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Equalities, Human Rights and Civil Justice Committee
The Scottish Parliament
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6 March 2026

Dear Karen,

Thank you for your letter of 26 February 2026 regarding the updates in relation to the Children (Scotland) Act 2020, Domestic Abuse (Protection) (Scotland) Act 2021 and the Female Genital Mutilation (Protection and Guidance) (Scotland) Act 2020.

In response to your specific questions on the Female Genital Mutilation (Protection and Guidance) (Scotland) Act 2020:

As noted, I stated to the Committee in June 2025 that the draft statutory guidance would be circulated to stakeholders for feedback during 2025. In line with this, officials circulated the revised draft guidance in December 2025 through the Addressing Violence Against Minority Ethnic Women and Girls network. This approach follows the initial review undertaken by the statutory guidance working group and is intended to ensure that specialist organisations, as well as health, education, social work and policing professionals who will use the guidance in practice are able to provide input to ensure the document is robust and fit for purpose.

The reference to 'stakeholders' related specifically to practitioner and specialist organisations directly involved in responding to and preventing FGM. There was no intention to imply that the Committee would not have an interest in the guidance. Please see attached our early draft of the statutory guidance. This draft is in its early stages and there will likely be changes as we receive feedback on it, however hopefully it is helpful for the Committee to see the guidance at this stage.

Our Public Health Scotland colleagues have provided the following information on the data they have access in regards to FGM:

PHS has access to the following datasets:

- The General/Acute and Inpatient Day Case dataset (SMR01) which collects episode level data on hospital inpatient and day case discharges from acute specialities from hospitals in Scotland

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- Maternity Inpatient and Day Case dataset (SMR02) which collects episode level data every time a mother goes in for an obstetric event (this can be an antenatal, delivery or postnatal episode)
- The Mental Health Inpatient and Day Case dataset (SMR04) collects episode level data on patients who are receiving care at psychiatric hospitals at the point of both admission and discharge.

The above datasets record "A personal history of female genital mutilation" if FGM has been identified. The SMR01 and SMR02 datasets will record if 'deinfibulation of vulva' has taken place.

The SMR datasets capture patient identifiers such as date of birth, sex, marital status and ethnicity where this has been recorded. Religion is not captured within these datasets.

A wide variety of geographical measures are also included or derived such as Carstairs/SIMD deprivation measures, census output area, NHS Board, Electoral Ward and Parliamentary constituency. For more information, the SMR crib sheets provide a summary of the codes available for each SMR record.

I hope this detail is of assistance to the Committee.

Yours sincerely,

KAUKAB STEWART

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FGM STATUTORY GUIDANCE

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1. Status and Purpose of Guidance

Status

1. This statutory guidance is being issued under Female Genital Mutilation (Protection and Guidance) (Scotland) Act 2020 section 2 and 3[1] and pertains to Scotland only.

2. As statutory guidance issued under the Act, a person executing public functions to whom this guidance is given must have regard to it in the exercise of those functions. This means that a person to whom the guidance is given must take the guidance into account and, if they decide to depart from it, have clear reasons for doing so.

Audience

3. This statutory guidance should be read and followed by all persons and bodies in Scotland who are under statutory duties to discharge their functions having regard to the need to safeguard and promote the welfare of children and vulnerable adults. The following list is not exhaustive, however may include: Police Scotland, NHS Health Boards and local authority services, professional bodies, integration joint boards, adult social work services, local authority services such as housing and education..

Aim and Purpose

[1] Female Genital Mutilation (Protection and Guidance) (Scotland) Act 2020

4. This guidance outlines the responsibilities of organisations and individuals in their professional capacity and promotes a consistent approach to Female Genital Mutilation (FGM) across all agencies and areas.

5. The guidance reflects the legal framework established through the following three Acts; The Female Circumcision Act 1985, The Prohibition of Female Genital Mutilation (Scotland) Act 2005 and The Female Genital Mutilation (Protection and Guidance) (Scotland) Act 2020.

6. Chapters 1 to 7 of this guidance provide an overview of FGM, including its definition, context, health consequences, and its relationship to other forms of violence against women (VAWG). These chapters also outline the legal frameworks in Scotland, England and Wales, and internationally, and offer practical advice on identifying and responding to risk, sector specific responsibilities, and good practice approaches across sectors.

7. Chapter 8 focuses specifically on the process for applying for FGM Protection Orders under the Female Genital Mutilation (Protection and Guidance) (Scotland) Act 2020 including who can apply and how, considerations to take when applying, what the orders can include and their impact.
8. This guidance should be considered in conjunction with other relevant safeguarding guidance, including, but not limited to Responding to Female Genital Mutilation in Scotland Multi-Agency Guidance, National Guidance for Child Protection in Scotland and The Adult Support and Protection (Scotland) Act 2007 and organisational protocols and policies identified.

9. This guidance is not intended to replace wider safeguarding guidance, but to provide guidance for organisations on their roles and responsibilities in responding to FGM.

10. Efforts to prevent and reduce FGM are most successful when the communities affected are actively and directly involved and supported to be so, as partners. The guidance, therefore, outlines how organisations need to work with communities; listen to their concerns; and find solutions and services which are relevant and workable.

2. The Law in Scotland

11. FGM is illegal in Scotland. It violates the rights of women and girls and contravenes international, Scots and UK law.

12. The Prohibition of the Female Circumcision Act 1985[2] provides specific legislation to make FGM unlawful in Scotland. The Prohibition of Female

[2] Prohibition of Female Circumcision Act 1985

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Genital Mutilation (Scotland) Act (2005)[3] as amended (the 2005 Act) makes it unlawful for a person to carry out specified FGM procedures on another person.

13. The legislation also makes it an offence for a person to aid, abet, counsel, procure or incite:
- Another person to commit an offence of FGM
- Another person to carry out FGM on herself or another person who is not a UK national or UK resident to carry out FGM outside of the UK (for example to arrange by telephone from Scotland for their daughter to have an FGM operation carried out abroad by a non UK national or UK resident).

14. The penalty on conviction on indictment is up to 14 years' imprisonment.

15. The Female Genital Mutilation (Protection and Guidance) Act 2020[4] strengthens the protections for women and girls at risk of FGM in Scotland. The Act creates FGM protection orders which are intended to prevent FGM from occurring, protect individuals who have already experienced FGM and reduce the likelihood of FGM-related offences.

16. The orders can put in place restrictions on travel, requirements to bring individuals to court or safe locations and prohibitions on contact or conduct.

17. The Act specifically applies to Scotland and includes protections where individuals may be at risk of being taken abroad for FGM.

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18. *Lines to be added on the law if a Scottish person is taken out of Scotland/UK for FGM to be performed and to note the role of the FMU. E.g The Forced Marriage Unit is a joint Foreign, Commonwealth and Development Office and Home Office unit which offers support to victims or potential victims of forced marriage. The Forced Marriage Unit can assist British nationals facing forced marriage abroad by helping them to a place of safety and helping them to return to the UK. It can assist non-British nationals facing marriage abroad by referring them to local organisations that can help. The contact details for the Forced Marriage Unit can be found in Annex X

19. Orders can be applied for by the person at risk, the Lord Advocate, local authorities, police and others with court permission. Please see Chapter 8 for further information and advice on the protection orders specifically.

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[3] Prohibition of Female Genital Mutilation (Scotland) Act 2005
[4] Female Genital Mutilation (Protection and Guidance) (Scotland) Act 2020

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3. The Law in England and Wales/International Law

20. This section outlines the law on FGM in England and Wales in relation to FGM. This is given as people often move or have connections across the border and it is important to be aware of how the law applies in other parts of the UK to provide consistent safeguarding against FGM.

21. The UK is also a part of or signed up to various global human rights agreements, outlined below, which highlight FGM as a serious violation which must be criminalised and prevented.

England and Wales

22. In England and Wales, the law is similar to Scotland's law on FGM. The Female Genital Mutilation Act 2003, as amended by the Serious Crime Act 2015, makes FGM a criminal offence and extends the law to acts committed abroad by UK nationals or residents.

23. However, there are some distinctions between policy and practice in England and Wales and Scotland. These include additional duties in England as Wales, such as mandatory reporting duty for regulated professionals. There is also an offence of failing to protect a girl from FGM, which can apply to parents of guardians. These duties do not apply in Scotland.

International Law

24. FGM is recognised as a fundamental violation of human rights. The UN Convention on the Rights of the Child[5] (CRC) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)[6] require states to eliminate harmful practices such as FGM. Additionally, the Istanbul Convention on Preventing and Combating Violence against Women and Domestic Violence[7], which was ratified by the UK in 2022, articles specify that states should criminalise FGM and ensure support for victims and survivors.

[5] Convention on the Rights of the Child | OHCHR
[6] Convention on the Elimination of All Forms of Discrimination against Women New York, 18 December 1979 | OHCHR
[7] CETS 210 - Council of Europe Convention on preventing and combating violence against women and domestic violence

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4. Understanding FGM

4.1 Definition

25. The World Health Organisation (WHO) defines FGM as 'all procedures all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons[8].

26. WHO classifies the practice into four types:

[8] Female genital mutilation - WHO Definition

- Clitoridectomy (Type I): 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).
- Excision (Type II): 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).
- Infibulation (Type III): narrowing of the vaginal opening by creating a covering seal. The seal is formed by cutting and repositioning the inner or outer labia, with or without removal of the clitoris
- Other (Type IV): all other harmful procedures to the female genitalia for nonmedical purposes, such as pricking, piercing, incising, scraping and cauterising the genital area. This includes labia elongation, also referred to as labia stretching or pulling, in which the labia minora are stretched sometimes using sticks, harnesses or weights.

27. FGM has no health benefits and there is no medical reason to carry out FGM. It harms girls and women and is a form of child abuse and violation of fundamental human rights.

4.2 Terminology

28. Female Genital Mutilation (FGM) is an internationally recognised term. It conveys the severe harm it causes to women and girls.

29. Women and girls affected by FGM may not describe themselves as 'mutilated' and may not recognise the term 'FGM'. Instead, they may use other words such as 'cutting' and 'circumcision'. Practitioners should be attentive to the language a woman uses to describe her experience and aim to mirror it in their own responses.

4.3 Context

30. FGM is practiced globally across different continents, countries, communities and belief systems. FGM is most prevalent in parts of Africa (particularly in countries like Somalia, Guinea, Djibouti, Ethiopia, and Egypt), Asia, and the Middle East. It also occurs in migrated communities worldwide, including in Europe, North America, and Australia[9].

31. The procedure is typically carried out on young girls between infancy and 15. However, FGM can happen at different times in a girl or woman's life,

[9] Female Genital Mutilation (FGM) Statistics - UNICEF Data

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including; when a baby is new-born, during childhood or as a teenager, just before marriage or during pregnancy[10].

32. FGM is often rooted in cultural or social norms, including beliefs about purity, modesty and marriageability. In some communities, FGM may be considered an important part of a girl's growth and development. It may not be seen as a form of abuse, but instead, a form of protection. Some people may believe that not following this practice could negatively affect their cultural identity or traditions.

33. It is important to be aware that no religious texts mandate FGM, and it is condemned by major faith leaders globally. Practitioners should approach the topic with cultural sensitivity and be cautious against profiling women or families.

34. Among communities where FGM is found, attitudes about the practice vary widely. As such, not all women and girls from communities or countries where FGM is practiced are affected or at risk. Assumptions should not be made based on a women or girls background or community.

35. It is difficult to assess the full scale of FGM in Scotland due to the hidden nature of the practice. While some information on FGM may be recorded through health or other services/settings, there is no consistent or comprehensive national data collection on FGM.

4.4 Health Consequences of FGM

36. FGM can have multiple and severe consequences for physical and mental health in the short terms and throughout a woman's life.

37. The immediate physical and mental health consequences can include:

- Severe pain
- Emotional and psychological shock (exacerbated by being subjected to the trauma by loving parents, carers, extended family and friends).
- Post-traumatic Stress Disorder
- Haemorrhage
- Wound infections including Tetanus and blood-borne viruses (including HIV and Hepatitis B and C)
- Urinary retention and leakage
- Injury to adjacent tissues
- Fracture or dislocation as a result of restraint

- Cysts, abcesses, scar tissues and tightness
- Infertility or fertility issues

[10] Female Genital Mutilation - Prevent & Protect | NSPCC

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- Damage to other organs
- Death

38. In the long term, women can experience recurrent sexual, psychological and physiological problems. These are likely to require specialist support, surgical and psychological interventions. Women may not seek this support as they may not view FGM is a harm or due to shame or fear of disclosure.

39. FGM may cause increased complications during pregnancy and childbirth. FGM is associated with an increased risk of caesarean section, postpartum haemorrhage, episiotomy, difficult labour and other medical issues[11].

40. Other long-term health risks of FGM can include:
- Infections (chronic genital infections, chronic reproductive tract infections and urinary tract infections).
- Vaginal problems
- Menstrual problems
- Sexual health problems (FGM damages the anatomic structures that are directly involved in female sexual function, and can have an effect women's sexual health and well-being)
- Mental health problems (women who have undergone FGM are more likely to experience post-traumatic stress disorder (PTSD), anxiety disorders, depression and physical responses to harm with no organic cause[12]). Important to be aware, that the fact that FGM is accepted in her culture and community does not protect a girl or woman from developing PTSD or other psychiatric disorders.

41. In consideration of the above consequences, professionals should ensure that girls and women are offered or referred to mental health support as well as treatment for any physical symptoms or complications.

4.5 FGM and other forms of VAWG

42. FGM shares some of the underlying drivers as other form of violence against women and girls such as honour-based abuse (definition in Annex X). These include the enforcement of patriarchal norms and control over women and girls' bodies, behaviours, and sexuality to uphold perceived family or community 'honour'. Practitioners should be aware that a woman or girl at risk of FGM may also be at risk of honour-based abuse.

[11] Sexual and Reproductive Health and Research (SRH)
[12] Sexual and Reproductive Health and Research (SRH)

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43. In some communities, FGM is a prerequisite for marriage, which can link it directly to forced marriage. This intersection can mean that girls who are risk

of FGM may also be at risk of forced marriage. Scotland's statutory forced marriage guidance provides guidance to organisations.

44. For organisations and professionals, it is important to understand these connections. A disclosure of FGM may indicate wider safeguarding concerns such as Forced Marriage. Effective responses require a joined-up approach – to ensure that the victim/survivor is protected from the risk of other harms.

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5. Identifying and Responding to Risk

45. This chapter provides guidance on identifying risks associated with FGM.

46. For under 18's, GGM is a form of child abuse as well as gender-based violence and the response should therefore follow child protection pathways. All responses to cases of FGM should be proportionate to the level of risk and always prioritise the safety and welfare of the child. For adults, professionals and organisations should assess for ongoing wider GBV risks or adult protection concerns.

5.1 Risk indicators

47. In different cultures and communities, FGM is performed at different ages. A girl/woman could be at risk in infancy, early childhood, adolescence, at marriage or first pregnancy. A professionals might identify potential risk to a girl at birth that may not become an imminent risk until she is older.
48. Below is a non-exhaustive list of risk indicators that indicate a girl should be viewed as an increased risk:

- The family is from a community in which FGM is practised • Parents expressing views which show that they value the practice.
- Other siblings or female relatives who have undergone FGM.
- The level of integration within UK society is also significant. It is believed that communities less integrated into British society are more likely to continue the practice.

49. Practitioners should not assume that all women who have experienced FGM or all men from affected communities will support the practice.

50. Practitioners must consider the risk factors within the context of the girl's overall situation, rather than assuming that an individual factor is an absoluteindicator of risk.
51. Practitioners should be aware that some evidence demonstrates that women who experience physical and/or psychological problems as a result of FGM, and who recognise the association, are less likely to support or carry out FGM on their own children and more likely to support or actively work to end FGM[13]. However, any woman may be pressured or threatened by her husband, partner or other family members to allow or arrange for her daughter to undergo FGM.

52. Indicators that a girl may be at imminent risk for FGM include:

[13] "I Can't Blame Mum": A Qualitative Exploration of Relational Dynamics in Women With Female Genital Mutilation (FGM) in the United Kingdom

• Parents say that they or a relative intends to take the girl out of the country for a prolonged period.

Girl tells a professional that she is to have a 'special procedure' or is to attend a special occasion to 'become a woman'.

A professional hears FGM coming up in conversation, for example a girl might be talking to her friends about it.

A girl might ask a teacher or another adult for help.

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53. Indicators that FGM has been performed include:

- Girl has difficulty walking, sitting, or standing
- Girl in school leaves the classroom for extended periods because of bladder or menstrual problems or ongoing bleeding or infection; she spends longer in bathroom because of difficulties urinating.
- Girl is withdrawn, depressed, shows significant behaviour change and other signs of emotional and psychological distress.
- Girl confides in a professional or asks for help but is not explicit about the problem.
- Girl needs excused from physical education or sport.
- Girl talks about pain or discomfort between her legs.
- Girl is reluctant to undergo medical examination.

54. This is not an exhaustive list of indicators. If any of these indicators are identified, professionals will need to consider what action to take

5.2 Protective Factors

55. When assessing concerns about FGM, professionals should focus primarily on identifying risk. However, consideration of protective factors is also important.

56. Protective factors are circumstances that reduce the likelihood of a girl being subjected to FGM. Considering protective factors may help professionals to take a balanced, proportionate approach, build trust with families, and strengthen resilience against harm

57. Examples of protective factors may include:
    - Family members who openly oppose FGM
    - Attendance at educational sessions about FGM

- Strong integration into communities where FGM is not practiced

58. Protective factors provide valuable context, but they must be viewed alongside risk factors and they should not be used to dismiss identified risks. If a girl is believed to be at immediate or significant risk of FGM, follow your organisation's child protection processes.

5.3 Risk assessment

59. It is important that a risk assessment (please see Annex X) is completed to determine the likelihood of a girl or woman being subjected to FGM so that appropriating safeguarding action can be taken. The main points to consider are below:

What risk factors are identified?

What are the mother's/family's views on FGM?

Protective (may be opposed to FGM and determined girl will not have it).

OR

Non-protective (may not realise health, legal, child protection issues and believe girl should have FGM).

OR

Undetermined.

Any conversation with the mother should happen separately to the conversation with wider family.

Is there an impending trip to the country of origin?
This significantly increases imminence of risk.

60. If there is a concern about FGM, practitioners should also consider the potential risk to other girls in the wider family/community who may also need protection.

61. The level or extent of risk may change over time. Practitioners should be alert to changes in circumstances which may elevate risk and the need to undertake the risk assessment.

62. Please see Annex X for a risk assessment framework which has been adapted from the Department of Health in England for Scottish context. (INCLUDED AT BOTTOM).

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63. If you know a child is at imminent risk of FGM:

- Contact Social work and Police Scotland immediately

  If you have significant concerns but do not think the child is at immediate risk:

  Follow your agency's child protection procedures and guidance within this document.

  Share appropriate and relevant information with social work

  Document your concerns and findings in accordance with your organisation's information governance policy..
- Consider the use of emergency measures such as FGM protection orders (chapter X) or child protection powers (relevant to social work and Police Scotland only).
- Do not attempt mediation with the child's family members which may increase risk. Further information on this risk can be found on page X

64.

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Commented [EH1]: As updated at the AVAMEWAG network on 11 December. We will be taking into account the feedback we receive and research being undertaken by Bristol University which will provide us with further evidence to help explain risk and protective factors and develop risk pathways.

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6. Roles and Responsibilities

6.1 Multi-agency approach

65. It is important that all agencies take a multi-agency approach. In 2017, the Scottish Government published 'Responding to Female Genital Mutilation in Scotland – Multi-Agency Guidance'. This guidance outlines how agencies such as NHS, Police Scotland, education and social work services have a statutory responsibility to protect girls and young women at risk of FGM. It also makes clear that efforts to prevent and reduce FGM are most successful when the communities affected are actively and directly involved, and supported to be so, as partners.

66. This means that agencies need to work with communities; listen to their concerns; and find solutions and services which are relevant and workable. This statutory guidance should be read in conjunction with the multi-agency guidance.

6.2 Roles and Responsibilities of Chief Executives, Directors and Senior Managers

67. Existing strategic bodies have a responsibility to develop and implement multiagency policies and procedures for FGM. This includes strategic partnerships, such as multi-agency Violence Against Women Partnerships, community safety partnerships, and local Child Protection and Adult Protection Committees who should work together to ensure a consistent and joined up and effective response.

68. All Chief Executives, Directors and senior managers exercising public functions should ensure:

- Staff are aware of their responsibilities and duties when working with victims/survivors of FGM.

- In each organisation/agency there is a person with lead responsibility for the issue of FGM. This is likely to be the person who holds the responsibility for protecting children, adults at risk, or victims of other forms of gender-based violence. The contact details of this person should be publicised both within the organisation and with appropriate external partners.

- The person with lead responsibility ensures there is an organisational response to FGM and ensures that cases of FGM are handled, monitored and recorded in line with the organisations recording procedures.

- Appropriate measures are taken to ensure staff have undertaken relevant training to ensure their understanding of the issue. Appendix X contains links and information on training.

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- Staff have an awareness and understanding of the nature and impact of FGM and how it impacts or fits into their organisations strategy and is relevant to their work.

- Staff have awareness and access to this guidance and multi-agency guidance[14] to support them to understand their statutory responsibilities when protecting individuals at risk of, or have undergone, FGM.

- Policies and procedures are updated regularly to reflect any structural, departmental and legal changes.

6.3 Information sharing and confidentiality

Data Protection

69. The data protection regime in the UK consists of two pieces of legislation: the UK General Data Protection Regulation[14], which replaced the EU GDPR following the UK's exit from the European Union in 2020; and the Data Protection Act 2018[15], which provides additional conditions and exemptions to the UK GDPR. It also governs processing for law enforcement purposes, in Part 3.

70. When considering how they approach data sharing, agencies should consult the Information Commissioner's Office Data Sharing Code of Practice[16], which is a statutory code of practice and gives information and support to assist organisations in sharing data lawfully. The GIRFEC information sharing guidance may also be useful to refer to for information and support.

71. As the code notes, organisations should approach data protection legislation as a framework to enable fair and proportionate sharing rather than a barrier, particularly in situations where more harm could come to individuals where data is not shared. Decision making to share information, or not, should always be proportionate, defensible and fully recorded.

72. Agencies should also familiarise themselves with exemptions in the Data Protection Act 2018, which can be applied on a case-by-case basis and can allow for data to be re-used or shared in certain ways in order to protect individuals. A guide to the data protection exemptions can be found on the ICO website alongside examples of the exemptions being applied.

73. Organisations should ensure that:

[14] Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (United Kingdom General Data Protection Regulation) (Text with EEA relevance)
[15] Data Protection Act 2018
[16] Data sharing: a code of practice | ICO

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15. Responding to female genital mutilation: multi-agency guidance - gov.scot

- Their policies and procedures regarding FGM include arrangements for sharing information and making referrals, including, where appropriate, with the police, social work and/or health professionals. This will depend on age of the victim.
- Staff understand the difference between breaking confidence (involving the family, community members, etc without the victim's consent) and sharing information with other professionals to protect the individual from significant harm. It is important to recognise that, while the use and sharing of personal data must be done lawfully, data protection legislation should not be seen as a barrier to protecting at-risk individuals.
- Further information on data sharing can be found in Chapter 3 of the Adult Support and Protection (Scotland) Act 2007: Code of Practice[17], in Chapter 1, paragraphs 128-153 of the National Guidance for Child Protection 2021[19] and GIRFEC practice guide 4[18].

Confidentiality

74. Issues may arise if an individual at risk of FGM is concerned that if their confidentiality is breached, and their family is alerted to the fact they have sought help, they could be at risk of harm or getting their family into trouble.

75. Confidentiality, privacy and information sharing are extremely important for anyone threatened with, or who has experienced FGM. Professionals must be clear about when confidentiality can be offered, and when information given in confidence should be shared. To note, within child protection and under 18 year olds, consent it not optional so should not be offered if it cannot be freely withdrawn.

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[17] Adult Support and Protection (Scotland) Act 2007: Code of Practice - gov.scot [19] www.gov.scot/binaries/content/documents/govscot/publications/advice-andguidance/2023/08/national-guidance-child-protection-scotland-2021-updated-2023/documents/national-guidance-child-protection-scotland-2021-updated-2023/national-guidancechild-protection-scotland-2021-updated-2023/govscot%3Adocument/national-guidance-childprotection-scotland-2021-updated-2023.pdf

[18] Getting it right for every child (GIRFEC) Practice Guidance 4 - Information sharing - gov.scot

7. Good Practice Response

76. A multi-agency approach to responding to FGM is to encourage engagement with families, to find supportive interventions, and to build trust with individuals and communities. To build trust, is important that communities are not marginalised, and that assumptions are not made about parents'/mothers' intentions.

77. The FGM Multi-agency guidance contains more detailed information on good practice for all practitioners[19].

7.1 Talking about FGM

78. FGM is a deeply personal issue. How it is discussed is as important as what is said and can shape all future interactions with a woman or girl. Building trust and preserving dignity are essential in providing effective safeguarding and care. It is important to approach the subject with respect, sensitive language, cultural awareness, and without judgement.

Sensitivity

79.

- Questions should be clear, sensitive, and respectful.
- Approach every conversation with empathy and without judgement
- Be careful to not show shock, use judgemental language or treat a woman as a "spectacle" which can cause deep distress, humiliation and shame. Reactions like this could deter women from seeking care or support and can damage trust within communities.
- Maintain a calm, professional approach, using culturally sensitive language,
- Be aware of cultural and religious sensitivities. Do not make assumptions about beliefs of practices based on someone's background. Instead, ask open ended questions and allow the individual to share their own experience.
- Mirror the women's terminology where possible. If they refer to FGM as "cutting" or "circumcision" use the same language in your responses.
- Maintain privacy and confidentiality. Ensure that conversations are taking place in a private setting and explain clearly how information will be used and shared.

[19] Responding to female genital mutilation: multi-agency guidance - gov.scot

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- Provide information about support services. Where possible, offer written materials, where safe to do so, in the individual's preferred language and format and explain what support is available.

Good Practice Use of Interpreters

80. It is important that all protected people and third parties have a clear understanding of the FGM protection order process from the start. If the use of an interpreter is required, consider the below points as the best practice approach.

81. Always use professional interpreters. The interpreter should have a strong understanding of the language/dialect of the victim, their culture and, if possible, awareness of the issues surrounding gender-based violence in minority groups.

82. Never use family members, friends or community members as interpreters in FGM cases. This is crucial as family and community members may be involved in encouraging or planning FGM for the individual. Additionally, disclosing that an FGM application has been made could increase the risk to the person seeking protection.

83. Generally in FGM cases, it is best practice to use female interpreters, unless the individual requests or suggests otherwise. This helps to reduce distress and encourages disclosure.

84. As much as appropriate, you should explain the context of the situation to the interpreter in advance and clarify their role as a conduit, rather than advocate or advisor.

85. Ensure the service user understands the interpreter's role and consents to their presence.

7.2 Dual Eligibility – 16/17 year olds

86. Young people aged 16 and 17 may be eligible for support under both Child Protection guidance and Adult Support and Protection (ASP). This overlap means practitioners must assess the individual's needs and circumstances to determine the most appropriate framework. This IRISS report Understanding age in Child Protection guidance and Adult Support and Protection legislation provides helpful guidance for practitioners working with 16 and 17 year olds in Scotland.

87. A child turning 16 does not automatically exclude a young person from child protection processes. Similarly, being 17 does not guarantee that ASP is more

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appropriate. The decision should be made by the practitioner and based on risk, capacity, and vulnerability, not just age and it is possible for both processes to run together.

88. IRISS guidance contains a Guidance and Legislation Table which will help compare child protection and adult, support and protection processes side-byside. This is designed to support reflective practice and discussions about how to approach complex cases involving this age group.

7.3 Health Professionals

89. All healthcare workers, including nurses, midwives and doctors, have a duty of care to girls and women who are at risk, or who have already undergone FGM.

90. Women and girls affected by FGM may present in a range healthcare settings e.g. obstetric and midwifery services, cervical smear screening, sexual and reproductive health clinics, mental health services, A&E and GP practices.

91. Further guidance for health professionals handling cases of FGM can be found within the multi-agency guidance here.

Role and responsibilities of health professionals include:

92.

- Being aware of and alert to risk indicators for FGM (Chapter X)
- Identifying and assessing risk of FGM during relevant consultations (e.g maternity booking, sexual health, GP)
- Asking about FGM sensitively and in private, using trained, independent interpreters where needed (family members or community members are not appropriate to use, please see page X for further good practice for interpreters).
- Follow the 'One Chance Rule'. There may only be one opportunity to speak to the potential victim so ensure that you take them seriously, respect their wishes and reassure them and establish a means of safe contact.
- Record information and steps taken clearly including ensuring clear visibility as a risk factor, for example, using codes or Chronologies/Significant Information sections.
- Share safeguarding concerns promptly with Social Work and Police when thresholds are met
- Providing or arranging clinical care for women and girls affected by FGM, including physical and psychological support
- Considering potential risk to children when an adult survivor is identified and act accordingly.
- Participate in child protection processes or Inter-Agency Referral Discussions when requested and provide evidence for civil measures such as FGM Protection Orders.

93. If you encounter FGM or an individual at risk of FGM:

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- If there is an immediate health need, seek emergency healthcare or call 999 if not in an appropriate health setting.
- If there is imminent or significant risk to a child (disclosure of imminent plans/travel); contact social work and Police immediately. Do not use family members to mediate. Follow appropriate child protection procedures.
- If FGM is strongly suspected or confirmed in a girl/woman ensure appropriate medical care is provided, initiate child protection procedures and consider risk to siblings or close relatives.
- If there is potential but not immediate risk follow appropriate safeguarding pathway, child protection procedures and consider IRD to agree monitoring and care going forward.
- If you suspect an Adult at risk follow the duties set out in the Adult Support and Protection (Scotland) Act 2007, reporting concerns to the local authority where action is needed to protect the individual from harm. Follow your organisation's procedures.

7.4 Police Scotland

94. Police officers and staff may encounter FGM through direct reports, referrals from other agencies, or during the course of other investigations. FGM is a crime and a child protection matter, police have a key role in safeguarding those at risk and helping ensure perpetrators are held to account. All responses should be trauma informed and co-ordinated with partner agencies such as social care.

95. The FGM multi-agency guidance provides detailed guidance for Police on responding to cases of FGM starting at page 33:

Roles and responsibilities of Police Scotland include:

96.

- Be aware of and alert to risk indicators of FGM (Chapter X)
- Follow the 'One Chance Rule'. There may only be one opportunity to speak to the potential victim so ensure that you take them seriously, respect their wishes and reassure them and establish a means of safe contact.
- Treating all cases of FGM as both a crime and a child protection matter, taking immediate protective action where an imminent risk is identified.
- Initiating and participating in IRDs with Social Work, education and Health and help co-ordinate proportionate and trauma-informed investigation.
- Seeking civil protection for the victim/survivor where necessary, including explaining and applying for FGMPO's.
- Liaising with the local authority under Adult Support and Protection procedures where adults are at risk.
- Ensuring all actions, decisions and evidence are recorded clearly and sensitively.

If you encounter FGM or an individual at risk of FGM:

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- If there is Imminent risk, take steps to prevent the procedure or remove the individual from harm. Convene an IRD urgently with Social Work/Health to agree immediate protective measures. Consider whether there is evidence to support an application for an FGMPO application.
- If FGM has occurred, ensure the child's safety and follow child protection procedures including consideration of medical care. Assess the risk to siblings and close relatives.
- If there is a non-imminent but credible risk, record the concern appropriately and share information with Social Work. Consider convening an IRD to agree on monitoring and safety planning. Consider whether a FGMPO is appropriate and proportionate.
- If an adult is at risk, liaise with the local authority under the Adult Support and Protection (Scotland) Act 2007 or other relevant legislative instruments. Where a crime has been disclosed, progress a criminal investigation and consider protective measures, including FGMPO, as appropriate.

7.5 Social Work

97. Local authorities have a statutory duty to promote, support and safeguard the wellbeing of all children and vulnerable adults in their area. Social workers play a central role in assessment, planning, and intervention for those at risk of, or affected by, FGM.

98. The FGM multi-agency guidance provides detailed guidance for Social Workers on responding to cases of FGM starting at page 39.

Role and responsibilities of social work include:

99. The role of the registered social worker in statutory interventions is outlined in the Guidance for local authorities 2010[20].

100. In terms of FGM, social workers have a responsibility to:

- Being aware of and alert to risk indicators for FGM (Chapter X)
- Follow the 'One Chance Rule'. There may only be one opportunity to speak to the potential victim so ensure that you take them seriously, respect their wishes and reassure them and establish a means of safe contact.
- Leading on assessment, planning and intervention for children at risk of, or affected by, FGM, and coordinating multi-agency protection.
- Using appropriate and evidence-based risk assessments, to consider both risk and protective factors for the individual and wider family.
- Screening and responding immediately to any concerns or disclosures, following child protection procedures or convening IRDs and agreeing on safety planning measures

[20] THE ROLE OF THE REGISTERED SOCIAL WORKER IN STATUTORY INTERVENTIONS: GUIDANCE FOR LOCAL AUTHORITIES - Role of the registered social worker in statutory interventions: guidance for local authorities - gov.scot

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- Considering emergency legal measures such as Child Protection Orders and FGMPOs where needed to prevent FGM or further harm.
- Supporting access to clinical and psychological care for those affected by FGM, including referral to specialist services as appropriate.

101. If you encounter FGM or an individual at risk of FGM:

1. If there is imminent risk, contact Police Scotland immediately and consider whether a FGMPO is required to prevent harm.
2. If FGM has occurred, supporting access to clinical and psychological care, assess risk to siblings and relatives, and progress child protection planning.
3. If there is a potential or non-imminent risk, implement an IRD or multi-agency plan with clear monitoring, review points and triggers for escalation. Maintain regular contact with the individual.
4. If an adults is at risk, initiate Adult Support and Protection (ASP) procedures and consider interfaces with Multi-Agency Risk Assessment Conference or other relevant safeguarding processes.

7.6 Education

102. Education settings are key environments for identifying and responding to the risk of FGM. Children and young people may feel safe at school and may disclose concerns, or staff may notice signs of FGM or risk factors (change in attendances, health or behaviour). All education staff have a responsibility to be vigilant and to respond appropriately, working closely with safeguarding partners.

103. National Guidance for Child Protection in Scotland 2023 states FGM should always be seen as a cause of significant harm and local authority child protection procedures should be invoked. Education staff should always ensure a co-ordinated response in accordance with local guidelines on FGM.

104. Further information for education staff on responding to FGM can be found on page 37 of the multi-agency guidance.

Roles and Responsibilities of education professionals include:

105.

- Being aware and alert to risk indicators for FGM (see Chapter X) such as distress/health changes after travel/ talk of a ‘special ceremony’/known family history.
- Follow the ‘One Chance Rule’. There may only be one opportunity to speak to the potential victim so ensure that you take them seriously, respect their wishes and reassure them and establish a means of safe contact.
- Responding appropriately to disclosures by listening, reassuring and supporting the child or young person, and passing concerns promptly to the Child Protection Lead for referral to Social Work.

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- Contribute to IRDs, if created, and protection planning and support the attendance and wellbeing of the child.

106. If you encounter FGM or an individual at risk of FGM:

1. If there is imminent Risk, contact social care or police urgently and follow the necessary child protection procedures.
2. If FGM has occurred, ensure the child's safety and follow child protection procedures, including consideration of medical care.
3. On concern or disclosure, refer to good practice within the multi-agency guidance: Responding to Female Genital Mutilation in Scotland Multi-Agency Guidance. Do not examine or interview the child extensively. Record the pupils' words and any relevant facts such as travel dates. Then inform the Child Protection Lead immediately for onward referral.

REFERRAL PATHWAYS TO BE ADDED (POSSIBLY AS IMAGES)

8. How to make an application for an FGM Protection Order

TO BE ADDED ONCE WE HAVE CONFIRMED DETAIL INCLUDING:

What the orders mean for the person.
Detail on the impact of them/considerations for making one
How to apply for FGMPO
Legal Aid assistance - information

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9. Annexes

ANNEX A: DEFINITIONS

Adult/ Woman

Child/ Girl

Forced Marriage

Honour Based Abuse

ANNEX B: SPECIALIST ORGANISATIONS

Amina Muslim Women's Resource Centre

Forced Marriage Unit

Hemat Gryffe Women's Aid

KWISA - Kenyan Women in Scotland Association

Scottish Domestic Abuse and Forced Marriage Helpline

Shakti Women's Aid

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ANNEX C: RISK ASSESSMENT

Commented [EH2]: This assessment will also be re considered based on feedback and evidence from Bristol Universities Academics research

Introduction:

The aim is to help make an initial assessment of risk, and then support the ongoing assessment of women and children who come from FGM affected communities (using parts 1 to 3).

Introductory questions:
(1) Do you or your partner come from a community where cutting or circumcision is practised?
(2) Have you been cut? It may be appropriate to use other terms or phrases.

If you answer YES to questions (1) or (2) please complete one of the risk templates.

PART ONE: For an adult woman (18 years or over)
(a) PREGNANT WOMAN: ask the introductory questions. If the answer is YES to either question, use part 1(a) to support your discussions.

(b) NON-PREGNANT WOMAN where you suspect FGM. For example, if a woman presents with physical symptoms or emotional behaviour that triggers a concern (such as frequent urinary tract infections, severe menstrual pain, infertility, symptoms of PTSD such as depression, anxiety, flashbacks or reluctance to have genital examination, see part 5); or if FGM is discovered through the standard giving of healthcare (for example when placing a urinary catheter, carrying out a smear test and so on), ask the introductory questions.

If the answer is YES to either question, use part 1(b) to support your discussions.

PART TWO: For a girl (under 18 years) Ask the introductory questions (see above) to either the child directly or the parent or legal guardian depending upon the situation. If the answer to either question is yes OR you suspect that the child might be at risk of FGM, use part 2 to support your discussions.

PART THREE: For a girl (under 18 years) Ask the introductory questions (see above) to either the child directly or the parent or legal guardian depending upon the situation. If the answer to either question is yes OR you suspect that the child has had FGM (see part 5), use part 3 to support your discussions.

In all circumstances:
The woman and family must be informed of the law in the UK and the health consequences of practising FGM.
Ensure all discussions are approached with due sensitivity and are non-judgemental.
Any action must meet all statutory and professionals responsibilities for child protection, and be in line with local processes and arrangements.

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Using this guidance does not replace the need for professional judgement in about the circumstances presented.

Guidance
The framework is designed to support practitioners to identify and consider risks for female genital mutilation, and to support the discussion with her and family members. It should be used to help assess whether a woman is either at risk of harm of FGM or has had FGM, and whether she has children who are potentially at risk of FGM, or if there are other children in the family/close friends who might be at risk.

When asking questions based on this guide, if any answer gives you cause for concern, you should continue the discussion and consider asking other related questions to explore this concern. Please remember that you must record either the assessment or the information obtained in the woman's record. The templates also require that you record when, by whom and at what point in the care pathway this has been completed.

Having used the guide, you will need to decide:
Do you need to make a referral through your local child protection processes, and is that an urgent or standard referral?
Do you need to seek help from your local child protection lead or other professional support before making a decision?
If you do not believe the risk has altered since your last contact with the family, or if the risk is not at the point where you need to refer to an external body, then you must ensure you record and share information about your decision accordingly.

You should refer a girl or young women under 18 who is discovered to have had FGM through your local child protection procedures during normal working hours if there is no imminent or urgent risk identified.

You should make an URGENT referral, out of normal hours if necessary, if a girl or young woman shows signs of very recently having undergone FGM. This may allow the police to collect physical evidence.

You should also make an URGENT referral if you believe that there are plans to travel abroad which mean there is a risk that a girl is imminently likely to undergo FGM if allowed to leave your care. In urgent cases, social work and the police will consider what action to take.

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