

**ANALYSIS OF THE
RESPONSES TO THE
CONSULTATION ON MULTI-
AGENCY PRACTICE
GUIDELINES ON FEMALE
GENITAL MUTILATION**

BACKGROUND

On 13 January 2014 the Department of Finance and Personnel (“DFP”) initiated a targeted consultation on draft Multi-Agency Practice Guidelines on Female Genital Mutilation. The draft Guidelines, which had been prepared on a cross-departmental basis and which were based on Home Office Guidelines, were issued to the following organisations/individuals:

- Children in Northern Ireland;
- Children’s Law Centre;
- Equality Commission;
- Health and Social Care Trusts;
- Irish Congress of Trade Unions;
- Northern Ireland Commissioner for Children and Young People;
- Northern Ireland Council for Ethnic Minorities;
- Northern Ireland Human Rights Commission;
- NSPCC;
- Regional Strategy Group on Domestic and Sexual Violence and Abuse;
- Royal College of Midwives;
- The Rowan (Sexual Assault Referral Centre for Northern Ireland);
- Victim Support NI
- Queen’s University of Belfast;
- University of Ulster; and
- Women’s Aid Federation Northern Ireland (“WAFNI”);

They were also placed on the Department’s website.

The consultation was scheduled to close on 21 February 2014. However, it was extended for a period.

This paper sets out the main comments which were received¹ and the proposed next steps. Please note that it does not rehearse the detail of the draft Guidelines, which are still available on the Department’s website.

The Department would wish to record its thanks to all those who considered, and commented on, the draft Guidelines.

RESPONSES

Children in Northern Ireland (“CiNI”)

DFP officials met with representatives from CiNI who were supportive of the draft Guidelines and keen to see further work being undertaken in this area.

¹ Minor adjustments to the text of the draft Guidelines have, where appropriate, been actioned and are not discussed in this paper.

Children’s Law Centre (“CLC”)

CLC said it was “extremely supportive” of the draft Guidelines. It felt there was a “worrying lack of information” for professionals in Northern Ireland who may be dealing with girls who are at risk or have already been subject to female genital mutilation (“FGM”).

CLC welcomed the clear statement that FGM is a criminal offence and the emphasis on the best interests of the child. It suggested that those who work with and for children in Northern Ireland should be “acutely aware” of FGM and equipped to deal with it “in a sensitive and proper manner, having the best interests of the child as the primary consideration”.

CLC welcomed the references to the United Nations Convention on the Rights of the Child (“UNCRC”) and suggested that the references could be expanded to include all relevant provisions within the UNCRC. It also emphasised the obligation on Government to make all those who work with children and young people aware of the principles and provisions in the UNCRC. This would include Government officials, parliamentarians and the judiciary. CLC proposed that training should be “systematic and ongoing” and “reflected in professional training curricula, codes of conduct and educational curricula”². It called for a “co-ordinated, pro-active approach” across Government and suggested that the draft Guidelines should represent “the beginning of a process of public and professional education which ultimately serves to protect and uphold the rights and best interests of children and young people at risk of FGM”.

CLC felt there was a “dearth of information” on FGM and expressed disappointment that the draft Guidelines did not provide information on the number of girls in Northern Ireland who are at risk of FGM. It also said it was unclear whether hospitals would be required to record cases of FGM or where there was a family history of FGM. It felt there was a “very real need to collect data on FGM so that we can begin to protect and uphold the rights of children and young girls” and “take appropriate steps to address this extremely serious issue”.

CLC suggested that a “lack of public information with regard to FGM presented as a serious barrier to addressing the issue” and it was disappointed that the Guidelines did not “suggest a course of action for taking forward an information campaign” on FGM. It was also disappointed that a “lead Department” was not identified and that the draft Guidelines use the language of encouragement, rather than obligation. In its view the draft Guidelines alone will not produce the necessary cross-departmental multi-agency approach and it called for a “co-ordinated, pro-active approach” and for “very clear obligations on all Departments and agencies to uphold the rights of children who are at risk or have been subject to FGM”.

CLC highlighted the Guardian’s “End FGM Campaign” and attempts to have FGM highlighted in schools. It also highlighted the UK Government’s declared intention to address FGM and said it would support an approach to the Government which was designed to address the awareness/information issues.

² UNCRC Committee’s General Comment No. 5

CLC noted the references to the existing child protection policies in the draft Guidelines and suggested that these should be amended to “reflect the specific considerations which must be taken into account by professionals with regard to FGM”. CLC also suggested that specialist health services in respect of FGM should be provided in Northern Ireland.

CLC called for training for health professionals, schools and the police. It also called for counselling and aftercare services.

CLC undertook to assist “in any way” to address the issue of FGM.

Belfast Health and Social Care Trust (“BHSCT”)

The BHSCT said that, overall, the draft Guidelines were “a well-structured, comprehensive document”. It acknowledged that the Guidelines had highlighted the prevalence of FGM “both internationally and in the UK”. It suggested, however, that “further research is needed to inform on the scale that exists across Ireland”.

It went on to say that “[t]argeting education and awareness at young females is vital and should include the legal ramifications. This practice needs to be acknowledged as a criminal activity and not an acceptable cultural norm.”

Northern Health and Social Care Trust (“NHSCT”)

The NHSCT welcomed the draft Guidelines and said they would help to promote “consistency of awareness and response”.

It suggested that it would be useful to mention safeguarding vulnerable adults, the Regional Child Protection Policy and Procedures, the UNOCINI assessment and referral and the Rowan.

The reference to a specialist FGM nurse was noted and queried (i.e. is there a need for a specific post?).

Like, CLC, the NHSCT suggested that the issue of FGM should be covered in training programmes. It also said that “specific awareness sessions/avenues to support implementation” were important.

South Eastern Health and Social Care Trust (“SEHSCT”)

The SEHSCT said the draft Guidelines were “clear and informative”, in that they set out the issues, but also “identify those at risk and provide clear guidance as to what to do for those identified”.

It suggested the Guidelines should highlight mental health and went on to say that young girls or women who present with “emotional/behavioural and/or mental health issues” may have been subject to FGM.

Again, the need for appropriate training was highlighted.

Western Health and Social Care Trust (“WHSCT”)

The WHSCT suggested that the Guidelines were heavily weighted towards children’s services.

Northern Ireland Commissioner for Children and Young People (“NICCY”)

NICCY did not provide a detailed response. However, it did commend “the four guiding principles of the UNCRC, namely non-discrimination (Article 2), the best interests of the child (Article 3), the right to life and full development (Article 6) and a child’s right to have his or her voice heard (Article 12).

Northern Ireland Council for Ethnic Minorities (“NICEM”)

NICEM recognised “the unique vulnerability of black and minority ethnic (BME) women to domestic violence and abuse”. It has worked to “prioritise and mainstream intersectional and multiple identity issues affecting BME women” through its Strategic Advocacy Project. In addition it has “engaged extensively” within the context of the United Nations Convention on the Elimination of all Forms of Discrimination Against Women (“CEDAW”) and has undertaken specific research into “the lived experience of BME women in Northern Ireland and specifically on the protection and rights of BME women who have experienced domestic violence”.

NICEM welcomed the draft Guidelines and said they should “promote legal interventions and provide a valuable educational resource for health professionals, the police service, school communities and health and social care children’s services”. It also felt the promotion of information sharing would “assist greatly in identifying victims, protecting vulnerable groups and prosecuting perpetrators”.

However, NICEM felt there was a “disparity between Northern Ireland and elsewhere in the UK (England, Wales and Scotland)” in terms of the investment and strategic priority which is placed on combating FGM. In particular, it noted that Westminster’s All Party Parliamentary Group on FGM had “successfully advocated for the inclusion of FGM in OFSTED inspections of schools in areas with high BME populations” and that the Crown Prosecution Service had devised an action plan in respect of FGM.

NICEM went on to say that the Scottish Education Secretary had “taken proactive measures to contact every head teacher to ensure teachers are trained on the warning signs and risks of FGM”. It suggested that “[b]roader deficiencies persist in the failure to identify victims or adequately safeguard vulnerable girls, the limited effort to engage and educate affected communities on the harm of the practice, the lack of cross-sectoral awareness raising, the absence of sufficient information sharing protocols and the negligible criminal investigations undertaken across the UK.”

NICEM recognised that “the entrenched cultural and attitudinal barriers which persist in affected communities “presented as a challenge. It felt that there was “[i]nsufficient strategic action ... to raise awareness of the harm of the practice and through community engagement and educational programmes with affected communities”.

It recognised that FGM was “a severe form of child abuse and a violation of human rights”, as well as a “manifestation of deeply entrenched gender inequality and patriarchal cultural norms”. It went on to highlight the vulnerability of victims and the difficulties which they face, which result in under-reporting. It suggested that there had been a “denial of access to justice” and it called for this to be addressed “as a priority at every level of the criminal justice system”.

NICEM said it was “essential” for key agencies to be engaged and it proposed three key actions, namely:

- awareness raising in respect of “the warning signs and harm of FGM across school communities, health and social services, and faith communities”;
- active promotion of “intervention measures” with a view to “increase[ing] referrals to PSNI and Social Services; and
- the utilisation of statutory child protection measures for “safeguarding vulnerable girls and ultimately, reducing the incidence of FGM”.

NICEM noted the relevance of international Conventions and highlighted specific recommendations from the United Nations Committee on the Elimination of Discrimination Against Women. It called on the UK to ratify the Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence (“the Istanbul Convention”) “as a matter of urgency”. NICEM believes that Convention will “provide an additional layer of protection for victims and vulnerable groups” and that ratification would be in keeping with a resolution of the European Parliament, which calls on States to combat FGM.

NICEM noted the absence of data relating to Northern Ireland. It has engaged with “health professionals who specialise in obstetrics” and has obtained “anecdotal information” which suggests that “approximately two new women present with FGM when accessing maternity services every month in the Royal/Lagan Valley hospitals”. It has been suggested that “the number of women seeking treatment is steadily rising with the ethnic and demographic makeup of victims being predominately women aged 18-35 and of Sudanese and Sub-Saharan African origin”. Only one victim under 20 has been identified but it is said that “due to inadequate screening, it is difficult to identify and treat victims who are children/young women”.

NICEM felt there had been “a widespread reluctance to actively address the issue of FGM on the basis of cultural relativism and fears over appearing racist or intolerant for condemning a long-standing cultural practice”. It believes there is “a demand from women and girls in affected communities for a more ‘interventionist’ stance on FGM from government” and, with a view to “[b]reaking the cycle of inter-generational abuse [and] overcoming cultural barriers”, it made the following recommendations:

- Educational and awareness-raising campaigns should target affected communities to build understanding of the harm of the practice.
- The availability of Home Office funding from the European Commission must be extended to Northern Ireland as a matter of urgency.
- Media and political commentators should avoid imposing blanket stereotypes on diverse and plural ethnic communities.

NICEM suggested that the following factors might affect reporting rates amongst girls:

- fear over separation from immediate family and support networks;
- a reluctance to pursue prosecutions against parents or immediate family;
- hierarchical family structures, oppressive cultural norms and limited rights awareness which prevent girls from identifying FGM as a crime;
- language barriers and unfamiliar surroundings;
- coaching from parents;
- discouragement from discussing the subject with class-mates, teachers or peers; and
- a reluctance to re-live the trauma and a desire to suppress memories.

For women NICEM suggested that the inhibiting factors were:

- structural failings leading to financial dependence on abusive partners and no recourse to public funds;
- dependence of some BME women on male partners for their immigration status and/or official leave to remain in the UK;
- lack of knowledge of their own legal entitlements in the UK;
- an absence of BME community infrastructure to provide practical support and assistance;
- lack of interpretation at the first point of contact for domestic violence, despite the requirement on public agencies to provide interpretation where necessary;
- reluctance to involve Social Services due to the fear that children will be removed;
- community pressure to remain in the family home and the stigma and shame attached to leaving the partner;
- reluctance of other family members to support the women in this process;
- reluctance to seek help from public authorities or 'outside' support agencies due to lack of culturally sensitive services;
- internalising religion and cultural beliefs that domestic violence is permissible; rather than a crime;
- legacy of poor police response from previous experience in their home country, and on occasion, in Northern Ireland.

NICEM said respondents to its domestic violence research had highlighted incidents which displayed "a pattern of behaviour reflecting institutional racism". It expressed concern about "the type of normative values held by staff working for public bodies

in Northern Ireland” and highlighted the “need for diversity training, as well as training on domestic violence, so as to challenge prejudicial attitudes about BME cases of domestic violence as well as the judgemental opinions held by staff in relation to this behaviour”.

With regard to health professionals, NICEM noted that the UK Government had “introduced mandatory guidelines for NHS acute hospitals in Great Britain to provide information on all patients who have undergone FGM, those with a family history of FGM or patients who have undergone related corrective procedures to ensure centralised data is available to effectively monitor the incidence rates and prevalence [of FGM]”. It went on to make the following recommendations:

- The DHSSPS should issue mandatory reporting guidelines on FGM for acute hospitals in Northern Ireland as a matter of urgency.
- General Practitioners (“GP”) and practice nurses should include a question on FGM in routine patient history of affected ethnic communities.
- The DHSSPS should consider the introduction of regulations on systematic screening to promote child protection and better identify girls at risk of FGM (Systematic screening of girls under six years of age is an established feature of child protection measures in a number of EU Member States, including France).
- The OPCS coding system should be updated to include patients identified as victims of FGM and those receiving corrective procedures, such as de-infibulation.
- Informational leaflets, posters and educational resources should be distributed across Health and Social Care Trusts, particularly in school infirmaries, maternity services and GP clinics. Community members should be involved and consulted on the most effective strategy for doing this.
- Obstetricians and midwives should be vigilant in ascertaining whether the patient presenting at an ante-natal booking has previously undergone FGM, including pricking and re-suturing. Patients should be informed of the available corrective procedures and referrals to trauma counselling should be provided when required.
- Comprehensive clinical guidance should be available to all relevant health professionals on appropriate treatment options and diagnostic tools.
- Existing guidance on the prevention and care of FGM is available from a range of professional bodies (e.g. the British Medical Association, General Medical Council, Royal College of Obstetricians & Gynaecologists, Royal College of GPs, Royal College of Nurses). These publications should be referenced in an appendix to the Multi-Agency Practice Guidelines to ensure they are accessible.
- Domestic violence training should be updated to sensitise health professionals to issues disproportionately affecting BME communities. This should include the provision of culturally appropriate and sensitive treatment of victims of FGM. This good practice measure should help to empower front-line staff with cross-cultural competence.
- Relevant health professionals (e.g. Community health visitors, obstetricians etc) should sensitively ensure families with a history of FGM (i.e. particularly when the mother is a victim of FGM) are aware of the illegality of FGM.

- Consideration should be given to the initiation of statutory safeguarding procedures, should there be reasonable cause to suspect a child to be at risk of significant harm. In such cases, it is essential that referrals are made to HSC Child Services and the PSNI.
- Funding for interpretation should be ring-fenced and relevant government authorities should plan their budgets to ensure BME women who need this service can access it.
- It is essential that FGM is recognised as a priority in the forthcoming Joint DHSSPS/DoJ Domestic and Sexual Violence and Abuse Strategy 2013-2020, this should also be read and understood in conjunction with other key strategies such as the forthcoming Racial Equality Strategy and Gender Equality Strategy. FGM should be understood as linking to wider issues of violence against BME women and girls, including forced marriage.

Turning to community leaders, NICEM said “[i]t must be reinforced that there is no developmental, religious or health reason to cut or mutilate any girl or woman”. It suggested that “Islamic Clerics and Imams” should be encouraged to publicly condemn FGM as “a deeply harmful cultural practice which has no basis or justification in the teachings of the Qur’an”.

As the Guidelines acknowledge, FGM will often take place in the school holidays because the extended leave period allows for recovery and avoids suspicions being aroused in terms of absences from school. NICEM said it was “essential that awareness-raising campaigns target schools with high volumes of newcomer children, particularly asylum-seeking children from high risk countries”. It went on to make the following recommendations in respect of the education sector:

- The Minister of Education, John O’Dowd MLA, should write a letter to every headmaster in Northern Ireland, demanding that teachers are educated on the warning signs and risks of FGM.
- Reporting incidents of FGM should be mandatory for teachers and school nurses. It should be a legal requirement that a child at risk is referred to the PSNI and social services.
- It is essential that a toolkit is developed for school management to assist in responding to the threat of FGM. This should inform the Continuing Professional Development (CPD) of teachers. The toolkit should be rapidly disseminated to schools as a pre-emptive measure before the onset of the “cutting season” in the summer recess period.
- Education on the warning signs and harm of FGM, coupled with measures to combat the practice, should be mainstreamed into the national curriculum across a range of subjects.
- The NSPCC ‘Pants’ Campaign should be highlighted as a good practice model for delivering a critical message in child friendly language which can form part of an early intervention strategy.
- Educational programmes and life skills classes should seek to empower girls at risk with the knowledge and confidence to respond to the threat of FGM and challenge cultural pressure exerted by family members. School counsellors, education welfare officers and child protection leads may be well placed to deliver training or interactive activities.

- Information on helplines should be provided to at risk pupils, alongside access to a private telephone on the school premises.

NICEM recognised the importance of the criminal justice system, but felt there were “a broad range of organisational barriers to effective FGM law enforcement, which include gender bias in the asylum process; insensitive treatment of women by health services; and failures of inter-agency co-operation in child protection”. It also recognised that there could be “difficulty in ascertaining whether the practice was perpetrated in the country of origin or in Northern Ireland”.

It is clear that NICEM would wish to see an action plan similar to that which has been devised by the CPS and, in its response, it called on the Public Prosecution Service to “formulate an Action Plan with performance indicators to increase prosecutions for FGM related offences”.

It is also clear that NICEM would wish to ensure that the protections which are available in respect of children and young people are appropriately applied and that suitable support and assistance is provided. However, not only does it want to see appropriate actions on the part of professionals, it wants parents to be educated in respect of their safeguarding responsibilities and the implications of the criminal law fully explained.

Finally, on the issue of communication/liaison between authorities, NICEM suggested that any over-arching inter-agency strategy should “address the vulnerability of BME women to violence, including FGM”.

Northern Ireland Human Rights Commission (“NIHRC”)

The NIHRC did not submit “formal advice” in relation to the draft Guidelines. However, it did highlight the duty on the State to “modify social and cultural patterns which see women as subordinate to men” (Articles 2(f) and 5 of CEDAW refer). It also highlighted the following General Recommendations from the CEDAW Committee:

- No. 14 (female circumcision);
- No. 19 (violence against women);and
- No. 24 (health).

NSPCC

The NSPCC said FGM was “a serious form of abuse which has devastating physical and psychological consequences for victims”. It had provided input into the draft Guidelines and believed they would be “useful, timely and ... informative ... for practitioners, professionals and volunteers”.

It highlighted its FGM Helpline, which provides “24 hour advice, information and support”. The helpline was launched in July 2013 and has received calls in relation to Northern Ireland.

The NSPCC also said that “it is vital that the Multi-Agency Guidelines should be consolidated with specialised training for professionals and a wide public awareness raising campaign”.

The Royal College of Midwives (“RCM”)

The RCM described the draft Guidelines as “thoughtful and comprehensive”. It suggested that Appendix D to the draft Guidelines should contain a reference to the recent RCM publication, “Tackling FGM in the UK, Intercollegiate recommendations for identifying, recording and reporting”. It suggested that the draft Guidelines were “very clear in relation to the law around safeguarding of children and the obligation to report any concerns to the relevant authorities”, but went on to say that they should explain that “there is not, in general, a requirement to report a criminal act that has been inflicted on an adult”.

The Rowan (Sexual Assault Referral Centre for Northern Ireland)

The response from the Rowan raised a series of questions. In particular, it noted that the current WHO definition of FGM referred to piercing and asked if that definition would include “lifestyle choices” in respect of piercing or other “consensual procedures such as...refashioning of the labia”.

The Rowan also asked:

- if male circumcision is a crime;
- who would conduct medical examinations and what training would be given;
- whether a “Forensic Medical Officer” would be involved, given that FGM is a crime;
- which doctors would be trained to identify FGM and “in which directorate do they sit?”;
- for clarification on the assistance which should be sought when a child refuses a medical examination;
- that adult victims of FGM be advised of the legal implications of stating specific facts (e.g. identifying the person who conducted the procedure) and of “their right not to make a complaint to PSNI”;
- whether the NSPCC FGM helpline offered support to adult victims³;
- who would provide “the specialist FGM counselling in NI”;
- whether the terms in Appendix B could be “spelt phonetically”;
- whether FGM is regarded as “[p]hysical or sexual assault”;
- who is best placed to see victims of FGM and where.

Victim Support NI (“VS”)

VS described the draft Guidelines as “comprehensive” and said they would bring “significant clarity in a number of areas, particularly in respect of current UK

³ The NSPCC FGM helpline does offer support to adult victims

legislation, UK and international prevalence and the wider context of FGM, including the cultural underpinnings and motives”.

However, it went on to say that “much greater clarity [was] required in respect of referral processes and protocols” and highlighted the “child protection issues if there are children known to be living with an adult who has been found to have undergone FGM and/or where there are additional children living in the home”.

VS saw “considerable merit in ensuring that the guidelines are widely publicised” and it “welcome[d] the potential to engage in further training”.

VS proposed the inclusion of “a right to information on the support services available” and suggested that criminal injuries compensation should be referenced. In this regard it highlighted its “Criminal Injuries Compensation Service, which is delivered free of charge and provides assistance throughout the claims process”.

VS suggested that it’s Witness Service, “which can support any adult who is giving evidence at Court and the NSPCC Young Witness Service, should be included in the context of legal interventions”.

Queen’s University of Belfast (“QUB”)

The QUB welcomed the draft Guidelines and specifically the section for schools, colleges and universities.

It felt that section 9.2 of the Guidelines did not “differentiate between appropriate members of staff undertaking different roles” and suggested that it would be “helpful to state at the outset of the section that a member of staff should consult with the teacher / welfare officer responsible for safeguarding, as early as when the concern is brought to their attention”.

The QUB suggested that members of staff should not give medical advice on the implications of FGM, but went on to say that it would be “appropriate for a member of staff to encourage the student to seek medical support”. It felt that the role of considering safeguarding and protection issues in respect of other female family members “rest[ed] with police and/ or social services, rather than the educational institution”.

It confirmed that it had “procedures for monitoring and following up on attendance and non-engagement with studies, which are reinforced for international students by UKBA visa requirements”.

It went on to say that was not clear whether “the actions equally apply to a person over the age of 18, or if the responsibilities of the institution are different due to the young person being an adult”. It suggested that a “paragraph on any additional or different considerations for handling cases where the woman is now over the age of 18 would be welcome”.

WOMEN'S AID FEDERATION NORTHERN IRELAND ("WAFNI");

WAFNI welcomed the draft Guidelines and said they were both informative and well structured. It agreed that it made sense to adopt a similar approach to England and Wales, but emphasised the need for sound local operational arrangements, which clearly state what is expected of professionals and address any perceived conflict of duties (e.g. in relation to confidentiality). Unambiguous pathways will, it believes, help to empower professionals.

WAFNI acknowledged that work would have to be undertaken with local communities, but suggested that that work should be set against a backdrop of wider engagement which seeks to strengthen the relationship with those communities. A broader, more constructive approach was more likely to result in positive engagement.

WAFNI felt Northern Ireland had been slow to recognise the issue of human trafficking and it was keen to ensure that FGM is not seen in hypothetical terms. It has provided support to women who were either victims of FGM or who had fled due to fears that their daughter was at risk of FGM. Accordingly, it proposed that the Guidelines should explicitly say that, whilst there was no systematic data collection within Northern Ireland, there were still likely to be cases within the jurisdiction.

WAFNI also stressed the importance of appropriate and targeted training and said that "first responders at every level" must be alert to the warning signs of FGM. The training should emphasise the universality of human rights, should note that FGM is a cultural practice and should reiterate the message that it is not racist to enforce the law on FGM. The training should be delivered by expert organisations, including organisations within the voluntary/community sectors, which are well versed in a "victim centred approach".

WAFNI acknowledged that expertise would have to be "grown" within Northern Ireland and proposed the designation of a specialist unit, such as The Rowan.

WAFNI called for children to be empowered to protect their human rights.

WAFNI noted the reference to the NSPCC helpline and suggested that its 24 Hour Domestic and Sexual Violence Helpline might also be of use to adults who, many years after being subjected to FGM, are still in need of support. WAFNI noted that its refuges and support services were there to support women and girls who were identified as either at risk of, or victims of, FGM.

WAFNI welcomed the fact that professionals were being directed to consider the welfare of other children within the family/wider family circle.

WAFNI asked about the role of UKBA and the handling of FGM victims who are subject to immigration control, as well as the handling of cases which may have links with the Republic of Ireland.

WAFNI suggested that it might be helpful to have a section or paragraph which acknowledges the linkages between statutory and non-statutory organisations and which sets out how a joined up approach might be achieved.

WAFNI suggested that Appendix C to the Guidelines (relevant organisations) should be re-formatted with a view to making it more user-friendly.

COMMENT ON RESPONSES AND NEXT STEPS

The responses to the draft Guidelines have been very positive and many of the issues which the consultees have identified chime with the issues which have already been identified within government.

We would, at the outset, wish to provide an assurance that the work in this area will not cease with the publication of the Guidelines. The information which has emerged during the consultation would appear to show that there are women within Northern Ireland who have been subjected to FGM. We have a duty to ensure that there is an appropriate safeguarding response when concerns are raised. The Guidelines should be seen as a first step, albeit an important step, and they will be used as a springboard for further discussions within the voluntary, community and statutory sectors. It is vital that the skills and experience within those sectors are harnessed and exploited and the offers of future partnership working are to be welcomed and will be utilised. No one body or organisation can deliver the actions which are required to both address and eradicate FGM and the need for a cross-departmental multi-agency approach has been rightly recognised. In this regard it is worth emphasising that, whilst the Department undertook the day-to-day work in relation to the draft Guidelines and the associated consultation exercise, it was acting in a representative capacity and with the express endorsement of other key players.

As mentioned previously, the draft Guidelines are based on Home Office Guidelines and, at this stage, we think it makes sense to retain the format and overall content, as this will facilitate early publication. A number of the issues which were raised during the consultation are second-stage issues, which will fall to be explored and addressed in the post-publication period. Looking ahead to that period we believe there are a number of steps which must be taken. Firstly, the key messages in the Guidelines must be widely disseminated and imbedded. In particular those messages must be relayed to, and endorsed by, parents and community leaders, who are very much in the forefront when it comes to safeguarding. Secondly, the detailed operational arrangements which are required on foot of the Guidelines must be put in place and staff within each organisation/body must have a clear understanding of what is expected of them. We recognise that further work will be required in terms of growing expertise within Northern Ireland. However, there is a wealth of experience and knowledge in other jurisdictions which can be drawn upon and it is expected that the partnership working will extend to those jurisdictions and help to ensure that best practice standards are met. On the issue of best practice, it should be noted that the guidance in respect of safeguarding procedures is soon to be reviewed and that will provide a welcome opportunity to further target, and refine, that guidance. Thirdly, each organisation/body must arrange appropriate training on

an ongoing basis. For example, at present, FGM is dealt with as part of the child protection training for Designated Teachers for Child Protection, their Deputies and Principals. The training covers warning signs and the appropriate response with signposting to further information and sources of help. We expect that similar arrangements are in place in other key organisations, but we will wish to ensure that that is the case. Fourthly, the linkages to other initiatives and strategies should be identified and the use of existing resources should be maximised. The responses to the consultation exercise have already identified some support services, but further work is required if all relevant services are to be clearly signposted. Fifthly, it is essential that young girls and women are given the help and assistance they need to both assert and protect their rights. The foregoing steps are by no means exhaustive and it is to be expected that, as the required work is taken forward, other steps will be identified.

It would seem sensible for the proposed Domestic and Sexual Violence and Abuse Strategy 2013-2020 to provide an over-arching framework for the ongoing work in this area and the Regional Strategy Group on Domestic and Sexual Violence and Abuse will be asked to consider the points which have been raised in the responses to the consultation that are relevant to its remit.

Finally, we will want to assess the impact of the Guidelines and any associated work. We will, therefore, undertake an initial review of progress in the Spring of 2015.