READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF EDUCATION, SOCIAL SERVICES AND HOUSING

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**30 January 2015**	**AGENDA ITEM:**	**12**
TITLE:	**UPDATE ON FEMALE GENITAL MUTILATION**		
LEAD COUNCILLOR:	**CLLRS HOSKIN, EDEN, GAVIN,TERRY**	**PORTFOLIO:**	**Health, Children's Social Care,Adult Social Care, Community Safety**
SERVICE:	**CHILDRENS SOCIAL CARE, PUBLIC HEALTH and ADULT SOCIAL CARE**	**WARDS:**	**BOROUGH WIDE**
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1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

To appraise and update the Health and Wellbeing Board on the current position in Reading in relation to Female Genital Mutilation (FGM). In December 2014, the Thames Valley Police and Crime Panel wrote to the Chair of the Reading Health and Wellbeing Board to request the Board have a regular overview item on the agenda for FGM.

This report sets out the work that is already in place and planned, in respect of FGM, and notes that the Children's Safeguarding Board and Adult Safeguarding Board will develop an action plan. This plan will be scrutinised by the Health and Wellbeing Board in its quality assurance role. The action plan will also be open to scrutiny by the Council's Adult's, Children's and Education Committee (ACE) which leads on health scrutiny for the Council.

2. RECOMMENDED ACTION

2.1	**The Health and Wellbeing Board notes the content of the report and agrees to have a continual annual overview of the Female Genital Mutilation issues in Reading to help tackle FGM.**
2.2	**The Health and Wellbeing Board notes that the Children's Safeguarding Board and the Adult Safeguarding Board will develop an action plan to proactively address FGM in Reading and the Health and Wellbeing Board will have an overview of the action plan.**

3. POLICY CONTEXT

FGM is defined by the World Health Organisation (WHO) as all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.

According to the World Health Organisation , FGM is practiced in up to 28 African countries and in some countries in the Middle East and Asia.

FGM is performed on women and girls at different ages, depending on the community or ethnic group that carries it out, though it is mostly carried out on girls between the ages for 5 and 8 years old. The procedure is traditionally carried out by women with no medical training.

It is recognised that women and girls may also be at risk of having FGM performed on them in the UK, or being taken from the UK to have the procedure performed overseas.

There are a number of different reasons why FGM is performed. The process is often seen as part of the family's culture, it is also seen as a right of passage. FGM is often important for the cultural identity of girls and women and may also impact a sense of pride, a coming of age and a feeling of community. Those girls and women who refuse can often face being ostracised and condemned by their communities. Religion can also be a justification for FGM, though it is practised by both religious and secular communities.

In the UK, FGM tends to occur in areas with large population of FGM practicing communities. The home office has identified girls from Somali, Guinean, Kenyan, Sudanese, Sierra Leonean, Egyptian, Nigerian, Eritrean, Yemeni, Kurdish and Indonesian communities as the most at risk of FGM. These are just some and not all of the communities at risk, however appendix 1 shows a map of known countries where FGM is practiced throughout the world and highlights other vulnerable communities too.

FGM can impact on the health of girls and women both long and short term. Short term health consequences of the practice can include infections, severe pain, emotional and psychological shock. Longer term consequences for women can be severe and wide ranging, including, chronic infections, renal impairment, complications during pregnancy and childbirth, psychological

issues, including depression and post stress-traumatic stress disorder , increased risk of sexually transmitted infections.

4. Background and Progress update on work to date

4.1 Local prevalence

There is an estimate of over 125,000 women in England and Wales to be living with the consequences of FGM, and 60,000 girls born in England and Wales to mothers who have undergone FGM. Locally in Reading we are unable to estimate prevalence of FGM. This is because there are current challenges in breaking down local census data by an individual's country of origin. This data issue is under national review so that estimates of local prevalence can be obtained in the future. Multi Agency Practice Guidelines published in 2011 (HM Government) identified Reading as an area of potential high prevalence of women and girls who might have suffered, or are at risk of suffering, FGM. This is because of the diverse population of Reading.

4.2 Local response

In February 2014 the Designated Nurse Safeguarding for the four CCGs in Berkshire West brought to the attention of the LSCBs, an intercollegiate report published by the Royal College of Midwives (RCM) entitled 'Tackling FGM in the UK'.

The Chair of the LSCBs requested a task and finish group be formed to review the abovementioned report with reference to the three Councils across Berkshire West.

The aim of the group was to scope local statutory responses to FGM and to develop recommendations for action based upon policy recommendations from the RCM document. The action plan contained in the intercollegiate document (attached at appendix 2) was used as a starting point to review the local response to FGM. The RCM report is therefore the starting point in developing a robust multi-agency and community approach to safeguarding children at risk of FGM across Berkshire West.

4.3 Findings from the Task and Finish Group

The LSCB task and finish group has established that across Berkshire West there is some awareness of FGM amongst local agencies and that some agencies are developing good practice to recognise and respond to women who have suffered FGM. The Berkshire LSCBs Child Protection Procedures support practitioners in referring girls at risk of FGM to Children's Social Care Services who then inform Thames Valley Police.

However, there is much still to be done locally. The key policy recommendations contained in the 2013 document are not yet fully addressed locally.

The group was unable to find evidence that routine enquiries about FGM are made across all healthcare settings.

Schools have a crucial part to play in recognising and responding to girls at risk of FGM. Peer support and education within schools will contribute to protecting and preventing girls suffering FGM.

Although individual organisations attempt to raise awareness of FGM there appears to be a lack of a co-ordinated and consistent approach.

A co-ordinated strategic direction is required to progress local developments that will ensure girls living in Berkshire West who might be at risk of FGM are identified and protected. Most successful models of addressing FGM currently existing within the UK are based upon the recognition that tackling FGM warrants a co-ordinated approach, from statutory and voluntary organisations as well as representatives from community groups of those affected.

The task and finish group recommend to the LSCBs that the local response to FGM should be a matter raised at the Health & Wellbeing Boards in order to ensure that addressing FGM is a priority for all agencies. Thereafter, in each of the three areas of Berkshire West quarterly FGM delivery and safeguarding partnership meetings are initiated to include developing policy and practice, awareness- raising, intelligence gathering and sharing and data monitoring. This will require commitment from Directorates of Public Health. It is essential that affected communities are represented from the start.

Without such co-ordinated strategic direction it will be difficult to progress key policy recommendations locally. An action plan is being developed under the LSCB which will require endorsement and input from the Adult Safeguarding Board and the Health and Wellbeing Board. The task group identified a number of actions

- **Update Child Protection procedures**
- **Increased training to improve recognition by the NHS and Social care and Education services of FMG**
- **Closer working with voluntary to improve services for young girls and women who have suffered FMG or are at risk of FMG**
- **Improved data collection**

- **Informed commissioning of local services for women and girls who have suffered, or might be at risk of suffering, FGM.**

- **Improved information and awareness of FMG in the communty**

4.4 Actions taken to date

Since April 2014 all NHS hospitals are required to record:

• If a patient has had Female Genital Mutilation
• If there is a family history of Female Genital Mutilation
• If a Female Genital Mutilation-related procedure has been carried out on a patient.

From September 2014 all acute hospitals are required to submit this data centrally to the Department of Health on a monthly basis. This is the first stage of a wider ranging programme of work in development to improve the way in which the NHS will respond to the health needs of girls and women who have suffered FGM and actively support prevention.

The child protection procedures were amended in June 2014 to reflect the 2013 intercollegiate document .

The Royal Berkshire Hospital NHS Foundation Trust (RBH) has encompassed routine questioning about FGM into all pregnancy bookings. Guidelines for midwives including a referral flowchart for midwives, following identification of pregnant women who have suffered FGM, have been developed for use within midwifery services.

A form adopted from the Bolton FGM Assessment Tool, has been developed at RBH to be used to support referrals to Children's Social Care Services. The form is currently being reviewed within RBH internal governance processes.

There is also a wealth of online resources. The Home Office has recently circulated free web based training. This has been advertised within individual agencies. National conferences specific to FGM are available but it is apparent that information about FGM is not currently contained in the LSCBs training programme. There is an opportunity here to provide information on FGM through level 1 and 2 domestic abuse training and via adult safeguarding training for wider coverage.

One member of the task and finish group met with representatives from two community groups in Reading, ACRE (Alliance for Cohesion and Racial Equality) and Utilivu Woman's Group, to learn more about their response to FGM.

Addressing FGM is seen as a priority within both of these organisations who have emerged as key partners in addressing the issue with those affected.
It has not been possible to locate representatives from affected groups or community based groups in Wokingham or West Berkshire.

4.5 Recommendations to the Children's and Adults Safeguarding Boards

The recommendations below will form the basis of the action plan drawn up by the two Boards

- Further clarity is required for frontline practitioners about the need to refer all female children in cultures where FGM is known to be practised to Children's Social Care Services. This must be done with respect and sensitivity to enable a professional assessment of risk to female children within that family.

- It is recommended that recognition and response to FGM is included in the LSCB training programme.

- It is apparent that whilst FGM is recognised within RBH maternity services, there is potential to increase recognition and response throughout other departments within the hospital. In particular, key clinical environments such as Urology, Gynaecology and the Emergency Department.

- There are opportunities for health care professionals to make sensitive enquiries about FGM at every contact with patients. Healthcare professionals need to follow the **'one chance rule'.** This states that the attending professional may only have one chance to speak to the victim and prevent future harm. Health visitors may visit homes of children and women affected by FGM. This gives them an opportunity to follow the 'One Chance ' rule. There is also an opportunity for FGM issues to be picked up in General Practice settings and for appropriate referral for example to domestic abuse services/interventions.

- Leaflets containing information about FGM and additional resources for help and support should be developed and made available within professional and community settings. This literature should be made available in a range of languages. This will require a commitment for funding.

- There is an opportunity here for school nurses to follow the 'One Chance' rule and identify young girls who may have undergone FGM or

are at future risk of FGM. In addition, other staff members from partner agencies such as Berkshire Women's Association, Children's Action Team and youth workers could be trained to pick up on issues around FGM and relay this knowledge and information to help onward referral where appropriate. There will be a further opportunity for to improve service when the council take over the role of commissioning school nurses

- The RBH is not currently listed on NHS Choices as a hospital where services for women who have suffered FGM, can be accessed. This is likely to be because there is not a specific FGM clinic at RBH and which is offered in some London hospitals. This is an issue for consideration by CCGs as commissioners of local health services, and also Directors of Public Health.

- Amendments are made to section 5 of the Berkshire LSCBs Child Protection Procedures.

- Training courses to raise awareness about FGM is made available through the LSCBs training group.

- Sources of funding are explored to progress the development of literature explaining about the consequences of FGM. Such literature needs to be available in a variety of relevant languages.

The group recommend emulating the 'Bristol Model' to address the issues relating to FGM. Key components of this approach include:

- ✓ The empowerment of affected communities utilising an educative approach
- ✓ Collective ownership – commitment from all key stakeholders
- ✓ A strategic overview Plans are in place to link in with the Domestic Abuse strategy Group (DASG) in early February . Service development and commissioning of support services eg. specialist FGM clinics for women and girls who have suffered FGM can be referred or self- refer, for discussion about surgical interventions and where psychological support can be made available.
- ✓ Training and resource development – websites, guidelines, lesson plans and leaflets to support learning and campaigning

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 This work is aligned with the strategic priorities of Reading Borough Council and the Reading Health and Wellbeing Strategy 2013-16.

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 Most successful models of addressing FGM currently existing within the UK are based upon the recognition that tackling FGM warrants a co-ordinated approach, from statutory and voluntary organisations as well as representatives from community groups of those affected.

7. LEGAL IMPLICATIONS

7.1 FGM is illegal in the UK. It's also illegal to take a British national or permanent resident abroad for FGM or to help someone trying to do this. FGM has been illegal in the UK for decades, it is only now that agencies are starting to openly talk about the practice, what it involves, the reasons some communities carry it out, and how we can work together towards eliminating it.

Prohibition of Female Circumcision Act 1985
Female Genital Mutilation (FGM) has been a specific criminal offence since 1985, with the introduction of the Prohibition of Female Circumcision Act 1985. However a 'loophole' was identified in the legislation, in that taking girls who were settled in the UK abroad for FGM was not a criminal offence. It is this 'loophole' that the Female Genital Mutilation Act 2003 ('the Act') intended to close.

Female Genital Mutilation Act 2003
The Act was brought into force on 3 March 2004 by the Female Genital Mutilation Act 2003 (Commencement) Order 2004. The provisions of the Act only apply to offences committed on or after the date of commencement. For offences committed before 3 March 2004 the Prohibition of Female Circumcision 1985, as re-enacted in the Female Genital Mutilation Act 2003, continues to apply.

The Act affirms that it is illegal for FGM to be performed, and that it is also an offence for UK nationals or permanent UK residents to carry out, or aid, abet, counsel or procure the carrying out of FGM abroad on a UK national or permanent UK resident, even in countries where the practice is legal.

8. FINANCIAL IMPLICATIONS

8.1 These need to be determined

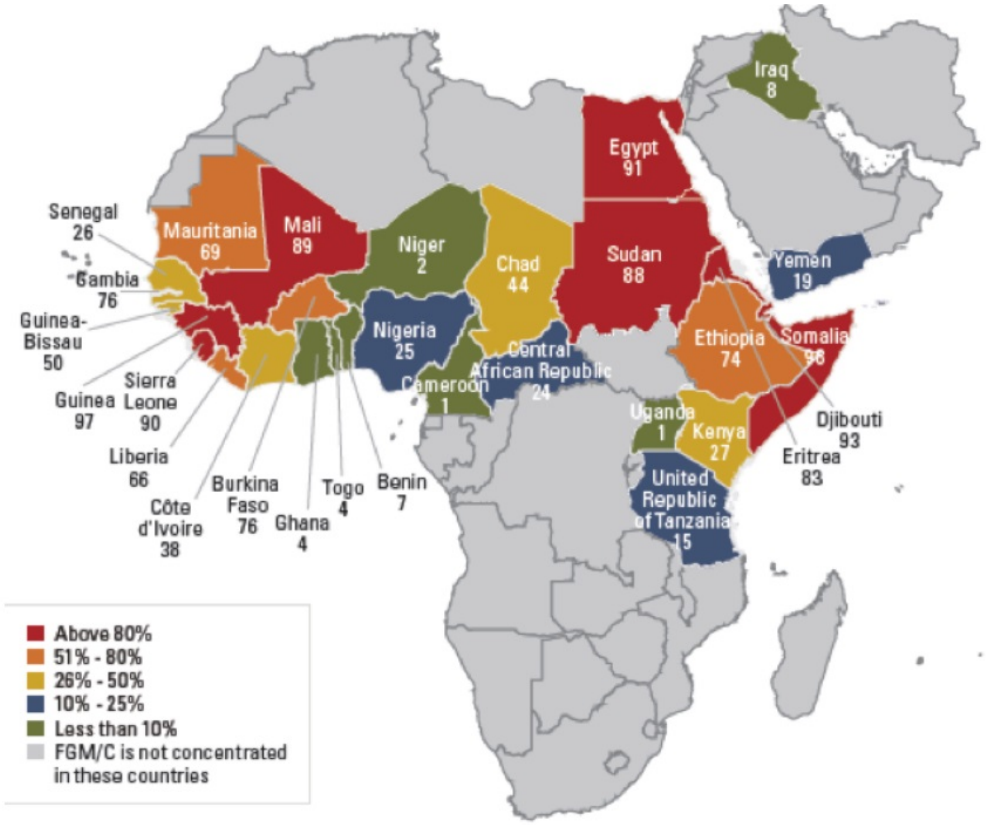
Background papers

- RCM, RCN, RCOG, Equality Now,
- UNITE (2013) Tackling FGM in the UK:

- Intercollegiate Recommendations for Identifying, Recording and Reporting. London: Royal College of Midwives. (Available at www.rcm.org.uk)
- HM Government (2011) Multi-Agency Practice Guidelines:
- Female Genital Mutilation. (Available at www.gov.uk)
- Berkshire Local Safeguarding Children Boards Child Protection Procedures. (Available at http://berks.proceduresonline.com/index.htm)

- Crown Prosecution Services website: http://www.cps.gov.uk/legal/d_to_g/female_genital_mutilation/#legislation

Appendix 1.



Source: UNICEF (July 2013), global databases based on data from Multiple Indicator Cluster Survey, Demographic and Health Survey and other national surveys, 1997–2012.

Appendix 2 Key Policies Recommendations (contained in Tackling FGM in the UK 2013)

Target Audience	Policy Recommendations/Rationale	Expectations of Action to carry out recommendation	Berkshire West Progress
All Agencies	**Treat FGM as Child Abuse** and integrate it into to all safeguarding procedures across the 4 countries of the UK (England, Northern Ireland, Scotland and Wales) outlined in Working Together to Safeguard Children (2013) (England), Co-operating to Safeguard Children (2010) (Northern Ireland), Child Protection in Scotland (2010) (Scotland) and All Wales Child Protection procedures (2008)	• NICE should revise their guidance on 'When to suspect Child Maltreatment' (Clinical Guidance CG89) to include FGM. • Girls born to mothers who have had FGM should be considered at risk of significant harm. They require monitoring through the child protection system until they are at an age when they can speak about FGM and are able to seek protection for themselves. • Lead Social Work agencies should urgently work to revise and clarify referral thresholds when risk of FGM is a concern or suspicion, including conducting assessments and monitoring of the child at risk. Referral pathways must be developed so that all health and social care agencies are aware of their respective roles and responsibilities.	Berkshire LSCBs Child Protection Procedures updated July 2014. Suggested amendment to be made to Policy and Procedure Group. When agreed, accompanying flow chart to be incorporated. Need to develop generic risk assessment tool. RBH have developed one for use in maternity services.
NHS	**Document and collect information on FGM and its associated complications in a consistent and rigorous way:** Good documentation is important for planning and commissioning services on FGM, providing quality care for girls and women affected, for research and for monitoring trends of FGM in the UK.	• The Health and Social Care Information centre should develop specifications to code FGM in hospital episode statistics and in maternity and child health datasets. • Every woman from practicing community who books for maternity care should be asked in a sensitive manner about FGM and the discussion recorded in paper based and electronic records, to include action taken or referral to the appropriate professional. • All new patient registrations in primary and secondary care, including A&E of young girls/women, should include detailed enquiry about country of origin. If the family is from FGM practicing community, document any presence of FGM to establish	Since September 2014 RBH submit monthly returns re FGM to DH. Routine questioning about FGM at all antenatal bookings. Guidelines and referral flowchart for pregnant women developed and

		a baseline for monitoring and sharing information with relevant agencies. • This information should be captured at all pregnancy bookings • The Royal College of Paediatrics and Child Health (RCPCH) should update the specifications for the 'Personal Child Health Record' (the Red Book) to include a code for the mother having FGM. This should include FGM in the electronic 'Red Book' (Personal Child Health Record) • Health practitioners in maternity services should ensure FGM is coded in electronic records and information shared with child health teams. • Adequate language translation services are required in areas of high prevalence.	implemented for midwives to use at RBH. Midwives record risk of FGM in maternity discharge records that are sent to GPs and Health Visitors. RBH staff have access to interpreter services via Prestige Network. Information Sharing processes re FGM requires further exploration and development. PCHR is not currently used to document risk of FGM.
Health, Social Care, education and the Police	**Share information on FGM systematically:** There is a need to develop information sharing protocols between health, the police and other relevant agencies such as social care and education.	• The NHS should develop protocols for sharing information about girls at risk – or girls who have already undergone FGM with other health and social care agencies, the Department for Education and the police. • These protocols should be based on national guidance and should regularly be reviewed for their effectiveness by public health directors and GP commissioners.	Information sharing processes re FGM requires further exploration and development.
Healthcare Professionals	**Develop the competence, knowledge and awareness of frontline health professionals to ensure prevention and girls' protection of girls at risk of FGM:**	• Health and Social Care staff must work to the WHO guidelines for nurses and midwives, the UK multi-agency practice guidelines and CPS legal guidance. www.who.int/reproductivehealth/publications/fgm/en/index.html • On the opening and re-suturing of women with Type III FGM, WHO	FGM guidelines in place at RBH. FGM awareness incorporated in ingle

	Ensure that health professional know how to provide quality care for girls who suffer complications of FGM.	guidelines should be followed. Guidelines can be accessed from the WHO website as follows: www.who.int/reproductivehealth/publications/maternal_perinatal_health/RHR_01_03/en/index.html • Refer all women identified with FGM for support and further medical and psychological assessment as appropriate. This must be done very sensitively. • A multi-agency and multi-professional approach should include the Medical Royal Colleges, professional organisations and trade unions for incorporating FGM into pre-registration education/undergraduate level training and continue professional development appropriate to the individuals' levels of responsibility and accountability. This should include a mix of face to face and the development of e-learning resources on FGM, which all relevant frontline professionals can access. • A lead agency should be involved in producing e-learning materials for healthcare and other practitioners. This agency should inv9olve the main health professional bodies such as the relevant medical royal colleges and health trade unions in developing training materials. • High quality information on the effects of FGM (health, psychological and rights-based) should be provided to all women identified as having FGM. • Healthcare practitioners need to consider the needs of both the future child as well as any other female children who may already be born or resident in the household with the woman. • Healthcare practitioners need to follow the 'one chance' rule. This states that the attending professional may only have one chance to speak to the victim and prevent future harm.	agency safeguarding children training. Access to Home Office FGM e-learning course circulated to the LSCB Training Group with the request to consider provision of multi-agency training about FGM. RBH has developed a leaflet for pregnant women. BHFT have developed a leaflet about diversity and cultural norms.
Health, Social Care, Education and	**Identify girls at risk and refer them as part of the safeguarding children obligation:**	• Professionals should identify girls at risk of FGM as early as possible. All suspected cases should be referred as part of existing child safeguarding obligations. Sustained information and support should	Incorporated in Berkshire LSCBs Child Protection procedures.

the Police	Early identification of risks of FGM to girls, referral, planned and sustained information and support to families are needed to protect girls from undergoing FGM.	be given to families to protect girls at risk. • In cases where FGM is identified in a woman who presents at maternity services, the implications for the woman and her future child should be discussed by the midwife or doctor and a clear plan of action including communication with relevant agencies detailed in paper and electronic records. • Professionals should refer all women identified as having undergone FGM who give birth the female children to the Multi-Agency Safeguarding Hub (MASH) for discussion and review. A home visit should be made by social services and further information on the law on FGM and support provided to women. This has been tried in Waltham Forest before the FGM Services closed down. Such visits have been welcomed by women. • It is important to share this information with the GP, the health visitor, school nurse and safeguarding leads in Schools so that they can engage in continuous dialogue and provide information to parents about illegality of FGM and monitor girls at risk. • Health practitioners offering travel vaccinations to children from practising communities for travel to countries where FGM is prevalent must be sensitive to the possible risk of FGM. • Girls from FGM practising communities who are put on child protection registers for other forms of abuse and those who come into contact with youth offending teams and CAMHS should be asked about their risk or experiences of FGM by trained professionals. • All responsible agencies should promote and sign post at risk girls and women to age appropriate information and support services such as the NSPCC helpline and specialist FGM clinics. • Refer all girls and women identified with FGM for support and further medical and psychological assessment as appropriate. Referral pathways must be developed so that all health and social care agencies are aware of their respective roles and	RBH have developed a flow chart to support decision making and referral. Midwives inform health visitors and GPs of pregnant women who have suffered FGM.

		responsibilities.	
All Agencies	**All girls and women presenting with FGM within the NHS must be considered as potential victims of crime and should be referred to the police and support services.** FGM is illegal in the UK. All professionals to be aware of the FGM Act (2003) and able to act on cases of FGM where a crime has been committed. All girls and women who were UK residents since March 2004 and have had FGM are victims of crime, with rights to redress, regardless of whether FGM was committed in the UK or abroad.	Protocols for information sharing between health, the police and other relevant agencies such as social care and education should be developed. These protocols should be based on national guidance and should regularly be reviewed for their effectiveness by public health directors and GP commissioners.	Requires further development. Currently referrals are made to CSC who then convenes a strategy meeting with the police.
Local Authorities, Service Commissioners and Social Services	**The NHS and local authorities should systematically measure the performance of frontline health professionals against agreed standards for addressing FGM and publish outcomes to monitor progress of implementing these recommendations.** Directors of Public Health, Health and wellbeing Board and Clinical Commissioning Groups to consider the needs of people affected by FGM with Joint Strategic Needs	• Directors of Public Health, Directors of Social Care and Children's Services, Clinical Commissioning Groups, Health and Wellbeing Boards should include FGM in the Strategic Needs Assessments (JSNA) and Violence against Women and Children strategies. • JSNAs should inform preventative strategies led by the Local Safeguarding Children Boards in collaborations with the local authority and Health and Wellbeing Boards. • In the absence of local prevalence data, local authorities to use socio-demographic data; e.g. Primary Level Annual Schools Census (PLASC), to map communities affected by FGM in their local area, and to plan for services to meet those needs. • In all areas, training on FGM should be integrated into all safeguarding training conducted by LSCBs. • Practitioners should be aware of their role in prevention during the	Refer to Health and wellbeing Boards

	Assessment (JSNA) and local strategies (e.g. Violence against Women and Girls strategies) particularly in areas where communities affected by FGM reside. Local Safeguarding Children Boards should be charged with leading a preventative response to FGM, including ensuring that information on girls at-risk is shared across health, social care and education with information sharing protocols based on national guidance, and regular reviews of how information is shared and used. Practitioners should refer all women from FGM affected communities who have had FGM and who have female children to the Multi-Agency Safeguarding Hub (MASH) for discussion, review and assessment	life-course of the girl at risk and be able to sensitively discuss FGM and prevention of harm with them. • In areas with high densities of communities affected by FGM, preventions should be explicit in local child protection policies. • LSCBs should publish and share their strategies in high density areas. • Preventative agendas should consider the need for empowering girls at risk to prevent harm, as well as support services for those affected by FGM. • The NSPCCs dedicated FGM helpline service is promoted across all settings, including health, social care and education as a resource for practitioners with concerns and girls at risk to claim their rights to protection. • Some practitioners – teachers, school nurses, GPs – are well placed to talk with girls at risk about prevention of harm. LSCBs should support such interventions. • Strategies for early identification of girls at risk should be put in place: At national level – health, Social Care and education performance in these areas should be monitored against the CQC and Ofsted inspections regime which are published. At local level – Develop FGM into quality standards for commissioning, by which health and social care institutions/service providers can be judged.	
UK departments for education	**Empowering and supporting affected girls and young women should be a priority consideration.** Many girls are too young to understand the implications of	• In areas where affected communities reside, schools should explicitly include discussions and information on FGM within Personal, Social and Health Education (PSHE) curriculum. Teachers, School Nurses, Health Visitors, Counsellors and Safeguarding Leads in schools should provide time for 1:1 conversations and information	Refer to Schools

	FGM for them. Young people may support FGM because they lack fact about it.	to girls from practising communities. These could be integrated into other messages (MSPCC Pants Campaign), encouraging girls and young women to report harm such as in the preventions of physical and sexual abuse. Young people should be signposted to the MSPCC FGM Helpline on 0800 028 3550 for advice, information and counselling.	
Home Office, UK Public Health Authorities and Social Services	**Develop and implement national public health and legal awareness campaigns in FGM, similar to previous campaigns on domestic abuse and HIV.** Current information provision about the health consequences is not reaching the affected communities and the general public is not aware of the illegality of FGM. There is support for stringer and effective action by the governments, particularly among young women from affected communities, who want to see the practice stopped.	Well-designed public health and legal awareness campaign about FG<, targeted at women and girls from at risk communities about the health and legal implications of FGM. These campaigns should also emphasise to the general public that FGM is illegal in the UK, a message endorsed by key professional organisation and NGOs.	