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A review of the law surrounding Female Genital Mutilation Protection Orders

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ABSTRACT

Performing Female Genital Mutilation (FGM) is prohibited within the United Kingdom by the FGM Act 2003. A mandatory reporting duty for FGM requires regulated health and social care professionals and teachers in England and Wales to report known cases of FGM in under 18-year-olds to the police. An Application to the Court for an FGM Protection Order (FGMPO) can be made to keep individual women and girls safe from FGM. This paper reveals the significant disconnect between the number of FGMPO applications and known recorded cases of FGM. The introduction of FGMPOs requires critical exploration as there is insufficient evidence to show that FGMPOs are effective in protecting women and girls from FGM. It is therefore unclear what impact, if any, FGMPOs are having upon the protection of women and girls at risk of FGM. The barriers to the implementation of FGMPOs and possible solutions are discussed.

AUTHORSHIP CONTRIBUTIONS

JH: Analysed the data and wrote the first draft of the manuscript

AGR: Devised the concept, obtained the data via the Freedom of Information Act 2000 and contributed to the drafting of the manuscript

FG: Legal research and contributed to the drafting of the manuscript

CP: Legal research and contributed to the drafting of the manuscript

KW: Advised on revalidation questions and contributed to the drafting of the manuscript

All authors edited the revised manuscript and approved the final manuscript prior to submission. **AGR** is the guarantor.

DECLARATION OF INTERESTS

None of the authors have any conflicts of interest to declare.

ETHICAL APPROVAL

This study involved obtaining and analysing information available through the provisions of the Freedom of Information Act 2000, an Act of Parliament designed to enable members of the public to receive information which is then considered to be in the public domain. No identifiable information was, or could have been, obtained through the Freedom of Information Act 2000 requests. No human subjects were used in this research. In addition, a literature review of legal sources relating to the development of Female Genital Mutilation Protection Orders was conducted. It is in the public interest that legislation is evaluated after implementation. In all those circumstances, ethics committee approval was not sought for this study.

FUNDING

This research received no specific grant, or any funding, from any agency in the public, private or not-for-profit sector. This research was entirely unfunded.

WHAT IS ALREADY KNOWN ON THIS SUBJECT

- Performing Female Genital Mutilation (FGM) is prohibited in the United Kingdom by the FGM Act 2003
- Within the schedule of the FGM Act provision is made for the granting of FGM Protection Orders (FGMPOs) to protect women and girls from FGM
- A mandatory reporting duty for FGM requires regulated health and social care professionals and teachers in England and Wales to report known cases of FGM in under 18-year-olds to the police

- There has been no comprehensive evaluation of the introduction of FGMPOs looking at their effectiveness protecting women and girls from FGM
- Demonstrating knowledge of legislation relating to health and social policy relevant to midwifery practice is a competence required by the United Kingdom Nursing and Midwifery Council (NMC).

WHAT THIS PAPER ADDS

- Midwives have a key role to play to raise awareness of the ability of women and girls to be protected by FGM Protection Orders
- NICE guidance already exists in relation to decisions by health professionals to report child abuse and neglect (**NICE, 2017**). Midwives will already be trained in this guidance and will know when to report risk of FGM in this context, this article focusses on specifics of FGMPOs, including where reporting is mandatory.
- This article contributes to evaluation of FGMPOs. Current texts tend to highlight law and practice and it is important that midwives do not give legal advice but understand the value of FGMPOs as one tool in the range of methods necessary to eradicate FGM.
- Consideration is given to the significant disconnect between the number of FGMPO applications and known recorded cases of FGM
- Conclusions are reached about the effectiveness and impact of FGMPOs
- A recommendation is made for a full evaluation of the introduction of FGMPOs by a national FGM Commissioner.

- Suggestions are made to develop language guidance for midwives to explain FGMPOs, without giving legal advice, and making non-discriminatory enquiries.

REVALIDATION CONTINUING PROFESSIONAL DEVELOPMENT (CPD)

REFLECTIVE QUESTIONS

Reflective question one

Janice is a midwife and has been caring for Zainab during her second pregnancy. Zainab lives in England. Janice is aware that Zainab underwent FGM as a teenager whilst living in Sudan. Janice has built a good relationship with Zainab, allowing FGM to be openly discussed. Following the delivery, whilst on a planned visit to Zainab's house to check the new baby, Janice notices suitcases packed in the dining room. Zainab appears unsettled at Janice's arrival.

A) How should Janice approach the conversation with Zainab about the above situation, and which questions are appropriate to ask while respecting Zainab and her family in their home?

Zainab explains to Janice that her husband is taking her 12-year-old daughter to Sudan to visit family. Zainab then becomes very emotional. Janice is aware that Sudan has a high prevalence of FGM.

B) How can Janice support Zainab?

C) What role can Janice play in protecting Zainab's 12-year-old from possible harm?

D) How can Janice use this scenario to educate her colleagues?

Reflective question two

Ayesha is a midwife working in the antenatal clinic at a large district general hospital in England. Ayesha has been caring for Mariam, a 25-year-old patient from Mali, during her pregnancy and Mariam has started to ask Ayesha questions about FGM. Mariam has a three-year-old daughter and a seven-year-old daughter. At her latest visit Mariam says she is particularly worried about protecting her daughters from FGM and that she has heard the Courts in England can protect people but does not know very much about this.

E) How can Ayesha explain what an FGM Protection Order is to Mariam?

F) How can Ayesha support Mariam to explore whether she wants to apply to the Court for an FGM Protection Order?

G) What other steps can Ayesha take?

Reflective question three

You have been asked to prepare a teaching session about FGM for the newly qualified midwives working in your unit. This session has proved popular and there is now interest from a number of children's nurses and members of the safeguarding team to attend.

H) Using Zainab's case as an example, what would you say about mandatory reporting of FGM in relation to Zainab?

- I) Using Zainab's case as an example, what would you say about reporting the risk of the child having FGM performed?
- J) How would you explain to your colleagues what an FGM Protection Order is?
- K) How will you change your own practise now that you know more about FGM Protection Orders than you did last week?

INTRODUCTION

Female Genital Mutilation (FGM) is a procedure where the female genitalia are altered, injured or removed (**WHO, 2020**) without medical indication (**Crown Prosecution Service, 2019**). FGM is commonly performed on girls between the ages of four and twelve years old as a 'rite of passage' to womanhood. However, the age when FGM is performed varies and can be significantly younger. As the campaign against FGM has intensified in the UK, concerns have arisen that parents are cutting children at a younger age to avoid detection (**Bentham, 2014**).

Performed worldwide, FGM transcends geographical borders, ethnicities and cultures. While the total number of women worldwide who have undergone FGM is unknown, the United Nations Children's Fund (UNICEF) estimate there are around 200 million women and girls living today who have been subject to FGM (**UNICEF, 2020**). FGM is also known as female circumcision and other terms including cutting, sunna, gudniin, halalays, tahur, megrez and khitan (**NHS, 2019**). According to UNICEF, there has been an overall decline in the prevalence of the practice over the last three decades, but not all countries have made progress and the pace of decline has been uneven (**UNICEF, 2020**).

FGM is either performed in the UK or girls are taken to countries of origin or to countries where FGM is medicalised. Girls who are subjected to FGM outside of the United Kingdom (UK) can be taken abroad either during school holidays or in between holidays, thus missing school, in order for them to recover before returning to school **(UNPF, 2017; National FGM Centre, 2019; Dean, 2014; Thandi, 2014)**.

The importance of midwives understanding law and its conscious application in professional practice has been highlighted **(Iwanowicz-Palus et al, 2018)**. Since at least 2009 the United Kingdom (UK) Nursing and Midwifery Council (NMC) has required nurses and midwives to demonstrate knowledge of law relating to health and social policy relevant to midwifery practice **(Nursing and Midwifery Council, 2009)**. In relation to training as a midwife, the Nursing and Midwifery Council still requires that assurance is provided that the professional has acquired adequate knowledge of the ethics of the profession and the legislation relevant for the practice of midwifery **(Nursing and Midwifery Council, 2019)**. Nonetheless, midwives are not lawyers and should not be giving legal advice. Knowing the law surrounding FGMPOs and the limitations on protections available to women and girls can assist midwives to understand when they have a duty to report concerns and when they might wish to assist clients to access legal services.

This paper reviews those aspects of FGM legislation which are relevant to health professionals, including midwives. This includes rationale for health professionals needing to know more about FGMPOs, so that they can better contribute to the protection of the patients and clients they serve. Reading of this paper and considering

the continuing professional development (CPD) reflective questions will also assist midwives to compile evidence that they are keeping up to date in relation to law relevant to the practice and education of midwifery. It is written on the assumption that midwives are aware and trained on when to report concerns regarding child abuse and neglect, including FGM **(Malik et al, 2018)**, and it deals with some specifics around FGMPOs.

Background

In April 2018 the UK Home Office revised data collection provisions to collect FGM data separately from other assaults. Prior to this the lack of consistent, high-quality data, and the aggregation of FGM data with other assaults, undermined the collection of FGM data and meant the value of recording data was lost entirely **(Malik et al, 2018)**. Previous work has highlighted the discrepancies between Health and Social Care Information Centre (now NHS Digital) FGM data and Police data, with recommendations including the appointment of an FGM Commissioner **(Malik et al, 2018)**.

This paper considers the data that is available about FGMPOs, the duties on stakeholders to report FGM and the effectiveness of FGMPOs at protecting women and girls from FGM now that FGMPOs have been in force for five years.

Health Consequences of Female Genital Mutilation

There is no accepted medical indication for any form of FGM within the UK healthcare community **(UNPF, 2019)**. There are no health benefits to FGM and it can cause serious harm including pain, difficulty having sexual intercourse, repeated infections

(which can lead to infertility), bleeding, cysts and abscesses, difficulty urinating and problems during labour and child birth **(NHS, 2019)**. There is an association between FGM and adverse mental health outcomes **(Abdalla, 2019)**.

The use of unsterile instruments during FGM can cause infections after the procedure, particularly due to the wound's close-proximity to urine and faeces. Long-term health complications can arise from any type of FGM **(WHO, 2001)**.

The possible immediate physical complications of all types of FGM include severe pain, bleeding and haemorrhage, which if not controlled can result in death. The most common long-term complications are dermoid cysts in the line of the scar and chronic urinary tract infections, which can evolve and lead to urinary tract stones, renal damage, fistulae and urinary incontinence **(WHO, 2018)**.

Women may suffer pain during menstruation, pain from sexual intercourse and complications during childbirth. Infibulated women usually must undergo de-infibulation prior to the delivery of the child. If de-infibulation is not performed both the life of the mother and the child(ren) could be at risk.

Overall, there is no doubt that women suffer significant physical, psychological, obstetric and sexual health issues as a result of FGM **(Pastor-Bravo, 2018)**.

FGM data collection

In 2014, a study estimated that approximately 60,000 girls aged 0-14 years of age were born in England and Wales to mothers who had undergone FGM. In addition to

this, 137,000 women and girls born in countries where FGM is routinely performed had become permanent residents in England and Wales (**Macfarlane & Dorkenoo, 2014**). Accordingly, there are many women and girls living in the UK with the consequences of FGM.

In September 2014, the Health and Social Care Information Centre began collecting data on FGM within England on behalf of the Department of Health (now Department of Health and Social Care) and the National Health Service (NHS). The aim of the data collection being to improve the NHS response to FGM and guide commissioning of services supporting women and girls. However, the statistics are only based on the number of women and girls treated by specific NHS medical services, rather an accurate reflection of the prevalence rates in England. The most recent data (**NHS Digital, 2019**) is that:

- There were 1,930 individual women and girls who had an attendance where FGM was identified in the period July 2019 to September 2019. These accounted for 2,825 attendances reported at NHS Trusts and GP practices where FGM was identified; and
- There were 940 newly recorded women and girls in the period July 2019 to September 2019. Newly recorded means this is the first time they have appeared in this dataset. It does not indicate how recently their FGM was undertaken, nor does it mean that this is the woman or girl's first attendance for FGM. The number of newly recorded women and girls has reduced over time. The NHS has noted that this is to be expected as the longer the

collection continues, the greater the chance of a women or girl having been recorded in it previously.

Despite legislation prohibiting FGM and the introduction of criminal offences related to FGM, at the time of writing this article there had only been one successful conviction for FGM in the UK. In addition to this isolated case there have been several failed prosecutions, some of which have been highlighted in the media. Regardless of the conviction rate, it is known that many women and girls who are citizens and residents of the UK have undergone, and remain at risk of undergoing, FGM. Where midwives are concerned that a child is at risk of FGM, usual reporting mechanisms for child abuse and neglect should be followed.

Overview of the law on FGMPOs

All forms of FGM have been prohibited in England and Wales since 1985, first by the Prohibition of Female Circumcision Act 1985, and later repealed and superseded by the Female Genital Mutilation Act 2003 (“the FGM Act”). This was subsequently amended by the Serious Crime Act 2015. This amendment saw the introduction of a new Schedule 2 to the FGM Act 2003, making provision for preventative measures aimed at protecting those at risk of FGM.

These preventative measures are known as Female Genital Mutilation Protection Orders (FGMPOs) and can be sought through a designated Family Court in England and Wales that deals with FGM (**HMCTS, n.d.**). An application form (**HMCTS, 2017**) and guidance are available (**HM Government, n.d.**).

An FGMPO can be made to protect either a girl or woman at risk of FGM without immediate criminal sanctions for parents (**Re E, 2015**). The terms of such an order can be broad and flexible, enabling the court to include whatever terms it considers necessary and appropriate to protect the girl. These include, for example, provisions requiring a person to surrender his or her passport. Breach of the order is a criminal offence.

An application for a FGMPO can be made by the girl who is to be protected by the order, or a relevant third party such as a Local Authority, or any other person with permission of the Court (**FGM Act, 2003**). A relevant third party applicant is a person or organisation that is allowed to make an application on behalf of another without the leave of the court. Only the Lord Chancellor can make a person or organisation a relevant third party, for example a Local Authority (**HMCTS, 2017**). Children may have a 'next friend' or someone to assist them, however this is not compulsory, if they have a legal representative or if the Court agrees. The Application will either be heard in public or private. If the court hears the application in public, the case is usually subject to reporting restrictions thereby ensuring that the family is not identified. If the Court proceeds to grant an order it may include conditions such as:

- Surrender of travel documents of woman at risk;
- Mandatory medical examination;
- Travel ban imposed on the child. This can be worldwide (**Re X, 2018**);
- Prohibition of specific persons from entering arrangements in the UK or abroad which would facilitate FGM; and/or

- Prohibition of contact to individuals who are, or may become involved in, committing FGM against the woman at risk.

Once granted, FGMPOs can be extended, added to, or revoked. The wording of Schedule 2 of the FGM Act 2003 allows for orders to be made against unnamed individuals. This allows orders to be granted without delay if the prospective offenders cannot be suitably identified. A single FGMPO can cover siblings and often does.

Duty to notify the police of Female Genital Mutilation

In addition to voluntary reporting child abuse and neglect in accordance with professional codes of conduct required by regulators of healthcare professionals, the FGM Act 2003 (**FGM Act, 2003**) places a duty on persons who work in a regulated profession in England and Wales (health and social care workers and teachers), to notify the police when, in the course of their work, they discover that an act of FGM appears to have been carried out on a girl who is under 18 years of age. The term 'discover' would refer, for example, to circumstances where the girl discloses to the stakeholder that she has been subject to FGM, or where the stakeholder observes the physical signs of FGM. The section does not apply to girls or women who might be at risk of FGM or cases where stakeholders discover that a woman who is 18 years of age or over has been subjected to FGM. It only applies when FGM is discovered having been achieved on a child under 18 (**HM Government, 2015**).

Concern has been raised that the duty imposed on professionals to report FGM may drive the practice underground. For example, women may be less inclined to seek out support from stakeholders for fear of criminal sanctions (**Proudman, 2017**). A criminal

prosecution can result in the double victimisation of the girl (as a victim of FGM and having her parents as suspects within the criminal justice system, rather than providing a family with support) so FGMPOs were a hopeful alternative. Concern has also been raised about a lack of awareness and training within the medical profession on the issue of FGM **(B and G (Children) (No2), 2015)**.

The British Association of Social Workers (BASW), the Professional Association for Social Work and Social Workers in the UK, has warned “*against blurring the boundaries between social work and other agencies such as the police and health*” **(BASW, 2015)**. Reliance on law enforcement to deal with social problems has led to consequences of increased surveillance and removal of children by the state and prosecution which increases vulnerability of women and children in communities which continue to practice FGM **(Proudman, 2017)**. This can militate against engagement with midwifery by women in vulnerable groups.

However, whilst it is vital not to target families in cultures which carry out FGM, the law has been extended to place a duty upon professionals to report FGM. This creates an extension of the boundaries of the criminal law so that stakeholders outside of the criminal justice system have become responsible in specific circumstances for implementation of FGM protection, including FGMPOs, albeit that those circumstances are limited.

Notably, stakeholders remain under no duty to report cases of those over 18 years of age who have undergone FGM nor where children or vulnerable adults are at risk of FGM, only to report FGM when they discover it has or appears to have occurred to

those under 18 years of age so that an investigation can be commenced. The absence of a duty to report risk does mean that children and adults at risk of FGM are, arguably, less protected than children who have suffered from it.

It is important that midwives, and other regulated healthcare professionals, understand that the law in England and Wales requires them to report, to the police, where FGM has been performed on children under the age of 18 years. Child protection procedures would also be engaged should a regulated professional believe that a child has suffered from, or is at risk of, FGM (because FGM involves physical harm). Therefore, in addition to making a report to the police where a regulated professional discovers an act of FGM appears to have been carried out on a girl who is under 18 years of age, local child protection procedures should be followed for both suspected cases of FGM and for those children at risk of FGM.

It might be said that mandatory reporting of FGM has made little progress on existing structures, but it is important to recognise that reporting can assist with data collection to formulate meaningful services. Importantly, midwives must understand that mandatory reporting of FGM having occurred to children is in addition to reporting of child abuse and neglect in accordance with professional codes of conduct that would cover a child at risk of FGM.

Engaging in the FGMPO mechanism

The key value of an FGMPO is to protect a person at risk of FGM and therefore prevent the crime of performing FGM. However, whilst there is no mandatory legal duty to report a child at risk of FGM, the voluntary guidance on child abuse and neglect

remains. This interaction between mandatory and discretionary duties means that midwives can maintain meaningful relationships with a woman in their care. It also means that midwives need to both understand and be able to explain their duties and the options available to access legal services. There are a range of materials available on law and practice in FGM (**Samuel, 2017**) but, midwives are not lawyers and should not be giving legal advice. This article focusses specifically on the evaluation of FGMPOs to enable midwives to be sufficiently aware of FGMPOs in their practice as midwives.

A review of FGM laws in 2017 concluded they are currently sufficient (**Gaffney-Rhys, 2017**). In this review, it was found that 96% of applications made for FGMPOs have been in relation to persons aged 17-years or under, which corroborates assertions that FGM primarily affects children. Eighty-nine per cent of applications were made by third parties, which is unsurprising given that the vast majority of persons protected by the orders are children and many of them will not be capable of instituting proceedings themselves (**Gaffney-Rhys, 2017**). The data thus demonstrates the importance of the third-party applicant process. Of the 42 applications made by third parties, 10 were instigated by Relevant Third Parties (Local Authorities), whereas 32 were initiated by third parties such as the police, family member(s), the Official Solicitor or representatives from the voluntary sector. However, three years have passed since the law was reviewed and this paper focusses on evaluation of the law introducing FGMPOs is overdue.

It is worth summarising significant cases that have come before the Family Court, whilst noting that the privacy of such cases means that not all are publicly available.

Most family law cases are held in private and, for understandable reasons, not publicly reported but here is an overview of the most relevant FGMPO cases which have been the subject of an appeal where decisions are more widely reported. What follows is a short summary from which some principles that are being applied by the courts can be distilled:

[NOTE TO EDITOR: THE THREE HIGHLIGHTED CASES WHICH FOLLOW COULD BE DISPLAYED IN SIDE-BOXES OR POP-OUT-BOXES IN THE PUBLISHED ARTICLE]

The case of Re E, 2015

This case highlights the difficulties that can occur in cases involving competing parents. Just days after the Serious Crime Act 2015 came into force a case involving three children was heard in the High Court (**Re E, 2015**). The applicant was the mother of three girls aged 12-years, 9½-years and 6-years. She indicated that the father had been violent towards her and her children and that she had always known that her husband considered FGM to be '*inevitable and necessary*'. In February 2015 the father allegedly sent ceremonial robes from Nigeria to London and at the start of the school holidays, it was said that he had contacted the mother, demanding to see his children immediately. The mother claimed that the father wanted the FGM procedure to take place at the start of the school holidays so that the girls could heal before the beginning of the new academic year. An *ex parte* (without notice) order was made restraining both parents from removing any of the children from England and Wales until further order (**Re E, 2015**). The orders also provided that 'the respondent [father] must

not himself, or encourage, permit or cause any other people to (a) use or threaten violence against the applicant or children (b) intimidate, harass, threaten or pester the applicant or the children'. Counsel for the applicant further requested a provision to prevent the father from coming within 100 metres of the children's place of residence or school, which the Judge, Mr Justice Holman ("Holman J") granted.

Later, it transpired that the allegation was unsubstantiated. The FGM Protection Orders were discharged and later removing the children to Nigeria was decided to be in their best interests. **(E (Female Genital Mutilation and Permission to Remove), 2016)**. The value of the initial orders is that this caused a delay to enable a thorough investigation into the risks to the children supervised by the court so, although in the end the FGMPOs were discharged, there is some positive in the ability to move swiftly if a parent is expressing the view that a child is at risk. Where parents discuss such matters with health professionals, whilst there is no duty to report, those professionals (including midwives) may choose to do so (given that the health consequences of FGM fall into the NICE guidance on child abuse **(NICE, 2017)**) or choose to encourage the parent to seek and FGMPO. Midwives therefore need to know the availability of relevant legal services. The importance of inter-agency cooperation has been emphasised by the government in its Multi-Agency Statutory Guidance on FGM **(UK Government, 2018)** but the ongoing effectiveness of FGM Protection Orders is uncertain **(Gaffney-Rhys, 2019)**.

After *Re E, 2015* a further 31 FGM Protection Orders were made in that year perhaps reflecting the initial hopes that the new legislation brought.

The case of Re Z, 2017

There are cases that have been decided where FGMPOs have been put in place until children reach their majority. In **Z (A Child), 2017** an FGMPO was made, and will remain in force until the six and a half year old girl ("Z"), for whose benefit the order was sought, attains her 17th birthday. Z's mother applied for a Prohibited Steps Order preventing the father from taking Z to Guinea, and a Female Genital Mutilation Protection Order (FGMPO). Z was joined as a party during the proceedings. Ms. Justice Russell held that as the central issue is FGM an FGMPO should be made, and that during the time Z spends with her father his passport will be lodged with the mother's solicitors.

The case of Re X, 2017

One other recent decision is also of further interest. In that case **(X (A Child) (Female Genital Mutilation Protection Order: Restrictions on Travel), 2017)**, the possibility of a 14-month-old child being subjected to FGM, should she be taken to Egypt, was raised by a health visitor. Following the referral, the local authority issued proceedings and the Judge Ordered an FGMPO until 22 August 2032. This included a total travel ban prohibiting Child X from travelling anywhere outside of England and Wales until 22 August 2032, when Child X reaches the age of 16 years of age. Here the effect of a health visitor's choice to report, even though it was not mandatory, can be seen. An appeal by the father **(Re X (A Child) (FGMPO), 2018)**, was allowed in relation to the travel

ban and the matter was remitted for a full rehearing. The case shows that front line professionals can be useful in raising risks of a child being subject to FGM. Notably the court made it plain that when considering an FGMPO, the courts will not automatically restrict parents but will balance the qualified right of private and family life (Article 8 of the European Convention on Human Rights (ECHR)) and the absolute right of the child not to be subject to FGM (Article 3 of the ECHR) **(European Court of Human Rights, 1950)**.

More recently, in a case between Suffolk County Council v RD and MA **(Suffolk CC v RD and others, 2020)**, the court set out what were referred to as “*contextual considerations*” as relevant factors to consider in making an FGMPO. These are helpful. The “*macro factors*” can be summarised as follows:

- 1) What is the prevalence to FGM in the country and, if known, the relevant region, to which it is proposed to take the child?
- 2) What are the societal expectations of FGM in that country?
- 3) Is FGM illegal in that country and, if so, how effective is the prohibition?
- 4) Is there an extradition treaty if FGM were to be carried out on a child taken abroad to allow a prosecution in the UK?

Micro factors include any history of FGM within the family, what are the attitudes of the wider family, what safeguards can the family put in place and how have the family cooperated?

Summary

These cases allow us to understand the factors that the courts consider relevant and to distil potential information that a midwife may hold that may be useful to those seeking an FGMPO. This is not to suggest that midwives engage in interviewing patients and clients, merely that they may already be in possession of relevant information which will allow them to assess whether to choose to report a risk or encourage a parent to seek an FGMPO. The cases also demonstrate that FGMPOs are not automatically granted but, once the process begins, there is accountable oversight including the potential for imprisonment, if breached. The process can lead to positive statements and declarations by parents not to put their child at risk of FGM: notably, both parents in Child X's case declared they had no intention of having their child subjected to FGM and that they did not support the practice.

AIM

Reviewing FGMPO effectiveness

Against the above legal background, this paper aims to review the introduction of FGMPOs and to compare the number of recorded cases of FGM in Health and Social Care Information Centre (NHS Digital) data against the number of FGMPOs applied for and granted between 2015 and 2019. Further, this paper aims to assess whether FGMPOs are useful as a protective measure and to provide information to regulated healthcare professionals, including midwives, which will be useful for their continuing

professional development (CPD). The focus of this article is on women and girls currently in the UK including children taken 'on holiday' when at risk of FGM, rather than deportation of migrants when at risk of FGM.

METHOD

Data was obtained from NHS Digital showing all recorded cases of FGM by NHS Trusts and GP practices between April 2015 and September 2019.

This data set was then compared to the number of FGMPOs applied for, and granted nationally, during the same time period. This data was obtained from Family Court Quarterly Statistics data (**Ministry of Justice, 2019**).

Following this a Freedom of Information (FOI) request (**Freedom of Information Act, 2000**) was made to the Crown Prosecution Service (CPS) to ask for the number of FGM prosecutions and convictions during the same time period.

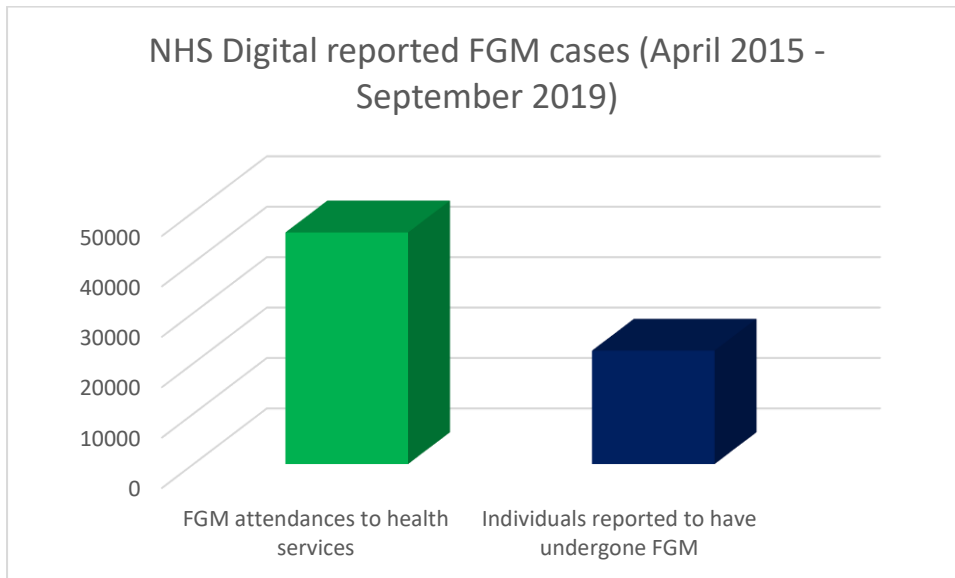
RESULTS

Between April 2015 and September 2019, a total of 45950 attendances to health services occurred in England by individuals who have been identified to have suffered FGM, or where the attendance to services was due to a consequence of suffering FGM (**NHS Digital, 2019**) (**Graph 1**).

Between this period a total of 22500 individuals have been recorded to have undergone FGM (**Graph 1**). Any individuals who have presented to health services on

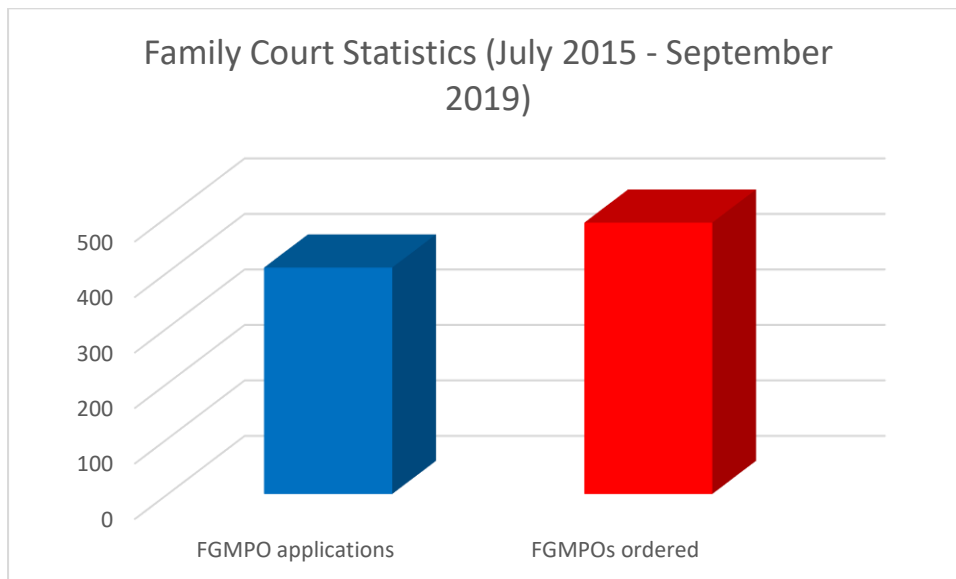
more than one occasion due to complications associated with FGM have only been recorded in this figure once (**NHS Digital, 2019**).

Graph 1: NHS Digital reported FGM cases



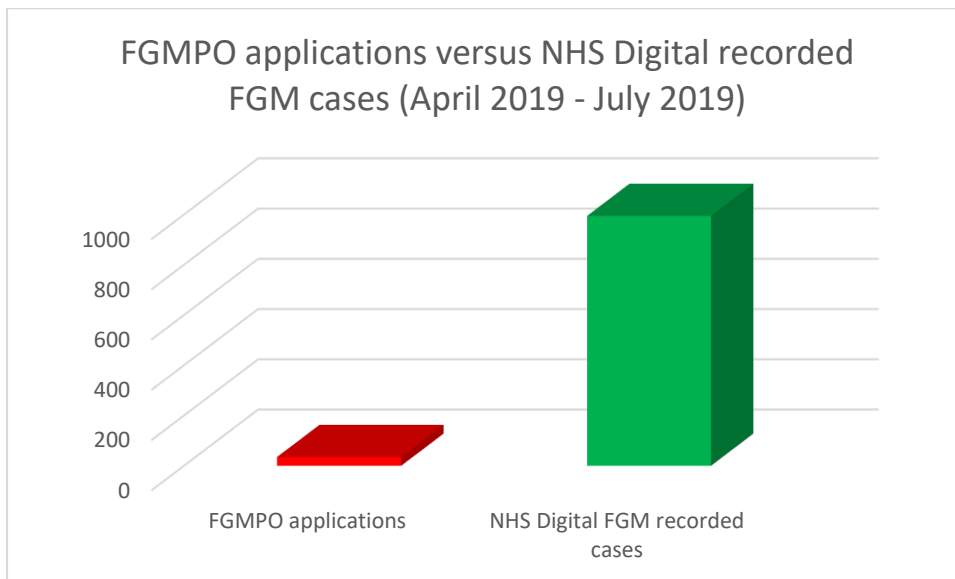
Family Court data was available for July 2015 to September 2019. During this period a total of 408 applications for FGMPOs were made to the Family Court in England and Wales. From these applications 489 orders were made (**Graph 2**). The disparity between these statistics is due to occasions where multiple orders have been granted stemming from a single application (**Ministry of Justice, 2019**).

Graph 2: FGMPO applications and orders (July 2015 to September 2019)



The discrepancy between NHS Digital data (showing the number of FGM cases) and FGMPO data is further highlighted on a micro-basis as well as a macro-basis. For example, in the quarter April 2019 to June 2019, there were 35 FGMPO applications made. This is a stark contrast to the NHS Digital figure of 995 newly recorded FGM cases in the same period (**NHS Digital, 2019**) (**Graph 3**).

Graph 3: Comparison between FGMPO applications and NHS Digital recorded FGM cases (April 2019 to July 2019)



The Crown Prosecution Service (CPS) reported that there were no FGM convictions in 2016-2017 or 2017-2018, however there was one offence charged in 2016-2017 which reached a Magistrates Court Hearing (**CPS, 2019**) (**Table 1**). In the 2018-2019 financial year there were two defendants prosecuted for FGM, one of whom was convicted and the other acquitted (**Table 1**).

Table 1: FGM offences charged and reaching a first hearing at Magistrates Courts (CPS, 2019)

		2016-2017	2017-2018	2018-2019
Female Genital Mutilation Act 2003 { 1 }	Genital mutilation of female	0	0	2
Female Genital Mutilation Act 2003 { 2 }	Aid / abet / counsel / procure the genital mutilation of a female	1	0	0
Female Genital Mutilation Act 2003 { 3A(1) and 5(2) }	Fail to protect girl from risk of genital mutilation	0	0	2

LIMITATIONS

The authors recognise that the NHS Digital dataset is not completely comparable to the Family Court Quarterly Statistics (**Ministry of Justice, 2019**) as the NHS Digital data records attendances and individuals in England only, whereas the Family Court data includes both England and Wales. Family Court data is available from July 2015 to September 2019 and NHS Digital data is available from April 2015 to September

2019. Notwithstanding that, it is very clear that there is a substantial difference between the number of women and girls who have been subjected to FGM living in the United Kingdom, and the number of Applications for FGMPOs that have been made.

DISCUSSION

This paper summarises the law introducing FGMPOs, as well as the rules surrounding mandatory reporting of FGM and when an FGMPO can be applied for (**Samuel, 2017**), in a way that will be useful to regulated healthcare professionals. This summary, in conjunction with the reflective questions within this paper, will be useful to midwives in both their clinical work, when providing advice to their patients and clients about protection from FGM, as well as in their preparation for revalidation (**NMC, n.d.**) – in particular providing evidence of keeping up-to-date with legislation and legislative-changes relevant to professional practice. It reiterates that midwives are not legal professionals and should not be giving legal advice but highlights some useful principles and evaluates progress since FGMPOs were made lawful.

A mandatory reporting duty for FGM requires regulated health and social care professionals and teachers in England and Wales to report known cases of FGM in under 18-year-olds to the police. The FGM duty came into force on 31 October 2015 (**HM Government, 2015**). Known cases of FGM are those where either a girl informs the person that an act of FGM – however described – has been carried out on her, or where the person observes physical signs on a girl appearing to show that an act of FGM has been carried out and the person has no reason to believe that the act was,

or was part of, a surgical operation within section 1(2)(a) or (b) of the FGM Act 2003 (**Female Genital Mutilation Act, 2003**).

FGMPOs were introduced to try to protect women and girls from being subjected to FGM. There have been a number of applications for FGMPOs before the court - all of the 489 orders were as a result of court hearings. Not all family law cases are published for the public, and detail of cases heard in private is not legally available via the Freedom of Information Act 2000 (**Freedom of Information Act, 2000**). Only cases which are precedent setting or of public interest are reported and published. As a result, this paper focused on using the reported cases that were of significant public interest, which set precedent in law, to underpin the background to this paper as well as to provide an evidence base to contribute to the discussion.

Alongside the legal duty imposed upon regulated health and social care professionals, and teachers, in England and Wales to report cases of FGM, in the circumstances set out in this paper, to the police, regulated healthcare professionals, including midwives, also, of course, have existing professional guidance on their obligations to protect people who are vulnerable or at risk from harm, abuse or neglect.

The Nursing and Midwifery Council (NMC), for example, requires (**NMC, 2018**) that registrants raise concerns immediately if they believe a person is vulnerable or at risk and needs extra support and protection. To achieve this, registrants must:

- take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse;

- share information if they believe someone may be at risk of harm, in line with the laws relating to the disclosure of information; and
- have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people.

Legislation introducing FGMPOs was clearly intended to extend specific protection and gather data on vulnerable people in relation to FGM and it therefore very squarely sits with the requirements of the regulator, in so far as nurses, midwives and nursing associates are concerned, to stay up to date with developments in relation to FGMPOs (and the reporting of FGM in general).

Whilst, in principle, a midwife or other healthcare professional is not a legal advisor they do have obligations to both their regulator and to the members of the public they are caring for. Such obligations include ensuring that they remain up-to-date about topical legislative issues which are relevant to professional practice so that they can provide appropriate advice to their patients and clients – not legal advice but advice on duties and obligations to report and availability of FGMPOs. Health professionals should be aware that it has been suggested that patients do not always know the law on FGM, even after a clinical consultation (**Larsson et al, 2018**).

The research described in this paper has found that there is a huge discrepancy between the number of attendances to health services in England between April 2015 and September 2019 by individuals who have been identified to have suffered FGM (45950 attendances), the number of individuals who have been recorded to have undergone FGM (22500 individuals) and the number of FGMPOs. Although it is likely

that individuals who are pregnant and have suffered from FGM will have had multiple attendances to health services during their pregnancy, the number of individuals (and attendances) still hugely exceeds the number of FGMPOs made by the court.

During the period July 2015 to September 2019, this paper reveals that a total of only 408 applications for FGMPOs were made to the Family Court in England and Wales. From these applications 489 orders were made. The disparity between these statistics is due to occasions where multiple orders have been granted stemming from a single application.

The very low levels of applications for FGMPOs may very well indicate a lack of awareness amongst the public and professionals about the legal protection that is available to protect women and girls from FGM, although specific research is required in a new study to understand the exact reasons behind the low number of applications compared with FGM cases.

Midwives' contact with women and families puts them in an ideal position to be able to have discussions with women and girls who may be at risk of FGM, or who may know people who are worried about FGM or are known to be at risk of FGM, about the protections that are available to them, including FGMPOs. It is worth repeating that, if treated as an abuse of children, risk from FGM can be the subject of a discretionary report to child protection services (**NICE, 2017; Lazenbatt, 2010; RCM, 2016; RCM, 2017**).

It is therefore part of the core professional duty of regulated healthcare professionals to be aware of the legal protections that are available regarding FGM (including FGMPOs) and to have sensitive conversations, when safe to do so, about these with their clients, patients and families when appropriate.

Given the current very low number of FGMPO applications, it is likely (although further work is necessary in another study to ascertain the level of understanding amongst healthcare professionals, including midwives, about FGMPOs) that an educational e-learning module on FGMPOs for healthcare professionals would be beneficial in increasing awareness.

Training and knowledge of the FGMPO law gives stakeholders the opportunity to provide vital information to parents or guardians or the relevant local authority and to consider whether a referral should be made because a child is at risk of harm. Guidance on such referrals is essential and coincide with the challenges that arise in relation to professional care and, perhaps, reluctance to report to the police. These are clearly challenges for professionals.

Problems with the numbers of prosecutions and convictions remain but estimated numbers of women and children affected by FGM remain high (**Proudman, 2017**). FGMPOs act as a form of protection for women and girls. However, it is concerning that the number of cases of FGM recorded in the NHS far exceeds the number of applications for FGMPOs. This may suggest that there are some women and girls who have undergone FGM who might, perhaps, have been able to have been protected by an FGMPO had an application been made to the Court. Front-line professionals need

to be vigilant and make sure they have processes in place to report FGM in accordance with the legislation and record FGM in accordance with the NHS requirements. In addition, it is crucial that healthcare professionals have information available about FGMPOs to be able to discuss with their clients.

Courts remain reluctant to make FGMPOs, particularly when the risk is abroad, rather than in England and Wales (**BA & Anor v JA & Ors, 2018**). In addition, one of the authors of this article, who practices family law specialising in FGM, has had applications for FGMPOs dismissed because the risk of FGM was abroad, not in England and Wales, and the child did not have secure immigration status and, as such, the child was not a British national. Local authorities appear reluctant to make applications for FGMPOs when a child does not have secure immigration British status.

Whilst FGMPOs cannot prevent the Home Secretary from removing the child from the jurisdiction, they could potentially be enforceable in the child's country of origin and send a strong message to family members that FGM will not be tolerated. It is manifestly unjust for a child with British citizenship to be afforded greater protection when there is a risk of FGM through a travel ban pursuant to a FGMPO (**Re X, 2019**) yet, when a child is a habitual resident but not a British national the courts cannot impose a travel ban (**Re A, 2019**) and *Suffolk CC v RD and others* (**2020**), even if the child is at high risk of FGM. This inconsistency needs reconciling as it could suggest legal action in terms of discrimination of the applicability of FGMPOs depending on the child's immigration status.

It is not currently known if stakeholders are reluctant to be involved in an application for FGMPOs but it is understood that professionals have to balance their care of a patient with their reporting duties and that some families might be deterred from seeking support for FGM due to concerns that an order could be made by the court and their children removed from their care. In addition, court approaches have not always prevented travel overseas and in some cases, appeals have led to FGMPO's being overturned. It may therefore be the case that court approaches could have a negative impact on wider aspects of child protection processes. FGMPO's are a relatively new medium in a suite of laws and operation needs to be properly assessed to see what steps are necessary to further eradicate FGM. At present, Family Court statistics show that the number of applications and orders made for FGMPOs is very small with only 25 and 35 made respectively in April to June 2019. In total, there have been 375 applications and 418 orders made up to the end of June 2019, since their introduction in July 2015 **(UK Government, 2020)**.

There is an ongoing need to collect better data in relation to FGM and FGMPOs, led by a national FGM Commissioner, in a way that doesn't target particular communities or create additional vulnerability for women and girls. All pregnant women and girls should be asked if they have had FGM, regardless of their ethnic group, so that birth plans can be appropriate. This could trigger mandatory reporting so training and guidance on how to approach such questioning is important. It would also be useful for midwives to collect data on ethnic group and family history perhaps by developing questionnaires, and other co-designed methods of information collection, to enable information gathering in a non-discriminatory manner. Exploring attitudes of men and women towards FGM is also important **(Larsson et al, 2018)**. If done appropriately,

these strategies could give midwives an evidential basis to consider discussions regarding FGM throughout the pregnancy ensuring appropriate support is offered, including sign-posting to legal services and explaining duties and obligations to report. Analysis of policies and procedures in this area would be valuable in future research.

Women suffer physical, psychological, obstetric and sexual health issues as a result of female genital mutilation and despite having a favourable perception of the healthcare received during the pregnancy and the delivery, the provision of health education, detection and treatment of female genital mutilation by healthcare professionals has, in other work, been seen to be lacking. Healthcare policy must address insufficiencies in delivering adequate care to immigrant women who have been the victim of female genital mutilation by implementing the necessary resources and training for professionals to effectively meet the specific healthcare needs of this population and prevent this cruel practice from being perpetuated **(Pastor-Bravo, 2018)**.

RECOMMENDATIONS

1. A newly-created FGM Commissioner **(Malik et al, 2018)** should also commission a full, independent, academic evaluation of mandatory reporting of FGM, the effectiveness of FGM Protection Orders and the interaction between mandatory and discretionary reporting.
2. A simple e-learning module should be specifically developed for healthcare professionals to learn more about FGM Protection Orders with the aim of giving them the confidence and competence to have discussions with at-risk

individuals and groups on reporting by professionals and available legal services.

3. Further culturally-sensitive public awareness raising about the protections that are available from FGM, including FGM Protection Orders, the application process for an FGMPO and the professional support that is available. Part of this may be the development of non-discriminatory forms that ask about FGM at every health appointment to capture those women at risk of FGM, or who are concerned about FGM, who are presenting with non-specific symptoms.
4. There needs to be greater encouragement of local authorities to apply for FGMPOs where the child's immigration status is insecure and they are at risk of removal to their country of origin by the Home Secretary where they might be subject to FGM.

CONCLUSIONS

Performing Female Genital Mutilation (FGM) is prohibited within the United Kingdom by the FGM Act 2003. In addition to professional obligations to report risk of FGM as a form of child abuse, there is a mandatory (legal) reporting duty pursuant to Section 5B of the FGM Act 2003, which requires regulated health and social care professionals and teachers in England and Wales to report to the police cases in which FGM has been performed on children aged under 18 years old (**Department of Health, n.d.**).

An Application to the Court for an FGM Protection Order (FGMPO) (**HMCTS, 2017**) can be made to keep individual women and girls safe from FGM. There is a significant

disconnect between the number of FGMPO applications and known recorded cases of FGM. The introduction of FGMPOs requires critical exploration as there is insufficient evidence to show that, on a population basis, FGMPOs are effective in protecting women and girls from FGM. It remains unclear what impact, if any, FGMPOs are having upon the protection of women and girls at risk of FGM and further research in this area would be welcomed, particularly investigating to what extent an FGMPO actually protects an individual women or girl from FGM. A full evaluation of the law introducing FGMPOs should be instigated by a newly-created FGM Commissioner.

This paper will assist midwives providing clinical care to their clients and providing evidence to their regulator that they are up to date with the latest legislation relevant to professional practice and they can use this update towards their continuing professional development (CPD).

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