



Bristol Safeguarding
Children Board

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FEMALE GENITAL MUTILATION GUIDELINES

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FGM and safeguarding children: practice guidance

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1. Purpose

- 1.1 This guidance is aimed at all front line practitioners and volunteers who work with children and young people aged 0-18 and groups working with parents of children. Female Genital Mutilation (FGM) is not an acceptable practice, it is illegal in the UK and it is a form of child abuse under UK law. These guidelines will support the statutory guidance outlined in 'Working Together to Safeguard Children - 2010' and the Female Genital Mutilation act 2003.
- 1.2 FGM directly affects women and girls but FGM can impact on the whole family and their communities. Practitioners and communities should be vigilant to the risks of FGM being practised or the long term impact of FGM.

2. Scope

- 2.0.1 This guidance is designed to provide professionals and practitioners within Bristol with information and advice about how to respond to indicators that a young girl is at risk of FGM or has undergone FGM.
- 2.0.2 Bristol Safeguarding Children Board (BSCB) should work with strategic partners to raise awareness of the risks of FGM, to educate communities who traditionally practice FGM about the law relating to FGM and child abuse. BSCB must ensure any FGM strategy has an equal balance in prevention as well as detection of FGM.
- 2.0.3 This guidance is primarily for victims of FGM who are under 18 years of age. Women over 18 years of age should be reviewed under the Safeguarding Adults process but any adult assessment must assess any potential risk of FGM to any other women or girls living in the same family.
- 2.0.4 Responsibility for co-ordinating a multi-agency response to FGM in Bristol is now with Safer Bristol as part of the 'Bristol end violence and abuse against women and girls strategy'. These guidelines are provided by BSCB in conjunction with Safer Bristol.

2.1 A victim centred approach

- 2.1.1 Whatever someone's circumstances, they have rights that should always be respected such as personal safety and accurate information about their rights and choices. Practitioners should listen to the victim and respect their wishes whenever possible. However, there may be times when a victim wants to take a course of action that may put them at risk – on these occasions, practitioners should explain all the risks to the victim and take the necessary child or adult protection precautions.
- 2.1.2 Young people, especially those aged 16 and 17, can present specific difficulties to agencies as there may be occasions when it is appropriate to use both child and adult protection frameworks. For example, some 16 and 17 year olds may not wish to enter the care system but prefer to access refuge accommodation.
- 2.1.3 This guidance takes account of the following documents related to FGM:
 - Bristol's FGM Guidelines
 - FGM Guidelines on the South West Child Protection Procedures (<http://www.online-procedures.co.uk/swcpp/>)
 - Royal College of Nursing- FGM educational resource (2006)
 - British Medical Association - FGM caring for patients and child Protection (2006)
 - London Safeguarding Children Board FGM Guidelines and toolkit (2009)

- Responding to FGM; striking the right balance in Europe between prosecution and prevention (2009)
- Working Together to Safeguard Children (2010) pg 195
- Ending FGM- A strategy for the European Union Institutions (2010)
- Draft Multi-agency FGM Practice guidelines for professionals (FCO 2010)

3. Definitions

3.1 The World Health Organisation (WHO-2010) has classified FGM as:

'all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organ for non-medical reasons'

3.2 FGM and other terms (see glossary) has been classified by the WHO into four types:

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).
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).
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.
4. Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

4. Communities at risk

4.0.1 FGM is a tradition practised in 28 African countries and parts of Asia and Latin America. The communities with the highest prevalence are generally from the Horn of Africa and include countries such as Somalia, Egypt, Mali, Guinea etc (C Momoh (2005)¹).

Appendix 2 gives a map of countries that practice FGM and the prevalence data related to FGM.

4.0.2 Those who are affected by FGM may be British citizens born to parents from FGM practising communities or girls resident in the UK who were born in countries that practice FGM. These may include immigrant, refugees, asylum seekers, overseas students or the wives of overseas students².

4.0.3 In Bristol we have a number of communities that come from areas where FGM is practised these include; Somalia, Sudan, South Sudan, Eritrea and Gambia, this is not an exhaustive list but highlights the communities that have been working with professionals in Bristol to eradicate FGM and raise awareness of the health risk to those who have had FGM or may be considering it.

4.0.4 Specific factors that may heighten a child's risk of being subjected to FGM include:

- The socio-economic position of the family and the level of integration within UK society;

¹ Momoh, Comfort. Female Genital Mutilation, (Radcliffe, Oxford, 2005)

² Female genital mutilation fact sheet (Government Equalities Office, 2009): <http://www.equalities.gov.uk/pdf/Female%20Genital%20MutilationFACTSHEET.pdf>

- Older female members of the immediate family or extended family having undergone FGM;
- The intention of a long holiday (usually during the school summer holiday) to the country of origin or where the practice is prevalent, or to another European country;
- Prolonged absence from school;
- The age at which girls undergo FGM varies enormously according to the community. The procedure may be carried out when the girl is newborn, during childhood, adolescence, at marriage or during the first pregnancy. However, in the majority of cases FGM takes place between the ages of 5-8 and therefore girls within that age bracket are at a higher risk (FORWARD 2009).

4.0.5 While women and girls born in the UK continue to undergo FGM, it is unclear whether the practice takes place in the UK. Families often take their daughters abroad during school holidays to have the procedure done.

'The girls knew from school that they shouldn't allow this to be done to them. They didn't want to be circumcised so they refused to go back. ... They went to the authorities and told them they were afraid to go back because of this. The authorities made the family promise that if they went back to their country on holiday, they would not do anything to the girls, so they couldn't circumcise the girls anymore³.

4.1 Why the practice continues

4.1.1 The WHO⁴ cites a number of reasons for the continuation of FGM, such as:

- Custom and tradition;
- A mistaken belief that FGM is a religious requirement;
- Preservation of virginity/chastity;
- Social acceptance, especially for marriage;
- Hygiene and cleanliness;
- Increasing sexual pleasure for the male;
- Family honour;
- A sense of belonging to the group and conversely the fear of social exclusion;
- Enhancing fertility

4.1.2 The WHO states that in every society where it is practised FGM is the manifestation of gender inequality that is entrenched in social, economic and political structures. FGM is a form of violence against women and girls⁵.

4.2 Religion and FGM

4.2.1 Muslim scholars have condemned the practice and are clear that FGM is an act of violence against women. Further, scholars and clerics have stressed that Islam forbids

³ *FGM is always with us* (Forward, 2009)

⁴ *Eliminating female genital mutilation: an interagency statement* (WHO, 2008)

⁵ *Eliminating female genital mutilation: an interagency statement* (WHO, 2008)

people from inflicting harm on others and therefore the practice of FGM is counter to the teachings of Islam.

- 4.2.2 FGM is practised amongst some Christian groups, particularly Coptic Christians in Egypt, Sudan, Eritrea and Ethiopia. The Bible does not support this practice nor is there any suggestion that FGM is a requirement or condoned by Christian teaching and beliefs.
- 4.2.3 FGM may also take place amongst some Bedouin Jews and Falashas (Ethiopian Jews).

4.3 Forced Marriage and Female Genital Mutilation

- 4.3.1 There have been reports of cases where individuals have been subject to both practices. One case reported to the British High Commission involved a 16 year old Somali girl who was rescued in Ethiopia⁶. She had been taken to Somalia to have FGM and to be forced to marry. She managed to escape the marriage but had not avoided FGM.

If you are concerned about an individual who may be at risk of both procedures you should consult the Multi-agency Practice Guidelines on handling cases of forced marriage. These can be found at <http://www.fco.gov.uk/en/travel-and-living-abroad/when-things-go-wrong/forced-marriage>

5. Prevalence

- 5.1 The World Health Organisation estimates that between 100-140 million girls and women have experienced female genital mutilation and up to three million girls undergo some form of the procedure each year⁷.
- 5.2 The 2007 DH funded study by FORWARD: *A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales*⁸ estimates that nearly 66,000 women with FGM were living in England and Wales in 2001 and their numbers are likely to have increased since then.
- 5.3 There were nearly 16,000 girls aged 8 or younger at high risk of WHO Type III FGM and over 5,000 at high risk of WHO Type I or Type II. In addition, over 8,000 girls aged 9 or more had a high probability of already having type III FGM and over 3,000 a high probability of having types I or II⁹.
- 5.4 In Bristol there are approximately 1500 girls aged 3-18 (information from the local authority equality data, May 2010) who come from countries where FGM is practised. Bristol has an expanding Black and Minority Ethnic population and some of the largest growing groups come from countries where FGM is practised.

6. Legislation

- 6.0.1 Professionals and volunteers from all agencies have a statutory responsibility to safeguard children from being abused through FGM.

⁶ *Female genital mutilation / cutting: A statistical exploration* (Unicef, 2005): http://www.unicef.org/publications/files/FGM-C_final_10_October.pdf

⁷ *Eliminating female genital mutilation: an interagency statement* (WHO, 2008)

⁸ *A statistical study to estimate the prevalence of female genital mutilation in England and Wales* (Forward, in collaboration with the London School of Hygiene & Tropical Medicine and the Department of Midwifery, City University, 2007): <http://www.forwarduk.org.uk/download/96>

⁹ *A statistical study to estimate the prevalence of female genital mutilation in England and Wales* (Forward et al, 2007)

6.0.2 FGM constitutes child abuse and causes physical, psychological and sexual harm which can be severely disabling. The UK Government's Every Child Matters: Change for Children Programme, which includes the Children's NSF ²⁰ and is supported by the Children Act 2004¹⁰, requires all agencies to take responsibility for safeguarding and promoting the welfare of every child to enable them to:

Be healthy

FGM has huge health implications for women and girls, especially physical, emotional and pregnancy

Stay safe

FGM is illegal and impacts on a child's safety and security

Enjoy and achieve

Girls who have undergone FGM can become quiet and withdrawn and they may not reach their full potential, or enjoy developing intimate relationships.

Achieve economic well-being

Girls who have had FGM may not achieve academically, because of time away from school, or their behaviour changes. This may impact on their future employment opportunities

Make a positive contribution

If a girl has undergone FGM and no professional/ community intervened to stop it or highlighted that FGM was illegal, then they may carry on the same cultural practices and not make a positive choice to stop FGM.

6.0.3 Under the Children Act 1989¹¹, local authorities can apply to the Courts for various Orders to prevent a child being taken abroad for any form of FGM.

6.0.4 In England, Wales and Northern Ireland all forms of FGM are illegal under the Female Genital Mutilation Act 2003¹². Scotland has its own FGM act.

6.1 Female Genital Mutilation Act 2003

- It is an offence if anyone aids, abets, counsels or procures any form of FGM for a girl or a woman for cultural or non-medical grounds;
- This act makes it an offence to take a UK national or resident overseas for the purpose of or to aid and abet, procure or carry out FGM;
- Any UK National or resident is protected;
- A person is guilty of an offence if he/she aids a girl to carry out FGM on herself;
- There are defences with regard to this Act. No offence is committed by an approved person (i.e. midwife or medical practitioner or person training to fulfil these roles) if they perform such a surgical procedure necessary for the girl's physical or mental health or in relation to a birth or labour;
- The penalty for FGM is up to 14 years imprisonment

¹⁰ <http://www.opsi.gov.uk/acts/acts2004/20040031.htm>

¹¹ <http://www.legislation.gov.uk/1989?title=children%20act%20>

¹² <http://www.legislation.gov.uk/ukpga/2003/31/contents>

6.2 Child protection and FGM

6.2.1 FGM is considered to be a form of child abuse (it is categorised under the headings of both physical abuse and emotional abuse). Working Together to Safeguard Children (HM Government, 2010), states that a local authority may exercise its powers under section 47 of the Children Act 1989 if it has reason to believe that a child is likely to suffer or has suffered FGM. Under the Children Act 1989, local authorities can apply to the Courts for various Orders to prevent a child being taken abroad for mutilation.

- Any information or concern that a child is at immediate risk of, or has undergone, FGM should result in a child protection referral to local authority children's social care;
- Every attempt should be made to work with parents on a voluntary basis to prevent the abuse;
- In line with the London FGM procedures, NHS Bristol has developed links with Community Advocates, recruited from within the community and supported by FORWARD, for campaigning against FGM. These campaigns could be consulted on how to engage with the communities that practice FGM or how to support and educate parents and families;
- A local authority must exercise its duty under s47 of the Children Act 1989 if it has reason to believe that a child has suffered, or is likely to experience FGM.

6.3 International legislation and agreements

6.3.1 There are two international conventions containing 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 Child¹³;
- The UN Convention on the Elimination of All Forms of Discrimination against Women¹⁴.

7. Signs and symptoms

7.0.1 Below are some indications that FGM may be planned, these statements in isolation do not prove FGM will happen but they are indicators for further investigation to exclude the risks of FGM:

- Parents from practising communities 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 of FGM is prevalent, including African countries and the Middle East;
- 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;

¹³ <http://www.unicef.org/crc/>

¹⁴ <http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm>

- 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.

7.0.2 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;
- A child may have difficulty walking, sitting or standing;
- 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;
- 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;
- child may ask for help or confide in a professional;
- A child requiring to be excused from physical exercise lessons without the support of her GP.

Guide to asking about FGM

- Different terminology will be culturally appropriate to the different cultures. Alternative approaches are to ask 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 professionals can use the question: "*are you closed or open?*" This may lead to the woman providing the terminology appropriate to her language / culture.
- 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 or woman's wellbeing and the welfare and wellbeing of any daughters she may have, or girl's she may have access to.

Remember:

- They may wish to be interviewed by a practitioner of the same gender.
- They may not want to be seen by a practitioner from their own community.
- Develop a safety and support plan in case they are seen by someone "hostile" at or near the department, venue or meeting place e.g. prepare another reason why they are there.

If they insist on being accompanied during the interview e.g. by a teacher or advocate, ensure that the accompanying person understands the full implications of confidentiality especially with regard to the person's family. For some, an interview may require an authorised accredited interpreter who speaks their dialect such as Language Line.

7.0.3 Many women, men and professionals appear to be unaware of the major health issues associated with FGM. The physical and mental trauma usually causes long term complications for these women. The consequences of FGM include:

7.1 The short term consequences for children and women subjected to FGM may include:

- severe pain and bleeding, which in some cases may result in anaemia;
- The pain and trauma can also produce a state of clinical shock;
- Infections are common, particularly as the procedure is generally carried out in unhygienic conditions and/or with instruments that are not sterilised;
- In some cases, potential fatal septicaemia and tetanus may occur.

7.2 Long term consequences of FGM may include

- Discomfort and pain during/after sexual intercourse and recurrent infection may lead to infertility;
- abscesses, painful cysts;
- keloid scarring. This can cause problems during pregnancy and childbirth;
- Women may feel angry, depressed and suffer from post traumatic stress disorder;
- infections , HIV, Hepatitis B.

8. Do's and don'ts

8.1 Think about engaging families and young people before concerns arise. This contact can educate these families about the Law, health risks and the statutory duties we all have to protect young people. This preventative work is essential.

8.2 Do

If you are a trusted individual of the potential victim you may wish to talk to them further about your concerns. Alternatively, you may be approached by someone concerned about FGM. When talking about FGM remember these points:

- Create an opportunity for the individual to disclose, seeing the individual on their own;
- If an interpreter is required, they should be female, appropriately trained in relation to FGM and must not be a family member or known to the individual. You **MUST** also know their views on FGM to ensure they advocate for the safety of the girl at risk;
- Use simple language and ask straightforward questions;
- Use terminology that the individual will understand, e.g. the individual is unlikely to view the procedure as 'abusive';
- Be sensitive to the fact that the individual will be loyal to their parents;
- Give the individual time to talk and take detailed notes;
- Get accurate information about the urgency of the situation if the individual is at risk of being subjected to the procedure;
- Give the message that the individual can come back to you again;
- Be sensitive to the intimate nature of the subject;

- Make no assumptions;
- Be willing to listen;
- Be non-judgemental (condemning the practice, but not blaming the girl/woman);
- Understand how she may feel in terms of language barriers, culture shock, that she, her partner, her family is being judged;
- Give 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.

8.3 Don't

- Promise complete confidentiality (blanket confidentiality cannot be given to the individual as this is a crime and child abuse and **Must** be reported);
- 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. (Appendix 3 has a guide of terms to consider);
- Do not use a male interpreter when talking to women.

Interpreters

Never use family members, friends, neighbours or those with influence in the community as interpreters. People may feel embarrassed to discuss personal issues in front of them and sensitive information may be passed on to others and place the person at risk of FGM in further danger. Furthermore, such an interpreter may deliberately mislead practitioners and/or encourage the person to drop the complaint and submit to their family's wishes.

9. Safety procedures

- 9.1 For many people, prosecuting their family is something they simply will not consider;
- If the victim is from overseas, fleeing potential FGM and applying to remain in the UK, is an extremely complicated process and requires professional immigration advice.
 - For many victims from overseas returning to their country of origin is not an option – they may be ostracised or subjected to violence if they do not agree to have FGM.
 - These risks should be explained, even just to exclude this option.
 - Many people, especially women, may be extremely frightened by contact with any statutory agency as they may have been told that the authorities will deport them and/or take their parents/children from them.
 - Practitioners need to be extremely sensitive to these fears when dealing with a victim from overseas, even if they have indefinite leave to remain (ILR) or a right of abode as they may not be aware of their true immigration position. These circumstances make them particularly vulnerable.
 - If it is discovered that they are in breach of immigration rules (for example if they are an overstayer), remember that they may also require medical treatment, or be the victim of a crime and be traumatised as a result.
- 9.2 Do not allow any investigation of their immigration status to impede police enquiries into an offence that may have been committed against the victim or their children.

10. Support Services

- 10.1 NHS Bristol has funded FORWARD to work with women, girls and men in Bristol so they can be positive role models and areas of support for communities. Women or girls who have had FGM can also access counselling and support from the 'Green House service' or 'Womankind'. Details of community support are available on the FGM leaflets designed for the community and professionals and can be accessed via www.avon.nhs.uk/kris or tel; 0117 3235463.

Part 2 -

1. Scenarios

1.1 A case study

1.1.1 Dr Comfort Momoh (a midwife working in London and has been fundamental in the health work related to FGM) discovered how complex the issues around FGM are and why it remains a problem when she visited Somalia from where many of the women who attend her London clinic originate (2004). Although the Somali government supported the banning of FGM, such a change could no longer be sustained once civil conflict started in the early 1990s, and the number of women having undergone FGM is 98% (reference?). Mobile populations and strong ideas have made education slow to reach people and affect what they do. FGM is mainly performed by lay practitioners or family members. However, some qualified midwives and doctors still carry it out although awareness of the harm caused is increasing. Dr Momoh describes the use of 'herbs, salt water, sugar, and camel dung' to stop bleeding, and also leg binding for several days (2004:631). She also found out some of the reasons for continuing the practice, and these affect those living in the UK too. For example, to:

- protect daughters from being raped;
- ensure young women remain pure for marriage;
- increase their eligibility for marriage;
- increase the dowry;
- maintain the family dignity.

1.1.2 Although more educated people and many urban dwellers are changing their ideas, Dr Momoh discovered that lay practitioners believe that they provide a wanted service and also risk losing their livelihood.

2. Child protection: actions to be taken by single and multi-agency workforce

2.1 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

2.2 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. The following agency specific guidance may help support the professional.

a. Children's Social Care

All referrals received by children's social care specifying a risk of FGM will be fully investigated. Social Workers will refer to South West Child Protection Procedures guidance relating to 'Female Genital Mutilation' and 'Managing Individual Cases' in undertaking any investigations.

Key principles

- FGM constitutes a significant risk of harm and should be fully and thoroughly investigated under s.47 Children Act 1989;
- Every attempt should be made to work in partnership with the family;
- The aim of any work with the child and family is to avoid the child undergoing any form of FGM not the removal of the child from the family.

All referrals to children's social care concerning FGM will be considered at a Strategy Discussion in order to plan the S.47 enquiry. Given the complexity of the issues involved it is not appropriate to hold this discussion by telephone. A Strategy Discussion should be held at the earliest possible opportunity, undue delay may place the child at risk of harm. In cases of possible and actual FGM the Strategy discussion must be a meeting of the following:

- Children's social care Social Work Assessment Team TM and SW;
- Community Paediatrician and a Health specialist in FGM;
- Police CAIT (DS or higher rank);
- Education (school attended by child/young person where appropriate);
- Voluntary agencies (BASE, Next Link, where appropriate);
- Legal advice (there may be a need to consider the use of specific legal orders to protect the child concerned).

The following issues should be part of the agenda in any strategy discussion regarding FGM:

- use of an interpreter in all dealings with the family (see SWCPP);
- provision of appropriate advice and information to the family where this has not already occurred, regarding the law and harmful consequences of FGM;
- where FGM has already occurred the Strategy Discussion should discuss how, where and when the procedure was performed and the implication of this;
- the provision of counselling and support services to the child/young person;
- risk to siblings and other children in the community;
- any intelligence on who has or is to perform the mutilation;
- the immediate health needs of the child;
- the possibility for prosecution.

Where the S.47 Enquiry finds that the child is at risk of harm a Child Protection Conference maybe appropriate in order to consider whether a Child Protection Plan is needed. Where the risk is considered to be more immediate it may be necessary to seek appropriate legal orders to protect the child.

b. Police

Initial steps when a girl may be at risk of FGM

If officers or members of police staff believe that a girl may be at risk of undergoing FGM, the duty inspector must be made aware and an immediate referral should be made to their local child abuse investigation team (CAIT). If this is outside the core hours, the duty inspector must ensure that appropriate protection measures are put in place and the on-call CAIT DS is spoken to. The CAIT will in turn make an immediate referral to the relevant local authority children's social care team. If any officer believes that the girl could be at immediate risk of significant harm, they should consider the use of police protection powers under section 46 of the Children Act 1989. A full Guardian incident should be created as this will enable CAIT to record strategy discussions later.

Next steps when a girl may be at risk of FGM

The first consideration should be informing the parents of the law and the dangers of FGM. This can be done by representatives from schools, local authority children's social care, health professionals and/or the police. It is the duty of all professionals to look at every possible way that parental cooperation can be achieved, including the use of community organisations to facilitate the work with the parents and other family members. If there is any suggestion that the family still intends to subject that child to FGM, the first priority is the protection of the child and the least intrusive legal action should be taken to ensure the child's safety. Officers should consider the use of police protection powers under section 46 of the Children Act 1989 and remove the girl to a place of safety (see Section 5.1). In addition, local authority children's social care should consider the use of a Prohibitive Steps Order or Emergency Protection Order (see Section 5.2). **The welfare of other children within the family, in particular female siblings, should be reviewed.** The investigation should be the subject of regular ongoing multi-agency reviews to discuss the outcome and any further protective steps that need to be taken with regard to that girl and any other siblings.

Initial steps when a girl is thought to have already undergone FGM

If any police officer or police staff is made aware that a girl has already undergone FGM, the duty inspector must be made aware and an immediate referral should be made to their local CAIT. If this is outside the core hours, the duty inspector and the on-call CAIT DS must manage the initial phase of the investigation and ensure that appropriate protection measures are put in place. The CAIT will in turn make an immediate referral to the relevant local authority children's social care team. A full Guardian incident should be created as this will enable CAIT to record strategy discussions later.

Next steps when a girl is thought to have already undergone FGM

If it is believed or known that a girl has undergone FGM, a strategy meeting must be held as soon as practicable (and in any case within two working days) to discuss the implications for the child and the coordination of the criminal investigation. There is a risk that the fear of prosecution will prevent those concerned from seeking help, resulting in possible health complications for the girl; thus police action will need to be in partnership with other agencies and communities. This should also be used as an opportunity to assess the need for support services such as counselling and medical help as appropriate.

Police officers may want to refer to the Crown Prosecution Service's guidance document entitled *Provision of Therapy for Child Witnesses Prior to a Criminal Trial*. A second strategy meeting should take place within ten working days of the initial referral.

Conducting interviews about FGM

As with all criminal investigations, children and young people should be interviewed under the relevant procedure/guidelines (e.g. Achieving Best Evidence) to obtain the best possible evidence for use in any prosecution. Consent should be obtained to record the interview and for allowing the use of the interview in family and/or criminal courts, unless this would hinder the investigation. In addition, information gained from the interview process will enable a risk assessment to be conducted as to the risk to any other children or siblings.

Medical examinations

Corroborative evidence should be sought through a medical examination conducted by a qualified doctor trained in identifying FGM. Consideration should be given as to the effective use of a specialist FGM nurse. In all cases involving children, an experienced paediatrician should be involved in setting up the medical examination. This is to ensure that a holistic assessment which explores any other medical, support and safeguarding needs of the girl or young woman is offered and that appropriate referrals are made as necessary.

c. Health

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

- The girl at risk;
- Any Younger siblings;
- If it is a woman daughters she may have now or in the future;
- Any extended family who may be at risk.

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.

Midwives: Midwives should talk about FGM at initial booking to all women who come from countries that practice FGM or if they are married to men from FGM practising communities. They should document if the woman has FGM what type and what plan is in place for delivery. They must also document that the woman has been told about the law and given a leaflet in an appropriate language that explains the risks of FGM, the law and local support services. All this information will be shared with appropriate health professionals (GP and Health Visitor). Professionals should consult with their child protection adviser and the relevant Social Work Assessment Team or Hospital Social Work Department about making a referral to them.

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 to daughters she may already have or may have in the future. Professionals should consult with their child protection adviser and with the relevant Social Work Assessment Team or Hospital Social Work Department about making a referral to them.

If a woman who has been de-infibulated (opened) requests re-infibulation (closed) after the birth of a child, this is illegal and should indicate a referral to social care; both adults and children. If she has given birth to a daughter or there are daughters in the family, health professionals should consult with their child protection adviser and with the relevant Social Work Assessment Team or Hospital Social Work Department about making a referral to them.

Health visitors: are in a good position to reinforce information about the health consequences and the law relating to FGM. Health visitors should discuss the risks of FGM and document the parent's response and the advice and any leaflets given to explain the law relating to FGM. Any concerns about a parent's attitude towards FGM should be taken seriously and appropriate referrals made. Professionals should consult with their child protection adviser, the Clients GP and the relevant Social Work Assessment Team about making a referral to them.

School Nurses: are in a good position to reinforce information about the health consequences and the law relating to FGM. The school nurse should work closely with the child's school supporting them in any concerns. The school nurse should be vigilant to any health issue such as recurrent urinary tract infection that may indicate FGM has been done. If the school nurse has contact with any family who come from a country where FGM is practised they should discuss the risks of FGM and document the parent's response and any advice and leaflets given to explain the law relating to FGM. Any concerns about a parent's attitude towards FGM

should be taken seriously and appropriate referrals made. Professionals should consult with their child protection adviser and the relevant Social Work Assessment Team about making a referral to them..

GP's, Treatment room and Practice Nurse: should be vigilant to any health issue such as recurrent urinary tract infection that may indicate FGM has been done. They also need to consider families who are requesting foreign travel vaccinations. This can be an ideal opportunity to talk about FGM, the health risks and the law document any advice or leaflet given out. It is an ideal time to talk to women from FGM practising communities about the issues of FGM when they attend for their routine Cervical smears. Any concerns about a parent's attitude towards FGM should be taken seriously and appropriate referrals made. Professionals should consult with their child protection adviser and with the relevant Social Work Assessment Team about making a referral to them.

Emergency departments and Walk in Centres: need to consider the risks associated to FGM so if girls from FGM practising countries attend with Urinary Tract Infections (UTI), menstrual pain, abdominal pain, or altered gait then their assessment should include assessing the risks associated with FGM. This should be documented and professionals should consult with their child protection adviser and the relevant Social Work Assessment Team about making a referral to them

Assessment Service for Asylum Seekers & Refugees: This service undertakes initial health assessments for asylum seekers and refugees from many parts of the world. The assessments are carried out by a qualified nurse or health visitor. This assessment includes family and personal history including family tree so they know who else is in the family and if they live in the UK. The assessment also includes sensitive questions about gynaecological topics including talking about FGM.

They should document if the woman has FGM and what type. They must also document that the woman has been told about the law and given a leaflet in an appropriate language that explains the risks of FGM, the law and local support services. All this information will be shared with appropriate health professionals (GP, Health Visitor etc). Professionals should consult with their child protection adviser and the relevant Social Work Assessment Team about making a referral to them.

Documents that guide health professionals include:

- FGM: Caring for patients and child protection (BMA, July 2006)
- Royal College of Nursing- FGM educational resource (2006)
- Royal college of Obstetrics and Gynaecology FGM guidelines

d. Schools and Colleges

If you have concerns that children in your school community are at risk or victims of Female Genital Mutilation in addition to this guidance we refer you to the South West Child Protection Procedures Guidelines for FGM (www.online-procedures.co.uk/swcpp). You may want to ask;

Ask

Ask children to tell you about their holiday. Sensitively and informally ask the family about their planned extended holiday ask questions like;

- Who is going on the holiday with the child?
- How long they plan to go for and is there a special celebration planned?
- Where are they going?
- 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?

If you suspect that a child is a victim of FGM you may ask the child;

- Your family is originally from a country where girls or women are circumcised – Do you think you have gone through this?
- Has anything been done to you down there or on your bottom?
- Do you want to talk to someone who will understand you better?
- Would you like support in contacting other agencies for support, help or advice?

These questions and advice are guidance and each case should be dealt with sensitively and considered individually and independently. Using this guidance is at the discretion of the Head-Teacher.

Record

All interventions should be accurately recorded by the persons involved in speaking with the child or young person. All recording should be dated and signed and give the full name and role of the person making the recording.

Refer

Child protection lead or Head- Teacher needs to seek advice about making referrals to the relevant Social Work Assessment Team and CAIT (Child Abuse Investigation Team) and to follow South West Child Protection Procedure Guidelines on FGM and CP referrals.

e. Voluntary sector

Any 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 child protection adviser (if they have one) and should make an immediate referral to either the local duty social care team, Crimestoppers tel: 0800 555 111 or the NSPCC help line tel: 0808 800 5000 about making a referral to them,

The referral should not be delayed in order to consult with your child protection adviser, a manager or group leader, as multi-agency safeguarding intervention needs to happen quickly.

If there is a concern about one child, consideration must be given to whether siblings are at similar risk.

It is expected that individuals that make a referral to the police or children's social care in their role with a voluntary sector organisation will not normally be able to remain anonymous. However, given the heightened sensitivity within communities that practise FGM and potential risk to those individuals, referrals made by members of the community who are working with a voluntary sector organisation can reasonably expect not to have this information passed to the family involved. They should still give their details and organisation contact information when making a referral but can request that they remain 'anonymous' with regard to the family or child who is the subject of the referral.

f. Protection of vulnerable adults

If you have suspicions or knowledge that a woman 18 or over is at risk of Female Genital Mutilation report your concerns to the Police and the Safeguarding Adults team.

Hotline number is 0117 903 1690

Alternatively you can contact the team via email safeguardingadults@bristol.gov.uk

You would need to contact the Safeguarding Adults team where a person 18 or over was at risk of harm.

For further reading and support see references, bibliography and local services.

BSCB FGM Working Group

These guidelines have been revised and developed from a multi-agency working group made up of the following professionals:

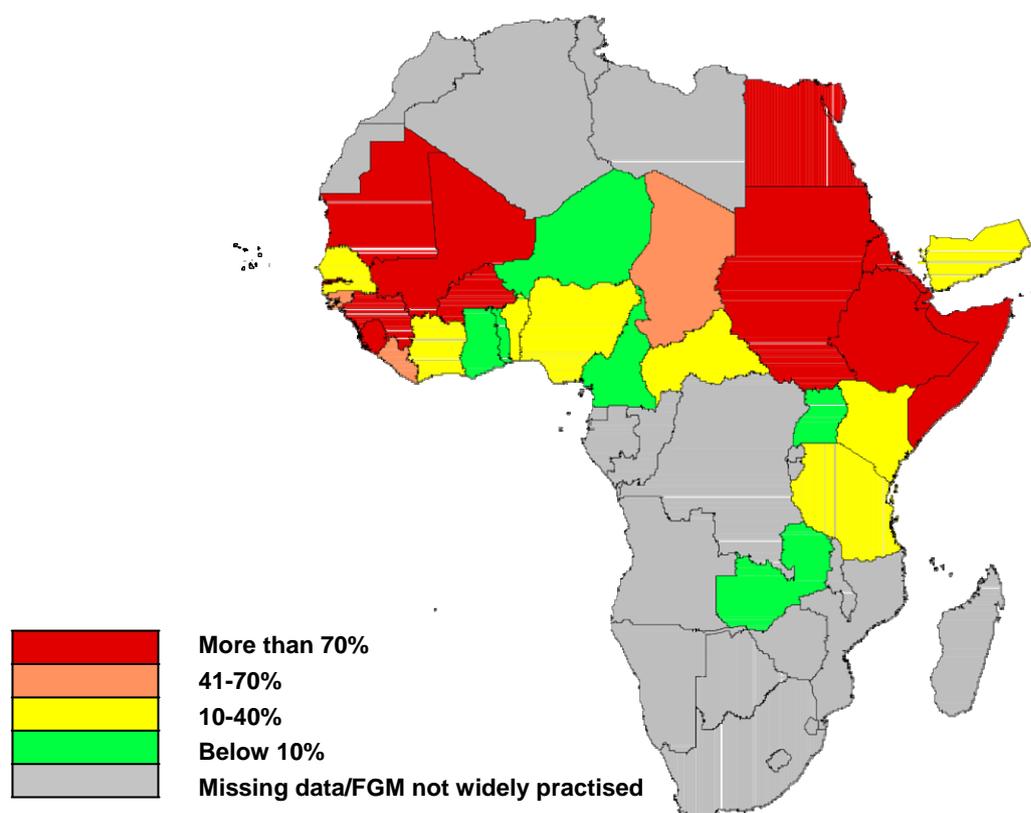
Name	Agency
Jackie Mathers	NHS Bristol
Niki Lawrence	North Bristol Trust (NBT)
Claire Smith	St Werburghs Primary School
Julie Coulthard	Children and Young Peoples services (CYPS)- Education PSHE Coordinator
Catherine Boyce	CYPS- Social care
Adam Bond	Bristol Safeguarding Children Board; Policies and Projects Officer -
Andy Sparks	Police- Child Abuse Investigation Team
Cliff Spence	Police- Community Cohesions
Kate Cooke	NHS Bristol Public Health
Sara-Jane Sheldon	Midwifery; University Hospital Bristol
Linda Hicken	Midwifery; NBT
Lindsey Dowdell	CYPS; Area Prevention Commissioning Manager
Michael Earle	Early Intervention - Social Care Worker
Lisa Zimmerman	Teacher at Bristol City Academy
Layla Ismail	Bristol Coordinator for FORWARD
Nimco Ali	Daughters of Eve
Naana Otoo-Oyortey	Executive Director; FORWARD
Mohammed Elsharif	NHS Bristol Public Health
Sharlene Farrugia	Platform 51
Julia Walton	BSCB & CYPS Communication Manager
Maria Bredow	Consultant Community Paediatrician; NBT
Alex Geen	Domestic Violence Health Improvement Worker - NHS Bristol Public Health
Neejat Hussien	Health advocate working with Youth Group

This group will continue to support the guidelines and work on appropriate community initiatives to educate both professionals and communities to issues related to FGM in the UK.

Appendix 1: Prevalence of FGM in Africa

Prevalence of FGM among women aged 15-49 in Africa

Source: UNICEF (October 2010), global databases based on data from Multiple Indicator Cluster Survey, Demographic and Health Survey and other national surveys, 1997–2009.

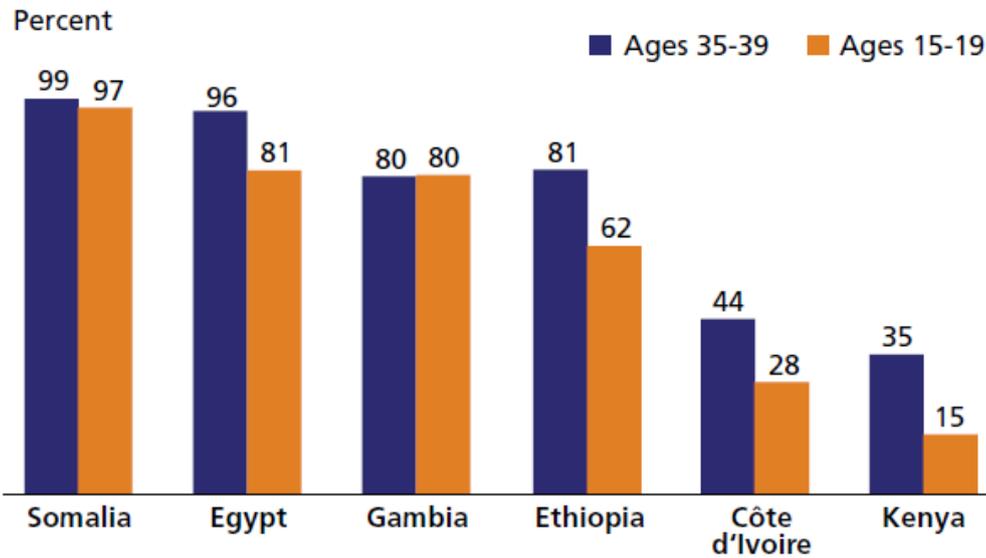


Data Year	Country	FGM Prevalence
2006	Somalia	97.9%
2005	Guinea	95.6%
2006	Djibouti	93.1%
2008	Sierra Leone	91.3%
2008	Egypt	91.1%
2006	Sudan	89.3%
2002	Eritrea	88.7%
2006	Mali	85.2%
2005/06	The Gambia	78.3%
2005	Ethiopia	74.3%
2006	Burkina Faso	72.5%
2007	Mauritania	72.2%
2007	Liberia	58.3%
2004	Chad	44.9%
2006	Guinea-Bissau	44.5%

Data Year	Country	FGM Prevalence
2006	Côte D'ivoire	36.4%
2008	Nigeria	29.6%
2005	Senegal	28.2%
2008/09	Kenya	27.1%
2006	Central African Republic	25.7%
1997	Yemen	22.6%
2004/05	Tanzania	14.6%
2006	Benin	12.9%
2006	Togo	5.8%
2006	Ghana	3.8%
2006	Niger	2.2%
2004	Cameroon	1.4%
2005	Zambia	0.9%
2006	Uganda	0.6%

Prevalence of FGM/C Among Younger and Older Women

While in some countries there is little difference in prevalence between older women (ages 35 to 39) and younger women (ages 15 to 19), in others—such as Ethiopia, Côte d'Ivoire, and Kenya—the difference is significant. This may be a sign that the practice is being abandoned.



Appendix 2: References and sources of information

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2. Royal College of Nursing (2006) – Female Genital Mutilation Guidelines: An (RCN) RCN educational resource for nursing and DfES (2006)- Working Together to Safeguard Children, HMSO, Norwich
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4. Bristol City Council Children & Young People’s Service - Catching in the Rye (2006)- (CYPS)
5. Agency for Culture and Change Management, South Yorkshire (2005)-Female Genital Mutilation Guidelines Area Child Protection Procedures
6. Momoh, Comfort (2005) Female Genital Mutilation, Radcliffe, Oxford
7. Adamson, F. (1992) Female genital mutilation: a counselling guide for professionals, London: FORWARD
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17. Office of the United Nations High Commissioner for Human rights (1987 & 2003) Convention against Torture and other Cruel, Inhuman or Degrading Treatment and Punishment, UNHCR: Geneva. Available online at <http://www.hrweb.org/legal/cat.html>
18. United Nations High Commissioner for Refugees (1981) Convention on Elimination of all Forms of Discrimination against Women, UNHCHR: Geneva. Available online at <http://www.unhcr.org/refworld/pdfid/4a8aa8bd2.pdf>

19. United Nations High Commissioner for Refugees (1990) Convention on the Rights of the Child, UNHCHR: Geneva. Available online at <http://www2.ohchr.org/english/law/crc.htm>
20. United Nations Population Fund (1994) International conference on population and development (ICPD), Cairo and ICPD+5 New York, and ICPD+10 Beijing, UNFPA: New York. Available online at <http://www.unfpa.org/public/home/sitemap/icpd/International-Conference-on-Population-and-Development/ICPD-Summary>
21. United Nations (1948) Universal Declaration of Human Rights, UN: New York. Available online at <http://www.un.org/en/documents/udhr/>

Appendix 3: Organisations and useful contacts

ACCM (UK)

King's House
245 Ampthill Road
Bedford MK42 9AZ
Bedfordshire

Telephone: 0044 (0) 77 1248 2568

Mobile: 0044 (0) 1234 356 910

Website: <http://www.accmuk.com/>

ACCM (UK) is a Non-Government Organisation (NGO) Charity working to Reaching Communities to improve the health, social and economic position of BME, asylum seekers, migrant and vulnerable communities locally, nationally and internationally.

ACCM (UK) works to tackle and eliminate harmful traditional practices, Female Genital Mutilation (FGM); Forced Marriage (FM); and Honour Based Violence (HBV) that impacts and violent the human rights and wellbeing of girls and women.

Daughters of Eve (DoE)

is a non profit organisation that works to advance and protect the physical, mental, sexual and reproductive health rights of young people from female genital mutilation practicing communities. As part of the FGM initiative, jointly funded by Rosa, The Esmee Fairbairn Foundation and Trust for London, they were able to realise a long held aim and host a Youth Conference

Webiste: <http://www.dofeve.org/> ;

If you would like to contact Daughters of Eve you can email using the form opposite or text us on 07983030488.

The Green House

Counselling for girls aged 5 and upwards who have had FGM

Website: <http://www.the-green-house.org.uk/>

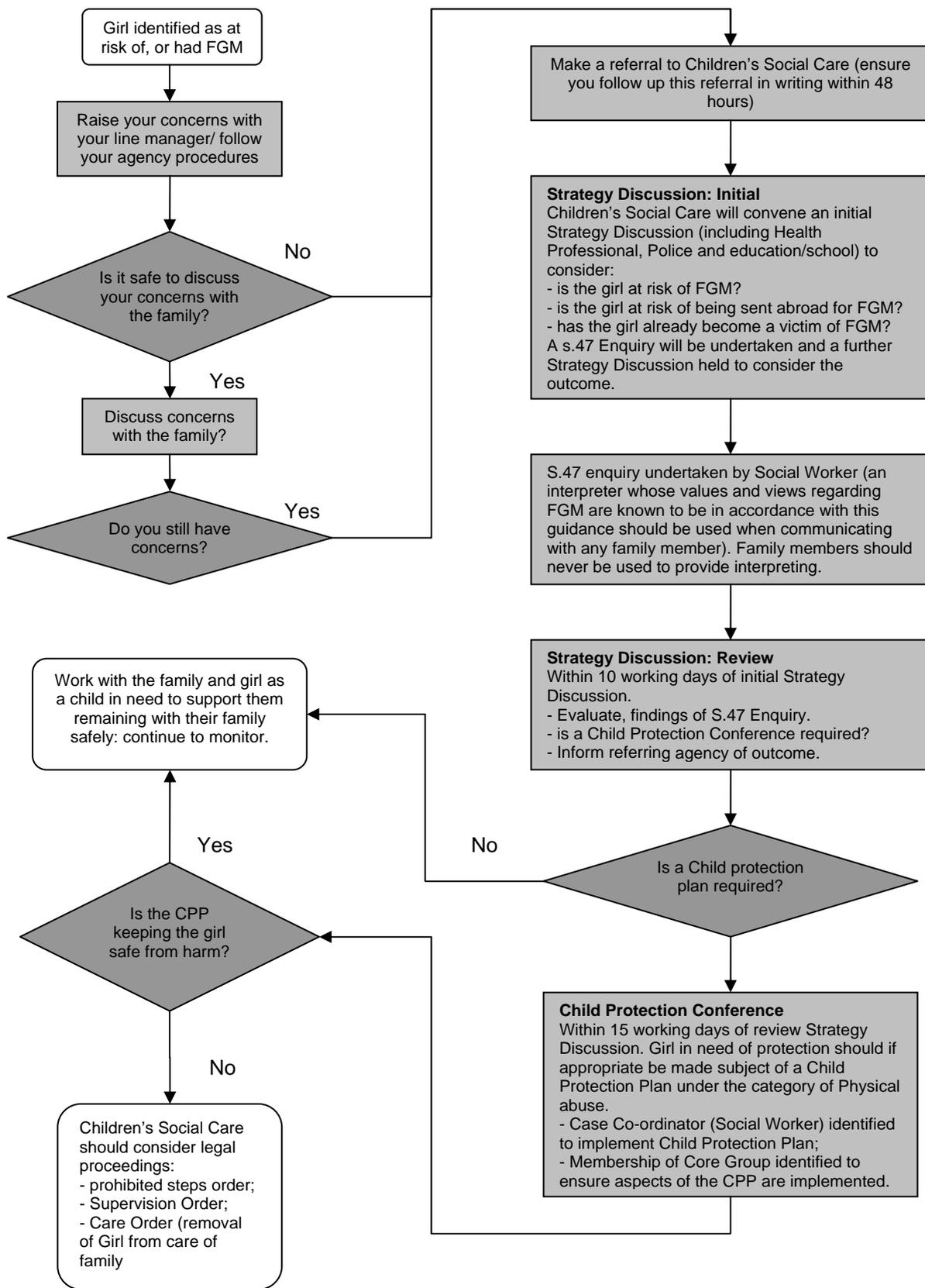
e-mail: info@the-green-house.org.uk

tel: 0117 9351707,

Office hours 9am - 1pm

24 hr answerphone

Appendix 4 – Flowchart developed from RCN Guidelines. Working Together to Safeguard Children and South West Child Protection Procedures. (ALTERNATIVE)



You should consider using an interpreter whose values on FGM are known, when talking to the family.
DO NOT use family members

