FEMALE GENITAL MUTILATION: IDENTIFICATION, REPORTING AND MANAGEMENT

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<table>
<thead>
<tr>
<th>Name and title of author/Reviewer:</th>
<th>Andrea Squires - Patient Safety Midwife Deborah Oughtibridge, Head of Safeguarding</th>
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<tbody>
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<td>September 2014 – amended: 8 Sept 2015 and January 2016</td>
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## Amendment Form

<table>
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<th>Brief Summary of Changes</th>
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| Version 1 (amended)      | January 2016         | • Added reference to new statutory duty for regulated Professionals to report FGM in under 18 year olds  
• Flowcharts amended      | Deborah Oughtibridge  |
|                          |                      | • Resources section enhanced                                                             | Debbie Rees Pollard  |
| Version 1 (amended)      | Re-issued 8 September 2015 | • Additional of new information regarding regulated professionals updating of flowcharts  
• Additional information received from the Health and Social Care Information Centre – see addition to section 7 | Deborah Oughtibridge |
| Version 1                | Re-issued 2 July 2015 | • Revised and re-issued due to change in national data collection requirements  
• This is a new document please read in full | Deborah Oughtibridge  
Andrea Squires            | 29 January 2015      |                                                                                         |                      |
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</tr>
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</table>
1. INTRODUCTION

The practice of Female Genital Mutilation (FGM) includes procedures that intentionally alter or injure female genital organs for non-medical reasons. The practice is irreversible and has no health benefits for girls or women and the procedure can cause physical morbidity and even mortality. An estimated 100 to 140 million girls and women worldwide are currently living with the consequences of FGM.

The practice became illegal in the UK in 1985 (The Prohibition of Circumcision Act 1985) and more recently the law was updated with the Female Genital Mutilation Act in 2003, whereby it is now also illegal to take a child abroad to have procedure performed. FGM is recognised internationally as a violation of the human rights of girls and women.

The reporting of any cases of FGM when they are discovered is mandated by Information Standard SCCI2026 to better support local processes in raising the awareness of the potential risks of FGM occurring to women and girls.

2. PURPOSE

The purpose of this policy is to:

- To ensure that there is prompt and early recognition of FGM by all clinical staff members.
- To ensure any safeguarding issues are identified and escalated appropriately.
- To ensure that women having undergone FGM receive the appropriate care.
- To set out arrangements for compliance with national reporting requirements.

3. CLASSIFICATION OF FEMALE GENITAL MUTILATION

The World Health Organisation (WHO) describes four classifications of FGM:

- Type 1 - Clitoridectomy: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).
- Type 2 - Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).
- Type 3 - Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.
DIAGRAM: Normal and Types 1, 2 and 3

- Type 4 - Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

3.1 Complications of Female Genital Mutilation

Immediate Complications
- Pain
- Haemorrhage
- Infection
- Urine retention

Long Term Complications
- Urine retention
- Urine infections
- End stage renal disease
- Keloid scarring
- Vesico vaginal fistula
- Recto vaginal fistula
- Vulval cysts
- Hepatitis neuroma
- Dysmenorrhoea
- Sterility
- Possible increased risk of HIV
- Sexual dysfunction
- Psychological trauma

### Childbearing Complications
- Urine infections
- Increased risk of candidasis
- Reduced vaginal opening which makes vaginal procedures difficult or impossible and painful
- Prolonged second stage
- Uterine inertia
- Increased risk of uterine rupture
- Increased risk of tears
- Increased risk of Post-Partum Haemorrhage (PPH)
- Increased risk of fetal asphyxia or death

### 4. WHO IS AT RISK OF FEMALE GENITAL MUTILATION

- It has been estimated that over 24,000 girls and women are at risk or have undergone the most severe form of FGM in the UK, although its true extent is unknown due to the hidden nature of the crime.

- FGM can be practised at any age.

- People from some communities within certain countries are more likely to practise FGM than others; this does not mean that every community from a particular country does practise FGM. However, because it can be difficult to ascertain whether a family/individual is from a practising community, professionals should consider whether their agency should be performing routine enquiry or selective enquiry (asking all females from countries where the practice is prevalent (see Appendix 1 for a map of Countries where FGM is prevalent).

- Girls may be at increased risk of harm if their mother, or any sisters/female members of the extended family, have experienced FGM.

- FGM is practised by families for a variety of complex reasons but usually in the belief that it is beneficial for the girl or woman. However, it is illegal to: perform, or arrange for someone to
perform, FGM in the UK (regardless of the nationality or immigration status or the perpetrator(s) or victim) perform, or arrange for someone to perform, FGM abroad (when either the perpetrator or victim is a UK national/permanent resident) encourage or assist a girl who is a UK national to carry out FGM on themselves, anywhere.

- FGM is a form of child abuse and a recognised strand of violence against women and girls. It can have severe short-term and long-term physical and psychological consequences for the individual.

### 5. IDENTIFICATION OF FEMALE GENITAL MUTILATION

FGM is a complex and sensitive issue that requires professionals to approach the subject carefully. All agencies should consider whether they should be performing routine enquiry (asking all service users) or selective enquiry (asking all females from countries where the practice is prevalent (see Appendix 1 for a map of Countries where FGM is prevalent).

Professionals in all agencies, and individuals and groups in the community, need to be alert to the possibility of a child being at risk of or having experienced female genital mutilation. There are a range of potential indicators that a child may be at risk of FGM; whilst on their own these do not conclusively inform us whether FGM has or is about to take place. If it becomes apparent that a girl is at risk of FGM, the professional must ensure that there is a discussion with the family about the health and legal implications, if safe and appropriate to do so.

Staff working in all clinical areas may identify FGM, however, staff working in the following areas are more likely to identify FGM, for example, Maternity, Gynaecology, Genito-urinary medicine (GUM), Paediatrics and Urology.

#### 5.1 For Children/Young Women

**Indicators that FGM may be about to take place include:**

- She is withdrawn from Personal, Social and Health Education
- She has talked about, or you know about, the arrival of a female family elder
- She talks about it to other children
- She refers to a ‘special procedure’ or ‘special occasion’ or ‘becoming a woman’
- She is going out of the country for a prolonged period
- She is taking a long holiday to her country of origin or another country where the practice is prevalent (parents may talk about it too)

**Indicators that a girl may have already experienced FGM include:**

- A girl has problems walking/standing/sitting
- A girl doesn’t take part in Physical Education or swimming
- She spends a long time in the bathroom/toilet
- She has bladder or menstrual problems
- She has prolonged or repeated absences from school
- She has a reluctance to undergo pelvic medical examinations
- She is asking for help but giving a lack of explicit information
• A change in behaviour or demeanour

If any of the above indicators are present practitioners should address the issue by:
• Exploring through observation
• Discussing the health and legal issues with the family, if safe and appropriate to do so
• Seek the advice of social care or safeguarding leads where appropriate and form a professional judgment about risk of harm

### 5.2 For Women

When asking about FGM, professionals should:

• Ensure that a woman is offered a female professional to speak to where possible
• Discuss with the individual on their own and in private
• Be sensitive to the intimate nature of the subject
• Be sensitive to the fact that the individual is likely to feel loyal to their family
• Consider the use of an Interpreter/Translation services for women whose first language is not English. Staff are discouraged to use Friends or Family to interpret.
• Be non-judgmental (pointing out the illegality and health risks of the practice, but without blaming eg. avoid terms like ‘wrong’ that indicate judgment)
• Get accurate information about the urgency of the situation if the individual is at risk
• Take detailed notes and keep a record
• Use simple language and ask straightforward direct questions that are understandable to the woman, such as:

  - “Have you been cut down there?”
  - “Is cutting practiced in your community?”
  - “Were you cut?”
  - “Is circumcision practised in your community?”
  - “Were you circumcision?”
  - “Do you have any problems passing urine?”
  - “How long does it take to pass urine?”
  - “Do you have any pelvic pain or menstrual difficulties?”
  - “Have you had any difficulties in childbirth?”
  - “Do you experience any pains or difficulties during intercourse?”

### 6. SAFEGUARDING ISSUES

• Safeguarding girls at risk of harm through FGM poses specific challenges because the families involved may give no other cause for concern with regard to their parenting responsibilities or relationships with their children. However, there remains a duty for all professionals to act to safeguard girls at risk of FGM under Working Together 2015.

• Anyone who has information that a child is potentially or actually at risk of significant harm must inform social care or the police.
• The local authority will exercise its powers and/or make enquiries to safeguard a girl’s welfare under section 47 of the Children Act 1989 if it has reason to believe that a girl is likely to be subjected to, or has been subjected to, FGM.

• If FGM is identified, the Safeguarding Pathway (Appendix 2) and Flow chart - data collection (Appendix 3) must be followed.

• Please refer to the Trust Safeguarding Policies for Adults and Children and Doncaster and Nottinghamshire Local Safeguarding Procedures.

7. DATA COLLECTION AND REPORTING

Data collection requirements:
A minimum amount of information must be collected at the time FGM is identified. This information, in accordance with the process laid out in Appendix 3, must be reported to the appropriate staff member within the Trust.

Data should be submitted every time a woman or girl has treatment related to her FGM or gives birth to a baby girl, and every time FGM is identified by a clinical member of staff, not just the first time.

Minimum mandatory data required:
• Postcode of usual address
• Forename
• Surname
• Care contact date
• FGM identification (type)

Types of FGM:

<table>
<thead>
<tr>
<th>FGM Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1</td>
<td>Partial or total removal of the clitoris and/or the prepuce (clitoridectomy)</td>
</tr>
<tr>
<td>Type 2</td>
<td>Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision)</td>
</tr>
<tr>
<td>Type 3</td>
<td>Narrowing of the vaginal orifice with creation of a covering seal by cutting the appositioning labia minora and/or the labia majora, with or without excision of the clitoris (infibulation)</td>
</tr>
<tr>
<td>Type 4</td>
<td>All other harmful procedures to the female genitalia for non-medical purposes, for example: prickling, piercing, incising, scraping and cauterization</td>
</tr>
<tr>
<td>Type 9</td>
<td>Not known</td>
</tr>
</tbody>
</table>

Data collection - Patient consent and confidentiality
As the FGM Enhanced dataset will be underpinned as a result of Department of Health directions under the Health & Social Care Act 2012 s.254, this effectively requires no patient consent to be sought in order to collect this information and subsequently share this with HSCIC.
However, where it is deemed clinically appropriate for FGM information to be noted and processed previously, then patients must be informed\(^1\) of how their information will be used and what steps the patient can take if they have any objections to the intended use of the information that is being collected about them.

Although the HSCIC is permitted to collect, hold and process patient-identifiable FGM information under the Health and Social Care Act 2012 s.254, it is obliged to ensure that there is a legal gateway in place before sharing this data with third parties.

It is not intended that patient-identifiable data will be shared with other parties. Such activity would require explicit patient consent, Section 251 support under the NHS Act 2006, or another statutory gateway.

It is intended however, that the FGM information collected and disseminated using the Clinical Audit Platform will support the publication of patient-anonymised Official Statistics.

The Trust will therefore:

- Record the FGM information in the patients notes, and then;

- Tell the patient that **unless they object** that we will send their FGM data plus their personal data - which will identify them individually - to HSCIC for further processing as directed by the Department of Health;

- Record their consent or non-consent to further processing in the patients notes;

- Explain to them that under DPA 1998 s.10, that if they do consent to our releasing their personal data to HSCIC that they can further challenge that ‘fair processing’\(^1\) at a later date with HSCIC should they wish to;

**Duty of Regulated Professionals – reporting of FGM in under 18 year olds.**

National Home Office guidance has been published in relation to mandatory reporting of FGM in girls under 18 years of age. Regulated health and social care professionals and teachers in England and Wales must report ‘known’ cases of FGM in under 18’s which they identify in the course of their professional work to the police.

**Mandatory reporting** must be via Police 101 telephone number unless an emergency.

The duty applies from **31 October 2015**

See Appendix 2b

\(^1\) Fair processing under the Data Protection Act 1998: Fairness generally requires you to be transparent – clear and open with individuals about how their information will be used. Transparency is always important, but especially so in situations where individuals have a choice about whether they wish to enter into a relationship with you. If individuals know at the outset what their information will be used for, they will be able to make an informed decision about whether to enter into a relationship, or perhaps to try to renegotiate the terms of that relationship.
8. MONITORING

<table>
<thead>
<tr>
<th>What is being Monitored</th>
<th>Who will carry out the Monitoring</th>
<th>How often</th>
<th>How Reviewed/Where Reported to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of reported cases of FGM</td>
<td>Information Services/Corporate Safeguarding Team</td>
<td>Monthly</td>
<td>Central Data Collection/Coding Head of Safeguarding Information services</td>
</tr>
<tr>
<td>General awareness of FGM</td>
<td>Training/Corporate Safeguarding Team</td>
<td>Ongoing</td>
<td>Via existing training/supervision Via recording of contacts to Safeguarding Team</td>
</tr>
</tbody>
</table>

9. TRAINING

General awareness will take place as part of publication of the policy. In addition information about FGM and this policy will be within mandatory Safeguarding training. Information is also available on the safeguarding section of the Intranet.

10. EQUALITY IMPACT ASSESSMENT

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See Appendix 4).

11. ASSOCIATED TRUST PROCEDURAL DOCUMENTS

PAT PS 8 - Safeguarding Adults Policy

PAT PS 10 - Safeguarding and Promoting the Welfare of Children

12. REFERENCES AND FURTHER READING


Resources available

Department of Health/NHS England

Female Genital Mutilation Risk and Safeguarding – Guidance for professionals published by the Department of Health in March 2015

Patient Information Leaflet in English, available to order from DH Orderline in other languages and English. Please note, all language versions are available to download on this page at NHS Choices.

Support materials and videos including patient information leaflets and health passports in 11 languages: www.nhs.uk/fgmguidelines

FGM Prevention programme work. Safeguarding women and girls at risk of FGM


This document provides practical help to support NHS organisations developing new safeguarding policies and procedures for female genital mutilation (FGM).

Commissioning services to support women and girls with FGM

https://www.gov.uk/government/publications/services-for-women-and-girls-with-fgm

This document sets out what some elements of a successful and safe service to support women and girls with female genital mutilation (FGM) might look like.

DoH/ NHS England  FGM Mandatory Reporting – support pack for health professionals-
professional duty to report cases of FGM in girls under 18 to the police

A package of support including:

- **Quick guidance** – a 2-page summary of the duty including a process flowchart
- **Poster** – a poster for health organisations to display about the duty
- **Training slides** – a training presentation organisations can use to help them deliver 10 – 15 minute updates to staff to explain the duty
- **Video interviews** with Vanessa Lodge, NHS E National FGM Prevention lead

An **information leaflet** for patients and their families which professionals can use to help when discussing making a report to the police.

The video can also be found at [www.nhs.uk/fgmguidelines](http://www.nhs.uk/fgmguidelines)

**Home Office FGM guidance and documents**

For information on FGM go to **FGM@dh.gsi.gov.uk**

- Here is the page on the **Gov.uk** site which links to all the relevant documents on the site - [https://www.gov.uk/government/collections/female-genital-mutilation](https://www.gov.uk/government/collections/female-genital-mutilation)
- ‘**A Statement Opposing Female Genital Mutilation**’ also known as the FGM Health passport, available to order from Home Office or to download from NHS Choices
## APPENDIX 1 - PREVALENCE

### Figure 1: Prevalence of FGM among Women Aged 15-49 in Africa

Source: UNICEF (October 2010), global databases based on data from Multiple Indicator Cluster Survey, Demographic and Health Survey and other national surveys, 1997–2009.

### Table: Prevalence of FGM Among Women Aged 15-49 in Africa

<table>
<thead>
<tr>
<th>Year</th>
<th>Country</th>
<th>FGM Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>Somalia</td>
<td>97.9%</td>
</tr>
<tr>
<td>2005</td>
<td>Guinea</td>
<td>95.6%</td>
</tr>
<tr>
<td>2006</td>
<td>Djibouti</td>
<td>93.1%</td>
</tr>
<tr>
<td>2008</td>
<td>Sierra Leone</td>
<td>91.3%</td>
</tr>
<tr>
<td>2008</td>
<td>Egypt</td>
<td>91.1%</td>
</tr>
<tr>
<td>2006</td>
<td>Sudan</td>
<td>89.3%</td>
</tr>
<tr>
<td>2002</td>
<td>Eritrea</td>
<td>88.7%</td>
</tr>
<tr>
<td>2006</td>
<td>Mali</td>
<td>85.2%</td>
</tr>
<tr>
<td>2005/06</td>
<td>The Gambia</td>
<td>78.3%</td>
</tr>
<tr>
<td>2005</td>
<td>Ethiopia</td>
<td>74.3%</td>
</tr>
<tr>
<td>2006</td>
<td>Burkina Faso</td>
<td>72.5%</td>
</tr>
<tr>
<td>2007</td>
<td>Mauritania</td>
<td>72.2%</td>
</tr>
<tr>
<td>2007</td>
<td>Liberia</td>
<td>58.3%</td>
</tr>
<tr>
<td>2004</td>
<td>Chad</td>
<td>44.9%</td>
</tr>
<tr>
<td>2006</td>
<td>Guinea-Bissau</td>
<td>44.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Country</th>
<th>FGM Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>Côte d'Ivoire</td>
<td>36.4%</td>
</tr>
<tr>
<td>2008</td>
<td>Nigeria</td>
<td>29.6%</td>
</tr>
<tr>
<td>2005</td>
<td>Senegal</td>
<td>28.2%</td>
</tr>
<tr>
<td>2008/09</td>
<td>Kenya</td>
<td>27.1%</td>
</tr>
<tr>
<td>2006</td>
<td>Central African Republic</td>
<td>25.7%</td>
</tr>
<tr>
<td>1997</td>
<td>Yemen</td>
<td>22.6%</td>
</tr>
<tr>
<td>2004/05</td>
<td>Tanzania</td>
<td>14.6%</td>
</tr>
<tr>
<td>2006</td>
<td>Benin</td>
<td>12.9%</td>
</tr>
<tr>
<td>2006</td>
<td>Togo</td>
<td>5.8%</td>
</tr>
<tr>
<td>2006</td>
<td>Ghana</td>
<td>3.8%</td>
</tr>
<tr>
<td>2006</td>
<td>Niger</td>
<td>2.2%</td>
</tr>
<tr>
<td>2004</td>
<td>Cameroon</td>
<td>1.4%</td>
</tr>
<tr>
<td>2005</td>
<td>Zambia</td>
<td>0.9%</td>
</tr>
<tr>
<td>2006</td>
<td>Uganda</td>
<td>0.6%</td>
</tr>
</tbody>
</table>
APPENDIX 2A – SAFEGUARDING PATHWAY

SAFEGUARDING PATHWAY

ADULT

- Has undergone FGM
  - Ask her if she would like to report to the police (and offer support doing this/offer to do on her behalf) and offer to refer her to support services
  - Does she have female children?

- Has undergone FGM or you have concerns she is at risk of FGM and you have concerns that she lacks capacity
  - The matter must be reported as an adult safeguarding concern using Appendix 3 (a copy must be sent to information services)

Go to Appendix 2B
APPENDIX 2B – SAFEGUARDING PATHWAY

CHILD

Are you concerned that a child (child is 0-18 years) may have had FGM or be at risk of FGM?

1. Child/Young person tells you they have had FGM
2. You have observed physical signs appearing to show of FGM
3. Parent/Guardian describes child has had FGM
4. You consider the child to be at risk of FGM

- Mandatory reporting duty for regulated professionals applies
- Professional who has identified the FGM calls Police 101 and informs the DBHFT Safeguarding Team

- Follow local safeguarding procedures and refer child to Social Care and inform the DBHFT Safeguarding Team
FLOW CHART – DATA COLLECTION

FGM and type identified by clinician

Document in notes including type

Notes received by Coding Department

Request patient consent and record outcome

Maternity Services

Put onto K2 system

Information services extract data from K2

Contact Safeguarding Midwife for advice if needed

Other clinical area

Contact Safeguarding Professional ext. 642437 & inform them of FGM Type and patient case note number. Inform them if consent obtained or not.

Safeguarding Professional
- Pull notes
- Contact Information Dept.
- Complete data collection with Information Dept. personnel
### APPENDIX 4 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

<table>
<thead>
<tr>
<th>Service/Function/Policy/Project/Strategy</th>
<th>CSU/Executive Directorate and Department</th>
<th>Assessor(s)</th>
<th>New or Existing Service or Policy?</th>
<th>Date of Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female Genital Mutilation</td>
<td>Safeguarding</td>
<td>Andrea Squires</td>
<td>New policy</td>
<td>05.02.15</td>
</tr>
</tbody>
</table>

1) **Who is responsible for this policy?** Safeguarding  
2) **Describe the purpose of the service / function / policy / project/ strategy?** To enable identification and management of FGM  
3) **Are there any associated objectives?** National Information Collection Requirement  
4) **What factors contribute or detract from achieving intended outcomes?** – Prompt recognition and adherence to policy  
5) **Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief?**  
   - If yes, please describe current or planned activities to address the impact  
   Only women are affected by FGM, no measures necessary  
6) **Is there any scope for new measures which would promote equality?** None  
7) **Are any of the following groups adversely affected by the policy?**  
<table>
<thead>
<tr>
<th>Protected Characteristics</th>
<th>Affected?</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Age</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>b) Disability</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>c) Gender</td>
<td>Yes</td>
<td>Policy only applies to females</td>
</tr>
<tr>
<td>d) Gender Reassignment</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>e) Marriage/Civil Partnership</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>f) Maternity/Pregnancy</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>g) Race</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>h) Religion/Belief</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>i) Sexual Orientation</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>
8) **Provide the Equality Rating of the service / function /policy / project / strategy** – tick (✓) outcome box  
   | Outcome 1 ✓ | Outcome 2 | Outcome 3 | Outcome 4 |

*If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a Detailed Equality Analysis form in Appendix 4*  

**Date for next review:** September 2017  
**Checked by:** Andrea Squires  
**Date:** 05.02.15