Women and Equalities Committee

15 July 2026

Baroness Merron
Parliamentary Under-Secretary of State for Women's Health and Mental Health

Professor Lucy Chappell
Chief Scientific Advisor at the Department of Health and Social Care
Chief Executive Officer at the National Institute for Health and Care Research

Follow up points from oral evidence: 1 July 2026

Dear Baroness Merron and Professor Lucy Chappell

Thank you for giving oral evidence to the committee on 1 July on female genital mutilation (FGM), particularly in regard to research into the benefits of reconstructive surgery for FGM survivors.

Due to the limited time available, there were a number of points that the committee was unable to explore fully. I would be grateful if you could therefore provide answers to the questions set out below.

The NIHR funding opportunity

The committee welcomed the NIHR's launch of a funding opportunity for research into reconstructive surgery for FGM survivors. As we discussed at the meeting on 1 July, all applications were rejected. The rejection letters stated that the opportunity may be "possibly readvertised." Following our invitation to both of you to attend the committee, Professor Chappell wrote to us outlining that the NIHR still intended fund research into reconstructive surgery for FGM, and that applicants were invited to a workshop on 25 June to provide methodological and technical advice on the design of the submitted studies.

During our evidence session, Professor Chappell acknowledged that the NIHR had been aware that funding would continue to be available when it sent out its correspondence. The research call specified that, "It is expected that applications will include co-applicants with lived experience and from appropriate charity/support organisations." With this in mind, the committee remains concerned about the handling of the

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application process. The co-applicants, being FGM survivors, likely invested considerable time, effort and emotional energy in the process. The committee is aware that it can be distressing for individuals, particularly those of lived experience, to be informed that an application for research that affects them personally is rejected. It is disappointing that in this case the NIHR could have provided an assurance that it still wanted the research to take place and set out further context but failed to do so.

1. Considering the NIHR still intends to fund a trial into reconstructive surgery, why was this not communicated to applicants in the correspondence rejecting their bids for funding?
    a. Following Professor's Chappell's comment that "in hindsight, we could have framed our letters better", will the NIHR make changes to its approach to ensure communication is handled appropriately and sensitively when inviting co-applicants with lived experience?

Travelling overseas for reconstructive surgery

The committee received evidence that some FGM survivors living in the UK are travelling abroad to countries like France and the Netherlands to undergo reconstructive surgery. While many of these countries have comparable healthcare systems, this comes at considerable expense and discomfort for such women, and receiving treatment abroad risks a lack of proper aftercare upon return home.

2. To what extent are Women's Health Hubs, FGM Support Clinics and other relevant health services in England and Wales aware of (a) FGM survivors travelling abroad to access reconstructive surgery and (b) instances where women have required NHS follow-up care or other support after undergoing FGM reconstructive surgery overseas?
3. Will you engage with healthcare professionals and systems in countries which offer this procedure to collaborate in research, evidence gathering and learning?

FGM survivors' access to services

During the evidence session, there was a number of references to existing services for FGM survivors. However, the committee's inquiry found that services for FGM survivors are inconsistent and patchy across the UK. Stakeholders underlined that a lack of long-

term investment in FGM Support Clinics could lead to closures. In its report the committee called on the Government to ensure all FGM survivors can access the essential support and care they need in a timely manner. The committee recommended that areas with a high prevalence of FGM survivors should offer funded multidisciplinary services that allow quick access to specialist care with clear referral pathways for those in low prevalence areas.

We note that, while the previous Women's Health Strategy explicitly addressed female genital mutilation (FGM), the renewed Women's Health Strategy, published in April, contained no reference to FGM, despite FGM's lifelong and profound health impacts. This is particularly notable as the Strategy acknowledged that women from ethnic minority backgrounds (and working-class women) are being failed "most of all" and that health inequalities persist among women from particular ethnic groups. With most women who have undergone FGM in the UK belonging to migrant communities and minority ethnic groups, failing to address FGM risks perpetuating those very health inequalities.

4. What steps have been taken to (a) ensure that FGM survivors across the UK can access appropriate local support and referral pathways and (b) healthcare services for FGM survivors, such as FGM Support Clinics, receive sustainable and long-term funding since your response to the committee's report?
5. Why is FGM not addressed in the Renewed Women's Health Strategy?
    a. Did the government engage with FGM survivors, relevant organisations and stakeholders when drafting the renewed Strategy?

<u>Specialist counselling support</u>

During the evidence session, Professor Moonesinghe noted that reconstructive surgery "is very unlikely to be sufficient in and of itself" and that it should be "parcelled up with psychological support as well."

The committee agrees that FGM survivors should receive psychological support, and previously recommended that FGM survivors should be able to access specialist counselling support "in appropriate settings". During our inquiry, we were concerned to hear accounts of unsuitable venues for counselling for FGM survivors and counsellors lacking sufficient training. In its response to our report, the government stated that some FGM clinics and Women's Health Hubs provide access to counselling onsite by dedicated counsellors while others commission local services or refer to standard NHS pathways such as NHS Talking Therapies.

6. What support are FGM survivors offered through NHS Talking Therapies? And how long is the waiting list for this care?
    a. Is specific training on FGM and cultural understanding provided to therapists within NHS Talking Therapies?
    b. Are there specialist practitioners within the service who specialise in FGM, or are survivors typically seen by general therapists?

Cosmetic procedures

During our inquiry into cosmetic procedures, we heard evidence that there continues to be a lack of comprehensive research into the long-term safety of breast implants. Witnesses pointed to concerns arising from the PIP implant scandal, the emergence of Breast Implant-Associated Anaplastic Large Cell Lymphoma (BIA-ALCL) and increasing reports of symptoms commonly referred to as Breast Implant Illness, arguing that further research is necessary to strengthen patient safety and support informed consent. We recommended:

> The Government should commission research to better understand the health impacts of breast implants, including their potential impacts on women with pre-existing auto-immune conditions. The research needs to be a mix of clinical research, including on the health impacts of siloxanes, and longitudinal, following a cohort of women over a period of time. Such studies are necessary to improve patient safety, diagnosis and treatment and for the purposes of informed consent. At present, we do not believe that enough information is available about breast implants for women to genuinely be able to give informed consent to receiving them.

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7. What progress is being made in response to the concerns the committee raised around breast implants, specifically our call for research into the safety of breast implants and the health impacts of siloxanes?

A copy of this letter and your reply will be placed in the public domain.

Kind regards

Sarah Owen MP
Chair, Women and Equalities Committee

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From Baroness Merron
Parliamentary Under-Secretary of State for Women's Health and Maternity

Professor Lucy Chappell
DHSC Chief Scientific Adviser
NIHR Chief Executive Officer

39 Victoria Street
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03 September 2026

Dear Sarah,

LETTER FROM BARONESS MERRON AND THE CHIEF SCIENTIFIC ADVISER TO THE WOMEN & EQUALITIES COMMITTEE FOLLOWING ORAL EVIDENCE SESSION ON 1 JULY 2026

Thank you for the opportunity to give evidence at the recent Women & Equalities Committee session on female genital mutilation (FGM), and for the follow up questions which have been answered as below.

Please let us know if you would like any further information and we will be happy to help.

1. ***Considering the NIHR still intends to fund a trial into reconstructive surgery, why was this not communicated to applicants in the correspondence rejecting their bids for funding? Following Professor's Chappell's comment that "in hindsight, we could have framed our letters better", will the NIHR make changes to its approach to ensure communication is handled appropriately and sensitively when inviting co-applicants with lived experience?***

When a National Institute for Health and Care Research (NIHR) funding opportunity does not result in a fundable application, it is standard practice across the NIHR for the call to be reconsidered internally, with options for next steps including making changes to the call specification, providing tailored support to applicants to revise their specification, or considering other routes for funding. In these instances, applicants are notified of the outcome of their application and that the call will be reconsidered. This enables applicants to receive an outcome on their application as soon as possible, rather than waiting until the NIHR has agreed the next steps which may take several weeks or months, depending on the complexity of the challenges.

In the case of this call on reconstructive surgery for FGM survivors, the NIHR Health Technology Assessment (HTA) programme followed this standard practice. The outcome letters sent to the applicant teams stated that the call would be reconsidered by the Programme Oversight Committee to consider next steps. Details of the process for this specific call are outlined in Annex A, as we committed to provide this detail during the oral evidence session.

The NIHR is dedicated to involving people with lived experience throughout the research cycle. Accordingly, all funding applications must outline their strategies for patient and public involvement and engagement. Involving people and communities enhances the relevance, quality, and impact of our research, and we sincerely value the significant contributions made by the public co-applicants during the development of these applications. We recognise the disappointment felt by co-applicants when applications are unsuccessful, particularly when the issues affect them personally. Moving forward, we will work with our public contributors on funding committees to improve how we communicate outcomes to unsuccessful applicants.

2. ***To what extent are Women's Health Hubs, FGM Support Clinics and other relevant health services in England and Wales aware of (a) FGM survivors travelling abroad to access reconstructive surgery and (b) instances where women have required NHS follow-up care or other support after undergoing FGM reconstructive surgery overseas?***

Data is not held by NHS England on either instances of FGM survivors travelling abroad to access reconstructive surgery or instances where women have required NHS follow-up care or other support after undergoing FGM reconstructive surgery overseas. The Government does not have data on the proportion of medical tourism cases requiring corrective surgery or the numbers of patients by treatment types. We continue to explore ways to improve our understanding of the scale of these issues.

3. ***Will you engage with healthcare professionals and systems in countries which offer this procedure to collaborate in research, evidence gathering and learning?***

NHSE and DHSC have not engaged with countries that offer reconstructive surgery for FGM. Decisions on whether the NHS offers a treatment are taken on the basis of the best available evidence. Independent bodies such as the National Institute for Health and Care Excellence (NICE), alongside professional organisations including the Royal Colleges, assess the safety, clinical effectiveness and, where appropriate, the value for money of interventions to inform these decisions.

This evidence-based approach means that decisions in the UK may differ from those taken in other countries. The fact that a treatment is available elsewhere does not, in itself, demonstrate that it is safe, clinically effective, or represents an appropriate use of NHS resources. The UK system is designed to ensure that patients receive treatments that are supported by robust evidence of benefit and safety, while making the best possible use of NHS resources to achieve the greatest overall health gain.

4. ***What steps have been taken to (a) ensure that FGM survivors across the UK can access appropriate local support and referral pathways and (b) healthcare services for FGM survivors, such as FGM Support Clinics, receive sustainable and long-term funding since your response to the committee's report?***

   A) ***Steps taken to ensure that FGM survivors across the UK can access appropriate local support and referral pathways.***

Integrated Care Boards and NHS Trusts commission FGM support clinics which offer a range of services to support women affected by FGM including physical treatment, counselling and further referrals to urology, gynaecology or other services, depending on clinical need.

There are at least 24 clinics across England, many of which accept self-referrals as well as referrals from health professionals. Clinics are commissioned at a local level by ICBs and NHS England does not hold national data on the total number of clinics. The NHS also provides clinical intervention, including deinfibulation, to manage medical complications associated with FGM.

Deinfibulation is widely available in maternity services for victims of FGM who require surgery during pregnancy and are seeking vaginal delivery, and is also available through ICB-commissioned gynaecological services.

Individuals with no recourse to public funds (individuals without a valid UK visa) would be eligible for NHS FGM care free of charge, provided they have not travelled to the UK for the purpose of treatment. This would include deinfibulation, as well as other FGM clinical services.

The FGM Enhanced Dataset identified 305 attendances in England between April 2024 and March 2025 which recorded deinfibulation as having been undertaken. There are limitations with this data due to data completeness (e.g. 65% of total health attendances where FGM was identified in England have a known deinfibulation status recorded). Health officials are working to address this with a revised dataset and updated guidance for clinicians, which will be rolled out later this year.

Every Integrated Care Board (ICB) is expected to provide support pathways relevant to their local population. How each ICB chooses to meet the needs of their population will differ, and in some higher-prevalence areas we know Women's Health Hubs will be used to provide FGM services. For example, in Tower Hamlets, the Women's Health Hub brings together healthcare professionals and existing services to provide integrated women's health services in the community that include multidisciplinary FGM services and access to appropriate specialist care pathways.

FGM clinics and Women's Health Hubs that offer FGM services provide information on FGM to attendees, as well as signposting to non-health related local services and access to FGM Health Advocates.

B) Steps taken to ensure that healthcare services for FGM survivors, such as FGM Support Clinics, receive sustainable and long-term funding since your response to the committee's report.

ICBs are responsible for commissioning services that meet the healthcare needs of their local population, including services tailored to the needs of FGM survivors.

ICBs have an understanding of the demand for FGM services in their area through the FGM Enhanced Dataset (through which they can access data on attendances in their area) and local needs assessments.

In the reporting period April 2024 to March 2025, there were a total of 6,980 individual women and girls who had a health attendance where FGM was identified across England. Out of these, 3,975 were newly recorded attendances (i.e. an individual was recorded in the dataset for the first time). 99.4% individual women and girls were aged 18 or over at the time of their latest attendance. The data is broken down by region to inform local commissioning.

Women affected by FGM receive services from across the NHS, for example through urology, gynaecology and specialist mental health services.

For some ICBs, the services for women affected by FGM may be delivered through a single service. However, in other areas, FGM services sit within broader NHS provision such as maternity clinics or gynaecology, with onward referrals made to other support such as mental health services as needed.

5. ***Why is FGM not addressed in the Renewed Women's Health Strategy? Did the government engage with FGM survivors, relevant organisations and stakeholders when drafting the renewed Strategy?***

The Renewed Women's Health Strategy sets out how the Government will make women's voices and choices central in healthcare, transform NHS performance in services that matter most to women, support all women to live healthy, prosperous lives and create an approach to research and development that works for and empowers women.

The Renewed Strategy deliberately avoids being a list of conditions or practices affecting women. Instead, it focuses on systemic changes including redesigning services, improving diagnosis, and embedding women's voices so that care improves across all conditions.

Given the focus on systemic change, we drew extensively on *all* women's voices in the development of the Renewed Strategy, including:

a. The call for evidence which informed the 2022 Women's Health Strategy with responses from nearly 100,000 individuals and over 400 submissions from individuals and organisations with experience in women's health;

b. The Change NHS engagement findings. Change NHS ran between October 2024 and June 2025 with over 270,000 contributions in total, used to inform the government's 10 Year Health Plan. Two thirds of public respondents were women;

c. To test views and gather evidence on more specific areas of focus for the Renewed Strategy, we held a series of seven roundtables on important topics. Each roundtable brought together women with lived experience alongside clinicians, academics, and expert organisations working with or representing women, with almost 100 attendees across all roundtables.

6. ***What support are FGM survivors offered through NHS Talking Therapies? And how long is the waiting list for this care? a. Is specific training on FGM and cultural understanding provided to therapists within NHS Talking Therapies? b. Are there specialist practitioners within the service who specialise in FGM, or are survivors typically seen by general therapists?***

Women affected by FGM who need mental health support can be referred to NHS services such as NHS Talking Therapies. NHS Talking Therapies offer evidence-based and effective psychological therapy services for mental health problems, including depression, anxiety disorders, as well as post-traumatic stress reactions. The latest available data for May 2026 shows that 87.1% of referrals completing treatment that month accessed NHS Talking Therapies within 6 weeks (NHS Talking Therapies Monthly Statistics Including Employment Advisors, Performance May 2026 - NHS England Digital). It should be noted that this data is not specific to women and girls affected by FGM.

The workforce within NHS Talking Therapies must complete safeguarding training with a focus on FGM, and those working in areas where patients affected by FGM may be seen more frequently are encouraged to complete e-learning FGM training. This recently updated learning has been developed by NHS England and informed by relevant Royal Colleges, clinical experts and incorporates the voices of women affected by FGM. The training provides staff with the skills to consider, recognise and discuss FGM with the women and girls they support. It includes a focus on the physical and psychological impacts of FGM, and how to speak to women about FGM in a trauma-informed way.

The NHS Talking Therapies workforce includes therapists trained in trauma focussed Cognitive Behavioural Therapy and Eye Movement Desensitization and Reprocessing for Post Traumatic Stress Disorder. Some FGM clinics and Women's Health Hubs provide access to on-site counselling through dedicated counsellors, while others commission local services or refer patients to Talking Therapies pathways. As these services are commissioned locally, provision varies across areas.

7. ***What progress is being made in response to the concerns the committee raised around breast implants, specifically our call for research into the safety of breast implants and the health impacts of siloxanes?***

As with any medical device, breast implants do not come without risks. The Medicines and Healthcare products Regulatory Agency (MHRA) closely monitors the safety of all breast implants as they are considered a medical device. The MHRA has published extensive guidance on breast implants including a risk awareness tool for patients to support decision making.

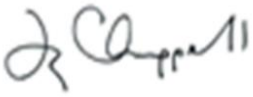
MHRA has reviewed the evidence on the safety of Poly Implant Prothese (PIP) breast implants and not found any evidence that PIP implants carry a greater risk of cancer or a condition sometimes called "breast implant illness" than any other type of implant. MHRA has undertaken an extensive review of the safety of the silicone (siloxane) used in PIP breast implants. This review found no evidence that silicone used in PIP implants causes health harms. These findings are supported by results from similar analysis conducted in Australia and France.

The NIHR funds research that benefits the NHS, public health and social care. Research on the safety of commercial cosmetic products is not within our remit. Manufacturers are ultimately responsible for ensuring their devices are safe and that any risks are understood and mitigated as far as possible.

We hope this response is helpful.

All good wishes,

BARONESS MERRON



LUCY CHAPPELL

Annex A – details of the recent call through the National Institute for Health and Care Research (NIHR) on reconstructive surgery for FGM survivors

During the oral evidence session on 1st July, we committed to follow up in writing with details of the timing of the recent call through our NIHR on reconstructive surgery for FGM. This is set out below.

- **Prior to the call launching in November 2025** – The NIHR Health Technology Assessment (HTA) programme worked closely with potential applicants as well as wider stakeholders in preparing the specification for this call, to ensure that the research addressed the right questions, would be feasible to deliver and acceptable to the patient group.
- **November 2025 – March 2026** – The HTA programme provided support to applicants via email and video call as they developed their applications.
- **12th-13th May 2026** – The HTA independent Funding Committee met to review the applications received to this call. They considered that neither application was ready for funding at this time.
- **22nd May 2026** – The HTA programme wrote to both applicant teams to notify them their applications had been unsuccessful. Both outcome letters stated that because nothing had been funded through this call, the call would be reconsidered by the Programme Oversight Committee to consider the next steps. This is standard practice for any funding opportunity that does not result in a fundable application, with options for next steps including making changes to the call specification, providing tailored support to applicants to revise their applications, or considering other routes for funding.
- **11th June 2026** – After consideration of next steps with DHSC, the HTA programme decided that a workshop with the applicant teams to support them in resubmitting was the most appropriate next step for this call. The HTA programme contacted both applicant teams to invite them to a workshop on 25th June to discuss their applications and offer support to help them in resubmitting.
- **12th June 2026** – The HTA programme spoke to both teams via video call to provide more detail on the aims of the workshop.
- **19th June 2026** – The HTA Programme Oversight Committee met to consider any additional support required to help the applicants develop high quality applications.
- **25th June 2026** – The HTA programme led a workshop with both applicant teams to discuss their applications and provide methodological and technical advice. The workshop was also attended by Prof Anthony Gordon (Programme Director for the HTA programme), Prof Danny McAuley (Scientific Director for NIHR Programmes), two NIHR Research Support Service Directors, experts in methodology and statistics, and an expert in patient and public involvement in research.

Following the HTA Programme Oversight Committee and applicant workshop, the HTA programme has now revised the call specification and readvertised it on 22 July 2026. The applicant teams have been asked to resubmit their applications by November 2026, for

consideration by the HTA Funding Committee in January 2027. This allows time for the teams to undertake the necessary revisions to their applications, working with the expert methodologists in the NIHR Research Support Service to produce the most scientifically robust and deliverable proposals.