BACCH Trainees' National Study Morning Child Sexual Abuse-20260323_105109-Meeting Transcript

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Emma Grindrod started transcription

ALI, Sakaria (UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST) 2:52

Then I'll talk about the child and young person presenting with FTCM, really from a, not from a clinical perspective, but from an approach, a policy approach, as well as what happens in the community. And then we will move on to discuss the legal legislation and the legal remedies in the UK.

with a particular focus on England and Wales. Okay, so I think most of you will have come across the WHO definition of FGM, which means that it comprises all procedures involving partial or total removal of the female genitalia and any injury to the female genital organs, whether it is for cultural or non-therapeutic.

reasons. So this is a fairly broad definition and we looked at it over the past five years and published last year the most up-to-date WHO guidance on this and the definition is one thing that has stayed the same.

The classification from the WHO talks about four different classifications. And this is again something that you may have come across. So there's type one, type 2, type 3.

Ruth Huey 4:05

Grocery list.

ALI, Sakaria (UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST) 4:12

Could I ask that everybody mute themselves? Fantastic. And type one, two and three have essentially stayed the same, but there's been type 4 that's been discussed and that has been brought out to really include all non-medical procedures that includes pricking,

piercing, cutting, but also elongation of the labia, which happens in parts of Rwanda and Uganda. And there is different countries will consider labiaplasty also a type of FGN. We are increasingly moving towards that in the UK. So if you hear of

Ruth Huey 4:51
Okay.

ALI, Sakaria (UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST) 4:52
any cosmetic procedures in children and young people under the age of 18, then that should be considered FGM in the UK. And you would have to see them as per all other types of FGM.
The main challenges and discussions have really been around which terminology to use. So we have had in our clinic a lot of young people who've said that they don't feel that their body is mutilated, but they would say that their genitals have been cut. So they would prefer the neutral term such as female genital cutting.
There is also the legal aspect of what mutilation, what is considered from a legal perspective mutilation, and as a result, we've moved to FGCN. There's been a lot of criticism from, particularly from academics, who've talked about FGM as being imprecise and that it's ethnocentric.
in that it really focuses on the global South. But whereas if you have any genital procedures that are non-medical in the global North, then that would not be considered FGM. And there have been cases in Sweden where young people who have gone for medical tourism for cosmetic procedures, those who came from FG. and affected communities were treated differently. And that's been criticized. And then there's been the suggestion that it is imprecise. And this has really kind of been still an academic issue, but from a legal perspective, all of these procedures would be classed as FGM.
in the UK.
It is also very widely practiced. I mean, this map really shows you that it's not a phenomenon that is specific to Africa. You will see that 230 million women and girls are affected in many countries, so more than 30 countries. Of that, more than 80 million are in Asia.
more than 6 million are in the Middle East, but it also stretches as far as Russia, where there is a significant community in the Caucasus, in Dagestan. We see it in certain communities in India, but we also see it in Kurdistan, Iraq, Saudi Arabia.
So I think when we're thinking about this practice, we really need to be fairly open-minded in terms of where a young person may come from. And we need to think

about communities rather than countries, because there are many communities that are not national and are transnational and that the
practises acts on that particular community rather than country. So for example, I mean the Fulani in or the Hausa in northern Nigeria, they are affected. There are certain communities of the Yoruba community in Nigeria that will practise it. And then there are other communities that won't in Nigeria. So
To suggest, therefore, that Nigeria has a significant number of children and young people who are at risk isn't limited to that particular country, but you have to really go into the details of which community we're thinking about.
And we also know that the vast majority of FGCM is carried out under the age of five. Increasingly, we're seeing significant medicalization of it, so it being done in early infancy, particularly in Malaysia and Indonesia, where more than 80% of girls have it, and they tend to have what's called the
sunna, which is the pricking of the ********, and that would be considered type 4. And that generally happens within the first month of life. And a lot of those communities would not consider that they have had FGM, but actually in the UK we would. And there have been a number of cases recently where
communities from the Boro community in India, Malaysia and Indonesia have been found to have.
possibly have committed FGM. I mean, those cases are still ongoing. In other parts of the world, so in Eritrea, in Mali, in Nigeria, we know that it happens in early infancy rather than just in the Neonatal period. And then as you go to West Africa, so in Sierra Leone, there are communities that practise as a rite of passage into womanhood.
So that tends to be correlated around menarche and when a girl is going into puberty is when FGM is considered.
Increasingly, we're seeing medicalization of it, particularly in the middle classes in the global South. We know that there is a significant increase of doctors and midwives in Egypt, for example, who practise it in a clinical setting. And there is a trend away from
the traditional practises of this FGCM practice, which was it happening in the rural communities being done by traditional practitioners rather than medical and nursing professionals, and that it was being done in a group, sort of a
a group of girls having it all done in the home setting. Increasingly what we're seeing is parents will say, oh, we would prefer the type 4 because that's the least harmful,

but we believe in the practise and therefore we will get it done by a medical professional. This is obviously very problematic and
At an international level, we're seeing really a significant shift to the medicalization of this practice.
When we also think about the topic of FGM, a lot of communities and families will not recognise the term. So the term FGM is very Western, it's very medical, but people might say, I have had female circumcision done. They might use local terms and traditional terms, so they may say good mean,
or in Somali, they may say or in Sudan in Arabic. So it's important to think about what local terms people use. So an approach to take might be that you ask, are you from a community that's affected by female genital cutting?
Do you know what I mean by that? Do you understand what cutting is? Have you heard of it? And then really having a conversation about what terminology the family and the young person may feel comfortable using, rather than saying, have you had female genital mutilation? Have you been mutilated? Or have you had FGM? Which FGM may mean
very little to people and they may say no, but if you asked a specific local term or a term that's simple English, they may well understand it. So I think this is something, particularly as doctors, we have to bear in mind. This particular
Table comes from the safeguarding.
guidance from Northern Ireland. I find it incredibly helpful and they've actually produced quite a lot of helpful work and this particular, you know, I'll share the link with you. Guidance is a very helpful guidance to read.
In terms of the beliefs and the misconceptions, there are a number of beliefs and they really range from one community to another. There is the idea of a rite of passage into womanhood, as I mentioned, and what is deemed to be socially acceptable, idea of femininity and what it means to be a woman.
and therefore people may feel that it's a social obligation, an obligation to the girl, but as well as an obligation to the community. In order to be part of that particular community, you must have gone through this particular rite of passage. We also see it as an idea of readiness for marriage,
You might see that in the Kurdish community, for example. So it may be done just before puberty to ensure that a girl is going into adulthood and that therefore the cutting and particularly infibrillation and the bleeding
on the marital bed is then a sign of a girl who's been, who has essentially is a virgin

and is therefore married and is having sexual intercourse for the first time. Other communities and particularly East Africa, so I mean in Tanzania,
Kenya, Uganda, there is the idea that the ******** is a male appendage and that there's a sense of a fear of it affecting what it means to be feminine. And therefore, the removal of the ******** means that you're going into your femininity.
And then there are the nomadic and pastoral communities where FGM may be done in order to suppress sexual desire and in order to purify the body. And this, again, is linked both ideas around religion, but also cultural ideas. And these are really interlinked and it's quite hard to separate.
Rate one from the other.
And lastly, we know that it's done for the marital wants and material wants. So the sense of purifying your body, having ownership of what your body looks like.
There are certain factors that influence the practice. So what we know to be protective factors is women who discuss it with husbands and male friends and men who have been with women who have not had FGCM or who have heard of
where there's been a conversation amongst men, generally there is sort of a trend against the practice. Knowing what the law is in the community and in the country that you live in is very important. If you have been exposed to TV and media and the global debate around anti-FGM campaigns,
then that is a protective factor. And if a mother knows an uncut person who has not had FGCN, then they are able to discuss the idea of what it means to be a woman who has not been cut. The risk factors generally tend to be a very isolated mother, particularly if there is a very dominant or patron matriarch or a grandmother who's very influential, if they have very little information or understanding of the law in the UK, or if FGN is a taboo subject and the idea of discussing female genitalia is a big taboo and they
stay away from it, then that tends to be a risk factor. And that's one of the things that we think about. We'll also have a think about what it means to have had FGCM and if that makes you at risk or is that a protective factor. So this is one of the things I frequently debate
People.
In terms of these cultural norms, what we know is that there's been recently quite a lot of European data that shows that many FGCM affected communities are abandoning the practice. There are some people who hold negative attitudes towards the practise before they move to the European countries.

And in particularly in Scandinavia, where they have looked at the ideas and attitudes at the point of arrival in those countries, and then subsequently 18 months later, two years later, once people are more socially integrated and have a better understanding of Swedish law, there is a reduction in abandonment certain new values that are different to the values that you may have held before you migrated to this new country.
Interestingly, we also see a generational shift that is very rapid, actually, and that is both in the global North as well as in the global South. People who've been exposed to the TV media, TV debates about FGM and anti-FGM movements are very likely to move away from it. And with the adoption of social media, we see a significant generational shift away from the practice. And then of course, there is those women who have been affected, particularly in terms of their health, who have had fistulas, who have had problems with birth and sexual intercourse. There is ideas around health and the negative aspects of the practice, which then leads to behavioural change and attitudes change.
In the UK, there is, I think people may have heard of the study from Dawkins from 2007, which used demographic health surveys from low and middle income countries that had, that were affected by FGCM and had communities. that were affected. And the number of those communities moving into the UK, and they estimated, and this is really estimates, that there were 60,000 infants born to women who come from FGCM affected countries. And they stipulated that those infants, those little girls or baby girl children would be at risk of FGCM. And that is really the number that the data until recently has used. There isn't a lot of data in terms of prevalence. There's more recently, there's been the NHS enhanced data set that's identified 35,000 women who've had it. And I'll come on to that. But in terms of medical data, there's the British Paediatrics Surveillance Study that was done in 2021. And that looked over a two year period at paediatricians and the number of referrals and cases that Paediatrics had come across. They identified 103 cases in the UK, of which one was performed in the UK. And that then led to a criminal offence that was prosecuted. And so that's not a whole lot over 2 years.
And we still do not have really accurate UK prevalence data. What we know from the data that exists is that the numbers are low and the risks of FGCM in the UK is also very low. However, there is still concerns, particularly from the police and the government,

that there is a hidden practise of FGCM in the UK, that it is being done in large numbers, and that although health professionals and the police may not come across these numbers, that it's still being practiced. I mean, I think
We can have a think about that, but the idea of hidden practise is still something that permeates in discussions with multi-agency, but the evidence for it is very limited.
Okay, so if we think about the child, the young person presenting with FGCM, you may have seen in England and Wales, the Department of Health has produced this not so very helpful document, I would say, and it's supposed to guide you to think about
both referral pathways as well as mandatory reporting. But you can have a look at it and I will send a link. Actually, there are certain parts that are fairly contradictory and more local guidance that we've produced with NHS England is this pathway. So this is a pathway for
children and young people suspected or confirmed FGCM in under 18s. If there is a case that comes up, of course, you have to think about mandatory reporting. And if that applies, there is a risk assessment that social care use and
There is a link to that too. And that risk assessment thinks about, does the young person say that they have had it? Is there a suggestion that they are at risk of it and that their parents might do it or any other carer or family member to them? Do they feel that there is other people that are at risk?
particularly other siblings. And that risk assessment is supposed to be completed by children's social care. Although a lot of the time we know that when it comes to the next step in step 2 of taking this to a strategy meeting, a lot of those risk assessments are not completed because it's tucked away quite far in government guidance and not really readily available.
So what is readily available is the working together document and that suggests that police, social care and health have to meet, that the named doctor or a senior paediatrician should attend that strategy meeting and to really think about risk factors and to also think about whether
there is a recommendation to be made around moving to section 47 or a medical assessment.
If that then is decided and a medical assessment for FTCM in a case that's either suspected or confirmed is made, then you move on to step 3, which is to think about the locally commissioned services. Unfortunately, there is not very many. There is the service in London

which I lead, where we see children and young people from all over the country. And actually, there are lots of SOCs who and community Paediatrics with significant expertise, including Michelle, including Anna, who will see these children and young people. So you really need to think about what's available in your locality and just think about a referral pathway initially through that. And of course, we're very happy to be contacted as well in London. We see all the children in London and then we see other children across the country. And then subsequently to communicate the outcome of that assessment to the multi-agency, so that's to the GP, but it's also to social care and police in order to then move on to the next step, which is either to close section 47 or to proceed on to policing pathways. We have a specific referral form in London,
We think about the reasons for the referral, we think about the child and their family. We want to know any strategy meeting minutes, any other assessments. So we have lots of children who are referred through, looked after assessment pathways. And so this is new asylum seekers or refugees who are having their initial health assessment. who confirmed that they have had some form of FGM done. And we would want to have all of those documents available to us as part of the referral.
In terms of the service that I lead, it was initially started in 2006 by a pediatrician, Dr. Hotes, who started at UCLH. And then there was another colleague in another part of UCL who was seeing 17, 16, 17 year olds in the adult women's clinic, and they combined forces in 2014, and it's been running ever since. At the moment, I lead it with Hazel Lerner, who's a paediatric and adolescent gynaecologist, and we provide a trauma-informed approach to both the assessment as well as the care, to think about the physical as well as the psychological health. We liaise with multi-agency, but we also work with communities and we work with charities. And this is the clinical team. There's also Louise, who is a highly experienced CNS in our service, and Philomena, who's our counselling psychologist, who has a lot of experience with and working with children and young people who've been through trauma. So we see children and young people in the clinic. We also do referrals for second opinion. if they're seen in SUSSEX in other places. And we provide ongoing care for gynaecological care, but also other care. So we pick up quite a lot of TB, for example, interestingly, we cheque for infectious diseases, so that then is seen locally. but similarly with mental health as well.
The examination is the key part for the multi-agency. That's really the thing that

they're interested in. Is there FGM? Is there not? Is it legal? Is it, you know, an illegal case? And next steps towards that. But we also think about the gynaecological care. So increasingly, a lot of young people want to have defibrillation, and that's a surgical procedure to really open up the scar tissue.
particularly for those that are affected by type 3. And that provides both physical but as well as mental health improvements. And this is increasingly a number of referrals that are, we're seeing as well. I think this is also linked with
providing people with an opportunity to talk about what's available for them. And similarly, with the psychotherapy themes, we see children and young people who talk about their body, what it means to be normal, what it means to be cut, or the sense of what it is to have had FGM, and really having
autonomy and a sense of complex layered trauma about talking about this particular topic, but also other types of trauma that they might have been through. We also hear from families who feel that they have been treated like criminals or that their identity as a British person has been affected or that their relationship with their child, if they feel that
they have been criminalised, that they will talk about their love for their child. And there's many other themes that come across in these consultations. Okay, so how long have I got? Okay, I've got time. Legal and policy approaches in the UK.
Of course, you will have seen quite a lot of media coverage on this topic. There is a lot of interest in this. It's a very politicised subject. And as health professionals, we sit somewhere in that conversation between anti-FGM activists, police, the government, and us providing both safeguarding as well as medical care for these children and young people.
So in the UK, we really think of it from a rights based approach. So the UN Convention on the Rights of the Child and ensuring that children's bodily integrity, but as well as their general well-being and their physical and mental health is protected.
And we, it's not just us in the UK, but it's really a very Western European approach, I would say, where we come at it from a UN rights of the child perspective, whereas colleagues in the global side who I speak with will come at it from a medical perspective. So at an individual health
perspective rather than a human rights approach, which is, you know, I mean, I think a lot of these things are interlinked.
You will have heard of the Istanbul Convention for Action on Violence Against

Women. In the UK, there is similar strategies on violence against girls and women. And in Europe, what we see is that in certain places, such as in Sweden and Switzerland, there is very specific legal provisions against FTCM, so very similar to the UK.
But in Germany, in France, in the Netherlands, in Austria, and really the vast majority of European countries, a lot of these prosecutions happen through child abuse and bodily harm, rather than specific FGCM.
legislation. France has the majority of criminal prosecutions. So in France, there have been more than 40 cases. The majority of those were in the 90s, less recently for some reason. Whereas in the UK, we have had three successful prosecutions. And there's often comparisons made with France. And
Why is it that France has had so many prosecutions and what is the obstacle to these, to criminal prosecutions in the UK? Is it professionals? Is it policing? Is it a lack of political will? And in the UK, the topic on FGM in children and young people has really
sort of talked a lot about prosecutions as a deterrent against the practise and that this is the best way to ensure that communities move away from the practice. So to that end, there have been a number of UK legislations, initially in 1985, the Female Circumcision Prohibition Act,
which subsequently became the 2003 Female Genital Mutilation Act and more recently the 2015 Serious Crime Act.
And then really in England and Wales, the law is slightly different to Northern Ireland and Scotland, so I'll talk about it separately. So the Prohibition of Female Circumcision Act in 1985 made it an offence to perform FGM on any child or really any person.
in the UK, in England and Wales, I should say. And it distinguished between necessary surgery for health to custom and ritual. So it said, you know, if it's medical procedure, that's very different to custom and ritual. And it made it punishable with a five year maximum imprisonment.
Then in 2008, the law was broadened out. It continued to talk about aiding, abetting, counselling or procuring FGM in any girl or otherwise mutilating any part of the female genitalia. It also made it an offence of a UK citizen to assist a non-UK national. or a UK resident who's not a British national, a UK national, either in the UK or elsewhere, and it's extended the imprisonment to a maximum term of 14 years.
It was felt that there were still not, the law was not stringent enough. And in 2015,

we've had the Serious Crime Act that came in practise and this talked about enlarging the territorial jurisdiction. So this is any habitual resident in the UK who either
Had a girl.
go through FGM either in the UK or elsewhere, or supported it or in any way abetted it or aided it. It also made it a criminal offence if a parent was unable to protect their daughter from having FGM, and this made it a punishable crime. So
This was in order to close the loophole of a grandparent who did it in another country while the parents were not there. So then in that case, the parent had failed to protect the child from the practice. It introduced anonymity for people who were at risk or who had reported it.
It introduced A mandatory reporting duty and FGM protection orders for those who were felt to be at risk of the practise of FGCM. And this was both for children as well as for adults. So anyone really who was at risk of it.
It also introduced a legislation that talked about how we capture data around this. So there is the FGMIS, which really sits in the NHS spine. And this is if a parent has had it and they've moved to the UK.
There is a flag that's put on the child who is British born on the NHS spine that flags it as the daughter of a mother who has had it. So this is really to think about the family history. There is an opt, there is not an opt out approach for this, although you can take legal
pathways, but nobody has tried to do that. However, for the NHS enhanced data set, and this is anyone who reports it to a medical professional, so for example, us in the clinic, we have to kind of upload this into the NHS digital
digital enhanced data set and report the type of FGM that was done and the age and where the child was or the young person was. There is an option of opting out from this NHS enhanced data set, which is a really big data, data analysis, like very big data set. But the
The route to that is not very clear and it's very slow. And so not very many people attempt it either. But again, this is part of the Serious Crime Act in England and Wales. So if we think about Scotland, so in Scotland, there was the most recent update is the FGM Act in 2020.
which broadened it out from not only having carried out FGM in Scotland, but also abroad. And they also introduced the FGMPOs after the successful introduction in England and Wales. And that happened in 2019, whilst they'd reviewed the Scotland

National Action Plan for FGM.
However, they have not introduced mandatory reporting in Scotland. So mandatory reporting does not exist in Scotland. In Northern Ireland, the Serious Crime Act had some of its parts that were introduced and other parts were really in line with previous Northern Irish law.
So in Northern Ireland, mandatory duty applies to all child abuse and it's not specific to FGM. And they have also introduced FGM protection orders and they've made it an offence to if you fail to protect your daughter from the practise and they introduce anonymity.
So in different parts of the UK, the law is slightly different as you see.
So mandated reporting, and I think I'll have to very quickly talk through this for about 5 minutes. So in, as I mentioned, in England and Wales, and that's really where I will focus this part on. In England and Wales, what happened was in 2014, David Cameron held
the Girls Summit, which happened in London. And from that came the FGM National Action Plan to really stamp out FGM in England and Wales. And David Cameron's government said that historically, professionals, so that is social care, education and health had been
passive in their approach to FGM and there had to be a more radical approach to really ensure that this hidden practise and those who were at risk were sufficiently protected and that's where the Serious Crime Act came from. But it also introduced new statutory guidance and that resource is continually up.
updated. And I would suggest people have a look at that. And part of that resource is this. So this is a poster on how to think about mandatory reporting. So if a child, a young person tells you that they have had it, then you have a legal duty to report it to the police.
and you really have 24 hours or the next working vein is the best practice. Initially when this was introduced, it suggested 28 days, but more recent guidance recommends that it's done within one working day. And you do that by calling 101. You inform them that a child or young person has told you that they have had it. You give them the details, but you also ensure that you tell the child and young person and their family and their parents and their carers that you have a legal obligation to report this. You would also report it, so that's if a child and young person tells you it. You would also report it if you find physical signs that are consistent with it,

without a history. The difficulty arises if you have a recent immigrant, so say for example, a 16 year old who has moved from Eritrea, and this is something I see frequently in the refugee health clinic that I do. And from your discussions, you ask, have you had any
cutting to your genitals and they say, yes, I have had this and this is what was done to me, you then have a legal obligation to do the mandatory reporting. And generally what will then happen is the police will then come speak to that child, a young person in their family. It can be quite distressing for recent immigrants and they might feel very frustrated because they'll say, well, this is something that happened to me when I was five years old.
but I have other health issues and I have other needs that really need to be addressed. And I'm not really interested in talking about the FGM. And that can be a sort of a source of conflict, but it's something that we think about. But similarly, it can be the duty can have protective approaches. And this is really how
was thought up initially, which is if you find, if a health professional finds physical signs that are consistent with FGM, you have a legal duty to report it. And this is where the idea of the historically passive approach, that's where that idea stems from.
Now, there is not a lot of data on how many reports are happening. All these reports are made to the local police forces. And at a national level, there was one Freedom of Information Act that was done by a group of researchers in Bristol who suggested that 74
reports were made in 2019 to 2020. So the question then is, is it that mandated reporting is being underutilised or people don't understand it? And is it really being sufficiently used? Or is it that the prevalence of this practise is much lower than presumed and these low numbers in the reports
are actually suggestive of a very low practise of FGCM.
I will finish in 2 minutes if that's okay.
AND.
Also, mandatory reporting will lead to sometimes arrest without...

CW **carla w** 40:38
Thank you for shopping.

AS **ALI, Sakaria (UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION**

TRUST) 40:40

Oh, I think somebody will have to mute themselves. I'm sorry. Frequent arrests of families and separation of families and children from their parents until the medical examination that's happened. So that can be very fairly traumatic. Referrals from schools, particularly if a child is due to go on holiday and they come from the affected community.

That can lead to passport removals, it can lead to medical examinations, either before or after they've returned from holiday. And this can be fairly traumatising for families. And this is something that we should think about as health professionals. We've written about the work that we do in our clinic.

And more than 60% of cases that we see in our service have not had FGM. And there's been a suspicion that's been raised. And as a result, they come to see us following a recommendation for medical assessment. And a lot of these assessments are for referrals around concerns about vulval appearances, particularly from nurseries and school teachers who

then instigate the mandated reporting. And as a result, children and young people are seen in our clinic. So what do communities tell us? So community and research tell us that a lot of families and FGCM affected communities report stigmatisation and alienation.

and they feel that they lose trust in health professionals, that if the mother has to talk about her experience of FGCN every time she sees a new GP or they come into a paediatric clinic or a trauma and orthopaedic clinic, the idea of having to revisit that can be

alienating, they feel that they may not want to access healthcare as a result. And it can be re-traumatizing too, particularly if there are frequent police questions and interrogations of something that had happened to the mother, but not to the child. And the parents may well say,

because it's happened to me, I would want to protect my daughter from it. So therefore, my child is not at risk. And this is, again, something that communities are campaigning against. We also see that local authorities are making British nationals where the parent has had FGM.

make them sign anti-FGM declaration. So promise that you will not do this to your child. And this can be very upsetting for families. And the interlinkages of safeguarding approaches and also ensuring that medical care is provided for children and young people, that can be really

quite tricky and that's I think one of the criticisms for mandatory reporting.
The government in its recent VOG strategy, so violence against women and girls in 2025 that came out just before Christmas actually, they have suggested that they will look at the mandatory reporting duty as it relates to FGCM and the impact that it's having on
health professionals and communities, but really they want to understand how frequently are health professionals utilising this and what's the action that the police are taking. There is also a lot of questions that have been raised about FGGMPO, so the Female Genital Mutilation Protection Orders, because they are civil law.
and they can be applied by the magistrates. But if there is a breach, so a breach may be if you take your child to Antwerp or Brussels and therefore they leave the UK, then that becomes a criminal offence. And communities and critics have
said that this is a backdoor way of criminalization of a child and their family because they come from certain communities. Families may not understand what an FGMPO means when they agree to it, so they may feel that this is a protective thing, but given that there is not very...
clear guidance from a legal perspective and legal resources for families, are they signing up to something that they feel is very restrictive? And there have been recent judicial reviews that have reported insufficient information is being provided to families. And lastly, policy reviews suggest that
that they may not really be as effective and they may not be used consistently across the country. So that's, again, something that should be looked at, although the VOG strategy doesn't talk about FGMPOs as much, which is a bit unfortunate.
We call for a new policy direction. So, and this is a recent paper that we wrote in the BMJ, where we said we really need to move away from criminal prosecutions and we need to think about the support and the education that's provided for those who are living with FGCM. There's also significant unmet health need,
particularly in older women who have had this procedure and that they are not getting care that they really need. We need to increase prevention through education and also training health professionals. And this is really what this talk is part of, really ensuring that health professionals understand what FGCM is.
and that they know the local pathways when children and young people present to their clinics. And lastly, that we really engage communities in a meaningful way and that we don't talk about them, but also include them in these discussions and research and policy settings so that they feel included rather than alienated and

stigmatized. And that's very important.
important. Lastly, I would recommend that you look at this. So this is from the Home Office and every time you talk about FGECM, you really need to educate people and tell them that the UK law is against this practise and that it's a serious criminal offence and parents should
read back to you that they understand that it's a serious criminal offence, because that education may be the thing that makes a difference for their daughters as a result. The Home Office has introduced a number of different languages stating what the UK law says in different parts of the country.
And lastly, really think about the community groups that are local to you. This is one that's particularly local to us in London. It's called Forward. I've worked with them a lot. And they engage both families as well as provide therapy and support for young people who want to talk about it.
in a non-health setting. Thank you very much for listening. My name is Zacharia Ali and that is my e-mail address. If you are interested in attending the study day, please e-mail me and I will ensure that you get the flyers sent out to you as well.
There are not many places on the study day because it's a very interactive, busy day. So if you are interested, I recommend that as soon as you get the flyer that you apply. Thank you so much. I'll stop sharing.

HE **HELLIWELL, Emily (SIRONA CARE AND HEALTH)** 47:56
Zacharia, thank you so much. That was a really informative, really interesting talk on FGMCM. If we have any questions, please can people pop them in the chat? I think it was really thought provoking about the way that we as doctors approach people, using the correct language, that table with all the correct terminologies on it.
and also about the protective factors and kind of getting the families on board. And I thought that was really amazing. We do have one question, so please, Miriam.
Floor is yours.

SM **SANDERSON, Miriam (CAMBRIDGESHIRE COMMUNITY SERVICES NHS TRUST)** 48:32
Hi, Zach. I had a question, and I don't know if this is a really stupid one, and I'm sorry for it. I was wondering, like, why is female genital circumcision or mutilation obviously horrible, but why is male circumcision allowed? And I come from a

community with male circumcision.
Normal, but I find it like I don't really understand the difference.

ALI, Sakaria (UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST) 48:57
Now, that's a very controversial question.

HELLIWELL, Emily (SIRONA CARE AND HEALTH) 49:00
Mm.

SANDERSON, Miriam (CAMBRIDGESHIRE COMMUNITY SERVICES NHS TRUST) 49:00
Sorry.
THE.

ALI, Sakaria (UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST) 49:03
Generally, I do not talk about male circumcision when I'm talking about FGCM. Partly, I mean, there is cultural but also medical reasons why male circumcision is recommended. Whereas what we know is that
FGM or FGCM causes a lot of harm and there is no evidence that is that suggests that there is medical benefit from having it done. So I would respectfully kind of step away from that question and say they are very two different topics.
Now, if you want to talk about male circumcision and the safeguarding approaches to that, I think that is helpful to talk about. I think there was a recent case of a young infant who had a lot of trauma from male circumcision, but I would say it's a separate topic, if that's okay.

SANDERSON, Miriam (CAMBRIDGESHIRE COMMUNITY SERVICES NHS TRUST) 49:57
Yeah, of course, no, that's no problem. Thank you.

HELLIWELL, Emily (SIRONA CARE AND HEALTH) 49:59
Pass.

Which?

Are there any other questions from anybody, please?

Emma Grindrod stopped transcription