Female Genital Mutilation (FGM) Toolkit

North East FGM Partnership Board

Introduction

This guidance is to help professionals who have a responsibility to safeguard children and protect and support adults, to identify and assess the risks of FGM. It should be read in conjunction with the HM Government Multi-Agency Practice Guidelines: FGM.

The information in this guidance may also be relevant to bodies working with women and girls at risk of FGM or dealing with its consequences.

FGM is a form of child abuse and violence against women and girls, and therefore should be dealt with as part of existing child and adult protection structures, policies and procedures.

What is FGM?

FGM is a procedure where the female genital organs are injured or changed and there is no medical reason for this.

Types of FGM

The World Health Organisaton (WHO) has classified FGM into four types:

- **Type 1** – Clitoridectomy: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris);

- **Type 2** – Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are the 'lips' that surround the vagina);

- **Type 3** – Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris; and

- **Type 4** – Other: all other harmful procedures to the female genitalia for nonmedical purposes, e.g. pricking, piercing, incising, scraping and cauterising the genital area.

Legislation

FGM is illegal in the UK under the Female Genital Mutilation Act 2003. A person is guilty of an offence if they excise, infibulate or otherwise mutilate the whole or any part of a girl's labia majora, labia minoria or clitoris.

Any person found guilty of an offence under section 1, 2, or 3 of the 2003 Act is liable to a maximum penalty of 14 years imprisonment or a fine (or both).

As amended by the Serious Crime Act 2015, the FGM Act 2003 now includes

An offence of failing to protect a girl from the risk of FGM
Extra-territorial jurisdiction over offences of FGM committed abroad by UK nationals and those habitually (as well as permanently) resident in the UK.
Lifelong anonymity for victims of FGM
FGM Protection Orders which can be used to protect girls at risk: and
A mandatory reporting duty which requires specified professionals to report known cases of FGM in under 18s to the police.

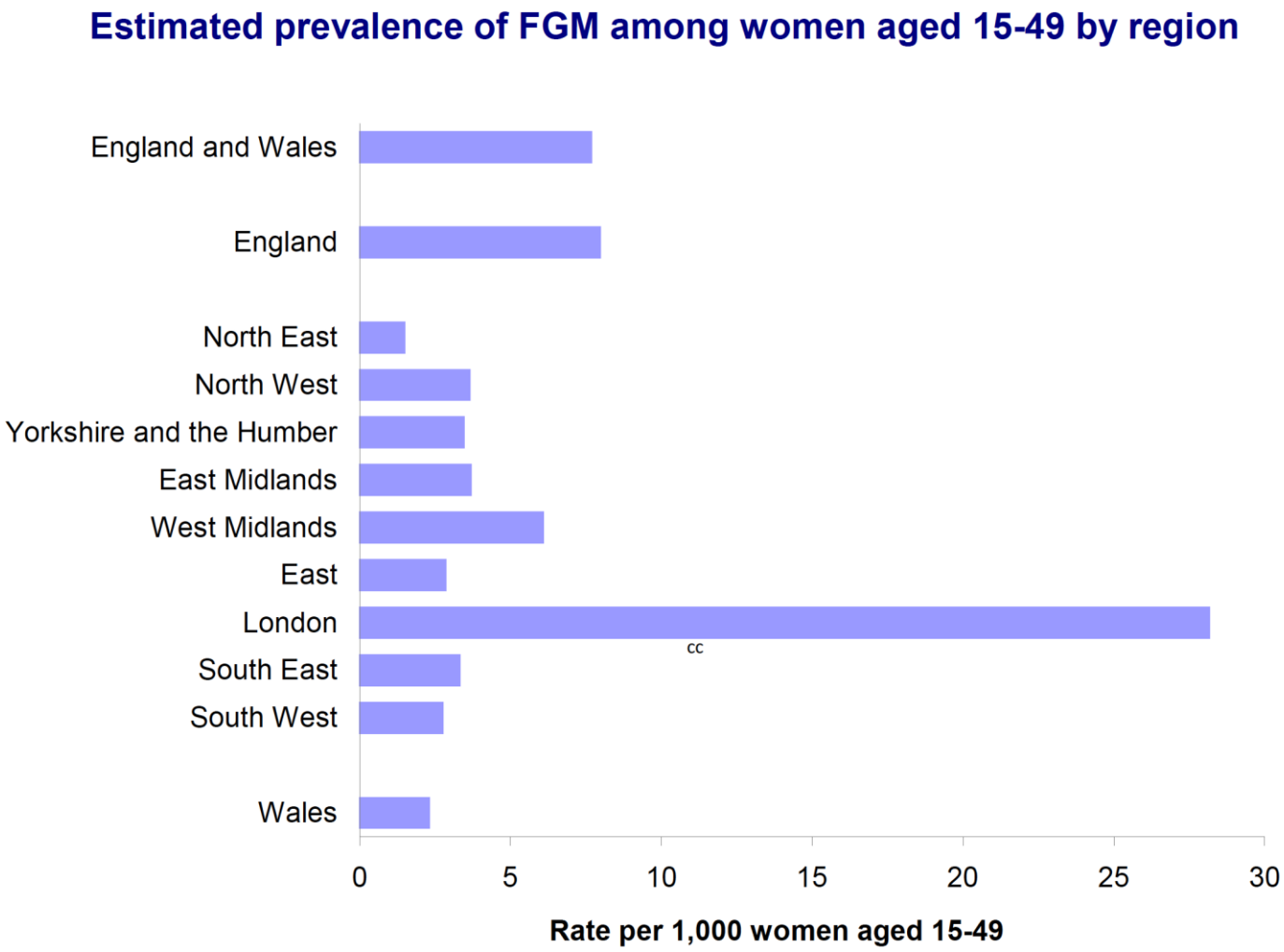
Who Practices It

FGM is prevalent in 30 countries. These are concentrated in countries around the Atlantic coast to the Horn of Africa, in areas of the Middle East and in some countries in Asia in various forms across all major faiths. It is estimated that approximately 137,000 girls and women who have migrated to the UK are living with the consequences of FGM.

UK communities that are most at risk of FGM include Kenyans, Somalis, Sudanese, Sierra Leoneans, Egyptians, Nigerians, Eritreans and Ethiopians. However, women from non-African communities that are risk of FGM include Yemeni, Kurdish, Indonesian, Malaysian, Pakistani and Indian women.

Estimated Prevalence of FGM

The 2015 study (Prevalence of FGM in England and Wales: Macfarlane A, Dorkenoo E) reported that no local authority area in England and Wales is likely to be free from FGM entirely.



Health Impact

FGM has no health benefits, and it can cause immediate and long-term health complications. It is frequently a very traumatic and violent act for the victim and cause severe pain, mental health problems and difficulties in childbirth. Men and women in practicing communities may be unaware of the potential harmful and welfare consequences of FGM.

Motives of FGM

FGM is a crime and child abuse and although no explanation or motive can justify it, FGM is a deeply embedded social norm, practiced by families for a variety of complex reasons including:

- Bringing status and respect to the girl
- Preserving a girl's virginity/ chastity
- It's a rite of passage
- Upholding the family honour

- To fulfil a religious requirement which is believed to exist
- Give a girl social acceptance, especially for marriage.

Risk Factors

The most significant factor to consider when deciding whether a girl or woman may be at risk of FGM is whether her family has a history of practicing FGM. In addition, it is important to also consider

• 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 who has a relative who has already undergone FGM must be considered to be at risk;

• The socio-economic position of the family and the level of integration within UK society can increase risk.

A girl talking about a long holiday to her country of origin or another country where the practice is prevalent.

This is not an exhaustive list of risk factors. There may be additional risk factors specific to particular communities.
If any of these risk factors are identified professionals will need to consider what action to take. If unsure of the level of risk discuss the case with the designated safeguarding lead.

If the risk of harm is imminent, emergency measures may be required.

Professionals should not assume that all women and girls from a particular community are supportive of, or at risk of FGM. Women who recognise that their ongoing physical and/or psychological problems are a result of having had FGM and women who are involved or highly supportive of FGM advocacy work and eradication programmes may be less likely to support or carry out FGM on their own children. However, any woman may be under pressure from her husband, partner or other family members to allow or arrange for her daughter to undergo FGM. Wider family engagement and discussions with both parents, and potentially wider family members, may be appropriate.

FGM Screening Tool

Attached is a toolkit to help professionals to identify and assess the risk of FGM. Professionals only need to complete the part that is applicable to the child/adult they are working with. This toolkit can be used to identify the relevant indicators.

Part One: Children at risk of being abused through FGM

Indicator	Yes	No	Suspected	Brief details
A child seeks help to avoid FGM or the circumstances in which FGM is a risk (eg going abroad)				
A parent or family member expresses concern that FGM may be a current risk				
Mother comes from a community known to practice FGM (see Appendix One)				
Mother has undergone FGM herself (see Appendix Two)				
Father comes from a community known to practice FGM				
Grandmother is very influential within the family				
A female family elder is involved/will be involved in the care of the girl				
Mother has limited contact with people outside of her family				
Parents have poor access to information about FGM and nobody has advise them about the harmful effects of FGM or UK law				
Parents stating that they or a relative will be taking the girl abroad for a prolonged period				
Girl has spoken about a long holiday to her country of origin/another country where the practice is prevalent				
Girl has attended a travel clinic or equivalent for vaccinations/anti-malarials for her country of origin/another country where the practice is prevalent				
Girl has confided in another that she is to have a 'special procedure' or to attend a 'special occasion'				
Girl has talked about going away 'to become a woman' or 'to become like my mum and sister'				
FGM is referred to in conversation by the child, family or close friends of the child (see Appendix Three for traditional and local terms)				
Girl has a sister or other female relative who has already undergone FGM				

Part Two: Children who may have been subjected to FGM and may be suffering physical or emotional harm

Indicator	Yes	No	Suspected	Brief details
Girl asks for help with symptoms of FGM				
Girl confides in a professional that FGM has been done				
Girl spends long periods away from the classroom with bladder or menstrual problems				
Girl finds it hard to sit still for long periods of time, which was not a problem previously				
Prolonged absence from school				
Noticeable behavioural changes following long summer holiday or prolonged absence from school				
Girl has spoken about having been on a long holiday to her country of origin/another country where the practice is prevalent				
Increased emotional and psychological needs eg withdrawal, depression				
Girl avoiding physical exercise or requiring to be excused from PE lessons without a GP's letter				

Part Three: Pregnant/non-pregnant women/girls, with FGM, with existing female children, anticipated female child or with other female children in household

Indicator	Yes	No	Suspected	Brief details
Mother comes from a community known to practice FGM (Appendix 1)				
Mother has undergone FGM herself (Appendix 2)				
Father comes from a community known to practice FGM				
Grandmother (maternal or paternal) is influential in family				
A female family elder is involved/will be involved in care of daughter				
Mother has limited integration in UK community				
Woman believes FGM is integral to cultural or religious identity				
Parents have limited/ no understanding of harm of FGM or UK law*				
Mother has been reinfibulated following previous delivery* *				
Mother requesting reinfibulation following childbirth*				
Woman's sisters'/brothers' daughters have undergone FGM				
Woman's sister/brother-in-law's daughters have undergone FGM				

Woman already has daughters who have undergone FGM***				

*It is important to consider the opposite of this as indication of willingness to abandon FGM practice: a woman who herself has ongoing physical, psychological and/or sexual dysfunction that she recognises/acknowledges are a result of her FGM, and/or who is involved or is highly supportive of FGM advocacy work/eradication programmes, is less likely to mutilate her own children.

**Reinfibulation following childbirth in Sudan is highly prevalent- not to be closed after birth carries great stigma. Reinfibulation *per se* does not necessarily indicate ongoing support of FGM by the woman herself. One should enquire how the woman felt about reinfibulation after birth. This is in contrast to a woman giving birth in the UK requesting reinfibulation- this should be considered a significant indicator of risk of FGM for a female child. In addition, a reinfibulated woman requesting elective c/section without medical indication should be explored as it may indicate an awareness re. the law and a wish to avoid deinfibulation. Enquiry needs to be sensitively made- as potential alternative explanation for maternal request c/section may relate to trauma/PTSD.

Reinfibulation in this country is potentially illegal under the FGM Act 2003- if a woman has been reinfibulated, it is important to establish which country this took place in and when.

*** if woman discloses she has daughter(s) who have already undergone FGM, it is important to establish when and where this took place and which type of FGM. This is for two reasons: 1) if child was a UK national at time of FGM, a crime has taken place- this should be escalated to Social Care and Police as per protocol; 2) if child was not a UK national at time of FGM i.e., FGM took place prior to coming to this country, it is important to enquire regarding FGM status of any subsequent daughters born in the UK. If no FGM has been carried out on UK-born female child, one should establish why this is the case (e.g. ?change in attitude or ?fear of prosecution ?lack of opportunity, ?child too young). This is a complex area- many women have greater agency in decision-making re. FGM when outside their country of origin and may elect not to continue FGM practice. This is an important indicator of positive attitudinal change and should be taken into consideration in risk assessment of any siblings.

Key Actions to be taken

Mandatory Reporting

The mandatory reporting duty requires regulated health and social care professionals and teachers in England and Wales to report 'known' cases of FGM in under 18s which they identify in the course of their professional work to the police.

A report to the police should be made where, in the course of their professional duties, they either:

- are informed by a girl under 18 that an act of FGM has been carried out on her; or
- observe physical signs which appear to show that an act of FGM has been carried out on a girl under 18 and they have 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.

Report to the Police by calling '101', the non-emergency number, within 48 hours where possible.

Full details of the mandatory reporting duty can be found in the Home Office and Department of Education document: Mandatory Reporting of FGM

Recording and Information Sharing

Enhanced Data Set for Health

Safeguarding Referral

FGM SUPPORT SERVICES

http://newcastlescb.proceduresonline.com/pdfs/fgm_multi_agency_practice_guide.pdf
PAGE 7/8 (NEED TO AMEND/UPDATE)

CONTACT DETAILS FOR CHILDRENS SOCIAL CARE & FGM LEADS
LOCAL CONTACTS &
INCLUDE
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/512906/Multi_Agency_Statutory_Guidance_on_FGM__-_FINAL.pdf
PAGE 71/72

PREVALENCE OF FGM IN AFRICA AND THE MIDDLE EAST (MAP)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/512906/Multi_Agency_Statutory_Guidance_on_FGM__-_FINAL.pdf
PAGE 10

TRADITIONAL AND LOCAL TERMS FOR FGM

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/512906/Multi_Agency_Statutory_Guidance_on_FGM__-_FINAL.pdf
AnnexG PAGE 71

This referral pathway can be used by all professionals including schools, health, local authority and voluntary sector