 1985, 2003 and 2015 Acts.

It was confirmed, on 11 June 2019, that the MoJ held the information requested.

However, we were advised that providing this evidence would exceed the maximum cost limit of £600 for central government set out in Section 12(1) of the FOIA. This was due to the lack of centrally, or indeed electronically, held data. We were informed that:

- Information covering the Prohibition of Female Circumcision Act 1985 has only been held centrally since 2011.
- Outcome information for criminal cases includes only the sentence received by the offender, without any information of the effect on other parties in the case, such as any child protection implications.
- Centrally held information does not include outcomes of the FGMPOs which have been granted.
- Centrally held information concerning interpreters refers solely to interpreter availability, and does not indicate whether or not the interpreter acted for victim or defendant in criminal cases, nor the nature of the charges faced by the defendant in such cases. Moreover, centrally held information on FGMPOs does not indicate whether or not an interpreter was involved in the case, or the language involved. No information was held pertaining to ethnicity, only whether the proceedings involved a 'British' person.⁵⁶

We were advised that obtaining the information requested would require 'manually examin[ing] individual case files from court records.'⁴⁶ We were provided with information regarding those Family Courts involved in making disposals of FGMPOs in 2016 and 2017. In 2016, these were: Birmingham, Bristol, Derby, Leeds, Leicester, Liverpool, Manchester, Sheffield

and Teesside County Courts and the High Court Family Court. In 2017, these were: Birmingham, Bristol, Cardiff, Derby, Leeds, Leicester, Liverpool, Luton, Manchester, Newcastle On Tyne, Oxford, Preston, Sheffield and Teesside County Courts and West London Family and High Court Family Courts.

We also made a separate FOIA request to the Home Office (HO). Some information was available on the outcomes of crime recorded by the police in England and Wales for Offences against the FGM Act 2003, breach of a FGMPO and failure to protect a child from risk of FGC/M. This is replicated in table 1. These figures indicate a total of only 173 police-recorded alleged offences under the FGM Act 2003 between 2009 and 2018 of which a mere two resulted in a charge or summons (in 2013 and 2017), although both of these were subsequently found not guilty.⁴¹ There were 24 alleged offences under the FGM Act 2003 still under investigation: one from 2014, four from 2016, ten from 2017 and nine from 2018. There were 28 incidents of police-recorded alleged failure to protect a child from risk of FGC/M during the same period, none of which culminated in a charge or summons. Four cases remain under investigation, three from 2017 and one from 2018. The three alleged breaches of an FGMPO, all reported in 2018, remained under investigation at the time this report was received. Police forces submit only one outcome per alleged offence. As such, it is impossible to identify whether cases resulted in multiple

outcomes, and what these were. Where it was recorded, the self-classified ethnicity of the alleged victims was: 28 'Black African', 4 'Indian', 5 'white British' and two 'Bangladeshi'. Figures collected do not distinguish between those born in the UK and those born elsewhere.⁴⁶

It is important to note that the data presented below is 'police-recorded offences', rather than confirmed convictions. None of the 42 'crimes' recorded as offences against the FGM 2003 Act in 2018 have, to date, proceeded to charge (table 1). As such, the crimes listed below cannot be definitively said to have occurred. Police record a report of a crime as a crime when, on the balance of probability, the action contravenes the law and 'there is no credible evidence to the contrary'.⁵⁷ 'A belief by the victim (or a person reasonably assumed to be acting on behalf of the victim), that a crime has occurred is usually sufficient to justify its recording.'⁴⁷ Below we discuss studies that indicate such reports may be unreliable especially as reports can be made anonymously or as part of a family or work dispute. Moreover, these data do not record the date when the alleged offence took place. Data, shown below, from the FGM Enhanced Dataset indicates that reports of FGC/M are often made some time after the incident took place. As such, recent reports may describe historical incidents and should not be interpreted as reflecting the current situation in the UK without further evidence.

Table 1 Outcomes of police-recorded offences against the Female Genital Mutilation (FGM) Act 2003, breach of an FGM protection order¹ and failure to protect a child from risk of FGC/M.²

	Year									
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Offences against the FGM Act 2003										
Charges/Summonsed					1				1	
ED ³ – Suspect identified, victim supports action					1	8	9	11	7	5
ED ³ – Victim does not support action	1					2	3	5	4	4
ED ³ – Suspect not identified								5	2	3
Further action taken by another body/agency							3	8	4	11
Further investigation not in public interest – police decision									1	1
Investigation complete – no suspect identified							4	21	12	9
Prosecution prevented or not in public interest								3		
Offences still under investigation						1		4	10	9
Total crimes recorded (all outcome types)	1				2	11	19	57	41	42
Breach of a FGM protection order¹										
Offences still under investigation										3
Total crimes recorded (all outcome types)										3
Failure to protect from risk of FGC/M²										
Charges/Summonsed										
ED ³ – Suspect identified, victim supports action							4	2	1	
ED ³ – Victim does not support action								1	2	3
ED ³ – Suspect not identified										
Further action taken by another body/agency								3	1	
Further investigation not in public interest – police decision										
Investigation complete – no suspect identified							1	3	1	2
Prosecution prevented or not in public interest										
Offences still under investigation									3	1
Total recorded crimes regardless of outcome type							5	9	8	6

Source: Home Office. Counts. England and Wales only.

¹ FGM protection orders were introduced in 2015

² Failure to protect a girl from risk of genital cutting/mutilation has only been an offence since July 2015

³ ED = Evidential difficulties

An individual offence will only appear in the year where the recorded crime date occurred, even if the pending under investigation carries across multiple years.

Further explanation of outcomes can be found at

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/560132/pprc-user-guide-oct16.pdf

Overall, the data demonstrates that the police record very few crimes related to FGC/M and even fewer of these offences are prosecuted through the courts. However, it is not possible to deduce the prevalence of FGC/M from this. As with many other forms of violence,^{58,59} it may be that police and court statistics reflect the ‘tip of the iceberg’ of actual criminal

activity in relation to FGC/M but it could also be that the incidence of FGC/M in the UK is in reality low. Only by examining other sources are we able to establish more clearly the explanations for this pattern.

Finally, we made a FOIA request to the Department for Education (DfE) regarding:

- The source and number of referrals made in relation to FGC/M by each local authority (LA) for each year since 2012, the ethnicity of the children about which referrals were made and the number of referrals with no further action;
- The number of section 17 (promoting the welfare of children within the family setting) assessments and section 47 (child protection from harm) enquiries/assessments (under the Children's Act 1989), whether translation was offered to the child or their family and how many resulted in no further action;
- The number of child protection conferences undertaken in each LA in relation to FGC/M since 2012, and whether translation was offered to the child or their family; and
- The number of child protection plans, interim or final care or placement/adoption orders started in relation to FGC/M by each LA since 2012 and, for child protection plans, ended and under what categories of abuse were children registered.

We were advised that the DfE does not hold information of relevance to any of these questions. Information regarding the number of times FGC/M had been identified 'as a risk factor' at the end of assessment, and what primary need had been identified in those cases was available. This information was not collected prior to 1 April 2016. Moreover, there is no explanation as to what circumstances might lead to a child being considered at risk of FGC/M. In some contexts, as mentioned below, a mother having experienced FGC/M is considered sufficient to indicate a reasonable risk to her child. For example, guidance from the

Bristol Children's Safeguarding Board states that: 'Any female child born to a woman who has been subjected to FGM must be considered to be at risk, as must other female children in the extended family'.⁶⁰ Further, existing research suggests that guidelines regarding what should, and should not, be considered a risk factor for FGC/M are not always applied uniformly or appropriately.¹⁶ Clarification of these processes is therefore required. DfE figures in table 2 show that between 1 April 2016 and 31 March 2018, 1910 referrals to children's social care were recorded with FGC/M identified as a risk factor at the end of the assessment. Of these, 1390 had been referred for reasons of 'abuse or neglect', 100 because the family was considered to be experiencing 'acute stress', 150 due to perceived 'family dysfunction' or 'absent parenting' and 30 due to some form of 'socially unacceptable behaviour'.

In conclusion, our research suggests that the evidence available (either publicly or on request) is extremely limited. While there is some information which might be used to indicate levels of concern (e.g. referrals and allegations of FGC/M), there is insufficient information from which to determine the actual scale of FGC/M presence or risk within the UK. That said, there is little here to suggest that 'tens of thousands of girls'⁶⁻⁸ living in the UK are at risk, from FGC/M practiced in the UK. Reassurance should be taken from the findings that the vast majority of referrals fail to proceed to charge, or conviction. More concerning, though, is the lack of evidence from which to determine whether correct procedures are being followed in these cases, particularly given their sensitivity and the documented

traumatic implications when things go wrong.^{15-17,61} The guidelines underpinning certain strategies are unclear. The presentation of some of these data appears misleading, potentially encouraging a sense that the FGC/M problem as it exists in the UK is larger than

it is. It is also shocking that arrangements for the collection and storage of this important information are so haphazard. The development of more comprehensive, electronic and centrally-held registers, for this and other forms of child abuse, must be a priority.

Table 2: Primary need identified at assessment¹ for referrals where FGC/M was identified as a risk factor at the end of assessment²

Primary need at assessment ¹	Number of episodes ³ with FGC/M identified as a factor at the end of assessment ²	
	2016-2017	2017-2018
Abuse or neglect	710	680
Child's disability or illness	10	20
Parent's disability or illness	1-5	10
Family in acute stress	40	60
Family dysfunction	70	50
Socially unacceptable behaviour	20	10
Low income	1-5	20
Absent parenting	20	10
Cases other than children in need	10	10
Not stated	70	80
Total	970	940

Source: Children in need census. <https://www.gov.uk/government/statistics/characteristics-of-children-in-need-2017-to-2018>. England only

¹ The main reason why the child started to receive services is recorded as their primary need

² An assessment may have more than one factor recorded

³ An episode is a referral to children's social care that has done onto assessment

Numbers are rounded to the nearest 10 and therefore may not sum to totals. Any number between 1 and 5 has been suppressed

2.2. FGM Information Sharing System

The FGM Information Sharing System⁶² (FGM-IS) was launched by the Department of Health and NHS England in July 2014. Any female infant born in England into a family with a history of FGC/M (on either parents' side) has a flag attached to her summary care record (SCR) which remains until she is 18 years old. Health care professionals can check the SCR if they are concerned that the child might have been subjected to FGC/M.

The questions developed to accompany this system are described in the Appendix. Answers to the questions are intended to provide indication of any risk posed and whether identified concerns should be reported to relevant authorities. This is despite some of the information collected,

such as being perceived to be a member of an FGC/M-affected group and family members having experiences FGC/M, not being considered to constitute a significant risk factor for FGC/M to children.⁶⁰ It is unclear whether this approach might therefore encourage overestimates of the level of risk to particular individuals.

Little information is released regarding the number of cases identified using this approach, and according to what criteria. As such, these data cannot be used to assess FGC/M prevalence or risk.

2.3. NHS FGM Enhanced Dataset⁶³

The FGM Enhanced Dataset requires NHS practitioners in England to record detailed information about FGC/M within the patient population.^{64,65} It was designed to collect FGC/M prevalence data at a population level, 'to produce information that helps to; improve how the NHS supports women and girls who have had or who are at risk of FGM, plan the local NHS services needed both now and in the future, and help other organisations e.g. local authorities to develop plans to stop FGM happening in local communities'.⁶⁴ Data is collected from NHS trusts and GP practices in England, through the NHS Digital Clinical Audit Platform (CAP).

Mandatory data collection and submission for all acute trusts was established on 1 July 2015 and for all mental health trusts and GP practices from 1 October 2015. Cases documented and submitted include: anyone receiving treatment related to FGC/M; when there is a change in a woman's FGC/M type; when FGC/M is identified in any other way, including by self-report; or when a woman with FGC/M gives birth to a girl.

Between April 2015 and March 2020, only 2.5% of GP practices (198 of the 8,046 eligible) and 62.7% of NHS Trusts (151 of the 241 eligible) submitted data to the FGM Enhanced Dataset.⁶⁶ The frequency of submissions across practices/trusts is inconsistent. Unfortunately, the nature of, or reason for, these submission practices is not investigated. The decision not to request nil returns means it is unclear if GP practices and NHS trusts which have not submitted data have done so because they simply did not have any FGC/M cases to

report, or might have cases which have not been reported for some reason. The NHS database also does not allow for recording those women who are asked and who do not have FGC/M or who do not have daughters with FGC/M. While the guidance states that private patients seen in an NHS healthcare setting should also be included, there does not seem to be a requirement for reporting on patients seen in a private setting. Further, these data do not appear to be adjusted for women who have died or left the UK since being recorded on the FGM Enhanced Dataset which further undermines its use as data cannot be directly applied to population figures.

According to the SCCI 2026 Implementation Guidance, the mandatory requirement is only for NHS trusts and GP practices to provide information on a patient's forename, surname, postcode, FGC/M type and care contact date. Other data is 'required', but only 'where applicable' and submissions are accepted to the FGM Enhanced Dataset without this additional information. This includes: further patient details including NHS number, birth date, country of birth and/or origin, pregnancy status, FGC/M family history and numbers of daughters born/aged under 18; a range of organisational and treatment information; and also whether the patient had been advised of the health implications and/or the illegalities of FGC/M during that contact. 'Optional' data includes the region of patient's country of origin, in which country and at what age FGC/M was performed, and country of birth/origin of the baby's father. The information which *must* be supplied by care providers is

therefore extremely limited. Even amongst those submitting information, few fulfil more than the minimum requirements.

Data completeness has generally improved since the initial years of data collection. However, these problems still limit the value of the FGM Enhanced Dataset for informing both the provision of services or understandings of FGC/M prevalence and risk. For example, FGC/M type³ is only known for 60% of women/girls in the 2019/20 dataset, and only 63% of those with FGC/M type 4 have a subtype recorded which enables us to determine whether the experience involved genital piercing or another type of incident. Information regarding the location where FGC/M was undertaken is only available for 46% of women and girls on the database in 2019/20. While this has increased from 31% in 2015/16, the availability of this evidence ranges from 8% to 73% in different regions of England.⁶⁶ Similarly, the age at which FGC/M was undertaken is only provided in 43% of cases in the 2019/20 returns, up from 32% in 2015/16. This coverage varies between 13% and 58% in different regions. Only 22% of the individual women recorded in 19/20 have comprehensive data regarding their FGC/M type, age and place when undertaken. This has changed little since the first years of the FGM Enhanced Dataset, when this figure was 18%. Information on each of these characteristics is critical if we are to make reasonable estimates of the number of women and girls who have experienced FGC/M, and speculate as to the nature of any continuing risk. These limitations must be also borne in mind while interpreting the data which follows.

There were 24,420 individual women and girls recorded on the FGM Enhanced Dataset as having had FGC/M at some point in their lives, between the introduction of the system in April 2015 and March 2020 (Table 3).⁶⁶ It is important to note that while these cases are newly identified and newly recorded by the NHS, the available evidence suggests that these are not recent incidents, in most cases representing women who experienced FGC/M as children prior to living in the UK. The number of cases identified each quarter is relatively stable, as shown in table 3, and in figure 1. However, the number of newly recorded cases in 2019/2020 was lower than that in proceeding years, continuing the gradual year-on-year declines seen since the FGM Enhanced Dataset was introduced.

There were 52,050 health care attendances related to – or involving notification of – FGC/M recorded on the FGM Enhanced Dataset during the same period (table 3).⁶⁶ Individual women and girls may have one or more attendances in the reporting period, and these attendances include both those who were newly recorded on the FGM Enhanced Dataset and those who had been previously identified. There was an increase in recorded FGC/M attendances during 2018/19 (11,575) and 2019/20 (11,895) compared with earlier years (for example, 9,490 in 2017/18).⁶⁶ In 2018/19, this was attributed to a change in recording practices by NHS Digital and a rise in attendances for deinfibulation,⁶⁸ which often occurs prior to childbirth. However, the numbers of deinfibulation are lower in the 2019/20 data, with levels similar to the pre-2018/19 period (table 4). This suggests

Table 3 Summary of data collected by the NHS Enhanced FGM Dataset. April 2015 to March 2020.⁶⁶

		2015/16	2016/17	2017/18	2018/19	2019/20
Data collection	Number of GP practices submitting data	66	90	92	72	59
	No. new cases referred	94	205	200	140	190
	Number of NHS trusts submitting data	118	124	123	118	119
	No. new cases referred	5,608	5,186	4,295	3,980	3,680
FGC/M cases	Total FGC/M attendances ¹	8,656	9,179	9,490	11,575	11,895
	Newly recorded ²	5,702	5,391	4,495	4,120	3,870
	Individuals ^{3,4}	6,195	6,415	6,590
Commissioning region (newly recorded individuals only)	London	2,940	2,560	1,955	1,725	1,540
	Midlands and E. England	1,015	1,070	965	985	885
	North England	1,130	1,175	1,085	995	1,070
	South England	620	580	420	360	330
FGC/M identification method ⁴	Not recorded	566	325	1,570	1,280	1,800
	Self-report	2,771	2,861	5,350	7,310	7,470
	On examination	978	886	1,040	1,375	1,330
	Other clinician	48	51	95	105	110
	Other	1,339	1,268	1,440	1,500	1,185

Source: NHS Digital

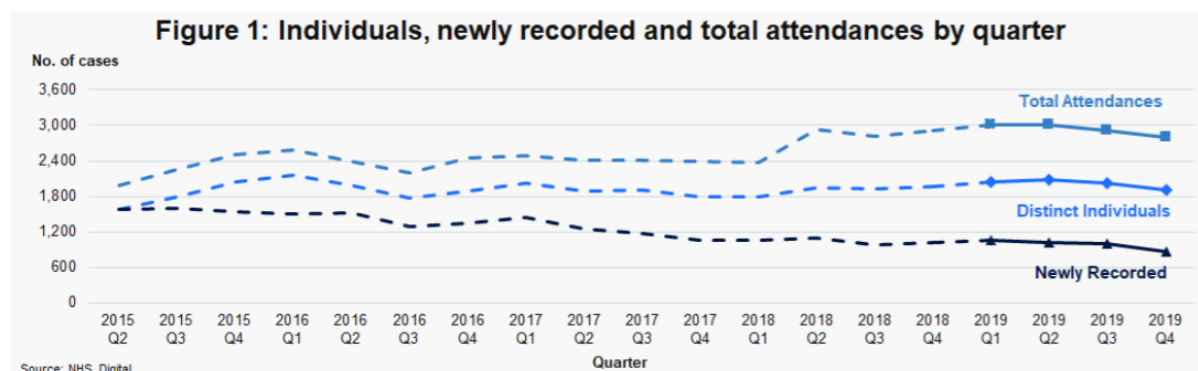
1 “Total Attendances” refers to all attendances in the reporting period where FGC/M was identified or a procedure for FGC/M was undertaken. An individual may have one or more attendances in the reporting period. This category includes both newly recorded and previously identified individuals.

2 “Individuals” counts each person only once – no matter how many attendances they had during the quarter.

3 “Newly Recorded” counts each person once, the first time they are recorded in the collection. An individual will only appear once as newly recorded no matter how many attendances they have.

4 Data for 2015/16 and 2016/17 is a breakdown of newly recorded cases. Data for 2017/18, 2018/19 and 2019/20 is a breakdown of individual women and girls. Totals do not always agree due to missing data and roundings used by NHS Digital.

Figure 1 Number of FGC/M cases recorded by the NHS FGM Enhanced Database between April 2015 and December 2019.⁶⁶



that changes in recording practices have had a significant effect on the evidence regarding FGC/M prevalence in the UK and our capacity to track this over time.

There are further problems with establishing FGC/M prevalence due to the data presentation approaches adopted. Data suppression is used to minimise the risk of individuals being identified. This limits our potential to identify the exact number of individuals affected. It is further complicated by the varying approaches adopted to this data suppression over time. Between 2015-2017, numbers of cases between 0-4 were presented as '*'. Since then, numbers of cases between 1-7 are rounded to five, with all other numbers rounded to the nearest five. While such approaches can protect patient confidentiality, the implications of this (and this inconsistency) for establishing prevalence is significant, particularly when the number of cases is small. To further compound this issue, since 2017 these rounded numbers are at times used to produce totals. As such, a total of 15 could represent anywhere between 3 and 21 actual individuals. Adding to this inconsistency, data from 2015/16 and 2016/17 is provided with a breakdown of newly recorded cases (i.e. by age, country of origin etc), whereas from 2017/18, the more detailed breakdown does not always distinguish between those cases which are newly recorded and those which are pre-existing.

There are also concerns with the accuracy of these reports. As shown in table 4, where this information is recorded, in any given year between half and three-quarters of cases recorded on the FGM Enhanced Dataset rely on people reporting their own FGC/M status, without

corroboration from health practitioners. While clearly less intrusive for patients, there are concerns regarding the accuracy of self-reports of FGC/M type,³ and even (for less invasive forms) whether FGC/M has been undertaken,^{20,69-72} particularly given that they often relate to experiences from many years earlier and during early childhood. For example, 20 of the 49 women attending 11 London clinics in Cohen et al's (2018) study who reported having had FGC/M did not know what type they had had.¹⁹ That said, there are also concerns regarding practitioners' abilities to accurately identify and distinguish between types of FGC/M, particularly less invasive forms.^{73,74}

The number of cases of FGC/M recorded for those aged under 18 is very low. Between 2015/16 and 2017/18, less than 2% of all attendances involved those aged under 18: 100 out of 6195 attendances in 2015/16, 80 out of 6675 attendances in 2016/17 and 70 out of 6265 attendances in 2017/18 (table 4). This proportion fell to less than 1% in 2018/2019 (45 out of 6490) and 2019/2020 (35 out of 6590). Any individual women/girl may have more than one attendance. As such, the actual number of individual girls affected may be far fewer. It is unclear whether this reflects the reality, or whether some girls who have undergone FGC/M have not yet had medical needs to bring them into contact with these reporting systems. The vast majority of the cases identified are in adult women through maternity services (80% in 2019/20⁶⁶).

The available data also suggests that the proportion of women/girls experiencing FGC/M in the UK is very low. Fewer than 5% of the incidents of FGC/M recorded on the FGM Enhanced Dataset since 2015

Table 4 Data on individual women and their healthcare attendances, recorded on the NHS Enhanced FGM Dataset. April 2015 to March 2020.⁶⁶

		2015/16	2016/17	2017/18	2018/19	2019/20
Age at last attendance ¹	Minor (0-17 years)	100	80	70	45	35
	Adult (18+)	6,095	6,595	6,195	6,445	6,555
Treatment function ¹	Not recorded	4,310	3,635	3,550	2,055	1,075
	Midwifery service	2,920	3,150	3,280	4,625	5,255
	Obstetrics	1,355	1,880	1,705	3,010	3,385
	Gynaecology	325	295	485	690	950
	Mental health	25	35	35	25	25
	Paediatric specialties ²	95	115	35	365	365
	General practice	110	130	205	585	530
	Other specialties	205	305	295	315	315
Country of birth ¹	Not reported/recorded	3,305	3,220	2,680	2,690	2,700
	Africa	2,645	3,070	3,115	3,285	3,280
	Asia	175	240	285	315	360
	UK	45	120	150	155	205
	Other	20	25	40	40	50
Country where FGC/M undertaken ¹	Not reported/recorded	4,285	4,290	3,780	3,775	3,530
	Africa	1,770	2,165	2,180	2,360	2,605
	Asia	110	150	205	240	290
	UK	20	65	90	105	145
	Other	5	10	5	10	20
Age FGC/M undertaken ¹	Unknown/not recorded	4,235	4,135	3,860	3,870	3,790
	Under 1	315	450	410	395	475
	Over 1, less than 5	460	550	520	670	680
	Over 5, less than 10	870	1,105	965	965	1,175
	Over 10, less than 15	190	260	225	225	245
	Over 15, less than 18	20	30	25	30	45
	18 or over	100	135	255	335	190
Age FGC/M undertaken. ^{1,4,5} UK cases only.	Unknown	8	12	10	25	25
	Under 5	0	0	5	5	0
	Over 5, less than 10	0	0	5	5	5
	Over 10, less than 18	0	0	5	5	5
	18 or over	10	45	70	70	110
FGC/M type ^{1,6}	Not recorded/known	2,790	2,895	2,645	2,495	2,635
	Type 1	1,225	1,385	1,425	1,525	1,575
	Type 2	1,060	1,100	935	1,100	1,055
	Type 3	750	810	725	860	825
	Type 4	140	280	350	330	360

Table 4 (continued) Data on individual women and their healthcare attendances, recorded on the NHS Enhanced FGM Dataset. April 2015 to March 2020.⁶⁶

		2015/16	2016/17	2017/18	2018/19	2019/20
FGC/M subtype for those with FGC/M type 4. ^{1,6}	Not recorded	-	-	-	95	135
	Pricking	-	-	-	30	10
	Piercing	-	-	-	160	180
	Scraping	-	-	-	15	15
	Incising	-	-	-	20	15
	Cauterisation	-	-	-	5	5
FGC/M type. Those born in the UK ^{1,6}	Not recorded/known	10	10	25	15	40
	Type 1	10	10	10	10	10
	Type 2	5	5	5	10	5
	Type 3	*	*	5	5	5
	Type 4	15	85	105	110	145
FGC/M type. UK FGC/M cases only ^{1,6}	Not recorded/known	*	*	85	5	5
	Type 1	*	*	5	5	5
	Type 2	*	*	5	5	5
	Type 3	*	*	5	5	5
	Type 4	10	50	75	90	135
Deinfibulation (total attendances)	Not recorded	5,432	5,698	5,965	5,380	5,600
	No	3,079	3,330	2,650	2,415	5,555
	Yes	145	154	880	3,780	740

Source: NHS Digital. Data suppression means that a value of 15 may involve between 3 and 21 actual cases.

1 Data on individuals, where each person is counted only once.

2 'Paediatric Specialties' includes all cases where the recorded treatment function is one of well babies, paediatrics or community paediatrics

3 Data on total attendances, which included all attendances in the reporting period where FGC/M was identified or a procedure for FGC/M was undertaken. An individual may have one or more attendances in the reporting period. This category includes both newly recorded and previously identified individuals.

4 Data for 2015/16 and 2016/17 is a breakdown of newly recorded cases. Data for 2017/18, 2018/19 and 2019/20 is a breakdown of individual women and girls.

5 The 2019/20 report acknowledges "that babies have been recorded in the dataset in error" and that "some entries aged under 18 may be incorrect".⁶⁶

6 See reference 3 for details on WHO classifications of FGC/M type

took place in the UK, although figures suggest that this has risen from 1% in 2015/16 to 5% in 2019/20 (although again, the impact of inconsistencies in approaches to data suppression on these figures is unclear). There are also differences in the typical nature of FGC/M as it is experienced in the UK, compared with that occurring elsewhere. Most cases of FGC/M recorded on the FGM Enhanced Dataset occurred when the woman

concerned was aged under 18. However, of those who had had FGC/M in the UK, all those recorded on the FGM Enhanced Database between 2015/16 and 2016/17, 82% of those recorded in 2017/18 (70/85) and 2018/19 (70/85) and 92% of those recorded in 2019/20 (110/120) were aged 18 or over at the time of the incident. The data suppression methods used mean that the figures presented may correspond to as few as eight girls in total who had

FGC/M while UK resident and aged under 18 since these records began.

In each year, the FGC/M type 1³ is the most frequently recorded on the FGM Enhanced Dataset, comprising around 40% of cases recorded in any year (table 4). Around 30% are recorded as FGC/M type 2, 20% as type 3 and 10% or less as type 4. Again, there is a contrasting picture presented by those born in, or having experiences of FGC/M, in the UK, where since 2017/18 over 80% of FGC/M cases recorded have been type 4. Again, data suppression means that the actual number of women/girls experiencing FGC/M types other than 4 in the UK may be as few as one or two. In which case the proportion of FGC/M cases in the UK which are type 4 could be closer to 100%. The FGC/M subtypes recorded in 2018/19 and 2019/20 for those having had FGC/M type 4 (regardless of place of birth or location where FGC/M took place) indicate that around three-quarters of incidents involved genital piercing (70% in 2018/19 and 80% in 2019/20). Again, data suppressions mean that the actual proportion of FGC/M type 4 which are piercings may be even higher.

The introduction of FGMPOs and other legislation relates to concerns that those born and resident in the UK may be taken to other countries for FGC/M. While information is recorded on the FGM Enhanced Dataset regarding a person's

place of birth and the place where FGC/M was undertaken, these are not provided in a way which enables the identification of the scale of this issue. However, data indicates very low numbers of attendance among those aged under 18, regardless of place of birth or where FGC/M was undertaken.

It is also difficult to determine from these data the extent to which FGC/M (in the UK or elsewhere) can be considered a contemporary issue affecting women/girls born and living in the UK today. While information is provided on age at which FGC/M occurred, this is not presented with reference to the age of the woman/girl at the time it was recorded on the FGM Enhanced Dataset. However, the data suggest that the vast majority of cases recorded, even those affecting girls aged under 18, took place some time ago.

While the exact numbers are impossible to determine using these figures, it is possible that in the 5 years since records have been kept, that as few as eight women/girls are recorded on the FGM Enhanced Dataset as having had FGC/M in the UK when they were aged under 18. In short, while incidents of FGC/M may continue to occur, these data suggest that these are extremely rare. It is also likely that a large majority of these were genital piercings. This evidence concurs with that from other sources, described in the next section.

2.4. Miscellaneous sources

There are few academic studies examining the rates of FGC/M in migrant-receiving countries and although they typically have a low sample size, these are still useful for supplementing information on FGC/M prevalence in the UK available from other sources.

Six academic studies have documented cases of FGC/M in the UK among children, either those aged under 18 or under 16 years. These corroborate the evidence presented here from the FGM Enhanced Dataset that the numbers of girls involved are low and the majority have the procedure performed, which involves a variety of FGC/M types, before they migrate to the UK. Five of these studies report findings from particular clinics in particular timeframes. In total, these five studies identified 25 girls who were either born in the UK or who were UK residents at the time of having FGC/M; seven reported by Ali et al (2020)⁷⁵, three cases reported by Creighton et al (2016)⁷⁶, 10 potential cases reported by Hodes et al (2016)⁷⁷, one case reported by Hodes and Beale (2017)⁷⁸, and four cases reported by Ayadi et al (2018).⁷⁹ It is difficult to determine whether any of these children will have been identified in more than one study (and therefore double counted), but overlaps in the dates of data collection described in the studies suggest this is a possibility. There were some data issues affecting these studies.⁷⁵ The authors described particular concerns regarding the process for referrals from relevant authorities to these clinics. Creighton et al⁷⁶ reported a seven-week delay, on average, between authorities being made aware of a case and that case being

referred to clinic for examination. The evidence from these examinations also suggested that the evidence on which these referrals were based was often unreliable.⁷⁶ Here, as in other research,¹⁶ false accusations caused considerable anger and humiliation. Moreover, even where FGC/M was established in the clinic and reported to the police, this was not always acted on.^{76,77} These add to the problems with police data discussed above.

By contrast, Hodes et al⁸⁰ conducted an epidemiological surveillance study using data submitted to the British Paediatric Surveillance Unit (BPSU), which collected information on FGC/M between November 2015 and November 2017. As a system which obtains an average monthly response rate of over 90% from consultant paediatricians, it has the potential to provide a more comprehensive impression of the scale of FGC/M in the UK for this period. This study identified 103 cases of confirmed paediatric FGC/M during this period. Sixty cases (58%) were classified as WHO type 1 or 2 FGC/M, eight cases (8%) as type 3 and 22 cases (21%) as type 4. The remaining 13% (n=13) of cases could not be assigned a WHO classification as the girls were not examined. No cases of piercing or cosmetic genital surgery including labiaplasty were reported. Over 70% of FGC/M was performed in countries of Africa, with fewer than five in each of the Middle East, South-East Asian and Europe. Police initiated a criminal investigation in nine of these cases. There was no further action in four of these, and no further details of actions in relation to a further two. In the remaining three, two were part

of a wider investigation on child cruelty and the last case, which was performed in the UK, resulted in a successful prosecution.

Most of these studies examine referrals to NHS trusts. The low number of studies is therefore partly explained by the difficulty in obtaining these data. Nationally, there are 16 NHS clinics which provide specialist FGC/M support: 11 within and five outside of London. One London and two of the non-London clinics provide support to children. However, neither of the clinics providing support to children outside London have released any evidence regarding girls who have been referred to them due to FGC/M.⁸¹

Studies of children in other European or Western countries reveal a similar trend. For example, 23 of the 1,003 Australian paediatricians included in Zurynski et al's study had seen 59 children with FGC/M.⁸² Most of these (90%) were identified during refugee screening and were born in

countries in Africa, while three were born in Australia. Of those born in Australia, two had had FGC/M performed in Australia and one in Indonesia.⁸² In France, there is an expectation that health professionals will examine the external genitalia of all girls involved in medical follow-up until they are 6 years old. While such medical follow-up is not compulsory, this approach provides much more comprehensive engagement than that adopted elsewhere. As a result more cases are identified: 120 girls between 1988-2007, of which 33 cases were brought to court.¹⁰

In summary, our review suggests that the opportunities for establishing insights into FGC/M prevalence using existing data sources and statistics are very limited. We now turn to describe some of the indirect methods currently used to establish FGC/M prevalence and risk in low-prevalence countries, before making recommendations to ensure that approaches adopted in the UK can reflect this more accurately.

Section 2: Indirect estimates of FGC/M risk and prevalence in the UK

3. Indirect methods for estimating FGC/M prevalence and risk among women in the UK

Indirect methods attempt to estimate FGC/M prevalence among adult women in the UK population, the vast majority of whom will have had the procedure performed prior to arriving in the UK. All estimates of FGC/M prevalence produced for the UK population to date have used an extrapolation approach, using census data and prevalence estimates for countries from which people migrate to the UK, often using data from Demographic Health Surveys (DHS)⁸³ or the Multiple Indicator Cluster Survey (MICS).⁸⁴ The prevalence of FGC/M in any country considered 'non-FGC/M practising' has been defined as 'the number of women and girls in that country who have undergone FGM at a certain point in time expressed as the proportion of the total number of women living in the country, but originating from countries where FGM is practised'.⁸⁵

Estimates of the number of women and girls aged over 15⁸⁶ living in England and Wales with FGC/M produced by these methods are highly variable, in part due to the differing approaches adopted. Leye estimated that 279,500 women living in the UK from high FGC/M prevalence countries had experienced FGC/M, based on analyses of the 1999 Labour Force Survey.⁸⁷ Dorkenoo et al produced an estimate of 65,790 first generation migrant women aged 15-49 living with FGC/M in England and Wales, based on data from the 2001 England and Wales Census and DHS.⁸⁸ In a follow-up study using more recent census and DHS data, Macfarlane and Dorkenoo estimated that 127,000 first generation migrant women aged 15 and

over were living with FGC/M in England and Wales.⁸⁹ Bansal et al (2013)⁹⁰ estimated that 3,780 women aged 15-49 living in Ireland have had FGC/M, while Baillot et al⁹¹ estimated a figure for Scotland of 8,065. An estimate of 178,781 foreign-born women and girls over the age of 10 living in the UK with FGC/M was based on 2011 census data and figures from the DHS, MICS and other data available in high FGC/M prevalence countries.⁹²

The DHS and the MICS provide nationally-representative data for a wide range of indicators in many countries in Africa, Asia, Latin America, Oceania and the Caribbean. But while the DHS aims to collect evidence which is comparable between countries and over time, the reliability of these figures for establishing prevalence rates even in high FGC/M-prevalence countries has been queried. There are concerns about data quality⁹³ as well as frequency of data collection. For example, surveys only monitor FGC/M for women/girls aged 15-49. National-level prevalence rates also do not take into account the ethnic and regional variation in FGC/M prevalence within countries, which may produce differences of between 1-99% between groups/regions.⁹⁴ Even where data is available, ethnic group or regional birth data is often not. While the intention is for five-year repetition of the DHS in each country, Somalia last had a full DHS in 2006 due to difficulties associated with the civil war. While some research suggests that support for FGC/M in Somalia remains almost universal,^{95,96} Kandala et al²²

suggested a lower prevalence in many FGC/M practising countries, although the reliability of this method has also been questioned.⁹⁷

Estimates for the number of girls at risk of FGC/M are equally problematic. Some studies (and the FGM Enhanced Dataset) provide information on the number of daughters born to women from high FGC/M prevalence countries.^{66,70} There is a temptation to treat these figures as indication of the numbers of girls at risk of undergoing FGC/M themselves. However, it is generally acknowledged that the likelihood of undergoing FGC/M is lower among those who are born in or who have moved to low FGC/M prevalence countries, particularly when they moved at very young ages, compared with those living in high prevalence countries, regardless of their mother's experience of FGC/M. Part of the explanation for this may be the practical and financial challenges that prevent families from having their daughters undergo FGC/M, even if they wish to: for example, finding someone to perform the procedure in the UK, the cost of sending children abroad for the procedure⁹⁸ or the fear of contravening the law, especially among those with vulnerable status in the UK such as refugees/asylum seekers. Indeed, several studies show some continuing support for FGC/M among UK residents, with people still unaware of the health consequences or illegality of FGC/M and some, particularly those who migrated at older ages, remaining in favour of FGC/M for other reasons, including a sense of pressure from older members of their communities.^{20,21,31} Other studies indicate a potentially global shift towards forms of FGC/M which are considered less severe as

well as a shift to a medicalisation of the procedure in response to greater awareness of the health risks associated with FGC/M.^{24,73,77,99-103}

But almost universally, evidence indicates that diaspora groups in low prevalence countries have reduced support for FGC/M. There is already considerable evidence for this in the UK, and this is mounting.^{16,20,21,104-107} Of the 54 participants recruited to Cohen et al's (2018) study, 48 participants reported they thought FGC/M should stop, despite 49 of the participants having undergone FGC/M themselves.²⁰

There are several reasons why support for FGC/M might be relatively lower in the UK. It may be that in general those who migrate to low FGC/M prevalence countries are already less supportive of FGC/M than non-migrants or people migrating elsewhere. Migrants may also be more wealthy, educated and/or young – factors which have been shown to be associated with lower levels of support for FGC/M.¹⁰⁸ Attitudes may also change following arrival in low FGC/M prevalence countries, due to an increased exposure to alternative cultures and the reduced pressure to conform to FGC/M from family and the community living elsewhere.^{92,94} Johndotter also argues that FGC/M should be recognised as a *strategy* with social meaning, rather than an end in itself.¹⁰⁹ As such, a change in life circumstances - for example following migration - may make this strategy irrelevant or unattractive, leading to its discontinuation. Connolly's qualitative study with thirty men and women from FGC/M affected groups living in the UK identified widespread support for the discontinuation of the practice among both men and women.¹⁰⁴ Carver (2021)

finds the main driver of this change among Somali refugees is increased personal knowledge of Islamic praxis coupled with distance from socio-cultural religious interpretations enforced by elders.¹⁰⁰

Balancing these competing influences can be tricky for individuals with heritage in FGC/M practising communities. Most participants in O'Brien et al's (2016) study did not support FGC/M and felt strongly that the law needed to be enforced.¹⁰⁷ The authors documented the 'huge attitudinal shift' which had been achieved with efforts to end FGC/M both at community- and national-level.¹⁰⁷ But they also recognised the ways in which FGC/M was important to certain cultural beliefs, particularly in relation to gender norms. A number of participants talked about the pressure from older relatives or the wider community and the possible negative consequences for women who had not had FGC/M. But there were also concerns, from men, women and younger people, regarding the impact of FGC/M on people's sexual behaviour and relationships. There was evidence that a lack of knowledge of available services to support women and girls who had had FGC/M. There were also concerns regarding criminalisation which had affected access to much-needed support.¹⁰⁷ Participants in Karlsen et al's (2019) study also described a dramatic change in attitudes to FGC/M among the Bristol Somali population, which was in large part due to the activities of local Somali anti-FGC/M campaigners, as well as wider recognition of the health consequences of FGC/M for women but also cultural changes amongst those living in both the UK and Somalia/Somaliland.¹⁶

Some researchers have responded to these changes by adapting their analytical

approaches to focus on, for example, 'first-generation girls who were younger upon arrival in Norway than the customary age for FGC/M in their countries of origin and second-generation girls who at the time of data collection (reference year/date) were younger than 18'.¹¹⁰ However, others argue that the impact of attitudinal changes on these risks cannot be quantified in a way that can be applied in numerical estimates at a population level.^{111,112}

The European Institute for Gender Equality (EIGE) have developed a methodology, which incorporates quantitative and qualitative components and allows for a difference in attitude towards FGC/M by practising communities post-migration.¹¹³ While their approach also focuses on calculating the number of girls at risk, it offers valuable insights for those seeking to better understand the changing prevalence of FGC/M over time or in different social contexts which may enable a more effective means of identifying and responding to any FGC/M risk in society. Data collection approaches which directly engage with the individuals affected – young people born and living in the UK – would appear to be a much more valuable than trying to establish present levels of risk using historical experiences which are increasingly irrelevant to Britain today.

4. Discussion

The calculation of direct estimates of FGC/M prevalence in the UK is seriously hampered by a lack of data. While a number of resources may be used to gain insights into this issue, none of these were developed, or are fit for, this purpose. They also all suffer from significant limitations.

Our findings speak to a lack of centrally-held accessible data from which to establish the number of cases of FGC/M being brought to the attention of statutory services or responses to them. Without this, it is impossible to evaluate their effectiveness or identify ways to improve them. Developing a more consistent, comprehensive, centralised and electronic approach to the collection of this data must be a priority. This should include full details of the identification, outcomes, process and consequences associated with each reported offence and pertinent details from which to determine the support provided to the victims and alleged perpetrators. Not surprisingly, the capacity to use these approaches to assess FGC/M prevalence is very limited.

The two recording systems operated by the NHS in England, currently unique in their collection of information from the local population, are also affected by a number of significant problems. Information from the FGM-IS is not made publicly available for the development of estimates of FGC/M prevalence or other use. By contrast, the information submitted to the FGM Enhanced Dataset has the potential to be more comprehensive and is made widely available. However, despite its mandatory nature, the proportion of NHS trusts and

GP practices submitting data is extremely low. The reasons for this remain unclear but need to be established if this resource is to have any hope of fulfilling its aim of supporting resource planning. Moreover, there are currently no means to record those women/girls who have not had FGC/M. Evidence suggests that most of the cases recorded are historical, and may have occurred many decades prior to their addition to the dataset. As such, these data cannot be assumed to provide insights into the extent to which FGC/M is being performed today. The level of detail provided on those cases submitted is often sparse, which limits the potential to distinguish between, for example, those of different ages, with different types of FGC/M and where FGC/M might have been performed in the UK or elsewhere. This also limits insights into whether and how the experience of FGC/M has changed over time.

Evidence from the FGM Enhanced Dataset suggests that the number of cases of FGC/M experienced by girls aged under the age of 18 is very low. It is impossible to determine exact numbers but figures suggest that these could be as few as eight cases of FGC/M (including genital piercing) performed on minors in the UK and recorded on the FGM Enhanced Dataset in the 5 years since it was introduced. This figure is corroborated by data from other sources, including existing academic/clinical studies.⁷⁵⁻⁷⁹ While it is also likely that some cases are missing from these figures, this evidence would suggest that the risk to young girls in the UK is well below the 'tens of thousands' reported by the Government and media.⁶⁻⁸

Methods of FGC/M prevalence estimation have typically involved extrapolating data from high FGC/M-prevalence contexts to low FGC/M prevalence settings. We have identified a number of problems with such approaches. The reliability of these data for establishing FGC/M prevalence, even in those countries where these data are collected, has been questioned. Moreover, the infrequent nature of the surveys in some areas – e.g. the DHS in Somalia – mean they cannot reflect potentially changing attitudes and practices of FGC/M among the local population. There is a dire need for methods which respond to the growing evidence that the likelihood of undergoing FGC/M is much lower among those who were born or moved to low prevalence countries, particularly at very young ages, than those living in high prevalence countries, including amongst those born to women who have experienced FGC/M themselves. Research suggests that there has been a dramatic shift in attitudes towards FGC/M among those with heritage in FGC/M practising groups living in low prevalence countries,

in part due to the success of national and community-level educational initiatives, many of them organised by people from FGC/M-affected groups.

These changing attitudes cannot be quantified in ways which can be applied in numerical estimates at a population level. However, there is a need to reflect on this evidence in light of the assumptions underpinning much current policy on this issue. Perceptions that FGC/M is valued and widespread among certain UK residents encourages responses to the protection of those perceived to be at risk which are at their best over-zealous. Existing FGM-safeguarding policies have been shown to have a direct and significant negative impact on the lives of those from FGC/M affected groups living in the UK, including on their sense of social exclusion and trust in statutory services.¹⁵⁻¹⁷ These findings suggest that there may be space for more measured responses, based on research which can more accurately reflect attitudes towards and practice of FGC/M among those living in the UK.

5. Recommendations

Our research in this area, presented in this report and in Karlsen et al,^{16,17} has identified a number of persistent issues with current approaches to FGM-safeguarding and the collection of data associated with these policies which must be addressed.

- The need to establish the prevalence and risk of FGC/M among the UK-resident population cannot be achieved effectively using any of the methods examined here. It can only be achieved by working in partnership with those with heritage in FGC/M-affected communities to develop research which explores the attitudes, knowledge and practices of those living in the UK today.
- Data collection approaches must directly engage with the individuals potentially affected – young people born and living in the UK – e.g. through an anonymous survey. This will establish present levels of risk far more effectively than using historical experiences which are increasingly irrelevant to Britain today.
- Following the recommendations of the Lammy Review,¹¹⁵ we need more consistent, comprehensive, centralised and electronic approaches to the collection and presentation of data which maintain the highest standards of methodological rigor, to ensure services can properly meet the needs of their users. Ethnicity must be consistently recorded by all public services as well as full details of the identification, outcomes, process and consequences associated with each reported offence and pertinent details from which to determine the support provided to the victims and alleged perpetrators. These data must be regularly subjected to rigorous analysis to identify and respond to problematic practices. These data are not appropriate for establishing FGC/M prevalence in the UK. However, without more effectively establishing the number of cases of FGC/M being brought to the attention of statutory services and responses to them, it is impossible to evaluate the effectiveness of these approaches or identify ways to improve them.
- The failure to collect nil reports and negative responses (e.g. among those without experience of FGC/M) and information on deaths/outmigration of those with FGC/M as part of the FGM Enhanced Dataset has produced serious impediments to its value as a means of establishing need for services, as well as FGC/M prevalence.
- Information to explain the current low response rates to the FGM Enhanced Dataset is needed, in general and in terms of the submission of non-mandatory information. Establishing whether this reflects time constraints on health professionals, language barriers, or a reluctance among health professionals to ask these questions or among patients to answer them is imperative in order to identify opportunities to improve these approaches.
- All authorities involved in FGM-safeguarding – including those working in healthcare, education, social services and the police – must

ensure that all engagement is sensitive, appropriate and proportional.

- Where risk assessment tools are used, these must be used consistently and based on reliable, validated methodologies considered appropriate by service users and their families, particularly in light of evidence of the potentially traumatic impact of current approaches associated with self-reported FGC/M experience.^{16,17}
- There is also a need to respond to the evidence regarding the traumatising effects of some approaches to adopted to the collection of data for the FGM Enhanced Dataset. In Karlsen et al,^{16,17} medical staff were perceived to prioritise extracting this information over and above their health needs and without consideration of their trauma in connection with their past experiences of FGC/M. This undermined participants' trust in health providers and encouraged a reluctance to seek care.

- Health providers have also expressed concerns regarding the impact of the mandatory reporting mechanisms related to the FGM Enhanced Dataset, an “unnecessary and misguided...policy that wrecks the basic medical promise of confidentiality” which “underpins the doctor-patient relationship”.¹¹⁴ Such approaches, regarding both the nature of questioning and mandatory reporting, are contrary to responses to other forms of abuse.

It is clear that current policy and practice relating to FGC/M in the UK is based on a number of incorrect assumptions, which have developed from misguided use of the available data and a lack of attention to the problems which affect its use. There is a clear need to protect children at risk. But there is no evidence from any of the sources examined here to justify the over-zealous and often heavy-handed approaches to FGM safeguarding currently undertaken in the UK, or the negative outcomes for individual children, their parents and families and their communities which often accompany them.

6. References and Notes

1. Whilst the term ‘female genital mutilation’ (FGM) is frequently used in policy and practice arenas, it is controversial for at least two reasons. First, it is applied to a wide range of procedures, some of which are not mutilating. Second, it typically excludes other procedures which are genitally mutilating, such as forms of cosmetic surgery and male circumcision. For more detailed discussion of this, see Shahvisi & Earp (2019). The term is commonly used in relation to statutory processes relating to FGM-safeguarding. However, academic opinion is more diverse with some scholars preferring the term, female genital cutting (FGC) (Shahvisi, A and Earp, BD (2019) *The law and ethics of female genital cutting*. In: Creighton, Sarah M and Liao, Lih-Mei (eds.) *Female genital cosmetic surgery: solution to what problem?* Cambridge University Press, pp. 58-71.)
2. <https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation>
3. The WHO definition of FGM includes a range of procedures including: clitoridectomy – the partial removal of the clitoris or prepuce (type 1); excision - the partial removal of the clitoris and labia minora (type 2); infibulation – the narrowing of the vaginal opening (type 3) and; any female genital piercing, pricking, incising, cauterising or scraping for non-medical reasons (type 4). Type 4 therefore includes procedures which might not be associated with long-term tissue damage. FGM mandatory reporting duty in the UK includes female genital piercing, tattooing and other procedures which are medically unnecessary. WHO definitions of Type 1 and 2 also mention ‘total’ clitoral removal, but this relies on anatomically incorrect understandings of the nature of the clitoris (For further discussion, see Abdulcadir, J., Botsikas, D., Bolmont, M., *et al.* 2016. Sexual Anatomy and Function in Women With and Without Genital Mutilation: A Cross-Sectional Study. *J Sex Med*;13(2):226-37).
4. UNICEF 2015. Female Genital Mutilation/Cutting: A global concern, at https://www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD.pdf
5. Under the UN’s 2030 Sustainable Development Goal 5.3, there is a commitment to “eliminate all harmful practices such as child, early and forced marriage and female genital mutilation”.
6. Home Affairs Select Committee 2016-17. Female Genital Mutilation: Abuse Unchecked’ – Ninth Report of Session, at <https://publications.parliament.uk/pa/cm201617/cmselect/cmhaff/390/390.pdf>
7. Guardian 2014. Michael Gove writes to every school in England about dangers of FGM, at <https://www.theguardian.com/politics/2014/apr/11/michael-gove-writes-schools-dangers-female-genital-mutilation>
8. Cameron, D., 2014. Girl Summit 2014: David Cameron’s Speech, at <https://www.gov.uk/government/speeches/girl-summit-2014-david-camerons-speech>
9. Baillot H, Murray N, Connelly E., Howard, N., 2018. Addressing female genital mutilation in Europe: a scoping review of approaches to participation, prevention, protection and provision of services. *Int J Equity Health*, 17(1):21.

10. Leye, E., Deblonde, J., García-Añón, J., Johnsdotter, S., Kwateng-Kluyitse, A., Weil-Curiel, L., Temmerman, M., 2007. An analysis of the implementation of laws with regard to female genital mutilation in Europe. *Crime, Law and Social Change*, 47(1):1-31.
11. The first successful prosecution for ‘having procured or undertaken FGM’ was of a mother from Uganda in early 2019. Neither parent was from an FGC/M-practicing background. In Ireland, a couple were convicted of ‘the FGM of their daughter’ in January 2020.
12. Home Office, 2016. Mandatory Reporting of Female Genital Mutilation: Procedural Information Home Office, at: www.gov.uk/government/publications/mandatory-reporting-of-female-genital-mutilation-procedural-information. See also documents related to mandatory reporting in healthcare available at: www.gov.uk/dh/fgm.
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Appendix: Questions used to inform collection of data for the FGM-IS

Part One (a): PREGNANT WOMEN (OR HAS RECENTLY GIVEN BIRTH)

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

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 FGM.

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, siblings and/or in-laws have undergone FGM			
Woman has failed to attend follow-up appointment with an FGM clinic/FGM related appointment			
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			

Indicator	Yes	No	Details
SIGNIFICANT OR IMMEDIATE RISK			
Woman already has daughters who have undergone FGM			
Woman or woman's partner/family 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 care services – if known, and you have identified FGM within a family, you must share this information with 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 safeguarding 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 Services/CAIT team/ Police/MASH, in accordance with your local safeguarding procedures.

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

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

Please remember: any child under 18 who has undergone FGM must be referred to police under the Mandatory Reporting duty using the 101 non-emergency number.

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

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

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			
A female family elder (maternal or paternal) is influential in family or 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			
Woman has failed to attend follow-up appointment with an FGM clinic/FGM related appointment			
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			

Indicator	Yes	No	Details
SIGNIFICANT OR IMMEDIATE RISK			
Woman/family believe FGM is integral to cultural or religious identity			
Woman already has daughters who have undergone FGM			
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			

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 safeguarding lead.

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

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

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

Please remember: any child under 18 who has undergone FGM must be referred to police under the Mandatory Reporting duty using the 101 non-emergency number.

Part 2: CHILD/YOUNG ADULT (under 18 years old)

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

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 female family elder 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 family			

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 safeguarding lead.

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

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

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

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			

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 safeguarding lead.

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

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

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

Please remember: any child under 18 who has undergone FGM must be referred to police under the Mandatory Reporting duty using the 101 non-emergency number.

Part 3: CHILD/YOUNG ADULT (under 18 years old)

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

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			

ACTION

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

Please remember: any child under 18 who has undergone FGM must be referred to police under the Mandatory Reporting duty using the 101 non-emergency number.

If you suspect but do not know that a girl has undergone FGM based on risk factors presenting, you should look to refer to Social Services / CAIT Team / police / MASH, in accordance with your local safeguarding procedures.

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

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