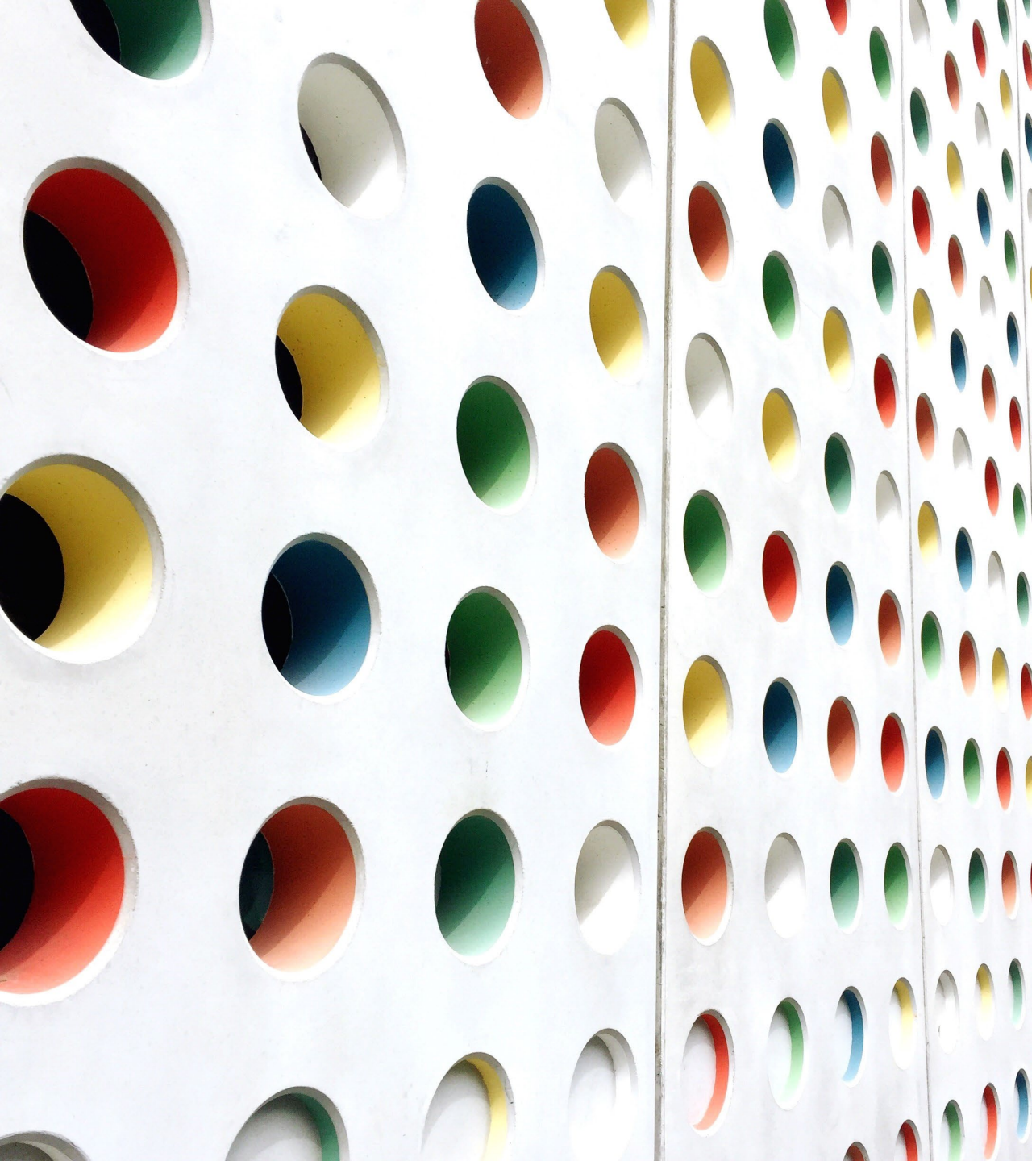

Evaluation of FGM Pilot Clinics

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Aims of the evaluation

Did the clinics improve the health outcomes of non-pregnant survivors of FGM?

- Consider the relevance of the original service specifications to promote the health and wellbeing of service users
- Explore the importance of the clinics being in a community setting
- Evidence the impact of the health advocate and a counsellor
- Update the economic review that was carried out in 2021. (NHS England: Economic Analysis of NHS FGM Support Clinics. University of York

Method

The evaluation adopted a mixed-modal approach that generated qualitative and quantitative data from the 8 clinics.

- Clinical staff including three consultants, One General Practitioner, seven FGM specialist midwives/nurses
- Two clinic management/administrative staff
- Eight health advocates
- Seven psychotherapists/counsellors
- Two voluntary sector service leads involved in delivering support and one commissioner
- Survey of all clinics to gather data on operation levels and symptoms of the patients
- Interviews with twelve women who accessed the clinics

Key Finding 1: Significance of the roles

"Being able to hold the women as a whole unit in some ways…the partnership working that we've got within the team works really well." (Psychologist)

Specialist midwives and nurses. The infrequency of the clinic operations meant the clinics needed highly knowledgeable, experienced, and committed leaders to support women with FGM.

Health Advocates. Increased awareness and access to the service – reduced DNAs, developed partnerships with the VCSOs and local community groups, provided emotional support, developed trust, reduced language barriers.

Counsellors/therapists – provided up to eight sessions to help with issues relating to historical trauma, low mental health, low self-esteem emotional and relationship issues.

Key Finding 2: Set-up and Operations

- **Clinic Locations – 5 community settings (Health Centres, GP practices), 3 Hospital settings.**
  - Success depended on clinics generating referrals - self-referrals, GPs, health advocates, or voluntary and community organisations.
  - Management of clinics needs consideration – multi-agency teams, and administration
  - Sharing data patient data and management was poorly defined.
  - No discernable difference in experience was reported by the women who accessed community or hospital clinics.

Key Finding 3: Performance of the Clinics

Number of new patients seen (estimated) 578 over two full operating years (2019-2021).

- Clinical interventions were delivered weekly or bi-weekly. This limited capacity.
- Some clinics were under-utilized; had low numbers of patients and struggled to generate referrals.
  - Experience of DNAs was high among some clinics at the start; impact of Covid-19
- Staff recruitment and retention was a concern among some clinics, particularly for specialist midwives and advocates.

Key Finding 5: Interventions and support

- De-infibulations = estimated 230 (40%) 2019-2021
- Counselling received = 163 (49%) 2020-2021
- Smear tests completed = 4 (two clinics only) - although 4 clinics offered
- Additional support to 20 women around housing, Home Office status, financial support, further mental health support. However, this was not a significant aspect of support.

Key Finding 6 – Impact on Women

- The research highlighted the very difficult life experiences of these women: trauma, abuse, forced marriage, and isolation. But also bravery.
- Experience of all clinics has been overwhelmingly positive. Very grateful for the holistic/caring support
- Health Advocate role - less of a direct impact on the women, but greater impact on engagement with the service.
- Psycho-sexual therapy and trauma counselling played a key part in their understanding and recovery
  - Understanding of their FGM and symptoms (e.g. painful sex, UTIs, thrush)
  - Impact of FGM on their emotional wellbeing, sexuality, relationships, and marriage
  - Physical changes as a result of de-infibulations – better sex and relationships, improved confidence

Key Quotes from women

“They were very supportive at the clinic, the care was wonderful. I was alone in the UK, and I have no relatives here. I came by myself. I didn’t feel that I was alone, all the staff were very supportive.”

“The procedure was so relieving to have it, I had been worried about it and it was in my own mind for ages, but it was so relieving.”

“The results were even more better than what I imagined, it’s life changing you know, I thought it would be with me all my life. But it’s so quick and I was so grateful that I found these people.”

Call for peer support from several women *“I would have liked more peer support from other women who had experienced the same thing as me.”*

Key Challenges and lessons learned

Set-Up Phase is important.

Operating Policies, lines of accountability, recruitment, equipment and supervision.

3 Rs – relationships, relationships, relationships – Needs time to develop and any MDT requires support and supervision.

Generating referrals is key. This is constantly needed as word of mouth is not a feature of access.

Promotion of the clinics is vital. Many women self-referred – found on the NHS website. Promotion through GPs and community needs to improve – some lack of awareness and understanding.

Administrative support is important – to relieve the midwives/nurses or advocates of the administration.

Data Management and repository

Outcomes data – service feedback from patients to validate the service and improve the offer if necessary.

Cost Effectiveness

The YHEC report found that the average annual cost per clinic after offset costs, was £51,785.

A cost per case was calculated at £1,433 by dividing the estimated costs of the eight clinics (£51,785 x 8 clinics x 2 years) by the total number of service users seen over 2019-2021 across all eight clinics (578 service users).

The clinics provided a cost saving of over £206,000 to the NHS over the pilot period.

An FGM clinic with an average annual cost of £51,785 would need to see 29 or more service users per year to be cost-effective.

Ten recommendations

1. NHS England to refresh commissioning guidance for FGM services and include an example of operating procedures.

2. Adequate IT, telephone and other equipment required to carry out their duties.

3. Ensure sufficient time for management and oversight of the clinic is incorporated into the monthly resources.

4. Ensure regular line management and supervision arrangements for multi-agency teams.

5. Agree with their Trust/ ICB Commissioner what data is required and how to store it.

Ten recommendations

6. Ensure that views from service users are collected.

7. Staff is sufficiently trained and confident in offering smear tests so patients accessing the clinics have a choice as to whether they receive the service.

8. Peer-to-peer support groups to support women beyond the clinic.

9. Adequate time and resources are committed to raising awareness of the service to increase referral numbers

10. consider the diversity of languages spoken by potential service users