Female Genital Mutilation

Guidance for all staff

BSCB FGM Working Group September 2015

Review Date: September 2016

Contents

FEMALE GENITAL MUTILATION

Female Genital Mutilation is illegal and is prohibited by the Female Genital Mutilation Act 2003.

There are an estimated 100 million to 140 million girls and women across the world who have been subjected to the operation. Currently, about 3 million girls, the majority under 15 years of age, undergo the procedure every year. World Health Organisation (2007).

Female Genital Mutilation (FGM) is practiced in over 28 African countries (Appendix 1), parts of the Middle and Far East. There are substantial populations from countries where FGM is endemic throughout the UK.

It is acknowledged that some families see FGM as an act of love rather than cruelty. FGM causes significant harm both in the short and long term and constitutes physical and emotional abuse to children and is unlawful in this country.

Accessible, acceptable and sensitive health, education, police, social care and voluntary sector services must underpin this guidance.

All agencies should work in partnership with members of local communities, to empower individuals to develop support networks and education programmes.

This practice guidance for Bexley mirrors draft London FGM procedures currently in consultation and will be reviewed following its publication.

1.1 Equality and Diversity Statement

This guidance affects a group of young females who are particularly vulnerable. Any decisions or plans for these girls/young women need to be based on good quality assessments and be sensitive to the issues of race, culture, gender, religion and sexuality, so far as not to stigmatise the child or the practicing community.

2 Legislation

2.1 International Standards

2.1.1 Legislation against FGM in the UK includes both international standards and national legislation.

2.1.2 There are two international conventions, which contain articles that can be applied to FGM. Signatory states, including the UK, have an obligation under these standards to take legal action against FGM. They are:

- **The UN Convention on the Rights of the Child**, ratified by the UK Government on16 December 1991, was the first binding instrument explicitly addressing harmful traditional practices as a human rights violation. It specifically requires Governments to take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.
- **The UN Convention on the Elimination of All Forms of Discrimination against Women**, which came into force in 1981, recognises FGM as a form of gender based violence against women. It calls on signatory

Governments to take appropriate and effective measures with a view to eradicating the practice, including introducing appropriate health care and education strategies.

2.2 **United Kingdom legislation**

2.2.1 In England, Wales and Northern Ireland all forms of FGM are illegal under the Female Genital Mutilation Act (2003), and in Scotland it is illegal under the Prohibition of FGM (Scotland) Act 2005.

The UK law states that "A person is guilty of an offence if s/he, excises, infibulates or otherwise mutilates the whole or any part of a girl's labia, 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"

2.2.2 FGM is a criminal 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.

2.2.3 Where FGM is identified in NHS patients, it is mandatory to record this in the patient's health record. All acute trusts are required to provide a monthly report to the Department of Health on the number of patients who have had FGM or who have a family history of FGM. This information is anonymous.

2.2.4 **Section 5B of the FGM Act 2003[1] has introduced a mandatory reporting duty which requires regulated health and social care professionals and teachers in England and Wales to report known cases of FGM in under 18's to the police (ring 101).**
https://www.gov.uk/government/publications/mandatory-reporting-of-female-genital-mutilation-procedural-information

The duty applies where in the course of their professional duties, the professional either:

- Is **informed by the girl** that an act of FGM has been carried out on her; or
- **Observes physical signs** which appear to show an act of FGM has been carried out and has no reason to believe that the act was necessary for the girl's physical or mental health or for purposes connected with labour or birth.

The professional is expected to make a referral within one month following their organisation's safeguarding procedures,this includes ensuring the family is aware of the report.The duty to report does not breach any confidentiality requirement or other restriction on disclosure which might apply.

The duty does not apply in relation to 'at risk' cases (only those which are visually identified or disclosed to a professional by the victim and is under 18yrs old). Suspected cases should follow Bexley safeguarding procedures.

See references for training materialsproduced for health professionals.

[1] As inserted by section74 of the Serious Crime Act 2015

2.3 Definition

2.3.1 "FGM constitutes all procedures 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)

2.3.2 The specific form that FGM takes varies from one country to another and there are difficulties associated with any classification. There is significant variation in the extent of the cutting because of the poor conditions in which it is carried out. Girls and women may not know the type they have experienced.

2.3.3 The age at which girls are subjected to Female Genital Mutilation varies greatly, from shortly after birth to any time up to adulthood.

2.3.4 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 and is illegal.

2.4 Types of FGM

Female Genital Mutilation and other terms (see glossary) has been classified by the WHO into four types diagrams can be found in appendix 2:

- Type 1: Circumcision
  Excision of the prepuce with or without excision of part or the entire clitoris

- Type 2: Excisions (Clitoridectomy)
  Excision of the clitoris with partial or total excision of the labia minora (small lip 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.

3. Reasons given for continued practice of Female Genital Mutilation

- Family honour;
- Custom and tradition;

- Hygiene and cleanliness;
- Preservation of virginity/chastity;
- Social acceptance especially for marriage;
- A mistaken belief that it is a religious requirement;
- A sense of group belonging.

4. Health Consequences of Female Genital Mutilation

Many women are unaware of the health consequences of FGM; in particular the complications affecting sexual intercourse and childbirth which occur many years after the mutilation has taken place.

4.1 Short-term health implications

a) Severe pain and shock;

b) Haemorrhage;

c) Wound infections including Tetanus and blood borne viruses (including HIV, Hepatitis B and C);

d) Urinary retention;

e) Injury to adjacent issues;

f) Fracture of dislocation as a result of restraint;

g) Damage to other organs;

h) Death.

4.2 Long-term health implications

a) Chronic vaginal and pelvic infections;

b) Difficulties in menstruation;

c) Difficulties in passing urine and chronic urine infections;

d) Renal impairment and possible renal failure;

e) Damage to the reproductive system including infertility;

f) Infibulation cysts, neuromas and keloid scar formation;

g) Complications in pregnancy and delay in the second stage of childbirth;

h) Maternal or foetal death;

i) Psychological damage, including a number of mental health and psychosexual problems including depression, anxiety, and sexual dysfunction;

j) Increased risk of HIV and other sexually transmitted infections.

5. Practice guidance

To be read in conjunction with London Child Protection Procedures 2015.

Universal services (health services, early years and schools) are the most likely to encounter a girl or woman who has been subjected to FGM. However, all services

must be vigilant to the risks posed to girls and women who have undergone FGM or who are at risk. A risk of FGM may be identified at birth but the girl may continue to be at risk throughout her childhood. Professionals must be familiar with the indications and the screening questions. Individuals should seek advice from the Child protection advisor within their organisation.

The requirement to undertake a risk assessment with a woman or young person will depend on the individual's role and responsibility. Your organisation should have guidance regarding how to initiate a discussion relevant to the services provided by the organisation. See appendix 2 for examples of screening questions which may be appropriate for your service. Agency specific guidance is also available **www.fco.gov.uk/fgm**.

When talking about FGM, general points include:

- ensure that a female professional is available to speak to if the girl or woman would prefer this;
- make no assumptions; give the individual time to talk and be willing to listen;
- create an opportunity for the individual to disclose, seeing the individual on their own in private;
- be sensitive to the intimate nature of the subject;
- be sensitive to the fact that the individual may be loyal to their parents/community;
- be non-judgemental (pointing out the illegality and health risks of the practice, but not blaming the girl or woman);
- get accurate information about the urgency of the situation if the individual is at risk of being subjected to the procedure;
- take detailed notes;
- give a clear explanation that FGM is illegal.

Health services: health professionals have particular responsibilities to ensure appropriate questions are asked and information documented. Parents should be given information about the legal and health implications of practicing FGM in a respectful and sensitive manner.

It should be documented if a female patient has:

- Undergone FGM;
- What type of FGM;
- If there is a family history of FGM;
- If any FGM-related procedure has been carried out on a women - (including deinfibulation).

Midwives should discuss FGM at the initial booking visit with all women who come from countries that practice FGM or if they are married to or in a relationship with men from FGM practising communities. Midwives must document that the woman has been informed about the health risks and the law and given a leaflet in an appropriate language (if available) that explains the health risks of FGM, the law and local support services. This information should be shared with the GP and the Health Visitor and should be recorded in the child's 'red book' as a 'family history of FGM'. Professionals should consult with their safeguarding leads for guidance and support. Midwives should be aware that some women may be traumatised from their experience and have already resolved not to allow their daughters to undergo this

procedure. Any concerns about a parent's attitude towards FGM should be taken seriously and a referral made to children's social care (MASH).

If a girl or woman who has been de-infibulated requests re-infibulation/re-suturing after the birth of a child, must be referred to Children's Social Care. Re-infibulation is illegal in the UK. Whilst the request for re-infibulation is not in itself a safeguarding issue, the fact that the girl or woman is apparently not wanting/able to comply with UK law due to family pressure and / or does not consider that the procedure is harmful raises concerns in relation to female children she may already have or may have in the future.

Risk can only be considered at a particular moment in time. Healthcare professionals should take the opportunity to continue discussions around FGM throughout the standard delivery of healthcare. If for example a health visitor or GP has been passed information from a midwife about potential risk of FGM, at the next appointment with the woman/child, the health visitor/GP should discuss this.

Risk assessment tools for health professionals are available from Department of Health publication *'Female Genital Mutilation Risk and Safeguarding Guidance for professionals'* (March 2015) . In addition NHS England has produced support materials for health professionals.(See references).

Schools: Students who fear they may be at risk of FGM may come to the attention of, or turn to a teacher. A student's friend may also report it to staff.It is important schools and colleges create an open and supportive environment by displaying age appropriate literature, raising awareness amongst staff, introducing FGM into the school curriculum as part of PHSE, citizenship, science.

Staff may be concerned about a student exhibiting some of the signs described in section 6. All efforts should be made to establish the full facts from the student. The member of staff (or school safeguarding lead) should be able to decide on the levelof response required. If there is an indication that the student is at risk of FGM or has undergone FGM the information must be shared with children's social care. Speaking to the student's parents may place the student at additional risk. Seek advice from the school safeguarding lead and children's social care before you do so.

Further guidance for teachers: HM Government. *Multi-Agency Practice Guidelines: Female Genital Mutilation*, 2011. **www.fco.gov.uk/fgm**

6 Indication for further assessment/referral

Female Genital Mutilation is a criminal offence, it is child abuse and cases must be dealt with as part of existing child protection arrangements.

Professionals need to be aware of the possibility of FGM and vigilant to the following potential indicators that FGM may take place and if present must clarify their concerns and consider seeking advice and/or implement child protection/safeguarding procedures. There is no requirement to refer pregnant women who have undergone FGM routinely to children's social care.

- The family comes from a community that is known to practice FGM, e.g. Somalia, Sudan and other African countries. (See appendix 1). It may be possible that they will practice FGM if a female family elder is present in the

family network.

- 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.
- 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.
- The child may confide to a professional that she is to have a 'special procedure' or to attend a special occasion.
- Reference to FGM/Circumcision is heard in conversation, for example a child may request help from a teacher or another adult.
- A child may spend long periods of time away from the classroom during the day with bladder or menstrual problems.
- There may be prolonged absences from school.
- 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.
- At antenatal booking the holistic assessment may identify women who have undergone FGM. Midwives and Obstetricians should then plan appropriate care for pregnancy and delivery
- Frequent/chronic urinary tract infections

If a professional is concerned that FGM has recently take place or there is a significant risk that a girl may be subjected to FGM a referral must be made to children's social care in line with referral procedures. CAF and inter-agency referral form

Talking about FGM

The terms 'FGM' or 'cut' are increasingly used at the community level, although they are not always understood by individuals in practising communities, largely because they are English terms. Using the term "FGM" should therefore be used with caution in discussion. FGM is known by a number of names, including 'female genital cutting', 'circumcision' or 'initiation'.

All conversations, advice given and actions must be fully recorded.An accredited female interpreter may be required. Any interpreter should be appropriately trained in relation to FGM and should not be a family member, not be known to the individual, and not be an individual with influence in the individual's community. This is because girls or women may feel embarrassed to discuss sensitive issues in front of such people and there is a risk that personal information may be passed on to others in their community and place them in danger.

These questions and advice are guidance and each case should be dealt with sensitively and considered individually and independently. Staff should seek advice and support from their line manager/safeguarding advisor. If in any doubt, safeguarding children procedures must be followed.

Health professionals should use the risk assessment tools included in Department of Health publication 'Female Genital Mutilation Risk and Safeguarding Guidance for professionals' (March 2015). All conversations must be fully documented.

If you suspect that a child may be at risk of FGM ask child/parent;

- Ask children/ to tell you about their holiday. Sensitively ask the family about their planned extended holiday ask questions like;
- Who is going on the holiday with the child/adult? Where are they going?
- How long they plan to go for and is there a special celebration planned?
- Are they aware that the school cannot keep their child on roll if they are away for a long period?
- Are they aware that FGM- including Sunna, is illegal in the U.K even if performed abroad? Use term that may be familiar as FGM.

If you suspect that a child / adult is a victim of FGM ask them;

- Your family/partner is originally from a country where girls or women are circumcised – Do you think you have gone through this or at risk of this practice?
- Has anything been done to you down there or on your bottom?
- Would you like support in contacting other agencies for support, help or advice?
- Inform them that you have to share information confidentially with relevant agencies if you are concerned that they or someone else is at risk of being harmed.
- What are the intentions/views of the client her partner towards the child regarding FGM?
- Does the client feel that she will be pressured into having FGM on her daughter and if so by whom, i.e. community family friend partner. And if so what would she do about this?
- Advise the client that it is illegal to perform FGM in the UK and to take a child abroad for FGM and ensure that this is documented in the records (mother and baby if applicable)
- Provide information about health risks to client
- Inform the GP, health visitor/school nurse

Links to forced marriage

There can be a link between FGM and Forced Marriage , particularly in adults/teenagers when the woman may be mutilated shortly before the marriage. Professionals should be alert to this and consider a joint response to the Forced Marriage through local protocols alongside protection from FGM. Professionals should consider whether a referral to the Multi Agency Risk Assessment Conference if the risk of forced marriage, serious injury or death is high. Advice should be sought from the agency's Child protection advisor

7 References

1. Africans Unite Against Child Abuse (AFRUCA)
2. British Medical Association (2004), Female Genital Mutilation: Caring for Patients and Child Protection. Guidance from the BMA Ethics Department
3. Royal College of Obstetricians and Gynaecologists. *Female Genital Mutilation and its management, Green-top guideline No. 53*, 2009. Available at **www.rcog.org.uk**
4. HM Government. *Multi-Agency Practice Guidelines: Female Genital Mutilation*, 2011. **www.fco.gov.uk/fgm**
5. Female Genital Mutilation Act (2003)
6. London Child Protection Procedures. (2015)
7. The Children Act (1989/2004/2014)
8. The UN Convention on the Elimination of All Forms of Discrimination against Women (1981)
9. United Nations Convention on the Rights of the Child (1989): Ratified December (1991)
10. UNICEF 2005, Innocenti Digest, Changing a Harmful Social Convention: Female Genital Mutilation/Cutting, UNICEF Innocenti Research Centre, Italy
11. Working Together to Safeguard Children – A guide to inter-agency working to safeguard and promote the Welfare of Children. HM Government (2015)
12. World Health Organisation: Estimated prevalence rates of FGM updated May (2001) http://www.who.int/reproductive-health/fgm/
13. Royal College of Nursing: *Female genital mutilation: An RCN educational resource for nursing and midwifery staff*, 2006. **www.rcn.org.uk**
14. Dept of Health: Female Genital Mutilation Risk and Safeguarding Guidance for professionals (March 2015)
15. Home Office: Draft Multi Agency Statutory Guidance on Female Genital Mutilation 2015. https://www.gov.uk/government/publications/mandatory-reporting-of-female-genital-mutilation-procedural-information
16. NHS E and professional bodies have developed a package of support including:
    - Quick guidance – a 2-page summary of the duty including a process flowchart
    - Poster – a poster for health organisations to display about the duty
    - Training slides – a training presentation organisations can use to help them deliver 10 – 15 minute updates to staff
    - Video interviews with Vanessa Lodge, NHS E National FGM Prevention lead
    - An information leaflet for patients and their families which professionals can use to help when discussing making a report to the police.

8 Glossary of Terms

1.	Female Genital Mutilation is sometimes called Female Circumcision or Female Cutting	
2.	Closed	The term “Closed” refers to type iii female genital mutilation where there is a long scar covering the vaginal opening. This term is particularly understood by the Somali and Sudanese communities
3.	BSCB	Bexley Safeguarding Children Board
4.	Infibulation	The term “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.
5.	LCPP	London Child Protection Procedures
6.	LSCB	London Safeguarding Children Board
7.	Sunna	Type i, Female Genital Mutilation may be known to some communities as Sunna which is an Islamic word used to describe an action by the Prophet Mohammed.
8.	UNICEF	The United Nations Children’s Fund
9.	MASH	Multi Agency Safeguarding Hub

9 Organisations that can help

NSPCC FGM Helpline
0800 028 3550
fgmhelp@nspcc.org.uk

Foundation for Women's Health Research & Development (Forward)
Unit 4, 765-767 Harrow Road, London NW10 5NY
Tel: 020 8960 4000
http://www.forwarduk.org.uk/key-issues/fgm

British Medical Association
BMA House, Tavistock Square, London WC1H 9JP
Switchboard: 020 7387 4499
Fax: 020 7383 6400
http://www.bma.org.uk/ap.nsf/Content/FGM

AFRUCA – Africans Unite Against Child Abuse
Unit 3D/F, Leroy House, 436 Essex Road, London N1 3QP
Tel: 020 7704 2261
http://www.afruca.org

Iranian and Kurdish Women's Rights Organisation
Tel: 020 7920 6460
http://www.ikwro.org.uk/index.php?option=com_content&task=view&id=93&Itemid=50

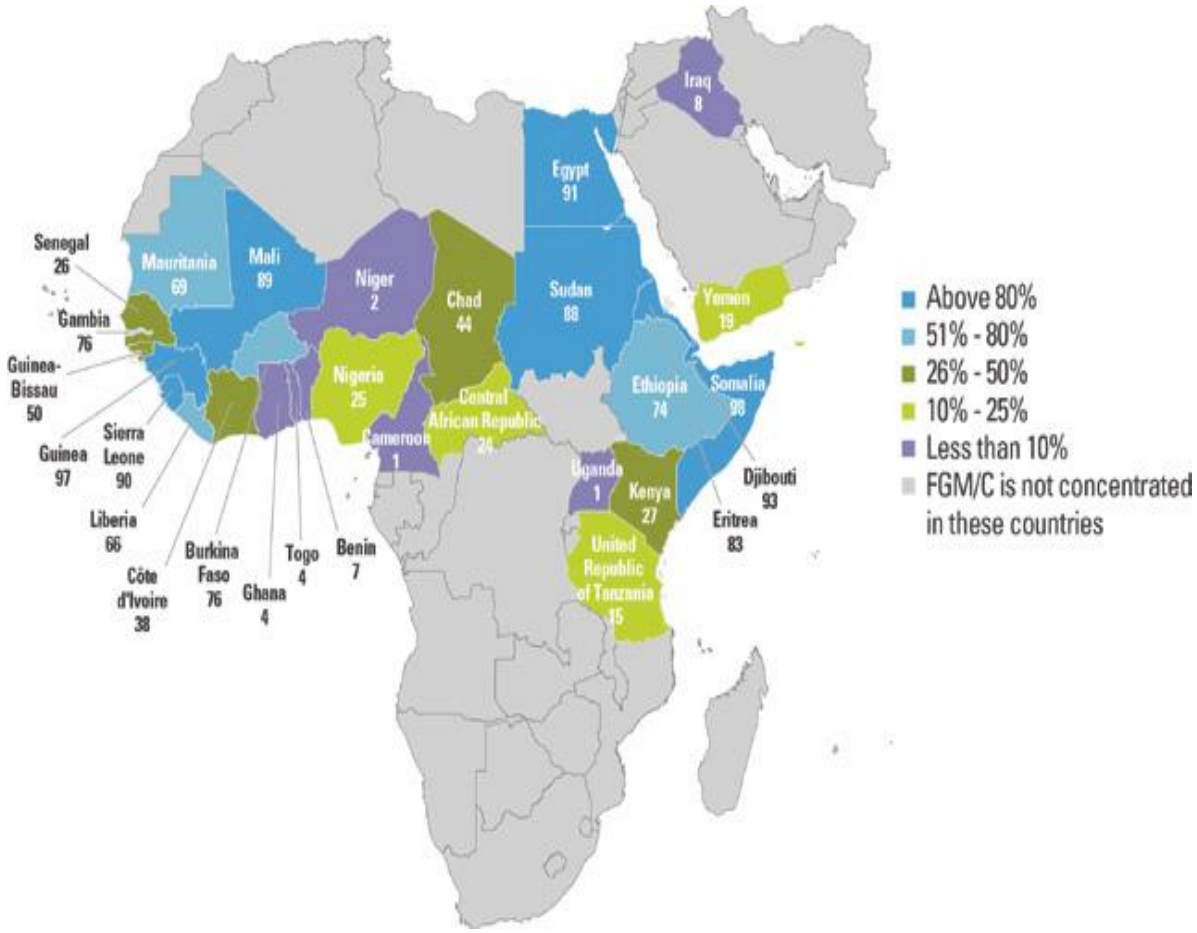
Woman Kind Worldwide
Development House, 56-64 Leonard Street, London EC2A 4LT
Womankind.org.uk
Tel: 020 7201 9982

FGM National Clinical Group
c/o University College London Hospital NHS Trust, Elizabeth Garret Anderson & Obstetric Hospital, Huntley Street, London WC1E 6DH
http://www.fgmnationalgroup.org/

UNICEF
UK Helpdesk: 0870 606 3377
http://www.unicef.org.uk/

World Health Organisation (WHO)
European Observatory on Health Systems & Policies, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT
Tel: 020 7927 2833
www.euro.who.int

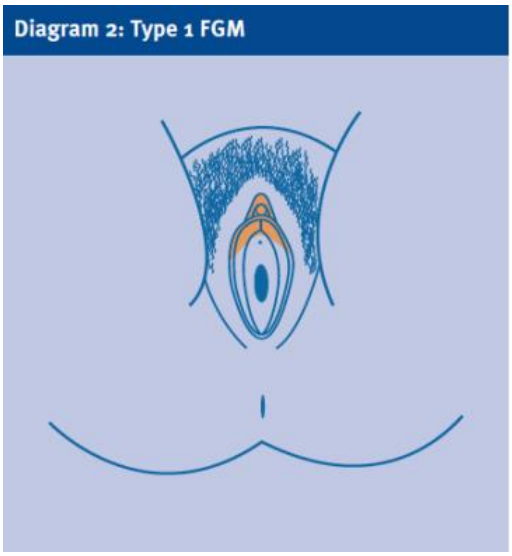
Appendix 1


Iraq
8
Egypt
91
Senegal
26
Mauritania
69
Mali
89
Niger
2
Chad
44
Sudan
88
Yemen
19
Gambia
76
Guinea-
Bissau
50
Nigeria
25
Central
African Republic
24
Ethiopia
74
Somalia
98
Guinea
97
Sierra
Leone
90
Cameroon
1
Uganda
1
Kenya
27
Djibouti
93
Liberia
66
Eritrea
83
Burkina
Faso
76
Togo
4
Benin
7
Côte
d'Ivoire
38
Ghana
4
United
Republic
of Tanzania
15
Above 80%
51% - 80%
26% - 50%
10% - 25%
Less than 10%
FGM/C is not concentrated
in these countries

Appendix 2

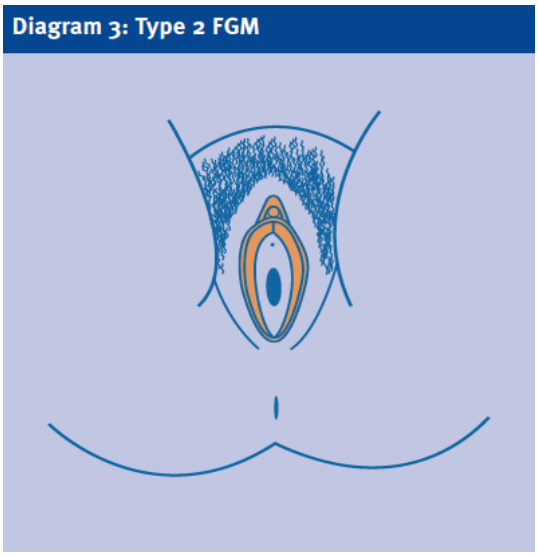
Clitoris removed

Diagram 2: Type 1 FGM



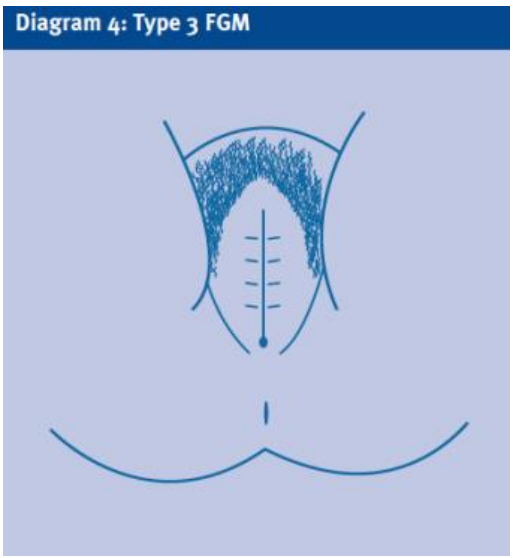
Clitoris and inner lips removed

Diagram 3: Type 2 FGM



All external genitals removed left only a hole the size of a matchstick

Diagram 4: Type 3 FGM



Other forms of mutilation

Diagram 5: An example of type 4 FGM