



Safeguarding children at risk of abuse through female genital mutilation

**London Safeguarding Children Board
London Councils
59½ Southwark Street
London SE1 0AL**

www.londonscb.gov.uk

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1. Introduction

1.1 Definition

1.1.1 The World Health Organisation (WHO) defines female genital mutilation as: all procedures (not operations) which involve partial or total removal of the external female genitalia or injury to the female genital organs whether for cultural or other non-therapeutic reasons” (WHO, 1996)

1.2 Summary profile

1.2.1 It is illegal in the UK to subject a child to female genital mutilation (FGM) or to take a child abroad to undergo FGM.

1.2.2 FGM is violence against girl children and women, a serious public health hazard and a human rights issue. Protecting children and mothers from FGM is everybody’s business.

1.2.3 FGM constitutes child abuse and causes physical, psychological and sexual harm which can be severely disabling.

1.2.4 Recent studies have found that approximately 80,000 women and girls in the UK have undergone genital mutilation and a further 7,000 girls under 17 are at risk¹.

1.2.5 Girls and women in the UK who have undergone FGM may be British citizens born to parents from FGM practising communities or they may be women living in Britain who are originally from those communities e.g. women who are refugees, asylum seekers, overseas students or the wives of overseas students.

1.2.6 London has substantial populations from FGM practicing countries.

1.3 This procedure

1.3.1 Professionals, volunteers and individuals coming across FGM for the first time can feel shocked, upset, helpless and unsure of how to respond appropriately to ensure that children are protected from harm.

1.3.2 This Procedure provides guidance for frontline professionals and their managers, individuals in London’s local communities and community groups, such as, faith and leisure groups, on:

- Identifying when a child may be at risk of being subjected to FGM and responding appropriately to protect the child
- Identifying when a child has been subjected to FGM and responding appropriately to support the child
- Measures which can be implemented to prevent and ultimately eliminate the practice of FGM; and

1.3.3 This Procedure should be read in conjunction with the *London Child Protection Procedures (London Safeguarding Children Board, 2007)*.

2. Legislation and policy

2.1 National legislation

¹ 74,000 & 7,000 girls at risk - Department of Health. CMO Update 37: February 2004. Available at DH website: www.dh.gov.uk /

86,000 - Powell RA, Lawrence A, Mwangi-Powell FN and Morrison L (FGM, asylum seekers and refugees: The need for an integrated UK policy agenda, Forced Migration Review 2002).

- 2.1.1 In England, Wales and Northern Ireland all forms of FGM are illegal under the Female Genital Mutilation Act 2003² and in Scotland it is illegal under the Prohibition of FGM (Scotland) Act 2005³.
- 2.1.2 A person is guilty of an offence if he, excises, infibulates or otherwise mutilates the whole or any part of a girl's labia, majora, labia minora or clitoris except for operations performed on specific physical and mental health grounds by registered medical or nursing practitioners. It is also an offence to assist a girl to mutilate her own genitalia (See FGM Type 3, in section 5.4 below or the Glossary in Appendix 7 for definition of infibulates).
- 2.1.3 FGM is an offence which extends to acts performed outside of the UK and to any person who advises, helps or forces a girl to inflict FGM on herself. Any person found guilty of an offence under the Female Genital Mutilation Act 2003 will be liable to a fine or imprisonment up to 14 years, or both.
- 2.1.4 Under the Children Act 1989⁴ Local Authorities can apply to the Courts for various Orders to prevent a child being taken abroad for mutilation.

2.2 International legislation

- 2.2.1 There are two international conventions, which contain articles, which can be applied to FGM. Signatory states, including the UK, have an obligation under these standards to take legal action against FGM:
- The UN Convention on the Rights of the Child⁵
 - The UN Convention on the Elimination of All Forms of Discrimination against Women⁶
- 2.2.2 These conventions have been strengthened by two world conferences: the International Conference on Population and Development (ICPD, Cairo, September 1994) and the World Conference on Women (Beijing 1995).

2.2.3 National policy

- 2.2.4 The UK Government's Every Child Matters: Change for Children Programme, which includes the Children's NSF⁷, and is supported by the Children Act 2004⁸, requires all agencies to take responsibility for safeguarding and promoting the welfare of every child to enable them to:
- Be healthy
 - Stay safe
 - Enjoy and achieve
 - Make a positive contribution
 - Achieve economic well-being
- 2.2.5 Working within this policy framework, professionals and volunteers from all agencies have a statutory responsibility to safeguard children from being abused through FGM.

² <http://www.opsi.gov.uk/ACTS/acts2003/20030031.htm>

³ <http://www.opsi.gov.uk/legislation/scotland/acts2005/20050008.htm>

⁴ http://www.opsi.gov.uk/acts/acts1989/Ukpga_19890041_en_1.htm

⁵ <http://www.unhcr.ch/html/menu3/b/k2crc.htm>

⁶ <http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm>

⁷ National Service Framework for Children, Young People and Maternity Services:

<http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/ChildrenServicesInformation/fs/en>

⁸ <http://www.opsi.gov.uk/acts/acts2004/20040031.htm>

- 2.2.6 A number of UK professional bodies which have published guidelines on FGM (see References in Appendix 7).

3. Context in which FGM occurs

3.1 Prevalence

- 3.1.1 FGM is a deeply rooted tradition widely practised mainly among specific ethnic populations in Africa and parts of Asia which serves as a complex form of social control of women's sexual and reproductive rights.
- 3.1.2 The World Health Organisation estimates that between 130-140 million girls and women have experienced female genital mutilation and up to two million girls per year undergo some form of the procedure each year.
- 3.1.3 The great majority of affected women live in sub-Saharan Africa, but the practice is also known in parts of the Middle East and Asia.
- 3.1.4 FGM is practiced in more than 28⁹ countries in Africa and in some countries in Asia and the Middle East, however in each of those countries the extent of the practice varies. African countries with the highest likelihood of FGM being practised are Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Guinea, Mali, Sierra Leone, Somalia and Sudan (See Appendix 8 for a profile of prevalence and legislation banning FGM in African countries).
- 3.1.5 It appears that the Democratic Republic of Congo (DRC), Ghana, Niger, Tanzania, Togo, Uganda, and Yemen have the lowest incidence of FGM. However, within each of these countries there are specific ethnic communities in which the incidence of FGM is high.
- 3.1.6 In England and Wales, women from non-African communities which are most likely to be affected by FGM, include Yemeni, Iraqi Kurd and Pakistani women.

3.2 Cultural underpinnings

- 3.2.1 Female genital mutilation is a complex issue, despite the harm it causes, many women from FGM practising communities consider FGM normal to protect their cultural identity.
- 3.2.2 As a result of the belief systems of the cultural groups who practice FGM, many women who have undergone FGM believe they appear more attractive than women who haven't been infibulated. Their perception is that normal female genitalia are both unattractive and unhygienic. In some cultures it is believed that a girl who has not undergone FGM, is unclean and not able to handle food or drink.
- 3.2.3 Infibulation (See FGM Type 3 in section 5.4 below or the Glossary in Appendix 7) is strongly linked to virginity and chastity. It is used to safeguard girls from sex outside marriage and from having sexual feelings. In more traditional cultures it is considered necessary at marriage for the husband and his family to see her closed. In some instances both mothers will take the girl to be cut open enough to be able to have sex. Women also have to be cut open to give birth. The consequences of this are pain, bleeding, varying degrees of incapacity and psychological trauma.
- 3.2.4 Although FGM is practiced by secular communities, it is most often claimed to be carried out in accordance with religious beliefs. However, neither the Bible, nor the Koran justify FGM. In 2006, top Muslim clerics at an international conference on FGM in Egypt pronounced that FGM is not Islamic (See Appendix 6 for Recent Progress Internationally).

⁹ World health organisation: <http://www.who.int/reproductive-health/fgm/>

3.2.5 Parents who support the practice of female genital mutilation say that they are acting in the child's best interests. The reasons they give include that it:

- Brings status and respect to the girl
- Preserves a girl's virginity/chastity
- Is part of being a woman
- Is a rite of passage
- Gives a girl social acceptance especially for marriage
- Upholds the family honour
- Gives the girl and her family a sense of belonging to the community
- Fulfils a religious requirement mistakenly believed to exist
- Perpetuates a custom/tradition
- Helps girls and women to be clean and hygienic
- Is cosmetically desirable, and
- Is mistakenly believed to make childbirth safer for the infant

3.2.6 It is because of these beliefs that girls and women who have not undergone FGM are usually considered by practising communities to be unsuitable for marriage. Women who have attempted to resist exposing their daughters to FGM report that they and their families were ostracised by their community and told that nobody would want to marry their daughters.

3.3 Cultural change in the UK

3.3.1 Some community groups/agencies report that increasing instances where young men and women who have grown up in the UK and assimilated British cultural beliefs and attitudes are experiencing difficulties amongst their peer group e.g. young men rejecting girlfriends when they discover that she was subjected to FGM as a child or a girl discovering that not all girls are subjected to FGM. Young people who resist FGM can also experience conflict within their family and community.

3.3.2 See also section 6.6.2 for the emotional and psychological impact of FGM reported by girls in the UK.

4. Principles supporting this procedure

4.1 The following principles should be adopted by all agencies in relation to identifying and responding to children (and unborn children) at risk of or who have experienced female genital mutilation and their parent/s:

- The safety and welfare of the child is paramount
- All agencies act in the interests of the Rights of the Child as stated in the UN Convention (1989)
- FGM is illegal and is prohibited by the Female Genital Mutilation Act 2003 and Prohibition of Female Genital Mutilation (Scotland) Act 2005
- It is acknowledged that some families see FGM as an act of love rather than cruelty. However, FGM causes significant harm both in the short and long term and constitutes physical and emotional abuse to children
- All decisions or plans for the child/ren should be based on good quality assessments and be sensitive to the issues of race, culture, gender, religion and

sexuality, and avoid as far as possible, stigmatising the child or the practising community

- Accessible, acceptable and sensitive Health, Education, Police, Children's Social Care and Voluntary Sector services must underpin this procedure
- All agencies should work in partnership with members of local communities, to empower individuals and groups to develop support networks and education programmes

5. Description of FGM

5.1 Types of FGM

5.1.1 Female Genital Mutilation and other terms (see glossary) has been classified by the WHO into four types:

- Type 1: Circumcision

Excision of the prepuce with or without excision of part or all of the clitoris

- Type 2: Excision (Clitoridectomy)

Excision of the clitoris with partial or total excision of the labia minora (small lips which cover and protect the opening of the vagina and the urinary opening). After the healing process has taken place, scar tissue forms to cover the upper part of the vulva region.

- Type 3: Infibulation (also called Pharaonic Circumcision)

This is the most severe form of female genital mutilation. Infibulation often (but not always) involves the complete removal of the clitoris, together with the labia minora and at least the anterior two-thirds and often the whole of the medial part of the labia majora (the outer lips of the genitals). The two sides of the vulva are then sewn together with silk, catgut sutures, or thorns leaving only a very small opening to allow for the passage of urine and menstrual flow. This opening can be preserved during healing by insertion of a foreign body.

- Type 4: Unclassified

This includes all other procedures on the female genitalia including pricking, piercing or incising of the clitoris and or labia; stretching of the clitoris and or labia; cauterisation by burning of the clitoris and surrounding tissues; scraping of the tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purposes of tightening or narrowing it; and any other procedure that falls under the definition of female genital mutilation given above.

5.2 Age and procedure

5.2.1 The age at which girls are subjected to Female Genital Mutilation varies greatly, from shortly after birth to any time up to adulthood. The average age is 10 to 12 years.

5.2.2 FGM is usually carried out by the older women in a practicing community, for whom it way of gaining prestige and can be a lucrative source of income in some communities.

5.2.3 The arrangements for the procedure usually include the child being held down on the floor by several women and the procedure carried out without medical expertise, attention to hygiene and anaesthesia. The instruments used include unsterilised household knives, razor blades, broken glass and sharpened stones. In addition the child is subjected to the procedure unexpectedly.

5.2.4 Increasingly some health professionals are performing FGM in the belief that it offers more protection from infection and pain. However, the medicalisation of FGM is condemned by all international groups including the WHO.

5.3 Names for FGM

5.3.1 FGM is known by a number of names, including female genital cutting or circumcision. The term female circumcision is unfortunate because it's anatomically incorrect and gives a misleading analogy to male circumcision. The names 'FGM' or 'cut' are increasingly used at the community level, although they are still not always understood by individuals in practicing communities, largely because they are English terms.

5.3.2 The Somali term for FGM is 'Gudnin' and the Sudanese the word for FGM is 'Tahur'.

5.3.3 See the Glossary in Appendix 7 for the difference between male and female circumcision and other terms relating to FGM.

6. Consequences of FGM

6.1 Many women in practicing communities appear to be unaware of the relationship between female genital mutilation and its harmful health and welfare consequences, in particular the complications affecting sexual intercourse and childbirth, which occur many years after the mutilation has taken place.

6.2 The health implications for a child of the FGM procedure can be severe to fatal, depending on the type of FGM carried out.

6.3 As with all forms of child abuse or trauma, the impact of FGM on a child will depend upon such factors as:

- The severity and nature of the violence
- The individual child's innate resilience
- The warmth and support the child receives in their relationship with their parent/s, siblings and other family members
- The nature and length of the child's wider relationships and social networks
- Previous or subsequent traumas experienced by the child
- Particular characteristics of the child's gender, ethnic origin, age, (dis)ability, socio-economic and cultural background

6.4 Short term implications for a child's health and welfare

6.4.1 Short-term health implications can include:

- Severe pain
- Emotional and psychological shock (exacerbated by having to reconcile being subjected to the trauma by loving parents, extended family and friends)
- Haemorrhage
- Wound infections including Tetanus and blood borne viruses (including HIV and Hepatitis B and C)
- Urinary retention
- Injury to adjacent tissues
- Fracture or dislocation as a result of restraint
- Damage to other organs
- Death

6.5 Long term implications for a girl or woman's health and welfare

- 6.5.1 The longer term implications for women who have been subject to FGM Types 1 and 2 are likely to be related to the trauma of the actual procedure. Nevertheless, analysis of World Health Organisation data has shown that as compared to women who have not undergone FGM, women who had been subject to any type of FGM showed an increase in complications in childbirth, worsening with Type 3. Therefore, although Type 3 creates most difficulties, professionals should respond proactively for all FGM types.
- 6.5.2 The health problems caused by FGM Type 3 are severe – urinary problems, difficulty with menstruation, pain during sex, lack of pleasurable sensation, psychological problems, infertility, vaginal infections, specific problems during pregnancy and childbirth, including flashbacks.
- 6.5.3 Women with FGM Type 3 require special care during pregnancy and childbirth.
- 6.5.4 The long term health implications of FGM include:
- Chronic vaginal and pelvic infections
 - Difficulties in menstruation
 - Difficulties in passing urine and chronic urine infections
 - Renal impairment and possible renal failure
 - Damage to the reproductive system including infertility
 - Infibulation cysts, neuromas and keloid scar formation
 - Complications in pregnancy and delay in the second stage of childbirth
 - Maternal or foetal death
 - Psychological damage; including a number of mental health and psychosexual problems including depression, anxiety, and sexual dysfunction
 - Increased risk of HIV and other sexually transmitted infections

6.6 Mental health problems

- 6.6.1 In FGM practicing communities, the procedure is generally performed on pre-pubescent and adolescent girls usually without anaesthetics and with [delete: crude] instruments such as razor blades. Case histories and personal accounts from women note that FGM is an extremely traumatic experience for girls and women that stays with them for the rest of their lives.
- 6.6.2 Young women receiving psychological counselling in the UK report feelings of betrayal by parents, incompleteness, regret and anger.¹⁰ It is possible that as young women become more informed about FGM and/or cross the threshold from traditional Africa to the modern sector this problem may be more frequently identified.¹¹ There is increasing awareness of the severe psychological consequences of FGM for girls and women which become evident in mental health problems.

¹⁰ Haseena Lockhat, 2004, 'Female Genital Mutilation: Treating the Tears', London: Middlesex University Press

¹¹ Excised girls requiring psychological counselling was highlighted by women's organization attending a recent Equality Now 'Annual Meeting for Grassroots Activism to End Female Genital Mutilation' which took place from the 20-22 October 2005 in Nairobi, Kenya.

6.6.3 The results from research¹² in practicing African communities are that women who have undergone FGM have the same levels of Post Traumatic Stress Disorder as adults who have been subject to early childhood abuse. Also that the majority of the women (80%) suffer from affective (mood) or anxiety disorders.

6.6.4 The fact that FGM is 'culturally embedded' in a girl or woman's community appears not to protect her against the development of Post Traumatic Stress Disorder and other psychiatric disorders.

7. Professional response

➤ **THERE ARE THREE CIRCUMSTANCES RELATING TO FGM WHICH REQUIRE IDENTIFICATION AND INTERVENTION**

- Where a child is at risk of FGM
- Where a child has been abused through FGM
- Where a prospective mother has undergone FGM

7.1 Professionals and volunteers in most agencies have little or no experience of dealing with female genital mutilation. Coming across FGM for the first time they can feel shocked, upset, helpless and unsure of how to respond appropriately to ensure that a child, and/or a mother, is protected from harm or further harm.

7.2 The appropriate response to FGM is to follow usual child protection procedures (see sections 10 and 11 below), to ensure:

- Immediate protection and support for the child/ren; and
- That the practice is not perpetuated

7.3 An appropriate response to a child suspected of having undergone FGM as well as a child at risk of undergoing FGM could include:

- Arranging for an interpreter if this is necessary and appropriate
- Creating an opportunity for the child to disclose, seeing the child on their own
- Using simple language and asking straightforward questions
- Using terminology that the child will understand e.g. the child is unlikely to view the procedure as abusive
- Being sensitive to the fact that the child will be loyal to their parents
- Giving the child time to talk
- Getting accurate information about the urgency of the situation, if the child is at risk of being subjected to the procedure
- Giving the message that the child can come back to you again

7.4 An appropriate response by professionals who encounter a girl or woman who has undergone FGM includes:

- Arranging for a professional interpreter and not agreeing to friends/family members interpreting on their behalf

¹² Behrendt, A. et al, 2005, 'Posttraumatic Stress Disorder and Memory Problems after Female Genital Mutilation', Am J Psychiatry 162:1000-1002, May

- Being sensitive to the intimate nature of the subject
- Making no assumptions
- Asking straightforward questions
- Being willing to listen
- Being non-judgemental (condemning the practice, but not blaming the girl/woman)
- Understanding how she may feel in terms of language barriers, culture shock, that she, her partner, her family are being judged
- Giving a clear explanation that FGM is illegal and that the law can be used to help the family avoid FGM if/when they have daughters

Case study: One woman's story¹³

'Margaret' remembers that she wanted to undergo infibulation, she couldn't go to school until it was done. But afterwards she was no longer able to do all the things she enjoyed as a child, climbing her favourite tree, playing football, riding a donkey and gymnastics, all these might tear the scar tissue.

Margaret says that in her teenage years she had very painful periods as a result of the infibulation. As a young married woman, she says, she had little feeling. Sex became a necessity just to satisfy her husband and produce children.

Margaret says 'your childhood is gone – you're disabled for life...'

8. Identifying a child who has been subject to FGM or who is at risk of being abused through FGM

8.1 A child at risk of FGM

8.1.2 Professionals in all agencies, and individuals and groups in the community, need to be alert to the possibility of a child being at risk of, or having experienced female genital mutilation. There are a range of potential indicators that a child may be at risk of FGM, which individually may not indicate risk but if there are two or more present this could signal risk to the child.

8.1.3 Indications that FGM may be about to take place include:

- The family comes from a community that is known to practise FGM. E.g. Somalia, Sudan and other African countries (see section 3. above). It may be possible that they will practice FGM if a female family elder is around
- Parents state that they or a relative will take the child out of the country for a prolonged period
- A child may talk about a long holiday to her country of origin or another country where the practice is prevalent, including African countries and the Middle East

¹³ Female Genital Mutilation DVD, Department of Health, 2006

- A child may confide to a professional that she is to have a 'special procedure' or to attend a special occasion
- A professional hears reference to FGM in conversation, for example a child may tell other children about it
- A child may request help from a teacher or another adult
- Any female child born to a woman who has been subjected to FGM must be considered to be at risk, as must other female children in the extended family
- Any female child who has a sister who has already have undergone FGM must be considered to be at risk, as must other female children in the extended family

8.2.1 Indications that FGM may have already taken place include:

- A child may spend long periods of time away from the classroom during the day with bladder or menstrual problems if she has undergone Type 3 FGM
- There may be prolonged absences from school if she has undergone Type 3 FGM
- A prolonged absence from school with noticeable behaviour changes on the girl's return could be an indication that a girl has recently undergone FGM
- Professionals also need to be vigilant to the emotional and psychological needs of children who may/are suffering the adverse consequence of the practice e.g. withdrawal, depression etc
- A child may confide in a professional
- A child requiring to be excused from physical exercise lessons without the support of her GP
- A child may ask for help

9. Identifying a young girl or mother who has undergone FGM

9.1 Health professionals gathering information

- 9.1.1 Health professionals in GP surgeries, sexual health clinics and maternity services are the most likely to encounter a girl or woman who has been subjected to FGM.
- 9.1.2 If the girl/woman is from a community which traditionally practices FGM, information gathering should be approached sensitively. A question about FGM should be incorporated when the routine patient history is being taken. A female interpreter may be required. The interpreter should be appropriately trained in relation to FGM and must not be a family member.
- 9.1.3 A suitable form of words should be used, 'circumcised' is not medically correct and although 'mutilation' is the most appropriate term, it might not be understood or it may be offensive to a woman from a practising community who does not view FGM in that way. Different terminology will be culturally appropriate to the different cultures.
- 9.1.4 A health professional may make an initial approach by asking a woman whether she has undergone FGM saying: 'I'm aware that in some communities women undergo some traditional operation in their genital area. Have you had FGM or have you been cut?' To ask about infibulation health professionals can use the question: 'are you closed or open?'. This may lead to the woman providing the terminology appropriate to her language/culture.
- 9.1.5 Asking the right questions in a simple, straightforward and sensitive way is key to establishing the understanding, information exchange and relationship needed to plan for the girl/woman's wellbeing and the welfare and wellbeing of any daughters she may have, or girl children she may have access to.

9.2 Pregnancy and childbirth

- 9.2.1 At antenatal booking the holistic assessment may identify women who have undergone FGM. Midwives and Obstetricians should then plan appropriate care for pregnancy and delivery¹⁴
- 9.2.2 Women with FGM Type 3 require special care during pregnancy and childbirth, especially if it is first pregnancy or the woman has had a previous caesarean section or re-infibulation took place in the past. Early antenatal registration is important in providing midwives with the opportunity to plan for this. Women may not know which type of FGM they have undergone, it is therefore best practice to examine the woman during the booking. Unfortunately many women only access services very late in their pregnancy.
- 9.2.3 The plan should be an extension of NICE guidelines that midwives are already familiar with i.e. history taking, offering individual care and being culturally sensitive. However the woman should be told that ideally she should be de-infibulated¹⁵ during 2nd trimester.

9.3 Counselling

- 9.3.1 All girls/women who have undergone FGM (and their boyfriends/partners or husbands) must be told that re-infibulation is against the law and will not be done under any circumstances. Each woman should be offered counselling to address how things will be different for her afterwards.
- 9.3.2 Counselling sessions should be offered and arranged, taking into account that the woman may not want to make the arrangements about it when her boyfriend/partner or husband or other family members are present. Professionals should be aware that there may be coercion and control involved which may have repercussions for the girl/woman.
- 9.3.3 Boyfriends/partners and husbands should also be offered counselling, they are usually supportive when the reality is explained to them.
- 9.3.4 Health professionals should communicate equally the disadvantages of infibulation and the benefits of remaining open after childbirth. It:
- Is more hygienic.
 - Means that sex will be much more comfortable and better once both partners get used to it.
 - Will make future births much easier and less risky
 - Increases the likelihood of conception
 - Reduces the chances of neonatal death¹⁶
- 9.3.5 Once girls/women know all the facts and the benefits of remaining open most of them are happy to remain so. Health professionals should not, however assume that this means that the woman will be more able to resist the pressure from the community to subject any daughter/s she may have to FGM.

10. Professionals and volunteers from all agencies responding to concerns

10.1 Summary response

¹⁴ Royal College of Obstetricians and Gynaecologists, 2003 and Royal College of Midwives, 1998

¹⁵ Whilst professionals may be aware that they cannot re-infibulate, the two edges must be over-sown or they may naturally knit back together and the result is the same as infibulation.

¹⁶ World Health Organisation, June 2006: <http://www.newscientist.com/article/dn9258-female-genital-mutilation-complicates-births.html>

- 10.1.1 Any information or concern that a child is at immediate risk of, or has undergone, female genital mutilation should result in a child protection referral to LA Children's Social in line with section 11 LA Children's Social Care, below and *section 6. Referral & Assessment, London Child Protection Procedures, LSCB, 2006.*
- 10.1.2 Where a child is thought to be at risk of FGM practitioners should be alert to the need to act quickly – before the child is abused through the FGM procedure in the UK or taken abroad to undergo the procedure.
- 10.1.3 See Appendix 1 for Multi-agency Child Protection Decision-making and Action Flowchart.

10.2 Education/ leisure and community and faith groups

Concerns that a child is at risk of being abused through FGM

- 10.2.1 Teachers, other school staff, volunteers and members of community groups may become aware that a child is at risk of FGM through a parent/other adult, a child or other children disclosing that:
- The procedure is being planned
 - An older child in the family has already undergone FGM
- School nurses are in a particularly good position to identify FGM or receive a disclosure about it.
- 10.2.2 A professional, volunteer or community group member who has information or suspicions that a child is at risk of FGM should consult with their agency or group's designated Child Protection Adviser (if they have one) and should make an immediate referral to LA Children's Social Care, in line with section 11 LA Children's Social Care, below and *section 6. Referral & Assessment, London Child Protection Procedures, LSCB, 2006.*
- 10.2.3 The referral should not be delayed in order to consult with the designated Child Protection Adviser, a manager or group leader, as multi-agency safeguarding intervention needs to happen quickly.
- 10.2.4 If there is a concern about one child, consideration must be given to whether siblings are at similar risk. Once concerns are raised about FGM there should also be consideration of possible risk to other children in the practicing community.

Concerns that a child has already been abused through FGM

- 10.2.5 Teachers, other school staff, volunteers and members of community groups may become aware that a child has been subjected to FGM through:
- A child presenting with the signs and symptoms described in section 8 above
 - A parent/other adult, a child or other children disclosing that the child has been subjected to FGM
- 10.2.6 A professional, volunteer or community group member who has information or suspicions that a child has been subjected to FGM should consult with their agency or group's designated Child Protection Adviser (if they have one) and make a referral to LA Children's Social Care, in line with section 11. LA Children's Social Care, below and *section 6. Referral & Assessment, London Child Protection Procedures, LSCB, 2006.*
- 10.2.7 If the child appears to be in acute physical and/or emotional distress, they should make an immediate referral to LA Children's Social Care (in line with section 11. LA Children's Social Care, below and *section 6. Referral & Assessment, London Child Protection Procedures, LSCB, 2006*), and to the local Health Service.

10.2.8 If there is a concern about one child, the child's siblings and the children in the extended family, should be considered to be at risk.

10.2.9 Once concerns are raised about FGM in relation to one child/family there should also be consideration of possible risk to other children in the practicing community.

10.3 Health

Concerns in relation to a mother who has undergone FGM

10.3.1 Health professionals encountering a girl or woman who has undergone FGM should be alert to the risk of FGM in relation to her:

- Younger siblings
- Daughters or daughters she may have in the future
- Extended family members

10.3.2 Health professionals in GP surgeries, sexual health clinics and maternity services are the most likely to encounter a girl or woman who has been subjected to FGM. All girls and women who have undergone FGM should be given information about the legal and health implications of practising FGM.

Health visitors, are in a good position to reinforce information about the health consequences and the law relating to FGM. Currently FGM is not always provided on post-natal discharge reports and is not recorded routinely in health visiting records. Health visitors should seek to record this information wherever possible.

10.3.3 If a girl or woman who has been de-infibulated requests re-infibulation after the birth of a child, where the child is female, or there are daughters in the family, health professionals should consult with their designated Child Protection Adviser and with LA Children's Social Care about making a referral to them.

10.3.4 After childbirth a girl/woman who has been de-infibulated may request and continue to request, re-infibulation. This should be treated as a child protection concern. This is because whilst the request for re-infibulation is not in itself a child protection issue, the fact that the girl or woman is apparently not wanting to comply with UK law and/or consider that the process is harmful, raises concerns in relation girl child/ren she may already have or may have in the future. Professionals should consult with the designated Child Protection Adviser and with LA Children's Social Care about making a referral to them (see sections 10 and 11 below).

10.3.5 If the girl or woman is a mother or prospective mother, her child/ren or unborn child should be considered at risk of significant harm. The health professional should consult with their designated Child Protection Adviser and should make a referral to LA Children's Social Care, in line with section 11 below and *section 6. Referral & Assessment, London Child Protection Procedures, LSCB, 2007.*

10.3.6 If the girl or woman has the care of female children, these children should be considered children at risk of significant harm, the designated Child Protection Adviser should be consulted and a referral made to LA Children's Social Care, as above.

10.3.7 See also the BMA Guidance: *FGM: Caring for patients and child protection*¹⁷

10.4 The police

10.4.1 The police have a key role in the investigation of serious crime.

10.4.2 All Child Abuse Investigation Teams (CAITs) in London have an awareness of FGM and the Metropolitan Police Service has a specific policy to deal with allegations of

¹⁷ [http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFfgm0706/\\$FILE/FGM0706.pdf](http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFfgm0706/$FILE/FGM0706.pdf)

FGM. The police response recognises the need for an effective investigative response to what is regarded as an extremely severe form of child abuse, recognising the immediate and long term pain, suffering and risks to health associated with this practice.

- 10.4.3 Where FGM has been practised the CAIT will take a lead role in the investigation of this serious crime, working to common joint investigative practices and in line with strategy agreements.
- 10.4.4 The police investigation will extend to identifying established excisors and investigating these with a view to identifying further victims and closing down these networks within the Metropolitan Police Service and beyond, where children in London are affected.

11. LA children's social care

Children's Social Care will investigate (initially) under Section 47 of the Children Act (1989).

If a referral is received concerning one child, consideration must be given to whether siblings are at similar risk.

Once concerns are raised about FGM there should also be consideration of possible risk to other child in the practicing community. Professionals should be alert to the fact that any one of the girl children amongst these could be identified as being at risk of FGM and will then need to be responded to as a child in need or a child in need of protection.

11.1 Strategy meeting

- 11.1.1 On receipt of a referral a strategy meeting must be convened within two working days, and should involve representatives from police, Children's Social Care, education, health and voluntary services. Health providers or voluntary organisations with specific expertise e.g. FGM, domestic violence and/or sexual abuse, must be invited; and consideration may also be given to inviting a legal advisor (*section 6. Referral & Assessment, London Child Protection Procedures, LSCB, 2006.*).
- 11.1.2 The strategy meeting must first establish if either parents or child has had access to information about the harmful aspects of FGM and the law in the UK. If not, the parents/child should be given appropriate information regarding the law and harmful consequences of FGM.
- 11.1.3 An interpreter and, if possible a community advocate, appropriately trained in all aspects of FGM must be used in all interviews with the family. A female interpreter should be used, who is not a family relation.
- 11.1.4 Every attempt should be made to work with parents on a voluntary basis to prevent the abuse. It is the duty of the investigating team to look at every possible way that parental co-operation can be achieved, including the use of community organisations and/or community leaders to facilitate the work with parents/family. However, the child's interest is always paramount.
- 11.1.5 If no agreement is reached, the first priority is protection of the child and the least intrusive legal action should be taken to ensure the child's safety.
- 11.1.6 The primary focus is to prevent the child undergoing any form of FGM, rather than removal of the child from the family.

11.2 Children at immediate risk of harm

11.2.1 If the strategy meeting decides that the child is in immediate danger of mutilation and parents cannot satisfactorily guarantee that they will not proceed with it, then an emergency protection order should be sought.

11.3 If a child has already undergone FGM

11.3.1. A strategy meeting must be convened within two days. The strategy meeting will consider how, where and when the procedure was performed and the implication of this.

11.3.2. If the child has already undergone FGM the strategy meeting will need to consider carefully whether to continue enquiries or whether to assess the need for support services. If any legal action is being considered, legal advice must be sought.

11.3.3 A second strategy meeting should take place within ten working days of the referral, with the same chair. This meeting must evaluate the information collected in the enquiry and recommend whether a child protection conference is necessary, in line with *section 7. Child Protection Conferences, London Child Protection Procedures, LSCB, 2006.*

11.3.4 A girl who has already undergone FGM should not normally be subject to a child protection conference or registered unless additional child protection concerns exist. However, she should be offered counselling and medical help. Consideration must be given to any other female siblings at risk (see good practice guidelines for Children's Social Care).

11.3.5 A child protection conference should only be considered necessary if there are unresolved child protection issues once the initial investigation and assessment have been completed.

12. Reducing the prevalence of FGM

12.1 The role of local safeguarding children boards

12.1.1 Local Safeguarding Children Boards (LSCBs) duties and responsibilities include promoting activity amongst local agencies and in the community to:

- Identify and prevent maltreatment or impairment of health or development, and ensure children are growing up in circumstances consistent with safe and effective care
- Safeguard and promote the welfare of groups of children who are potentially more vulnerable than the general population
- Increase understanding of safeguarding children issues in the professional and wider community, promoting the message that safeguarding is everybody's responsibility

The LSCB should undertake initiatives in relation to FGM which fulfil these duties and responsibilities.

12.1.2 LSCBs are responsible for ensuring that should ensure that single agency and inter-agency training on safeguarding and promoting welfare is provided in order to meet local needs i.e. that staff who have responsibility for child protection work are acquainted with child protection procedures in relation to FGM and are confident working with local preventative programmes relating to FGM.

12.1.3 London's LSCBs may consider developing and supporting a centralised virtual team of experts to advise professionals on the prevention of FGM in the community and the appropriate professional response to individual cases.

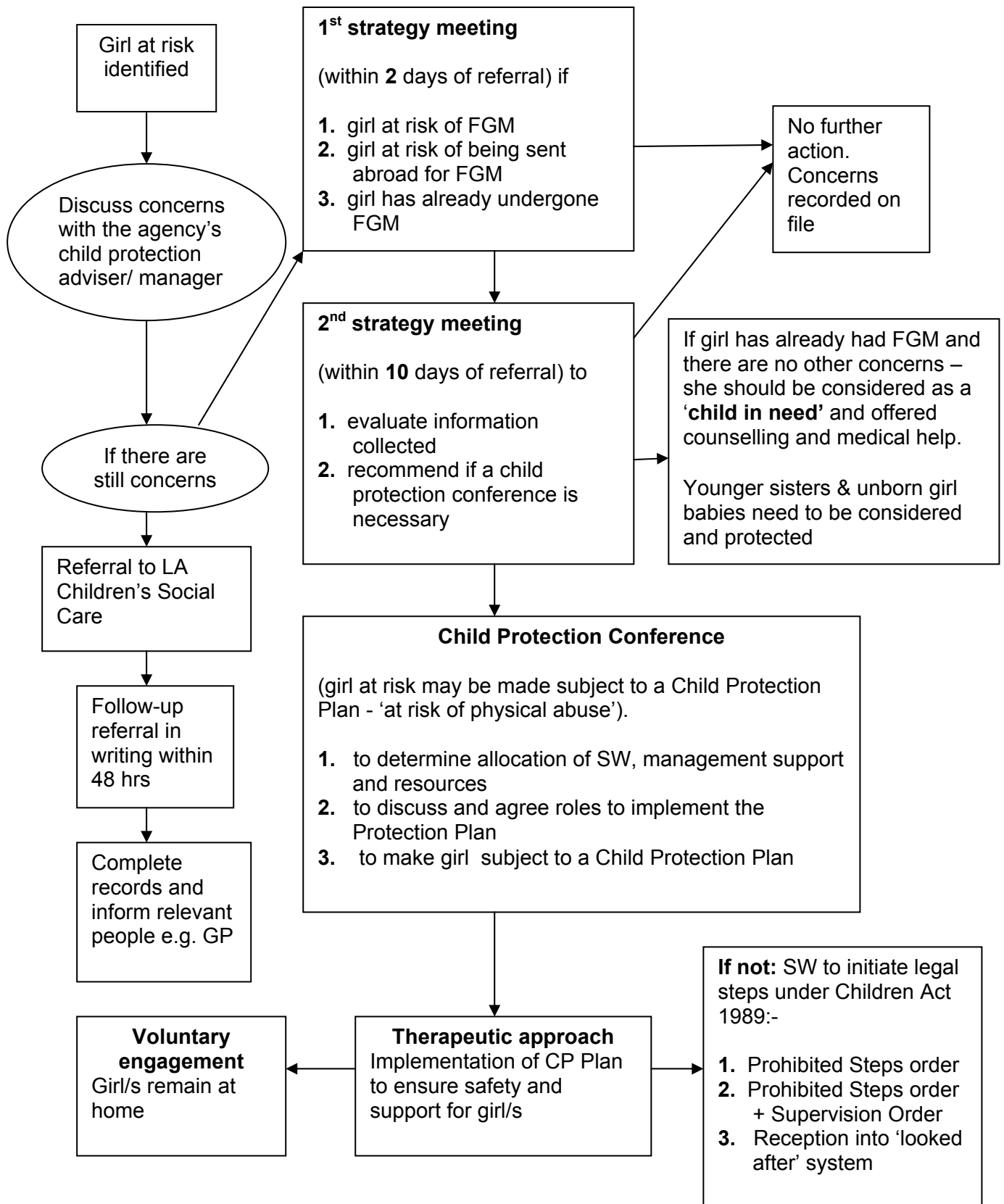
13. Information sharing

- 13.1 Professionals in all agencies need to be confident and competent in sharing information appropriately both to safeguard children from being abused through FGM and to enable children and women who have been abused through FGM to receive physical and emotional and psychological help.
- 13.2 Professionals in all agencies should share information in line with Section 3. Information Sharing, in the *London Child Protection Procedures (2007)*: www.londoncpc.gov.uk

Christine Christie, London Safeguarding Children Board Manager, April 2007

Appendix 1

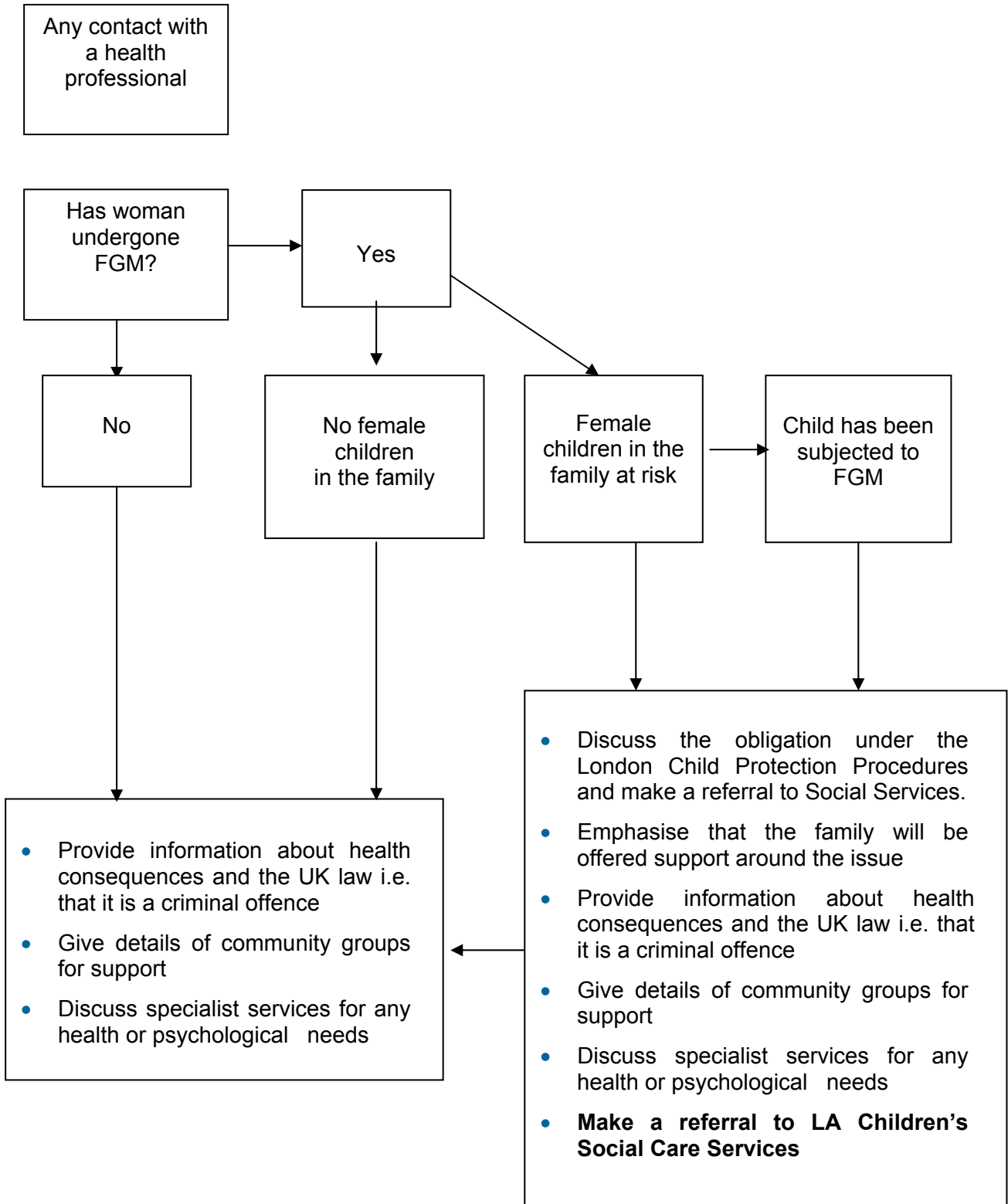
Multi-agency Child Protection Decision-making and Action Flowchart (based on the London Child Protection Procedures, LSCB (2007))



Appendix 2

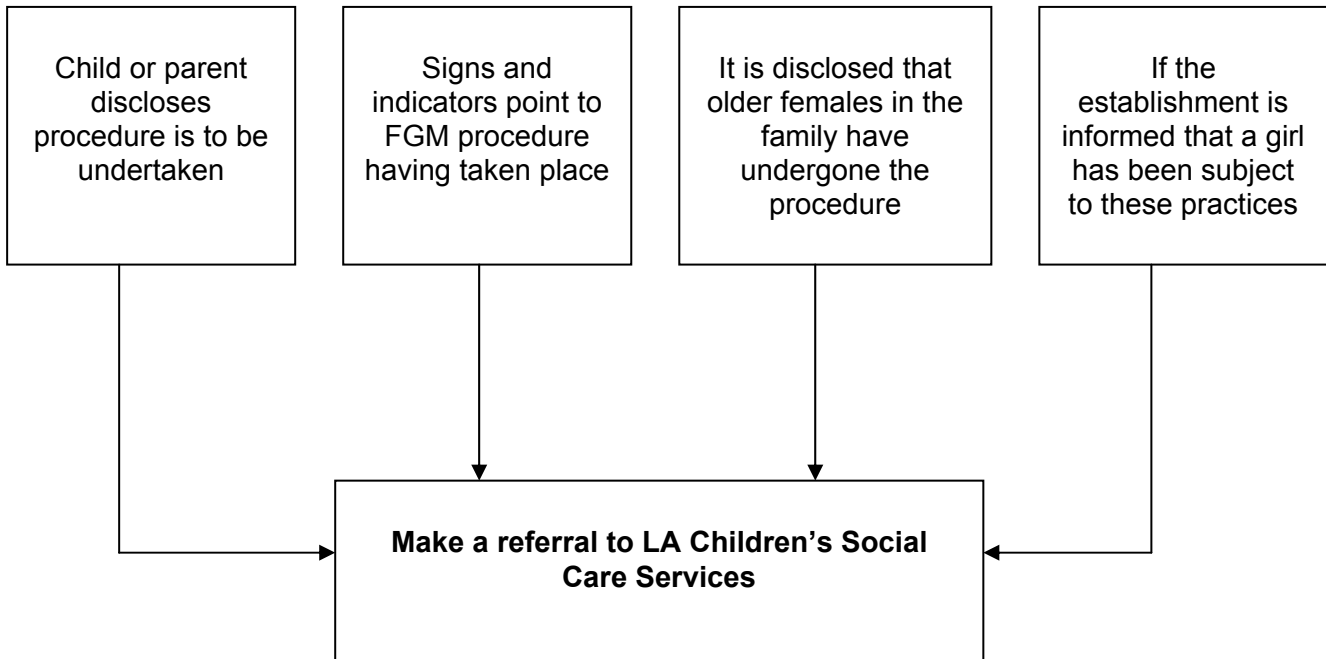
Decision-making and Action Flowchart for Professionals in Health

Working with Women



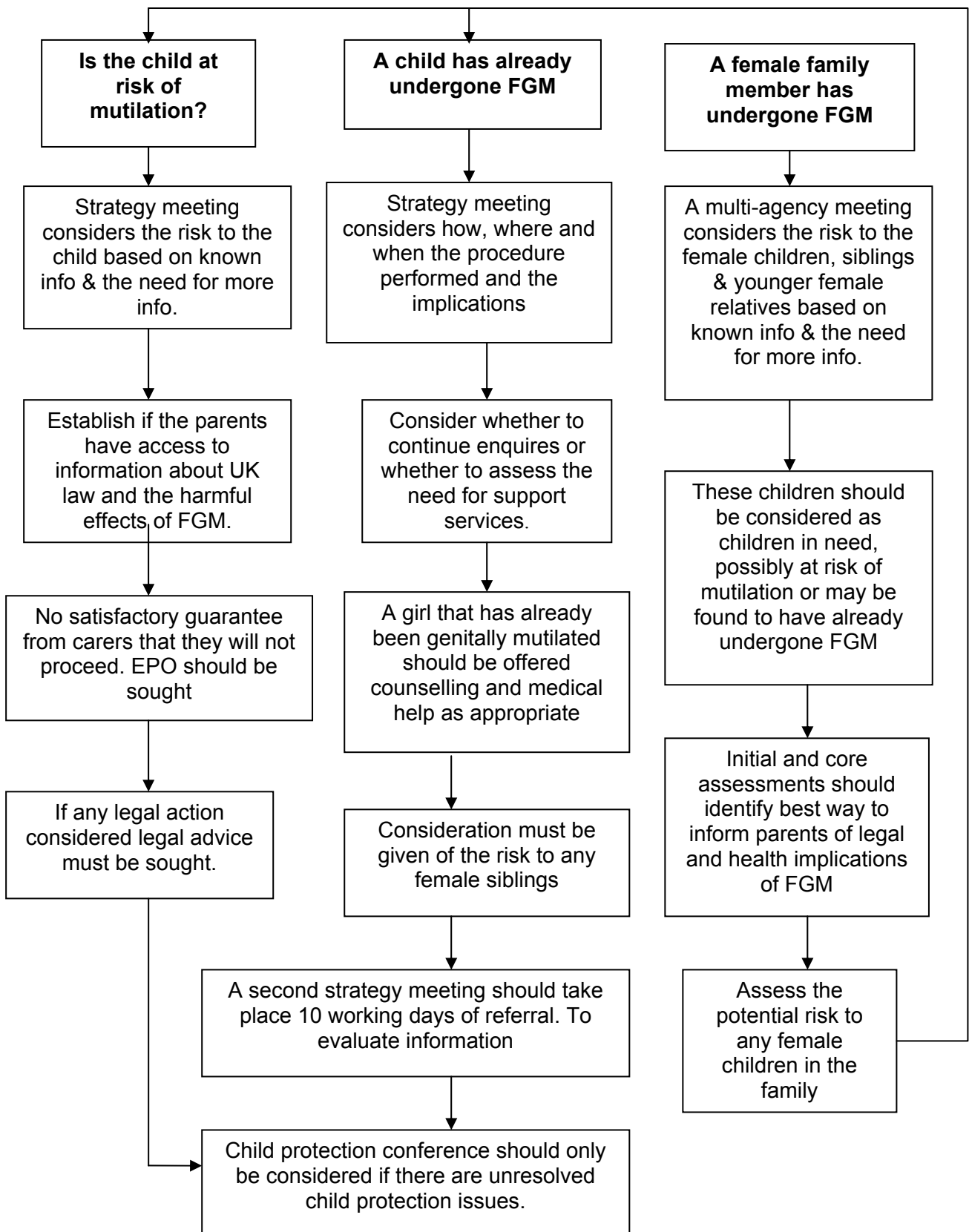
Appendix 3

Decision-making and Action Flowchart for Professionals in LA Education and Schools, & Professionals and Volunteers in the Voluntary Sector



Appendix 4

Decision-making and Action Flowchart for Professionals in LA Children's Social Care



Appendix 5

Recent Progress Internationally

Female Genital Mutilation not Islamic – say top Egyptian clerics

The Foundation for Women's Health Research and Development (FORWARD) and the London Central Mosque Trust & the Islamic Cultural Centre (ICC) welcome the break through announcements by top Muslim clerics to disassociate Islam from Female Genital Mutilation (FGM). The declaration was announced on 22 November 2006 during an international conference on FGM in Cairo, Egypt.

The Grand Sheikh of al-Azhar, the highest Sunni Islamic institution in the world, Sheikh Mohammed Sayyid Tantawi categorically stated "FGM has neither been mentioned in Quran nor Sunnah¹⁸". This statement was reaffirmed by the top official cleric and Grand Mufti of Egypt, Sheikh Ali Gomaa who said "Prophet Mohammed didn't circumcise his four daughters". Sheikh Yousif Algaradawi, a prominent Islamic figure, also addressed the conference by avowing that "FGM is not an Islamic requirement". These statements have come from the highest Islamic figures in the world which should be binding for all FGM practicing communities who are Sunni Muslims.

These announcements have long been waited for by FORWARD and ICC who are working jointly to eradicate FGM in the UK where some Muslims mistakenly think that FGM is an Islamic requirement.

For the last two decades FORWARD has maintained its position that the only way to eradicate FGM is to engage with FGM practicing communities particularly the religious and community leaders.

FORWARD and ICC urge all Imams and Muslim clerics in the UK and Europe to take notice of the declarations made in Cairo and follow the example of their counterparts in Egypt. We would urge all UK clerics to make similar statements and to actively educate their followers that female genital mutilation is not an Islamic requirement.

The FGM Act 2003 makes FGM illegal in the UK and anywhere in the world for UK citizens and permanent residents. The penalty for carrying out, aiding, abetting or counselling to procure FGM is 14 years imprisonment, a fine or both.

WEST AFRICA: Communities choose health over tradition

On 3rd December 2006 150 communities in Guinea collectively abandoned the practice of female genital cutting – a landmark declaration in a country where more than 97 percent of women undergo the ritual.

Delegations led by women from each village converged on the central Guinean town of Lalya to speak about genital excision and participate in the declaration. All of Guinea's ethnic groups practice genital cutting, despite a law that forbids it.

The Senegal-based NGO Tostan organised the Guinea declaration after working with communities to show how traditional practices such as genital cutting are harming individuals and communities.

Khady Bah Faye, Tostan's communications officer, said that the Guinea declaration shows that momentum against the harmful practice is growing in Africa. She said Tostan has also been getting requests for assistance from the Gambia, Burkina Faso and Benin. The NGO has also worked in Mali and is about to begin in Mauritania.

¹⁸ A saying or action ascribed to Prophet Mohammed (peace be upon him) or an act approved by the prophet.

More than 1,800 communities in Senegal, where excision is practiced among 28 percent of the population, have publicly abandoned genital cutting in the past nine years, Faye said. She said the continued rate of abandonment after at least two years was 65-80 percent.

“This has been a practice that has gone on for 2,000 years and yet it is going to take an understanding by people who believe this is part of their culture to understand the dangers to women so it can be eliminated,” said Ann Veneman, executive director of the United Nations children’s agency (UNICEF).

Appendix 6

Prevalence Profile and Legislation banning FGM in Africa

These figures are offered only to give an indication of the scale the practice of FGM, they are figures for Africa, not for communities in the UK for which prevalence data is not available.

| Country | Prevalence | Illegal / since |
|--------------------------|-------------|--|
| Benin | 30% | Not yet |
| Burkina Faso | 72% | 1996 |
| Cameroon | 20% | None |
| Chad | 60% | Went before parliament in 2001, not yet in place |
| Central African Republic | 43% | 1966 |
| Djibouti | 98% | 1995 |
| Egypt | 97% | 1959, there are grey areas, but in 1997 court upheld govt banning of FGM |
| Eritrea | 90% | No specific banning law for fear of driving the practice underground |
| Ethiopia | 90% | 1994 |
| Gambia | Approx. 70% | None |
| Ghana | 15% | 1994 |
| Guinea | 99% | Late 1980's |
| Guinea Bissau | Approx. 50% | 1995 govt proposal to ban was defeated |
| Ivory Coast | 45% | 1998 |
| Liberia | 60% | None |
| Mali | 93% | None, but draft legislation and govt campaigns against |
| Mauritania | 25% | Not illegal, but banned in hospitals |
| Niger | 5% | Not yet, draft legislation |
| Nigeria | % | In some areas since 1999 |
| Senegal | 20% | 1999 |
| Sierra Leone | 90% | None |
| Sudan | 91% | 1956, rescinded in 1983. Opposed by govt but not in law |
| Somalia | 100% | In some areas since 1999 |
| Kenya | 38% | 2001 |
| Tanzania | 18% | 1998, however not enforced |
| Togo | 12% | 1998 |
| Uganda | 5% | Considering banning, children's legislation can be used |
| Yemen | 23% | Not illegal, but banned in hospitals |

Source: *Female Genital Mutilation: Treating the Tears*, Haseena Lockhat (2004)

Appendix 7

Glossary of Terms

1. Female Genital Mutilation is sometimes called female circumcision or female cutting.
2. Type 1, Female Genital Mutilation may be known to some communities as 'Sunna'. Sunna is an Islamic word used to describe an action by the Prophet Mohammed.
3. Infibulation is derived from the name given to the Roman practice of fastening a 'fibular' or 'clasp' through the large lips of a female genitalia (usually within marriage) in order to prevent illicit sexual intercourse.
4. De-infibulation is the name for having FGM reversed and opening the entry to the vagina again.
5. Re-infibulation is the term used when women seek to be restored to their previous state usually following child birth.
6. The term "closed" refers to type 3 Female Genital Mutilation where there is a long scar covering the vaginal opening. This term is particularly understood by the Somali and Sudanese communities.

References & Resources

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Agencies offering help and advice, and who may be able to put enquirers in contact with local women's groups

Foundation for women's research and development (FORWARD)

Unit 4
 765-767 Harrow Rd
 London NW10 5NY
 Tel: 020 8960 4000
 Fax: 020 8960 4014
 Email: forward@forwarduk.org.uk
 Internet: www.forwarduk.org.uk - go there now

International planned parenthood federation

Regent's College
 Inner Circle
 Regent's Park
 London NW1 4NS
 Tel: 020 7487 7900
 Fax: 020 7487 7897
 Email: info@ippf.org
 Internet: www.ippf.org - go there now

Black women's health and family support (BWHAFS)

82 Russia Lane
 London E2 9LU
 Tel: 020 8980 3503
 Fax: 020 8980 6314
 Email: bwhafs@btconnect.com

Rainbow

Suite 5a

Queens Studios

121 Salusbury Road

London

NW6 6RG

Tel: 020 7625 3400

Fax: 020 7625 2999

E-mail: info@rainbo.org

Internet: www.rainbo.org - go there now