

The logo for FORWARD, featuring the word in white capital letters on an orange rectangular background. The letter 'O' is stylized with three horizontal lines passing through it.

FORWARD

‘DO NO HARM’

Lived Experiences and Impacts of the UK’s
FGM Safeguarding Policies and Procedures,
Bristol study

February 2021

A decorative graphic consisting of numerous horizontal brush strokes in white and orange, creating a textured, layered effect across the middle of the page.

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Lived Experiences and Impacts of the UK’s FGM Safeguarding Policies and Procedures, Bristol study

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Executive Summary

Over the latter half of the last decade, the UK government has intensified its response to Female genital mutilation (FGM). Citing estimates that as many as 60,000 girls, born to mothers with FGM, are *potentially* at risk, a swathe of legislative changes and new safeguarding measures have been introduced.

Among these, the FGM Mandatory Reporting Duty obliges professionals to report to the police when a girl under 18 years of age has undergone FGM. New court powers, known as FGM Protection Orders, have also been introduced to protect girls considered to be at risk. In healthcare, education, social care, and at the UK border, several new safeguarding and risk assessment procedures have been instated.

These new policies and procedures have given FGM a special status within the national approach to child safeguarding. While the UK government's commitment to end FGM is to be commended, concerns have begun to surface about the inadvertent harm that this far-reaching and stringent approach to FGM safeguarding might be causing to families and communities, as well as to their relations with professionals and public authorities.

This study, carried out by FORWARD and the University of Huddersfield, examines the views and lived experiences of these policies, both among African diaspora communities and regulated professionals in Bristol. Using a Participatory Evaluative Ethnographic Research (PEER) approach, we spoke to 38 women, men and young people from diaspora communities, and to seven statutory professionals working in education, policing, midwifery and social care. In examining this range of perspectives, we hope to open up new opportunities for meaningful debate and to contribute

to positive progress on FGM safeguarding efforts in Bristol and across the country.

Results

The accounts presented in this research reveal worrying indications that the safeguarding policies enacted since 2014 may have inadvertently done a great deal of harm to families, communities and the young girls themselves, both in Bristol and potentially across the UK. Their targeted and heavy-handed approach have increased the scrutiny, suspicion and stigmatisation experienced by parents and families in many area of their lives, from school, to healthcare, to overseas travel. These experiences have taken a significant toll on the mental health of parents who said they had no intention of carrying out FGM on their daughters, and in some cases even campaigned against it. Professionals participating in the study were equally concerned about the ways in which the current policies had burdened some families, and warned against a growing disconnect between them and the diaspora communities as a result.

FGM Mandatory Reporting Duty

The FGM Mandatory Reporting Duty, which requires professionals to report *known* cases of FGM to the police, applies only if a girl discloses that she has had FGM, or when there is physical evidence that it has

taken place. Yet participants from Bristol's diaspora communities stated that reports made to the police under this duty were often unsubstantiated and influenced by bias. They believed that some professionals would “*jump to conclusions*” based on a family's ethnic origin. These errors of judgement were seen to be devastating for the families, leaving them faced with complex legal processes and little to no support.

Professionals participating in the study appeared equally troubled by the “*problematic*” implementation of the Mandatory Reporting Duty. They described a lack of adequate cultural knowledge of FGM, leading to a “*knee-jerk*” implementation of the duty by some of their peers. They also noted that FGM appeared to have been singled out unnecessarily from other forms of child abuse with this dedicated reporting duty. They warned that this could contribute to the stigmatisation of certain communities, and that it could distract professionals from other, more established child safeguarding procedures.

FGM safeguarding and risk assessments in schools

Schools were a common setting in which parents had encountered FGM safeguarding procedures. The safeguarding guidelines available to professionals, including those working in education, list several risk indicators that can help them to identify if FGM has occurred or if a girl is at risk. The list includes, for example: that a girl's mother has undergone FGM; that a girl has frequent urinary, menstrual or stomach problems; or, that a family is travelling for an extended period of time to an area with a high prevalence of FGM.

The guidance cautions professionals against taking any one of these indicators in isolation as evidence of FGM. Although it advises them to conduct a full risk assessment, our research reveals worrying reports of families being immediately referred to social services and the police, based solely on their holiday plans or their daughters' frequent visits to the bathroom. Several of the professionals interviewed echoed these concerns. They too were aware of cases in which a family's ethnic origin had seemingly been the principal basis for referral.

Additionally, the list of indicators that professionals are instructed to consider during FGM safeguarding

were themselves criticised by participants from diaspora communities. The indicators were seen to contain too many “*grey areas*” and to prompt unjustified scrutiny. Many of the risk indicators were felt to describe behaviour that could be attributed to a broad number of reasons, often unrelated to FGM. Participants, both professional and communities, feared that due to this strong focus on FGM, signs of other health issues or forms of abuse might be overlooked or wrongly interpreted as signs of FGM, endangering the welfare of many young girls.

FGM safeguarding and risk assessments in healthcare

The new FGM Information-Sharing System, introduced in 2014, allows healthcare staff to indicate on a girl's health record that she is potentially at risk from FGM, for instance, she has been born to a mother who has undergone FGM. This information thus becomes available to other healthcare professionals to perform further FGM risk assessments on a routine basis. This can, for example, take the form of ongoing conversations with mothers or pregnant women who have undergone FGM.

Several participants who were pregnant, or who had recently given birth, described enduring repetitive and uncomfortable conversations on FGM during appointments, often at the expense of other important health-related discussions. Alarming, many participants had also heard of young girls being subjected to unnecessary physical examinations due to an FGM risk flag on their health record. These experiences had been so distressing that some families shied away from seeking medical help to avoid them. Professionals in the study raised similar misgivings about the potential distress experienced by patients from diaspora communities during medical care. Many pointed out that the sensitivity and care stipulated in the guidelines, though necessary, could not always be applied in practice, due to time pressure and capacity limits.

Doubts were also expressed by both professionals and diaspora communities about the very idea of recording the potential risk of FGM on a girl's health record. It was feared that this could negatively affect how some healthcare professionals perceived and interacted with their patients. In addition, the participants from diaspora communities

also challenged the very presumption that girls were more at risk simply because they were born to mothers with FGM. As indicated by previous research, as well as the participants' own lived experiences, FGM practices are increasingly being abandoned by the UK's diaspora communities.

FGM safeguarding interventions

Following the observance of FGM safeguarding procedures, such as those carried out in schools and in medical settings, a family can undergo further investigation if a suspicion of FGM is raised. This can involve home visits, carried out by social services and the police, or the issue of an FGM Protection Order by the family courts.

As with their encounters of other FGM safeguarding measures, participants' experiences of these procedures had been overwhelmingly negative. Some shared stories of unannounced home visits, happening without prior appointment, and seemingly conducted with a presumption of guilt. The presence of police on a family's doorstep was distressing and was felt to risk harming a family's reputation in the community. Furthermore, FGM Protection Orders had in some instances apparently been issued without definitive evidence of risk, leaving the families burdened with the tedious prospect of contesting the order while having their movements restricted.

Operation limelight

In the run up to the summer holidays, many families dreaded going to the airport, for fear of suffering the scrutiny of Operation Limelight. Under this operation, flights to and from FGM-prevalent countries are targeted by the police and the Border Force. Research participants described feeling singled-out and harassed when they were pulled aside at the airport and questioned about the purpose of their travel. Professionals in the study pointed out that Operation Limelight had restricted the movement of some families in a way not experienced by the wider UK population. Some felt that the nature of this approach resembled the treatment of people who had committed a crime and acknowledged the anxiety and stress that this could cause the families.

Impacts of FGM safeguarding

The current approach to FGM safeguarding has had a broad impact on the lives of the families and the girls whom it was instated to protect. Many key areas of life are touched by FGM safeguarding procedures, from pregnancy and childbirth to schools, medical appointments, and holiday travel. As a result, many participants spoke of a persistent feeling of being "suspected" of wrongdoing as they went through their lives. There was a strong sense that, although the safeguarding approaches had been designed to protect young girls, they had instead inadvertently become a basis for targeting, harassment and racial profiling of their communities. Such experiences had taken a significant toll on parents' and families' mental health and wellbeing. Worse still, according to many participants, this had also come to affect family life, with the potential to "break whole families apart".

In general, trust and engagement between professionals and these communities had been damaged by FGM safeguarding procedures, as families felt increasingly alienated by these negative experiences. Paradoxically, these impacts were seen to have ultimately hindered grassroots FGM prevention efforts and possibly undermined the effectiveness of FGM safeguarding altogether.

Policy reflections and recommendations

Our research has identified problems both with how the current policies were being implemented on the ground and with the design of the policies themselves. We make several recommendations, some of which were recommended directly by our participants.

Improved training for professionals: Holistic training for professionals must form a critical first step in addressing the failings of current FGM policy. It should not only improve their understanding of FGM and ensure compliance with safeguarding guidelines, but also address potential biases in decision-making and encourage more sensitive engagement with communities.

Review FGM safeguarding in medical care:

Safeguarding approaches for medical settings should be re-examined and adapted, both for them to be more

effective in addressing FGM and to eliminate potential distress for patients.

Reconsider police involvement in routine FGM

safeguarding: Police involvement in FGM safeguarding procedures, such as home visits, should be a last resort. It should be used only when there is strong evidence that FGM has taken place or that a girl is at imminent risk. In most cases, a move to less heavy-handed approaches would be more successful at achieving the policy goals.

Provide support for families affected by FGM

safeguarding: Access to legal, financial, and emotional support should be a fundamental requirement of all FGM safeguarding procedures to support families affected. Families should also be informed of their rights in a clear and accessible way to empower them in safeguarding situations and help those who have experienced discrimination to take actions about it.

Review the national FGM safeguarding risk

assessment guidelines: A full review of the FGM risk indicators must be undertaken. The Bristol Safeguarding Children's Board has already set a promising process in motion by launching new, more nuanced risk assessment guidelines. This review remains necessary at a national level.

Review of the special policy approach to FGM

safeguarding: The current, special approach to FGM safeguarding should be entirely reconsidered. This review should be based on the following areas for investigation: firstly, FGM risk estimates in the UK should be updated, grounded in high-quality data and taking into account cultural shifts in attitudes towards FGM among diaspora communities; secondly, an assessment of the effectiveness of FGM safeguarding policies, based on the collection and release of relevant data by local authorities; and, thirdly, further research into the lived experiences of FGM safeguarding, conducted on a national level.

Community centric approach: A community-centric approach must be integrated into all current and future FGM prevention efforts. This shift in focus would recognise the role that communities themselves play in ending FGM practices, and engage them fully in the design and delivery of safeguarding policies. Additionally, it is crucial that adequate support be made available for girls and women who are still affected by FGM practices.

Introduction

The term ‘Female genital mutilation’, or FGM, refers to practices in which parts of the female external genitalia are altered, injured, or removed for non-medical reasons¹. Typically carried out on young girls between infancy and 15 years of age², FGM is a human rights violation, has no benefits, and potentially causing devastating physical and psychological harm. In the worst cases, it can even lead to the child’s death.

FGM has been a criminal offence in the UK since 1985, and in 2003, the FGM Act extended this to include extra-territorial offences and increased the maximum penalty from 5 to 14 years’ imprisonment³. Over the latter half of the last decade, the UK government has further intensified its response to FGM⁴, backed up by estimates that around 60,000 girls in the UK were born to mothers who have had FGM, and were therefore considered to be *potentially* at risk⁵.

At the 2014 Girl Summit⁶, then Prime Minister David Cameron pledged to end FGM within a generation and launched a £1.4 million FGM prevention programme^{7,8}. The following year, amendments to the Serious Crime Act (2015)⁹ extended the scope of the criminal law and made several other legislative changes. These changes included the introduction of the FGM Mandatory Reporting Duty, which requires professionals to report to the police when a girl under 18 is *known* to have undergone FGM¹⁰. Another legislative change introduced new court powers, known as FGM Protection Orders, to protect girls who are at risk¹¹.

Additionally, across healthcare, education, and social care, new safeguarding and FGM risk assessment procedures were introduced to help professionals carry out their safeguarding duties¹². In healthcare, two new requirements allow information

on FGM to be recorded and shared. Firstly, the FGM Enhanced Dataset¹³ requires NHS practitioners to record detailed information about women and girls who have already undergone FGM. Secondly, the FGM Information-Sharing System¹⁴ allows healthcare staff to flag a girl’s medical record if they consider her to be at risk of FGM; in particular, if she has a family history of FGM. Meanwhile, at the UK Border a new safeguarding initiative, known as Operation Limelight¹⁵, was implemented to prevent FGM from being carried out abroad by focusing on passengers travelling between the UK and FGM-prevalent countries.

These wide-ranging new policies and procedures, as a whole, have given FGM a special status within the national safeguarding approach. Their targeted nature and stringent requirements, regarding both reporting and routine risk assessments, go far beyond the UK’s safeguarding approach to other forms of child abuse. The UK government’s commitment and efforts rightly reflect the seriousness of FGM’s impact on the women and girls subjected to it. However, concerns have begun to be raised about the inadvertent harm that those measures might themselves be causing to the children that they seek to protect, as well as to their families and wider communities^{16,17,18,19}.

Through the grassroots community work carried out by FORWARD with African diaspora communities across the UK, we have heard first-hand that the new approach to FGM safeguarding has often caused fear, distress and stigmatisation for the people it affects. Research published in 2019 by Dr Saffron Karlsen and her colleagues at the University of Bristol, supports this notion, highlighting the ‘traumatisation’ and ‘disempowerment’ suffered by Bristol’s Somali community¹⁸. Further research published by the Royal College of General Practitioners has raised ‘major concerns’ that the new policies are potentially leading to the breakdown in trust between professionals and diaspora communities in the UK¹⁹.

The study presented in this report is one of the first to examine the lived experiences of the new FGM safeguarding policies in the UK, integrating perspectives from both African diaspora communities and professionals tasked with carrying out FGM safeguarding duties. The research was carried out in

Bristol by FORWARD and the University of Huddersfield. The 38 members of diaspora communities participating in the study included women, men and young people of diverse African heritage, whose countries of origin have a high prevalence of FGM. The seven professionals interviewed included healthcare and social care workers, teachers, and police officers. By bringing together these perspectives, we hope to open up new opportunities for meaningful debate and to contribute to positive progress on FGM safeguarding efforts in Bristol and across the country.

We took ‘Do No Harm’ as our guiding principle in examining the policies and procedures governing FGM safeguarding. Given the emerging indications of their potential negative impact, we made this principle fundamental to our assessment of the views and lived experiences of these policies.

Background

The World Health Organisation estimates that over 200 million girls and women alive today have undergone some form of FGM, with occurrences concentrated mainly in Africa, but also existing in some areas of Asia and the Middle East²⁰.

The practices that come under the definition of FGM are sometimes also referred to as female genital cutting or female circumcision. Several other names originate from cultures where FGM is practiced, such as sunna, gudniin, tahur, and khitan, amongst others². Since FGM is the term used most widely in UK legal and policy contexts; as such, it has been used throughout this report to refer to these practices.

Prevalence and risk of FGM in the UK

There is lack of reliable statistics on FGM prevalence, or estimates of the risk of FGM occurring in the UK²¹. A 2015 study, based on 2011 census data, estimated that 137,000 women and girls permanently resident in England and Wales had been born in countries where FGM was practised and had themselves undergone the procedure. Another estimate, presented in the same study, suggested that the UK was home to around 60,000 girls under 15 years of age who were born to mothers who had undergone FGM²². On the basis that FGM is often considered to be intergenerational, meaning that girls whose mothers have had FGM are thought to be at risk², this estimate has since been widely cited in UK governmental guidance²³ and in the media²⁴ as evidence of a highly prevalent risk of FGM in the UK.

More recently, however, legal and medical practitioners, as well as academics, have questioned the reliability of this assumption^{15 18 25}. A growing body of evidence

suggests that attitudes towards FGM among the African diaspora in Europe are considerably altered following immigration, as are the practices themselves^{26 27 28 29 30}. This could be because of increased contact with other cultures, and reduced pressure from community and extended family in the migrants' home countries. In the UK, preliminary research even suggests a broad opposition to FGM in these communities^{27 31}. Although FGM is still thought to be practiced by some diaspora families in the UK - mostly among newly arrived immigrants³² - there is currently no evidence to suggest that it happens on as large a scale as has been estimated. Arguably, a great deal of caution should be exercised when deciding whether being born to a mother who has had FGM is a valid indication of risk²⁵.

This observation is further supported by data that the Department of Health and Social Care and NHS England have collected since 2014, through the NHS Enhanced dataset. Since its launch, they have identified 25,710 cases of FGM among women attending care in NHS acute trusts, mental health trusts and GP practices³³. However, according to their latest 2019-2020 annual report, in 98 percent of cases identified, the FGM had occurred at least ten years previously, and the majority happened outside the UK³⁴. While the interpretation of this data is cautioned due to concerns over data collection, accuracy and completeness³⁵, the figures suggest that fears of continued risk of FGM for young girls may have been overstated. This raises questions about the safeguarding measures implemented in response to the assumption of high prevalence of risk.

The FGM safeguarding framework in the UK

Girls considered to be at risk of FGM have come to occupy a special status within the approach to child safeguarding in the UK. According to current policy, the unique ‘timescale’, ‘profile’ and ‘characteristics’ of FGM, as opposed to other forms of harm or abuse, together mean that ‘the potential risk to a girl born in the UK can usually be identified at birth [...], meaning that any safeguarding measures adopted may have to be in place for more than 15 years over the course of the girl’s childhood’¹⁰. For this reason, safeguarding professionals are required to take a differentiated approach to FGM safeguarding. This special status of FGM is manifested in several legislative changes and procedures, which are outlined below.

The FGM Mandatory Reporting Duty

The FGM Mandatory Reporting Duty came into force in October 2015. Under the duty, health and social care professionals and teachers in England and Wales are required to report all cases in which a girl under 18 is *known* to have been subjected to FGM to the police. Failure to comply with this reporting duty can result in an investigation of the professional’s fitness to practise by their regulatory body.

A *known* case of FGM is defined as one in which either a girl has explicitly told a professional that she has undergone the procedure, or the professional has seen physical signs indicating that FGM has taken place³⁵. The FGM Mandatory Reporting Duty does not apply in suspected FGM cases, nor does it concern girls who are considered to be at risk of undergoing FGM. In these cases, professionals are instead required to follow their locally mandated safeguarding processes³⁶.

FGM safeguarding and risk assessment

New resources and guidelines for FGM safeguarding and risk assessment were introduced in 2016 to help professionals involved in child protection to identify risk and suspected cases of FGM^{37 38}. Initially developed for healthcare professionals by the Department of Health and Social Care, the guidelines were subsequently made available to local Safeguarding Children’s Boards so that they could be adapted for use by other professionals.

The FGM Information-Sharing System

Launched by the Department of Health and Social Care and NHS England in 2014, the FGM Information-Sharing System is a national IT system designed to facilitate the safeguarding of girls under 18 years of age in medical settings. The system allows healthcare professionals and administrative staff to make a note of the *potential* risk of FGM on a girl’s health record, thus rendering this information available to other authorised healthcare professionals. Typically, a risk indication of this nature is added to a girl’s health record if she is known to have an immediate family history of FGM³⁹: for example, if the girl’s mother has had FGM. The risk indication can, however, also be added following an FGM risk assessment that concludes that a girl is potentially at risk^{40 41}.

FGM Protection Orders

Brought in under the Serious Crime Act 2015, FGM Protection Orders are civil orders granted by a family court to protect girls thought to be at risk of FGM, or to have already been subjected to FGM⁹. They involve, for example, surrendering the girl’s passport to authorities, in order to prevent her from being taken abroad for an FGM procedure. A request to the family court for a Protection Order can be made by a variety of people, including the girl herself, a local authority, the police, a teacher, a charity, or a family member. As of June 2020, since their introduction, a total of 614 Protection Orders had been granted in the UK⁴².

Operation Limelight

Carried out by the UK Border Force and police forces in airports, Operation Limelight aims to detect and prevent potential cases of FGM from being carried out abroad^{43 44}. Starting as an initiative at London Heathrow Airport, it has since been extended to other parts of the UK (and the USA^{45 46}).

Under Operation Limelight, passengers travelling between the UK and FGM-prevalent countries may be stopped for questioning, and their baggage checked for items associated with FGM. Operation Limelight is often stepped up during the school holiday periods, particularly the long summer holidays. Girls are considered to be most at risk at this time, as they

are thought to have more time to ‘heal’ from the procedure before returning to school²⁴⁷.

The Bristol context

After London, Bristol is estimated to have one of the largest African diaspora communities affected by FGM in the UK²⁰, and hence was a clear choice for the location of our study. Our research greatly benefited from the longstanding relationship that FORWARD and Refugee Women of Bristol had established with local African diaspora communities. Both organisations had already been working closely with these communities over the past twelve years with the aim of eliminating FGM in the city.

This cooperation began in 2009, when FORWARD and Refugee Women of Bristol initiated the Community Development and Awareness Programme. The programme was part of a city-wide partnership response to FGM called The Bristol Model⁴⁸ and it adopted a coordinated approach that united professionals and communities in a joint effort. Most importantly, the programme recognised the vital role that communities can, and do, play in eliminating FGM. Its activities included training forty women as Community Health Advocates and influential agents of change in their communities.

In the twelve years since, the Community Health Advocates have acted through schools, places of worship and family functions to raise awareness of FGM law in the UK and of the harmful effects of these practices. At the same time, they have been signposting support services and helping to safeguard girls who are at risk. This community-centric effort has reportedly been very successful in shifting attitudes towards FGM across Bristol⁴⁹. Notably, it was instrumental in the launch of the award-winning Rose Clinic, a community-based healthcare clinic that provides services for women in Bristol who have been affected by FGM^{48 50}.

Since the launch of the current FGM safeguarding framework, FORWARD and Refugee Women of Bristol have witnessed first-hand the negative effects that it has had on Bristol’s African diaspora communities. We have gathered considerable anecdotal evidence: of girls who were increasingly reluctant to use FGM-related services, out of fear that their parents might

be reported; of families feeling distressed and frightened by FGM safeguarding procedures in schools and medical institutions; and of growing mistrust between the community and professionals tasked with implementing FGM safeguarding processes.

Given the concerted grassroots efforts that had already been happening in Bristol to fight FGM practices, the introduction of the new stringent safeguarding procedures naturally prompted some frustration among the city’s diaspora communities. Tensions in these communities rose even further in 2018, following the collapse of a local FGM prosecution case. In 2016, a taxi driver and father of Somali origin was prosecuted, after an anti-FGM activist claimed that he had spoken about allowing his six-year-old daughter to undergo a ‘special procedure’. Two years later, the case collapsed due to ‘wholly inconclusive’ evidence⁵¹, but not before it had gained high-level local and national attention as the first FGM case to be brought to prosecution in the UK. This case was a major catalyst for the increasing sense of stigmatisation and mistrust among Bristol’s African diaspora communities, particularly among the Somali community, regarding FGM safeguarding processes.

In light of this growing rift, our study hopes to offer a deeper understanding of FGM safeguarding experiences, by bringing together the perspectives both of the African diaspora communities and of regulated professionals who hold safeguarding responsibilities.

The ‘Do No Harm’ principle

“... the negative effects that we try to reduce through Do No Harm can be viewed from a human rights perspective, in terms of safeguarding, equality, dignity, non-discrimination or the right to a healthy environment.” (Charancle and Lucchi⁵²)

The ‘Do No Harm’ principle has become central to many forms of social intervention, from humanitarian action to research, including those related to child protection⁵³. In the UK, protecting against harm is a key part of professionals’ and local authorities’ statutory responsibilities^{54 55}.

The origins of ‘Do No Harm’ reach back to the Ancient Greek Hippocratic Oath, which required physicians to swear to uphold certain ethical

standards. In the early 1990s, with increasing awareness of the unintended negative impacts of humanitarian interventions, the principle was adopted by agencies of the United Nations, governments and non-government organisations in an effort to guard against these harms⁵². More recently still, the principle has been developed into a broad framework to avoid exposing beneficiaries of social and humanitarian interventions to additional risk or suffering, and to mitigate any potential negative effects for society, the economy and the environment⁵².

Living a life free from harm and abuse is considered both a fundamental human right (Human Rights Act 1998⁵⁶; Children Act 1989⁵⁷) and an essential requirement for human health and wellbeing (Care Act, 2014⁵⁸). It is incumbent upon policymakers and

professionals to be aware of - and guard against - any negative consequences that safeguarding policies could have for children, families, and communities.

With growing evidence of the potential negative impact of FGM safeguarding policies and procedures, the observance of 'Do No Harm' in the UK has been cast into doubt in this area. Therefore, we believe it is imperative that our research examine the communities' and professionals' lived experiences of FGM safeguarding through a 'Do No Harm' lens.

Method

A two-stage research approach was followed for data collection, which took place between December 2018 and April 2019. The first stage of the research was carried out with participants from African diaspora communities. The second stage involved regulated health and social care professionals, teachers and the police.

First stage: Interviews with community members

A Participatory Evaluative Ethnographic Research (PEER) approach was used to carry out qualitative, in-depth conversational interviews and focus group discussions with community members. We used the PEER approach as a means to move away from conventional research approaches and to actively involve members of the communities in most aspects of the research process. PEER helped us to establish a more reciprocal relationship between researchers and participants than might exist in other forms of research. Additionally, in the case of a sensitive topic like FGM, this approach helped to mitigate some of the power dynamics that can arise between researchers and participants. In several previous studies, FORWARD had already successfully pioneered, and specialised in, the PEER approach with African diaspora communities, to gain insights into sensitive topics that are typically difficult to research in hard-to-reach communities^{59 60 61}.

The interviews and focus group discussions were facilitated with a series of prompts. These firstly looked at the diverse impacts of the different FGM safeguarding policies and procedures. They also explored the risks and benefits that the participants

felt these policies could harbour for the girls, for families and for their communities at large. The discussions went on to explore recommendations for policy and practice improvements.

Recruitment and sampling

A purposive sampling method was used to recruit participants over the age of 18. A total of 23 women and 15 men took part in the research (see Table 1). To reduce barriers to participation, focus group discussions were divided according to age (18-30 years; 30+ years), gender and ethnicity. In this first stage, the research purposely brought together the perspectives of a wide range of participants. Every participant self-identified as originating from a country where FGM is practised, including Sudan, Egypt, Somalia, the Gambia and Sierra Leone. This approach deliberately moved the sole focus away from Somali communities, who have recently been at the heart of the FGM safeguarding debate and related research efforts⁶². In this way the research sought to contribute views and experiences from other ethnic communities to the debate.

Table 1: Sampling

Ethnicity	Sample
Somali women	15
Somali men	13
Sudanese women	7
Egyptian woman	1
Gambian man	1
Sierra Leonean man	1
Total	38

Consent

Consent from participants was obtained in both verbal and written form. Throughout the research, participants were also provided with opportunities to ask questions or to seek clarification on any aspect of the research. This interactive consent process created a valuable space for more open discussions and ensured that participants could easily engage with, or end their involvement in, the research at any time. After the interview, participants were offered a 'debrief' to respond to any support needs in relation to issues raised during the research process. All associated travel costs were paid for and refreshments were provided. The participants received gift cards as a gesture of thanks for giving their time to the research project.

Second stage: Interviews with regulated professionals

During the second phase of the research, a total of seven regulated health and social care professionals took part in one-to-one, in-depth interviews. These included a midwife, a school safeguarding lead, a local

councillor, a police detective, and three social workers. The interviews were facilitated by a series of semi-structured questions, which followed a similar format to those used in the interviews with members of the diaspora communities.

Data analysis

The focus groups and interviews were digitally recorded, and the data were then transcribed and analysed using a thematic approach⁶³. To protect the identity of participants, any personal identifying information was removed. The names used in this report are pseudonyms.

Ethical approval and safeguarding

Ethical approval of the research was sponsored by the Ethics and Integrity Committee of the School of Human and Health Sciences at the University of Huddersfield. This preliminary process was completed in advance of data collection. Ethical guidelines were used to develop the research protocol, including the UK Research Integrity Office's checklist for ethics in research⁶⁴, as well as recommendations made by the World Health Organisation⁶⁵. Furthermore, given that FGM is a child protection issue in the UK, we incorporated principles from key child safeguarding documents, including the Department for Education's 'Working Together to Safeguard Children'⁶⁶.

Results

All diaspora participants in our research opposed, and in some cases even advocated against, FGM. They generally welcomed the introduction of policies to protect girls from FGM, and to raise awareness of its negative consequences. Nonetheless, they were unanimously concerned about how the current FGM safeguarding policies had been designed and implemented, and the harms that they may be causing.

The following sections examine the views and lived experiences of the UK's current FGM safeguarding policies and procedures among women, men and young people from Bristol's African diaspora communities and those of statutory professionals tasked with implementing the policies in their line of work. These accounts will first be explored on a policy-by-policy basis to provide an understanding of the way each policy has been implemented and received. We will then go on to look at how these policies, taken as a whole, have impacted community members' lives. Lastly, we make several policy recommendations that could improve current processes and inform the debate on FGM safeguarding efforts.

FGM Mandatory Reporting Duty

Since 2015, regulated professionals in healthcare, social care and education have been under a statutory duty to report *known* cases of FGM among girls under the age of 18 to the police. This duty is known as the FGM Mandatory Reporting Duty. Our study's participants from African diaspora communities had had no direct experience of this particular policy area, but all had heard of it – albeit with a varying degree of knowledge.

In principle, the research participants supported the introduction of the FGM Mandatory Reporting Duty.

They suggested that it would be a deterrent to anyone considering having FGM performed on their daughter, as well as an aid in raising awareness about FGM's consequences: *"People will be more aware of the consequences [...] and that will put them off even thinking of doing FGM."* (Yusra, woman, Sudanese). Many participants also appreciated the existence of a policy ensuring that families who had carried out FGM on their children would face criminal justice, thinking of it as *"a way of holding people to account."* (Adam, man, Sierra Leonean)

That being said, this positive view was considerably mitigated by a clear discomfort with the idea that professionals, such as doctors, midwives or teachers, could go directly to the police without first speaking to the families or conducting a preliminary investigation. Instead, it was felt that police involvement should be considered a last resort, to be used only when there was *"strong evidence"* that FGM had taken place:

► *"It is better to investigate and analyse information thoroughly before they take any action [...]. There is a negative impact [that comes] with reporting the police, for the child and for the family. That's why I think reporting should be like [only] when they are completely confident and sure that the incident is there."* (Yusra, woman, Sudanese)

► *"I would like [them to] make a proper investigation with the family before it goes to the police because there is a lot of misunderstanding around this area. If midwives or teachers think FGM is happening [...], just work it out with the family first before reporting to [the] police. Speak with [the] family before escalating in other ways."*
(Haboon, woman, Somali)

These concerns mainly stemmed from participants' belief that, in Bristol, many of the reports made to the police were considerably influenced by biases against African diaspora communities. The Mandatory Reporting Duty is only supposed to apply when FGM is known to have taken place (e.g. if a girl discloses that she has had FGM, or when there is physical evidence). Yet many participants believed that professionals sometimes reported suspected cases to the police without sufficient evidence, and may *"jump to conclusions because a family is from one of the so-called 'countries where FGM takes place'."* (Maryam, woman, Somali). This perception was often based on instances that they had heard about from other members of their communities. A number of participants also cited the aforementioned Bristol court case (see page 13 of this report), which collapsed due to inconclusive evidence. It was seen as an illustration of how badly the FGM Mandatory Reporting Duty had been handled:

► *"I don't know if you heard [of] the accident that happened here [in Bristol]. Somebody reported a family and then at the end, they didn't [do FGM], they had done nothing to their daughter. They went to high court for something they haven't done. They're reporting it [FGM] without any investigation, any evidence."*
(Nancy, woman, Sudanese)

The fear was that such mistakes could have a devastating impact on families' lives. After a report to the police, a family might be left to face complex legal processes for a crime they had not committed: *"Imagine that you haven't done anything; someone reports you and you end up in a court... all that is stress; all the harassment, the hassle."* (Yusuf, man, Somali). Participants were also disappointed by the apparent lack of support or compensation offered to families who were affected by an erroneous report: *"at the end of the day, [the professional] will tell you:*

'oh, I'm sorry, I was thinking it was FGM'. But you've already put this family in a lot of trouble!" (Hani, woman, Somali). While participants said that they fully recognise that professionals often had the best interests of the child at heart, they argued that authorities could not simply "criminalise" families like this in their efforts to protect children.

Alongside these criticisms, many members of the communities interviewed expressed a great deal of sympathy with the professionals tasked to comply with this duty. Those who fail to report a case of FGM can themselves face an investigation by their regulatory body, and so participants understood the pressure on professionals to report suspected cases. A fear of being penalised was seen to have possibly reinforced bias, and contributed to professionals' errors and overreactions: *"Staff are afraid, afraid. So sometimes they overreact. They believe that sometimes it's better to make a mistake rather than not [to report]."* (Yusuf, man, Somali)

Some participants also argued that professionals were not always provided with enough training to equip them with the expertise needed to carry out their duties effectively. As a result, it was felt, families throughout the communities were at risk of being unfairly reported to the police: *"The professionals need training if this is going to work. Otherwise, families will be at risk."* (Maya, woman, Somali). If professionals were to identify and report FGM properly, they would need to possess enough knowledge of the cultural context of FGM. In the participants' view, most of the professionals were not *"experts in this traditional [cultural practice]"* and *"it is difficult for someone who hasn't got much understanding [of FGM] to report it."* (Maryam, woman, Somali)

Similar concerns over the adequacy of the training received dominated discussions during interviews with professionals. They too appeared to be troubled by the reality that professionals implementing this policy in Bristol did not always have the knowledge needed to report cases of FGM to the police in an adequate manner: *"there are huge problems in the way it [the FGM Mandatory Reporting Duty] is implemented, because there isn't enough understanding for people to be able to report with any sort of good knowledge."* (Local councillor). Some professionals were concerned that reports to the police could in some cases be based on bias rather than real evidence of FGM taking

place. Others pointed out that professionals were often confused about the exact requirements of the FGM Mandatory Reporting Duty. For instance, the police detective interviewed remarked that many of the FGM reports received by their service related to women over the age of 18, rather than to girls under 18.



The FGM Mandatory Reporting Duty singles out FGM, which can be stigmatising for a community.

Police detective

► *“My assessment is that the mandatory reports we get are wrong; they don’t follow the guidance. The reports we tend to see are ‘a female has gone to see her midwife, she’s due to have a baby and she discloses she’s had FGM as a child, many years ago in her country of birth’ [...]. But that’s nothing to do with a child under 18. I don’t think professionals really understand the duty.”*

(Police detective)

Some professionals also advised against making the FGM Mandatory Reporting Duty applicable to all statutory professionals. They said not all of them would have had the same level of training or expertise as safeguarding leads, who they believed were the best equipped to carry out this duty.

► *“It should be a safeguarding professional who has [received] training [who] makes that referral, having obtained all the necessary information. I think [this] would allow us to consider contextual information and ensure a proper assessment has been made, prior to then going down the road of making a phone call [to 101]. [...] Then, parents would not have to be put through this horrific process.”*

(School safeguarding lead)

Without proper training, the professional participants were concerned that the duty could be leading to a “knee-jerk reaction” (Midwife), something which they had themselves observed among their colleagues. They feared the damaging effects that this could have, especially in terms of harming and alienating communities: *“I just worry about alienating, and giving that sense of alienation, criminalisation, to whole sections of the community if [the FGM Mandatory Reporting Duty] is not employed sensitively.”* (Midwife). They suggested that there was a need to equip professionals with better knowledge of FGM - and generally with a deeper cultural awareness - to ensure that the FGM Mandatory Reporting Duty was carried out appropriately. It was broadly felt that the application of the policy would remain problematic, *“unless you are going to do really good awareness[-raising] and education first.”*

(Local councillor)

Besides concerns expressed over the FGM Mandatory Reporting Duty’s current implementation, professionals in the study were generally sceptical of the policy itself. They questioned whether a FGM-specific Mandatory Reporting Duty brought any real benefit to safeguarding efforts, or to the girls that it sought to protect. With the introduction of this duty, they suggested, FGM had been singled out unnecessarily from other forms of child abuse, stigmatising certain communities as a result. They saw distinct advantages in taking a more holistic approach to child safeguarding, and to treating and investigating all forms of child abuse in the same way:

► *“[The FGM Mandatory Reporting Duty] singles out FGM as a particular issue, which can be stigmatising for a community, whereas we should be looking at all forms of abuse, within every community. We should be looking at safeguarding as a whole, and teaching professionals to spot the signs of any abuse, within any family.”*

(Police detective)

► *“[The mandatory reporting duty] is not [found] around an awful lot of other safeguarding issues that are also very serious, but don’t [specifically] impact on BAME communities [...] So, my [opinion] would be: either it’s mandatory reporting of all safeguarding issues that affect children, or it’s not. I don’t really think it’s helpful to have [a reporting duty for] some and not others.”*

(Local councillor)

Some professionals went further, expressing the view that it “*doesn’t make sense*” to require professionals to call the police for cases of FGM but not do the so for other forms of child abuse. They cautioned that this approach could be confusing, as it was “*removing them [the professionals] from the current [safeguarding] processes.*” (School safeguarding lead). The approach was also thought to be potentially dangerous, in that it could alter professionals’ perceptions of the relative severity of different forms of child abuse:

► *“[During training], when you have to say [to the staff] that FGM is a mandatory reporting, and then you come to, say, ‘Child Sexual Exploitation’, and you say that’s not a mandatory reporting, everyone [may] think ‘well, that’s not a serious one then.’”*
(Local councillor)

FGM safeguarding and risk assessments in schools

In 2016, further FGM safeguarding and risk assessment guidelines were introduced to help professionals involved in child protection, including those working in education, identify suspected cases of FGM and assess the risks that it may be performed on young girls. If such a case is identified, professionals are advised to make a referral to their local children’s social services³⁵.

Bristol’s Local Safeguarding Children Board provides several indicators in its guidance to help local professionals decide if such suspicion of FGM, or of the risk of FGM, is well-founded. These indicators include, for example: ‘a child’s mother has undergone FGM’, ‘a girl has frequent urinary, menstrual or stomach problems’, ‘a family is leaving the country for an extended period of time, travelling to an area with a high prevalence of FGM’, and ‘a child confides in another that she is to attend a special occasion’⁶⁷. The guidance cautions professionals against considering any one of these indicators in isolation as sufficient evidence that FGM has been performed or is going to be carried out. Instead, they are advised, upon identifying any of these indicators, to conduct a full risk assessment before making any referral to social services.

Yet the experiences of families with their children’s schools suggested that, in practice, this advice is not

always followed. In some instances, referrals appeared to have been made immediately, based on a single, isolated indicator and without the recommended preliminary risk assessment.

For example, an indicator that had in multiple cases received particular attention from school staff was the request made by parents for an extended summer holiday to take their children on a visit to their country of origin. According to the accounts of several study participants, this request alone appeared to be routinely considered to suggest a risk of FGM being conducted abroad. In many instances, it led to an immediate referral to social services, which was then followed with an intervention by social services and the police.

► *“What happens nowadays is you book to fly a week before the start of the summer holiday. And while the reason you’re doing that is because the tickets are cheaper, if you book [it] one week before [the start of the school holiday], it’s classified as a risk of FGM. The schools say that ‘...they are getting a long holiday, and the reason why they are getting it is probably [that] they want to undertake FGM back home.’ So they call social services, social services call the police [...].”*
(Zakariya, man, Somali)

► *“When children are going on holiday in the summertime, mothers face fear, because the police can call you and say, ‘Okay, you are going on holiday, and you’re going to do this to your daughter.’ The assumption is that you are going on holiday and you are doing FGM to your daughter. It’s really the holiday that you were thinking about.”*
(Asha, woman, Somali)

Some research participants, both from the diaspora communities and among the professionals, were of the view that school staff rarely took the time to conduct a risk assessment prior to making a referral to social services. Instead, they said whenever families planned to travel to Africa for the summer holidays, reports to social services appeared to be made immediately:

► *“Schools are supposed to do their own risk assessment to assess the family - and [to] only refer [them] to social care if they actually pose [a] risk. Nobody cared. Rather than actually looking at*



Schools are supposed to do their own risk assessment. Nobody cared. They just decided that everyone going to Africa should be referred to social care.

Social worker

the documentation, they just decided that everyone going to Africa should be referred to social care.”

(Social worker)

In other instances, there was a sense among the participants from diaspora communities that school staff, once informed of a girl's travel plans, directed a great deal of attention towards her to detect other signs that might confirm their suspicions. For example, with one of the risk indicators listed in the guidance being that 'a girl has confided in another that she is to have a 'special procedure' or to attend a 'special occasion', any mention of a special occasion made by the girl could trigger a report to social services:

► *“Sometimes the kids will go and tell them [at school] the stories we talk about: ‘oh, I’m going on holiday for a ‘special thing’ and, like, ‘we’ll have a big celebration when I go back home’ and straight away, they [the school staff] will think that, maybe, she’s having FGM. We are having big celebrations, things like that and the family will be reported as going to do FGM to the girls.”*
(Dina, woman, Egyptian)

Holiday plans were not the only isolated factors that were enough to prompt suspicion and a referral to social services by school staff. For example, the fact that 'a girl may have frequent urinary... problems' after undergoing FGM is another risk indicator mentioned in the local safeguarding guidance⁶⁷. It appeared that, in some instances, a girl's frequent visits to the toilet had often been thought by school staff to indicate FGM and had triggered reports to social services: *“In schools, if a girl goes to the toilet a few times, they straight*

away jump to FGM, and then teachers report.” (Hodan, woman, Somali). Similarly, Safiya, an anti-FGM advocate from the local Sudanese community, described how a friend of hers, also an anti-FGM advocate, had been contacted by her daughter's school regarding the need for a medical examination of her daughter because she had been visiting the toilet frequently:

► *“I had a friend whose daughter in Year 1 went to the toilet a few times [...] and the teacher called the parent and suspected it [FGM] and [asked] to have their daughter examined. Why would you have your daughter examined? She is just a young girl trying to settle down in the year, and the mother was an [anti-FGM] advocate actually, and she was surprised how the school handled it [...]. Some people really need to be careful how they implement it [the FGM safeguarding guidelines].”*
(Safiya, woman, Sudanese)

The professionals interviewed echoed these concerns. Many reported having seen signs of a biased implementation of FGM safeguarding in schools. They stated that, in their experience, school staff would often bypass the risk assessment protocols and decide to immediately report their suspicions to social services, due to a girl's ethnic origin. For instance, the local councillor interviewed, who worked in education, had found that in the period following the council's regular safeguarding training sessions, they tended to receive *“a whole heap of referrals; half of them would be absolute nonsense, and they would be because somebody is from a particular ethnic minority background.”* (Local councillor). Some professionals also pointed to a seemingly poor understanding of the risk indicators and how to use them, as an underlying reason of these overly hasty referrals: *“There’s a real difference between all [the] agencies about how they assess risk and what they understand risk to be - and how they consider the urgency of that [risk].”* (Police detective)

It cannot be judged, based on our research alone, how common such premature referrals to social services and the police in Bristol schools might be. Some participants suggested that *“it all depends on the area and [the] school”*, with individual schools seeming to differ in their approach to safeguarding. Indeed, it should be noted that although the experiences recounted by participants of safeguarding in schools where overwhelmingly negative, there were also some

accounts of more sensitive encounters – of school staff conducting risk assessment in a sensitive and considerate manner. For example, in the words of one participant:

► *“When I went on holiday, the teacher said: ‘I want to tell you about the [FGM] law’, and I said, ‘I already know and I am not going to do it’ [...]. She was OK and I didn’t find it offensive - and she talked in a polite way.”*

(Rahma, woman, Somali)

In addition to concerns regarding some schools’ apparent bias and non-adherence to the official guidelines, there was a general feeling among many members of the communities that the content of the risk indicators was itself the cause of unwarranted scrutiny and suspicion. Some described the risk indicators as “shocking” and “bewildering”. Others criticised them for containing “grey areas”. For instance, one participant noted that the risk indicator of a girl frequently visiting the toilet, rather than suggesting FGM, “could mean other things, like infections, or [other types of] abuse.” (Saynab, woman, Somali). Another participant was critical of the indicator relating to a child exhibiting withdrawn or quiet behaviour, asking: “how many children go through changes and have bad days?” (Rahma, woman, Somali). It was argued that the vagueness of the risk indicators left them open to interpretation and bias, and could ultimately lead to differentiated treatment of families from certain ethnic communities. They supposed that a girl showing some of these signs would probably be treated very differently if she was white:

► *“If a white girl had all of those indicators, would you consider FGM then? Or this is just for this community? [...] So, unfortunately, it is a type of discrimination [...] because it is about dealing with different communities differently.”*

(Maryam, woman, Somali)

An additional concern was that, as a result of the strong focus on FGM, signs of other health issues could be misinterpreted as indicators of FGM and therefore overlooked. This was thought to have engendered yet another risk facing the girls whom these safeguarding policies have sought to protect.

► *“...if a young girl goes frequently to the toilet, [...] you have a girl who is developing into her adolescence, she could be having her period, she could be going through a lot of other things. If we just say: “the only*

thing she has is FGM”, because of her ethnicity, it actually creates an unhealthy environment for the young girls, because all their other issues have been ignored.”

(Yusuf, man, Somali)

This view was also expressed by some of the professionals in the study, who believed that the unique level of attention given to FGM could well distract some professionals from investigating other forms of harm that a child might be experiencing:

► *“We shouldn’t be looking at a particular family from a particular country and think “FGM”. Because actually, there could be physical abuse, there could be anything. That blinds us to other issues that could be happening. And we jump to a conclusion that it’s a particular type of abuse.”*

(Police detective)

It was generally suspected by participants, particularly those from diaspora communities, that these indicators had perhaps been developed without sufficient consultation or input from the people whose lives they affected. Several participants felt that there had been a “policy rush [...] without taking into consideration the voice of the community” (Yusuf, man, Somali), and that, had the communities been consulted “we wouldn’t be in the situation we are in now.” (Guled, man, Somali)

FGM safeguarding and risk assessments in healthcare

Similar FGM safeguarding procedures and risk assessments are applied in healthcare settings, where they are facilitated by the new FGM Information-Sharing System. This IT system, introduced in 2014, allows healthcare professionals and administrative staff to indicate on a girl’s health record that she is potentially at risk of undergoing FGM. Such an entry is made if, for instance, the girl is born to a mother with FGM. This information thus becomes available for other healthcare staff to access and consider when they are providing care to the girl^{10 68}.

Healthcare staff are encouraged to conduct FGM risk assessments alongside the provision of standard healthcare, notably by having ongoing conversations with mothers and pregnant women

from the communities where FGM is considered prevalent¹². According to the guidelines, they should ask their patient if she has had FGM and then determine the risk that it may be performed on her daughter or her unborn child. Over the course of this conversation, the healthcare professional is also advised to inform the patient that FGM is illegal, to explain its negative health consequences, and to give her leaflets containing additional information about FGM¹². At the same time, however, the guidelines ask professionals to approach these conversations with due sensitivity and without judgement.

Some of the community members interviewed described particularly negative experiences of FGM risk assessments that they had undergone in medical care. These experiences had occurred in a range of different settings, including in antenatal clinics, during appointments with their GPs, and during visits to hospitals' Accident and Emergency departments.

Several women, who were pregnant or had recently given birth, described having to endure repetitive and uncomfortable conversations about FGM with their healthcare professionals. Even during appointments where the purpose was entirely unrelated to FGM, they had been asked to respond to detailed, persistent enquiries about their history of FGM and their intention to perform it on their daughter. These conversations had unfortunately often come at the expense of other important discussions relevant to their pregnancies.

► *"When I had my daughter, when I had her in the hospital and stayed there for about five days, they kept talking to me about FGM until I went off."*
(Dina, woman, Egyptian)

► *"If they just know you are pregnant with a girl, they do this [talk to you about FGM]. Every time. All the appointments. I feel like it is a very big issue in their mind."*
(Filsan, woman, Somali)

While accounts of these experiences mostly came from women in antenatal care, some fathers too had been approached by healthcare staff on the subject of FGM. One participant spoke of his surprise and shock when, during a medical examination of his pregnant wife, he was asked to sign a declaration that he would not have FGM performed on his yet-to-be-born child:

► *"Imagine, my wife was pregnant. Even I didn't know whether the child would be a boy or girl when they gave me a form to sign. I said: 'what is this form?' You know; 'we want you to sign [...] that you are not going to practise FGM'. I said: 'what do you mean by that? I don't have children.' Also, the pressure, I had to sign last time. I signed. These things are putting pressure on the community. The community will be better off without these legislations."*
(Zakariya, man, Somali)

Young parents continued to encounter FGM safeguarding and risk assessments during medical visits once their daughters had been born. During these visits, a particular source of anxiety was the possibility that a physical examination would be carried out on their daughters. The FGM safeguarding guidelines state that 'unless you are already delivering care which includes a genital examination, you should not carry one out'¹⁰. Yet many parents, had heard of cases in which young girls had been subjected to genital examinations unrelated to the purpose of their health visits. These examinations had reportedly occurred in A&E and with GPs at healthcare centres.



When I had my daughter in the hospital, they kept talking to me about FGM until I went off.

Dina, woman, Egyptian

► *"A friend of mine [...], her one-year-old daughter was very sick and she took her to the A&E. The doctors checked everything, and then they turned around and said: 'now we need to check down there'. The mother said: 'why? Why [do] we need to do that? What is wrong with down there?' They told her they were worried about FGM, and whether FGM [had] been performed. The mother told them that culturally FGM is not even performed at that age, but they said they*

needed to check anyway. The mother felt she had no option and she couldn't refuse. Of course, the child was not cut. I am guessing the reason they did that is because that little girl was flagged up [on the FGM Information-Sharing System]. This is the reality and this is how [it is] affecting families every day."

(Maryam, woman, Somali)

Such experiences could be so distressing and uncomfortable that some of the women explained they now *"dread becoming pregnant"* (Maryam, woman, Somali). Likewise, several fathers remorsefully stated that they almost *"wish that they may not even have a girl, because [of] the hassle, [the] complications, [the] lack of understanding."* (Idris, man, Somali)

There was significant concern among the participants from diaspora communities that these safeguarding practices could hurt doctor-patient communication, in turn putting the health of the girls themselves at risk. Participants explained that, in spite of their concerns, they would not feel confident enough to challenge a *"well-spoken professional"*, and that the fear of these safeguarding procedures could be so strong that some parents felt compelled to consider keeping their children at home.

► *"Families have told me that if, for example, their child starts bed-wetting, or has a rash or any other illness that is common with young children, they will think twice before taking that child to [see] a doctor or [to] A&E. [...] Honestly, this is not something I am making up, this is real life. They think, 'if I seek help, social workers will get involved.'"*

(Maryam, woman, Somali)

Similar concerns were raised in discussions with professionals in our study. It was clear that they appreciated how uneasy these experiences could make patients feel. Many pointed out that the necessary levels of sensitivity and care, though stipulated in the guidelines, could not always be applied in practice. The midwife, for instance, explained that medical care staff rarely had the time to have *"proper"* and *"sensitive"* conversations with patients of the kind that the current safeguarding system relied on: *"you know what it's like as a healthcare professional. People don't have time to have conversations."* (Midwife). Another professional, meanwhile, linked this problem to the very nature of medical training, which could lead medical staff to become overly reliant on a 'medical model' of

safeguarding assessment, rather than a more sensitive 'social model': *"[they] don't see the person, [but] see the medical issue", meaning that patients "get asked again and again and again."* (Local councillor)

There was also a wide range of views and doubts expressed, by both professionals and those from communities, about the very premise for using a FGM Information-Sharing System in medical care settings. A few of the diaspora participants welcomed the use of a risk indication system in healthcare, as they felt it could act as a *"preventative measure"* protecting children from FGM. A majority, however, wondered whether the kinds of factors considered could ever reliably indicate a 'potential risk' of FGM. In particular, many expressed concerns and upset about the presumption fundamental in the current system – that girls were necessarily at risk if they were born to mothers with FGM. They believed that there had been a considerable change of attitudes towards FGM among their communities and that these practices were being abandoned. The inference that a girl was definitely at risk simply because her mother had undergone FGM was unfounded in their view.

► *"What do they mean by 'potential risk'? I want to ask you [...]. Is it because the mother has had FGM, so she's definitely going to do it to her daughter? If that's what they mean, [then] they're wrong. Because I had it - I would never do it to my daughter!"*

(Asha, woman, Somali)

► *"They believe that a mum who is affected [by FGM] will affect her child, and this really makes me cross. A lot of families disagree."*

(Haboon, woman, Somali)

► *"I know people who have undergone FGM. Now that they've come here, they will not allow their children to undergo FGM."*

(Adam, man, Sierra Leonean)

Participants also questioned the appropriateness of mentioning this potential risk on a girl's health record. For many, the reality that their daughters could be flagged as potentially at risk on the healthcare system was unsettling, as they felt that their daughters should be treated like other girls. They considered it particularly unfair that from that moment on, girls from their communities would become associated with FGM for every healthcare professional they visited. It was also feared that certain stereotypes could be reinforced by

mentioning the potential risk on a girl's health record. They worried that this would add to the stigma against certain communities and that it could affect how healthcare professionals viewed and interacted with their patients:

► *"I would personally feel uncomfortable with that [...], because that can lead to very negative stereotypes, and if you're meeting a health professional, they might even think of you in a certain way just because you're on that system."*
(Hani, woman, Somali)

The professionals interviewed similarly felt uncomfortable about the stigma that could be created by the FGM Information-Sharing System. While some pointed to the system's potential advantages - saying, for instance, that *"it's got some quite deep and quite nuanced questions around it and is a really valuable tool"* (Midwife) - they were clearly bothered by its potential to be used or interpreted inappropriately. Several professionals stated that a label of 'potential risk' might overshadow the conversation between a healthcare staff and their patient, distracting them from the original purpose of the patient's visit:



You've got this label attached to you on your health records. And so, I've framed the conversation from the outset.

School safeguarding lead

► *"You've got this label attached to you on your health records. And so, whenever somebody meets you, rather than discussing, for example, 'I've got a rash on my leg', if there's a flag that pops up at that point in time [then] I've framed the conversation from the outset and I've put you in a state of mind to have a certain type of discussion."*
(School safeguarding lead)

As in the case of the FGM Mandatory Reporting Duty, there was scepticism here too among some professionals about the need to single out FGM from other forms of child abuse with a dedicated FGM Information-Sharing System. They argued that children were at risk of experiencing a lot of other issues besides FGM and wondered why such a system was devised for FGM but not for other forms of child abuse: *"I don't understand really why you would have this particular risk indicating system, when you don't have a domestic abuse risk indication and for other things."* (Local councillor)

Experiences of FGM safeguarding interventions

Following one of the various FGM safeguarding procedures carried out in schools, medical care and other contexts, a family whose child is considered to be at risk of FGM can sometimes undergo further safeguarding investigations. These can range from home visits by social services and the police, or a requirement to sign declaration forms, to the receipt of an FGM Protection Order.

Home visits

Referrals to social services can sometimes lead to home visits to the family, conducted by the police and social services. These visits are intended for further investigation and assessment of the FGM risk, as well as an opportunity to inform families about child protection laws⁶⁷. Some of our diaspora participants had direct experience of home visits, while others learned of these visits from their close friends. They had generally understood them to be particularly intimidating and distressing experiences.

The participants suggested that home visits usually happened unexpectedly, without prior appointment. In such cases, the home visits clearly went against the Bristol Safeguarding Children's Board's guidance, which instructs social workers to speak with the family on the telephone first prior to arranging a face-to-face home visit⁶⁷. The assessments themselves, meanwhile, were often seemingly conducted with a presumption of guilt. Parents who had experienced home visits described them as tantamount to *"accusations"*, against which

they felt they needed to defend themselves, sometimes even in the presence of their children:

▶ *“You get a visit from the social services and police, and they will come without an appointment, unexpected. [...] it’s not like a social visit, more like an accusation. And then you have to obviously explain to them what your beliefs are and so on.”*
(Maryam, woman, Somali)

▶ *“You haven’t committed a crime. They don’t need to come to your house and make you feel like you’re a criminal in front of your children [...]. A lot of people get stressed because of that.”*
(Safiya, woman, Sudanese)

Moreover, judging by many participants’ accounts, the police and social services did not always seem to take due consideration of the upset and harm that they could be causing during these visits. During one visit, for example, children with no prior knowledge of FGM were lectured about the practice by the police:

▶ *“[The school] reported a family to the children services [because] the family was travelling to Morocco [...]. This family, [who] have three girls, had a visit from the police. To the house. And all the children were called into a room and lectured by a police officer, telling them everything about it [FGM]. That’s exactly what happened. And he [the police officer] belittled the mum in front of them, who have never heard of this [FGM]. He said [to the mother]: ‘we told you now, you should not be performing this.’ And the mother said: ‘I wasn’t planning to do anything, you’re telling my children things that they don’t even know!’”*
(Guled, man, Somali)

A frequent failure to provide support in the form of interpreters during home visits was also seen to contribute substantially to the visits’ distressing nature. Although professionals are advised by the local guidance to ‘always use an interpreter if the family do not understand English’⁶⁷, many participants stated that in practice this had rarely been the case. With no interpreter present, families had been left feeling scared, confused and unable to form an accurate understanding of the situation, or knowing how they should respond. In particular, the participants explained that there was often an acute sense of anxiety and fear among the families that their children might be removed from their care during such visits. Stories

of children being taken away from their families had become deeply rooted in some of the African diaspora communities’ perceptions of social services, in light of a few instances of this actually happening.



You haven’t committed a crime. They don’t need to come to your house and make you feel like you’re a criminal in front of your children.

Safiya, woman, Sudanese

A social worker participating in the study stressed just how great an impact the absence of interpreters during home visits could have. The panic arising from home visits had motivated several families she knew to leave the UK altogether:

▶ *“I think the language barrier is a big issue. If you bring an interpreter from the same language or same country, explaining clearly what’s going on, it’s easy for the family then to understand. But the police and social services come and give details in English. It scares the family [...]. We have cases in Bristol, where people didn’t understand what they [the social services and the police] were looking for - and they just took their children and left the country!”*
(Social worker)

Professionals interviewed understood the fear experienced by some families during home visits. A social worker recounted how upset a mother she knew had been when she received a home visit, having done nothing wrong: *“One lady told me, ‘You know; I wet myself! I wet myself when the social care came to my place! I never expected they would come to my house. And when I saw they were talking to my children, my girls, I was shivering.’”* (Social worker). Other professionals observed that in the current safeguarding approach, the potential negative impact of these home visits on families was unavoidable:

► *“I think it’s really difficult for the family, and I think it’s really distressing. [...] I think sometimes it doesn’t matter how nice of a person you are: the fact that you are there in someone’s house is just too much! And it can never be a positive thing for them [...]. It can have a huge impact on people’s lives.”*

(Police detective)

Indeed, many of the community participants stated that the mere presence of police in their homes would be a considerable source of worry for parents. Police officers arriving on the doorstep and entering a home is quite conspicuous. Whenever it happened, they explained, parents would worry that the home visit might be witnessed by other people in their community, and interpreted as a sign of criminality, or of some other form of wrongdoing.

► *“Without talking to the family, the social services and the police go to their house and expose that to the wider community... It is not good for the family, and it is not good for the little girl. Because people will ask what happened. Because the police don’t normally come [to people’s houses]!”*

(Zakariya, man, Somali)

► *“The complications that the police can cause [...] If they [the community] associate the police with one family, other people of the community will think they are involved with very dodgy things, or that they are involved in [a] very serious criminal offence.”*

(Idris, man, Somali)

The fear of receiving a visit from social services and the police had become ever-present, causing widespread stress and anxiety among parents. One of the social workers starkly summed up this constant, nagging fear by saying families “are scared and worry all the time [...] People do not live in freedom.”

(Social worker).

Signing declarations

Until recently, in accordance with the guidance issued by the Bristol Safeguarding Children’s Board, families were often asked to sign a Written Undertaking during FGM safeguarding home visits⁶⁷. This form required the parents to declare that they understood that FGM was illegal, that they would not subject their daughter

to it, and that they would protect her from anyone who might intend to do so. The Local Safeguarding Children’s Board eventually acknowledged that the form was having a negative impact on the community, and it was discontinued in 2019. Nevertheless, we have decided to present our findings relating to the experiences of this former procedure, both in order to do justice to our participants’ accounts, and to shed light on its impact for learning purposes.

While the Written Undertaking form was still in use, the guidance expressly stated that it ‘should only be used by social services and the police as part of a Multi-Agency assessment’⁶⁷. During our research, however, it became apparent that some professionals had been using this form as part of a standard process for whenever families travelled abroad. Some participants described being asked about the form, not only during home visits, but also by their schools or their GPs who have requested them to sign the form at a police station: “If you are going for holiday, if you have a girl, you have to go [to the police station] and sign these papers.” (Faiza, woman, Sudanese)

Parents, who had done nothing wrong, found themselves in the humiliating position of being in a police station, required to sign those papers. They said the experience made them feel powerless, as if they were being treated as criminals:

► *“When people come out from the police station, a lot of them say they feel like criminals. It was a very uncomfortable feeling [...]. When you are in that environment, when you are in the police station, you kind of feel powerless. [...] and you feel so small sitting there.”*

(Safiya, woman, Sudanese)

Speaking of these experiences often led to strong emotional reactions among participants. Some felt, for instance, that being asked to sign these forms had called into question their standing as good parents: “you feel like you are not a responsible adult”. Many participants were also angry about effectively having to obtain “permission” to travel from the authorities. They asked what right the authorities had to subject them to this level of surveillance:

► “It is none of their business! Why do I need to tell them [the police] where I am going? [...] this is very wrong.”

(Rahma, woman, Somali)

► “You can’t leave the country without permission from the police and I don’t understand why I need to tell them.”

(Hodan, woman, Somali)

This view was also shared by some of the professionals interviewed. They felt that the nature of this approach resembled the treatment of people who had committed a crime: “it must make you feel like a criminal to have to ask the police for permission to travel.” (Police detective)

Protection Orders

FGM Protection Orders are granted by the courts to protect young girls who are thought to be at risk of FGM. These court orders can, for example, instruct a girl’s family to surrender her passport, to prevent her from being taken abroad⁶⁹. None of the community members in the research had direct experience of FGM Protection Orders, but some knew of people who had gone through the process.

They were particularly concerned that FGM Protection Orders might be issued without enough grounds for suspicion. This would leave families with the burden of having to contest the decision, while at the same time having their movement restricted: “they confiscate their passports, they cannot travel [...] they are under watch. If the suspicion is not true, then you damage the whole family.” (Guled, man, Somali). Indeed, several members of the communities had friends who had experienced this exact problem. As well as the fear of losing considerable amounts of money due to cancelled travel plans, the prospect of having to navigate what could sometimes be years of legal processes was a considerable source of anxiety and stress for families.

► “It happened to one of my friends. Her child said she’s going on holiday [and that] she’s going to have a big party. And they took her passport and she went to court. And she was in and out of court for three years, based on just the child’s words. [...] we’ve seen a lot of families, you know, suffering. Families, they spend five

or six thousand [pounds], book the tickets and [then] their passports are taken away for no reason.”

(Dina, woman, Egyptian)

Moreover, families subjected to a protection order lived with the constant fear that further action might be taken against them and their children. Parents would worry endlessly about what might happen after their passports had been confiscated. In particular, they feared that their child might be removed from their care. Several participants suggested that these fears stemmed, in part, from the fact that families did not always receive sufficient support after a protection order was issued:

► “It is really frustrating that we know some families who cannot sleep, who are always looking over their shoulders, [wondering] what’s going to happen tomorrow. [...] if you are going to introduce legislation that will impact communities, you should have support in place. But these FGM protection orders came with no support whatsoever. [...] if those people don’t access support, they are worried all the time about the police coming back. You know: ‘what’s going to happen? Today they took the passport. Will they take the girls away?’”

(Social worker)

The social worker went on to highlight that there was no clear system in place to allow families to retrieve their passports after an FGM Protection Order had been issued. In some cases, this had meant that families had to wait until their daughter turned 18 before recovering their passports.

► “When do you let that family go? There’s no system at the moment [through which] that family could get their passport back, because they’ve been ‘educated’ [about FGM]. This can last until she is 18 years old. I think that’s not good enough.”

(Social worker)

There is currently no data available about the number of FGM Protection Orders granted in Bristol. But the police detective taking part in our research stressed that they were a rare occurrence in comparison to other cities across the UK. This is because the authorities in Bristol acknowledged the gravity of this approach, trying at all costs to avoid it:

► “[In Bristol], we have very few [FGM protection] orders compared to other places in the country [...].

We actually do things a little more sensitively than what happens elsewhere. [...] the judges in our family courts won't let us seize passports. But if you are a child living in London, your passport will be seized by the police until you reach the age of 16-17. So there's a real difference in practice, depending on where you live."

(Police officer)

Operation Limelight

Operation Limelight was launched in 2014. It is a safeguarding intervention carried out at UK airports, aiming to prevent girls from undergoing FGM abroad. The Border Force and police forces focus on passengers travelling to and from countries deemed to be FGM-affected⁷⁰. In practice, this can often involve interviewing parents at the airport to determine if they are travelling with an intention to perform FGM, and sometimes includes inspecting their luggage⁴⁴. Operation Limelight is generally an intensive exercise. For instance, on a single Thursday in 2018, an estimated 500 people were spoken to at Heathrow Airport on their return to the UK from FGM-affected countries⁷¹.

As with encounters of other FGM safeguarding procedures, research participants who had encountered Operation Limelight had found the experience embarrassing and upsetting. Despite having held no intention to carry out FGM on their children, they found themselves stopped and questioned about the purpose of their travel. They felt that they needed to prove themselves innocent and justify their travel to the authorities in a way that no other passengers would be asked to do.

► *"It's like you are a suspect already. You have to explain yourself and make it clear that 'I'm only going for holiday'. If a white person was going on holiday, they don't need to explain all that. I feel like I need to be clear so that they don't think I'm going because of this [FGM]. I haven't seen my family back home for so long, so I have to do more explanation, more elaboration than other communities. Inside, you feel you are a criminal."*

(Filsan, woman, Somali)

What is more, participants who had experienced Operation Limelight suspected that the colour of their skin had likely been the sole basis for singling them out from among the other passengers. This sense of



Our families are scared to go on holiday. They are not free to go anywhere.

Amira, woman, Somali

discrimination was deeply hurtful. A mother from the Somali community, talked about her distress at being singled out from other white passengers travelling to the same destination as follows:

► *"It's so embarrassing [...]. I was travelling to Dubai [...]. I was travelling with my husband and my four children; I have three daughters. I was stopped. When he [the police officer] saw me, he came straight away and he said to me 'can you go to the corner', and I said 'what about the people next to me', and he said 'no, I want you'. They will pick you, because the next one in front of me was a white girl, but he stopped me. I would never do it [FGM] to the girls and I was really cross about this. Why on earth did you not stop the people before me? All these people are going to Dubai. He stopped me there and he questioned me."*

(Hani, woman, Somali)

Another participant recounted the story of his friend, a Somali mother and anti-FGM advocate. He described how she had been stopped and questioned at the airport, and condemned the biased assumption that certain communities intend to carry out FGM:

► *"A friend of mine was travelling and the police stopped her. And she said: 'I advocate against FGM... and you stop me and my child?' Because she is from a Somali background and she's black, you know, you've got colour. So, when you are travelling, they identify you for a reason. They ask you, 'Where are you going?' I hate that presumption. If the person is black or from a minority community, it doesn't mean that they are doing it. You know, FGM. I am at risk. I am likely to be stopped at the airport. Because I'm black and I'm Muslim. Because of that."*

(Idris, man, Somali)

Other participants echoed this resentment and reaffirmed the idea that this targeted approach was discriminatory: *“Why do we have to be stopped at the airport when we are actually just [going] on holiday like anyone else?”* (Safiya, woman, Sudanese). Some went so far as to label Operation Limelight a “racist approach”, *“because how can you actually just target a whole community because of their ethnicity?”* (Yusuf, man, Somali)

Knowing that Operation Limelight might be carried out at the airport, families felt particularly anxious whenever they travelled abroad. Going on holiday invariably prompted a fear of being stopped by the authorities: *“When you are at the airport, you feel, like: ‘I hope they’re not going to stop me!’ You know: that uncomfortable, nervous, stressful moment.”* (Safiya, woman, Sudanese). They said that, in effect, Operation Limelight had taken away their freedom and their right to travel like any other family:

► *“Our families are scared to go on holiday. They are not free to go anywhere. They are asked [about FGM] before they leave and asked when they come back as well. They have been asking lots of questions at [the] airport in summertime. People come back from holidays. Families, Somali families, are in front of the police. ‘Oh you have a little girl, where have you been?’ That is not really nice to us.”* (Amira, woman, Somali)

The reality that Operation Limelight had burdened some families in ways not experienced by the wider UK population was not lost on professionals either. The safeguarding lead at school, for instance, recalled the anxiety many parents showed before travelling: *“Parents are telling me, ‘can I please have one of those leaflets to show that I’ve had a conversation with you? Because I don’t want to be stopped at the airport.’”* (School safeguarding lead). Other professionals noted the damaging effect that this excessive scrutiny could have on the parents’ mental health and on their children:

► *“Every time you want to go somewhere, your plans are going to be scrutinised. If you ever want to go on holiday you are going to think... ‘where am I going and how do I prove I am not going to have this done to my children?’ So, I suppose they are constantly living with it in the back of their minds and it must put pressure*

on them. And they must worry about what impact it has on their children.”

(Police detective)

Impacts of FGM safeguarding

In the previous sections, we have looked at the lived experiences of each FGM safeguarding policy separately. Taken as a whole, however, these policies also have a broader impact on the lives of the families they affect. Many key areas of life can be impacted by FGM safeguarding, from pregnancy and childbirth, interactions with schools, or visits to the doctor to holiday travel. Our presentation of the research findings would therefore be incomplete without looking at the potential cumulative effect that these safeguarding policies and procedures can have on families’ lives, their health and their wellbeing.

Central to the conversations with members of diaspora communities was the persistent feeling of being “suspected” of wrongdoing by the professionals that they encountered across many different areas of life. They repeatedly felt singled out, treated differently or criminalised: *“it feels like everywhere you go, there is a professional to point a finger at you... You know? It’s horrible.”* (Hani, woman, Somali). They felt helpless and frustrated at not being able to do anything to allay these constant suspicions. One participant even joked that their communities *“need to come up with something like a tattoo on the forehead, saying: ‘We won’t do it!’”* (Rahma, woman, Somali)

Participants in the research also repeatedly described the general stigmatisation and discrimination that they felt had characterised the majority of the FGM safeguarding procedures that they encountered. There was a strong sense that, although the safeguarding approaches had been designed to protect young girls, they had instead inadvertently become a basis for targeting, harassment and racial profiling of their communities: *“[the policy] was designed to protect them [the young girls], but it has been used to damage, to harass families, to profile the community, and that is very serious.”* (Yusuf, man, Somali). There was an overwhelming feeling that FGM safeguarding *“had been taken too far”*, and that the community had become the *“real victims”*.

Some of the professionals taking part in the study also emphasised the importance of seeing community members' experiences of FGM safeguarding in the broader context of the everyday racism, stigma and discrimination experienced by African diaspora communities in the UK. One participant noted, for instance, that the increased focus on FGM could have "[given] people ammunition to use it against those communities [...]. And that 'It's important not to fuel further racism.'" (Local councillor)

This general sense of discrimination and inequity throughout daily life appeared to have taken a significant toll on parents' mental health. It had often left them feeling stressed, frustrated and angry:

▶ "Parents are always stressed before going on holiday [...] and mothers are feeling unease during [visits to] antenatal clinics. There is a feeling of being watched, a feeling of not being able to fully parent the way you want to, because you think they will see your actions differently."
(Maryam, woman, Somali)

▶ "A lot of people feel quite vulnerable and upset [...]. You become a very angry person and you want to tell your frustration to someone else. [...] a lot of people are scared, even though they don't have anything in mind, to do FGM on their girls."
(Safiya, woman, Sudanese)

What is more, according to many participants, this negative impact on mental health had, perhaps inevitably, come to affect family life, with the potential to "break a whole family apart" (Hani, woman, Somali). Family cohesion and harmony has come under a great deal of pressure because of FGM safeguarding:

▶ "There is a disruption of harmony and cohesion, and it's very distressing. Sometimes it can lead to a break-up, or to poor child-parent relationships [...]. It can lead to depression, anxiety, and mental health illness."
(Zakariya, man, Somali)

Compounding these difficulties, several participants spoke of the general lack of support available to them when dealing with FGM safeguarding procedures. For instance, in their experience, no support was provided to families who faced suspicion from professionals, or who had to deal with complex legal processes. Nor was any dedicated support available for individuals or

families who might have suffered from mistakes made by healthcare, social care or law enforcement professionals:

▶ "As far as I know, there are no services in place to help families affected. There is no support for the families who have been hindered or intimidated by the officers at the airports, or professionals who did a mistake."
(Idris, man, Somali)

▶ "I don't think there's support for families, for the kids who have gone through the system of being suspected of FGM. I don't think there's support for them."
(Filsan, woman, Somali)

They argued that unless a person or family knew how to defend themselves, or was able to hire lawyers to represent them, the situation was unlikely to improve: "our community, not knowing anything, not knowing the language, they are suffering. They are voiceless. There's no chance for them." (Guled, man, Somali)



It feels like everywhere you go, there is a professional to point a finger at you... You know? It's horrible.

Hani, woman, Somali

Many community members interviewed noted that the irony of the distressing experiences brought on by the new legislation, was that they had long been in the process of abandoning FGM. In some cases, they had even been advocating against it. The fact that they saw themselves as the ones standing up against their extended families and communities to protect their girls made the extra burden of the new legislation even more aggravating:

▶ "They didn't acknowledge [us]. These posh people sit down and say, 'We got this legislation. It [FGM] must stop.' I said: 'Wait - I stopped that way before you!' [...]"

They think they are the ones who are going to help, but they're not. I'm sorry, they're not."

(Asha, woman, Somali)

In this sense, a particular source of resentment for many of the participants was the belief that, despite having been on the frontline in the struggle against FGM since before the policies' introduction, they had not been consulted in their development: *"We try, you know, as a community, to help each other not to do FGM. And when they are making legislations, they never consult the community. They just do it by themselves."* (Omar, man, Somali)



[The policy] was designed to protect young girls. But it has been used to damage, to harass families, to profile the community, and that is very serious!

Yusuf, man, Somali

A further alarming impact of the current policy approach to FGM was the damage that appeared to have been done to the trust and engagement between professionals and the affected communities:

▶ *"[FGM policy] will break down trust and that is what is happening right now."*

(Rahma, woman, Somali)

▶ *"[FGM safeguarding] is destroying the relations between the schools, parents and communities. And it's not just the schools – doctors, midwifery and nurses as well."*

(Guled, man, Somali)

Many of the professionals interviewed were equally concerned about this erosion of trust. They spoke of a real disconnect that was forming with the communities in question as a result of these new measures: *"I think there is this idea of feeling stigmatised or discriminated against, [and] it could lead to [a] breakdown of relationships with professionals, be it healthcare professionals or even teaching."* (School safeguarding lead)

Other professionals emphasised the need to consider the effects of the new FGM safeguarding procedures more broadly, in the context of the many other measures in the UK focussed on these diaspora communities. They expressed their worry that, where the FGM policies contribute to a more general feeling of being stigmatised and targeted, they could result in an unwillingness to engage with professionals and authority more generally:

▶ *"You are at risk of breaking down community relations [...], particularly if certain communities feel like they are always demonised in areas of safeguarding. 'I've got to deal with FGM. Now I have to deal with PREVENT and extremism. My sons are black, so now I've got to deal with [policies targeting] knife crime.' And it's just 'and, and, and, and, and, and...!' So you begin to build this defence system - that 'I don't want to engage with authorities in any way'."*

(School safeguarding lead)

This deterioration of trust and communication has, unfortunately, begun to hinder FGM safeguarding efforts. Social and welfare organisations working directly to support communities have already observed concerning negative effects on their work. Several participating professionals working in this field felt that their existing community engagement and FGM awareness-raising grassroots work had been jeopardised because of the current policies. A social worker in our study explained that members of these diaspora communities had become increasingly cautious around them out of fear that *"the work we do is attracting the police and the social services [...]. They stay away from [us]."* (Social worker)

Policy reflections and recommendations

FGM is a human rights violation, and governments have a responsibility to respect and protect the rights of those who are affected by, or at risk from it. The UK government's goal to end FGM within a generation is to be commended. That being said, the accounts presented in our research suggest that, despite those efforts, the policies enacted since 2014 have inadvertently done considerable harm to families, communities and the girls themselves.

These unintended impacts have in turn had negative implications for the mental health of those affected, while contributing to the alienation of many African diaspora communities, and damaging the trust that existed between them and professionals. Moreover, the alarming scale of these impacts have risked undermining FGM safeguarding efforts altogether.

Our research identified problems both with how the current policies were being implemented on the ground and with the design of the policies themselves. In the following pages, we will reflect on the concerns raised by both members of the diaspora communities and professionals in order to identify opportunities to reassess the current policies.

Improved training for professionals

Many of the issues uncovered in this research suggest that professionals in Bristol may not have been adequately equipped with the training needed to carry out FGM safeguarding duties they have been assigned. The findings raise serious concerns about non-compliance with local guidelines, bias affecting professionals'

decisions and a lack of sensitivity in the application of safeguarding procedures.

For instance, our findings suggest that the FGM Mandatory Reporting Duty may often be initiated based on nothing more than a suspicion, while in other instances, reports made to the police were simply irrelevant. We also heard worrying accounts of an insufficient adherence to safeguarding guidelines in schools, where FGM risk assessments were sometimes bypassed. As a result, families had been referred directly to social services and the police on the basis of isolated and insufficient factors, such as their holiday plans or their daughters' needs to visit the bathroom frequently.

Our research also indicates that FGM safeguarding procedures were not always handled with due sensitivity and care. This notably seemed to be a recurring issue in healthcare settings, where patients reported undergoing uncomfortable, intrusive and overly persistent risk assessments. Moreover, our research participants had heard of girls being subjected to unnecessary and unsanctioned physical examinations to check for signs of FGM during unrelated medical appointments. A similar lack of sensitivity seemed to affect home visits from social services and the

police, which allegedly occurred without appointments and were of an accusatory nature, leaving many families and children feeling distraught.

The research participants felt that a number of factors could sometimes be at play in these cases. They referred to a poor understanding of the guidelines, lack of cultural knowledge, and a huge amount of pressure on professionals to ‘get it right’. Some professional participants pointed to a “knee-jerk” implementation of the policies by some of their peers. The seeming inadequacy of the FGM safeguarding training available to professionals was suggested by professionals and community members alike as a key underlying problem. Many explained that training should be more holistic, not only providing professionals with a better understanding of FGM and safeguarding guidelines, but also countering the influence of bias, and encouraging more sensitive engagement with the communities involved.

Review the approach to FGM safeguarding in medical care

Under the FGM Information-Sharing System, medical professionals are currently required to perform FGM safeguarding routinely as part of their patient care. This system relies heavily upon professionals carrying out their duties with ‘sensitivity and compassion’. Yet the accounts from some professionals taking part in this study suggested that this was often difficult to achieve in practice. Due to the time constraints that are common in their line of work, it was generally felt that medical staff were usually under too much pressure to be able to ensure the appropriate and sensitive conduct of these conversations. In addition, the nature of medical training was seen to contribute to the problem, as it at times led medical staff to see only the medical issues and they would not be sufficiently aware of the wider social context. Safeguarding would thus sometimes boil down to medical professionals asking the same, standardised questions “*again and again and again.*” In the worst cases, these kinds of constraints would lead to an approach to safeguarding that was intrusive, distressing, and harmful to doctor-patient relationships.

Safeguarding approaches for medical settings should be re-examined and adapted, both to make them more

effective in addressing FGM, and also to eliminate potential distress for patients. This area would benefit from further research, including looking at a wider range of accounts, on a national level, both among patients from diaspora communities, and from medical professionals.

Reconsider police involvement in routine FGM safeguarding and risk assessments

All the members of diaspora communities participating in our research acknowledged the gravity of FGM and generally welcomed the introduction of policies aimed at protecting young girls. They largely felt, however, that police involvement should be considered as a last resort, and should only be used when there was “*strong evidence*” that FGM had taken place. All participants worried that police involvement in FGM safeguarding could have a particularly damaging effect on the families involved. Those reported to the police under the FGM Mandatory Reporting Duty could, for instance, become entangled in strenuous unnecessary legal processes. Police home visits, moreover, were described as intimidating and distressing. Participants also took pains to explain that the mere presence of police officers on a family’s doorstep could put the family’s reputation in the community at risk.

These concerns were shared by some of the participating professionals. They described such interventions as having a potentially “*huge impact*” on community members’ lives. Based on these accounts, there appears to be a need to reconsider whether police involvement in routine FGM safeguarding and risk assessments is necessary, and to look into alternative, less heavy-handed approaches that might be more appropriate and effective.

Provide support to families affected by FGM safeguarding

In the view of many of the research participants, the introduction of the new safeguarding policies and procedures were not accompanied by enough efforts to support affected families. For example, families who had been reported under the FGM

Mandatory Reporting Duty, or who had received FGM Protection Orders, were left to deal with complex legal processes without adequate legal, financial or emotional support. Similarly, there were reports of families not being provided with needed language assistance from interpreters during home visits. In general, there was seen to be a widespread lack of support services for families in relation to FGM safeguarding, whether in cases where they had suffered as a result of professional error, or in the course of routine safeguarding interventions, such as Operation Limelight.

Community members' access to legal, financial and emotional support, as relevant to their circumstances, should be considered a fundamental requirement of all FGM safeguarding procedures. Individuals and families should also be informed of their rights in a clear and accessible way when dealing with FGM safeguarding procedures. For instance, they should be provided with interpreters and translated documents, where appropriate. Adequate information on their rights would support communities to feel more empowered in a range of safeguarding situations, as well as help those who have experienced unjustified and unlawful discrimination to take action about it.

Review the national FGM safeguarding risk assessment guidelines

The guidelines underpinning FGM safeguarding procedures were themselves criticised by many participants in the study, especially by those from diaspora communities. Above all, the list of FGM risk indicators that professionals are instructed to consider during their safeguarding work was condemned for containing too many "grey areas". Certain risk indicators, such as 'a child's mother having undergone FGM', 'a child frequently going to the toilet' or a family 'travelling for an extended period to the country of origin', were felt to have prompted unwarranted scrutiny of families who had no intention of subjecting their daughters to FGM. Additionally, the inference that a girl was potentially at risk if her mother had undergone FGM was considered to be out of date and unsubstantiated.

The Bristol Safeguarding Children's Board has already begun to take positive initiative in this regard and has consulted with the city's diaspora communities to launch new, more nuanced risk assessment guidelines. This is a promising step forward, and its effectiveness should be closely monitored. Nevertheless, the issues raised in our findings also call for a full national review of the risk indicators and assessment guidelines currently used across the country.

Review the special policy approach to FGM safeguarding

Beyond an immediate review of the policy implementation, procedures and guidelines outlined above, our research points to a pressing need to entirely reconsider the current, special approach to FGM safeguarding. The decision to give FGM a targeted and far-reaching safeguarding status in 2014 may have helped to raise awareness around FGM in the short run. Yet, in the present research, seven years on, the approach of singling out FGM was identified as problematic by community members and professionals alike, due to its potential to cause more harm than good.

Many of the participants warned that the introduction of a special FGM safeguarding approach could aggravate certain prejudices when considered alongside the broader context of everyday racism, stigma and stereotypes experienced by African diaspora communities in the UK. Compounded by the problem of inadequate training, this targeted national approach was seen to have created an environment of suspicion and even an apparent presumption of guilt of certain communities. For instance, differentiating FGM from other forms of child abuse with a mandatory reporting duty to the police has seemingly led to frequent overreactions and unfounded reporting. Similarly, participants feared that in healthcare, the practice of mentioning a girl's 'potential FGM risk' on her health record would reinforce some healthcare workers' inaccurate stereotypes of certain communities and could have a negative impact on their interactions with patients. Further concerns were raised about Operation Limelight, which appeared to single out many families for questioning based solely on their racial profiles.

Furthermore, there was alarming evidence that the special attention paid to FGM may have inadvertently

harmed young girls. Many participants felt that it had distracted professionals' attention and hindered them from considering or noticing other health or abuse issues that a child might be experiencing. The heavy focus on FGM has at the same time had a damaging effect on the interaction and trust between professionals and communities. Our findings suggest that some community members are now reluctant and afraid to engage with certain professionals, for fear of being scrutinised or reported, even when it comes to matters concerning the health of their children.

Meanwhile, the professionals in our study were sceptical of the value of singling out FGM from among other forms of child abuse with a differentiated safeguarding approach. Several criticised this distinction as confusing and liable to detract from the standard child safeguarding procedures. They also feared that it could alter professionals' perceptions of the relative gravity of different forms of child abuse. The general opinion among them was that child safeguarding as a whole required a holistic approach, in which professionals were trained to spot all potential signs of abuse and to respond in an equitable and appropriate way.

In light of this concerning evidence, we call for a rigorous reassessment of the need to give FGM its current, special status within child safeguarding. This review should notably be centred around the following areas of investigation:

Review of the estimates of FGM risk in the UK

The decision to give FGM a special status within safeguarding policies was originally impelled by estimates that thousands of girls in the UK were at risk of FGM, simply because their mothers had undergone FGM. Yet a growing body of research, of which this study forms a part, suggests that FGM may no longer be practiced on as large a scale as has been assumed until now. This new evidence calls into question the very basis for today's targeted and stringent approach to FGM safeguarding. The statistical estimates on FGM risk must be reviewed and updated, taking into account the changing attitudes and practices regarding FGM in the communities concerned. This review, it is hoped, would provide policymakers, professionals and

communities alike with a more robust representation of the real risk of FGM in the UK today.

Assessment of the effectiveness of the special policy approach

In addition to a review of the estimates of FGM risk in the UK, it is also necessary to conduct a comprehensive national assessment of the effectiveness of an FGM-specific approach to safeguarding. To date, little of the data needed for such an assessment are publicly available, such as data held by local authorities, police forces and healthcare services. In particular, we would welcome the collection and release of more data on the number of FGM cases reported to police under the FGM Mandatory Reporting Duty, and on the outcomes of these reports⁷². In healthcare, similarly, there is a need for data on the number of risk assessments carried out and their outcomes. With regard to FGM Protection Orders, while the number of orders granted in the UK is already published on a quarterly basis, more data should be published on the reasons for which the individual protection orders are granted. Finally, more public data are needed on Operation Limelight. Notwithstanding its receipt of the World Class Policing Award in 2019⁷³, little documentation has been made available showing its effectiveness. These could include, for example, information on the numbers of families intercepted at UK airports and on the number of FGM cases that the operation has potentially prevented.

Safeguarding experiences beyond Bristol

Finally, further research is required to examine the lived experiences of FGM safeguarding among diaspora communities and professionals in other areas of the country besides Bristol. While the insights gained from this research are of national relevance, it is important to note that safeguarding responsibilities are enacted under different local authorities. Their application – and the experiences of those affected by them – may therefore vary considerably at the local level.

Community-centric approach to safeguarding

It is crucial that a community-centric approach is integrated into national FGM policies and prevention efforts. This cannot be limited to awareness-raising work. Rather, the approach should recognise the role that communities themselves play in ending FGM practices, engage them fully in the design and delivery of safeguarding policies, and provide adequate care and support for those affected by FGM practices.

The diaspora communities participating in the research often spoke of their own fight against FGM. Given their efforts to protect their daughters since well before the new policies were enacted, they were angry to have been at the receiving end of sometimes heavy-handed and punitive new measures. Indeed, community engagement efforts have been extremely successful in combating FGM in the past. For instance, the Bristol Model approach, outlined earlier in this report, has successfully mobilised community advocates to spread awareness and resulted in a marked shift in attitudes towards FGM practices⁷⁴. The importance of the community's role in ending FGM has been further emphasised in several other studies^{75 76}. In the present study, professionals and community members alike expressly supported such an approach, advocating for: *“empowering communities, [and] trusting that they can make a difference”* (Social worker)

Likewise, we advocate for an approach in which all future policy reviews are fully informed by community consultation and engagement. Many participants were critical of the development of the

UK's FGM safeguarding policies for what they felt had insufficient input from the people whose lives they concerned. In order to maximise the potential positive impact of FGM policies and ensure they are rooted in cultural nuances, it is important that all future policy reviews are informed by insights from local community members and organisations, and implemented in collaborations with them. This is of especial relevance to the recommendations for improved training and review of safeguarding guidelines and policy approach, already made in this report.

Finally, we call for the suitable provision of care and support to those affected by FGM. Central to the UK's response to FGM is a commitment to adopt a ‘victim-centred approach ... based on a clear understanding of the needs and views of girls and women affected by FGM’⁷⁷. Despite this stated goal, participants in our study felt that far more needed to be done to address these needs. Counselling support for women and girls affected by FGM, and medical services that catered specifically to their needs, were top of the list of services called for by participants. In this context, the Rose Clinic in Bristol was repeatedly mentioned as a positive example of a facility providing medical support for women and girls affected by FGM. The participants noted, in particular, the *“culturally meaningful”* services that the Clinic offered, and the *“sensitivity”* with which those services were provided. Some even went as far as to state that the clinic *“has done way more for the community than these laws.”* (Nawal, woman, Sudanese). More research is needed into the requirements and scope of new services to support women and girls affected by FGM.

Conclusion

Since the 2014 Girl Summit, the legislative changes introduced in the UK to protect girls from FGM have given these practices a special status within child safeguarding. This has justified a swathe of new targeted safeguarding measures. Unfortunately, such a special and far-reaching approach has inadvertently caused a great deal of harm to girls, families and entire communities in Bristol, and potentially across the UK.

Parents and families who held no intention of carrying out FGM on their daughters (and in some cases even campaigned against these practices) faced increased scrutiny, suspicion and stigmatisation in many areas of their lives, from schools and healthcare, to family homes and overseas travel. This had taken a big toll on their health and emotional wellbeing. Moreover, the welfare of young girls had in some cases been undermined, as the increased focus on FGM diverted professionals' attention away from other issues and needs that they were facing. A growing concern among both the diaspora communities and professionals is the damage caused to the trust and engagement between them, as a result of these negative experiences. Paradoxically, these impacts were seen to have ultimately hindered grassroots FGM prevention efforts and possibly undermined the effectiveness of FGM safeguarding overall.

The implications of these findings are alarming. They suggest that the current policies are having a profound impact on key aspects of UK society, from

mental health and access to quality healthcare, to the racism experienced by the African diaspora communities. These harms cannot be ignored, and concerted action is urgently required to mitigate them. Our evidence points to the need to re-examine the targeted approach to FGM safeguarding, grounded in a national assessment of its effectiveness and necessity. The study also presents a powerful opportunity to strengthen the UK's policy response to FGM. Crucially this requires the adoption of a community-centric approach, that recognises the role that communities can, and do, play in eliminating FGM, and involves them in a meaningful way in future policy development and implementation efforts.

It is our sincere hope that, by minimising the harmful impacts that FGM-related interventions cause to girls and their families, the goal of eliminating FGM in the UK within a generation can be more effectively attained.

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