Replenish Learning Policy and Procedure

Identifying and Responding to Concerns about Female Genital Mutilation

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Chapter 1: Purpose of this guidance

Introduction

This guidance is designed for all staff and volunteers within agencies that work to:

- safeguard children and young people from abuse
- support those who have been subjected to Female Genital Mutilation (FGM)

It is based on the Multi Agency Statutory Guidance on Female Genital Mutilation April 2020

This document provides information and guidance on:

- identifying when a girl (including an unborn girl) or young woman may be at risk of FGM and responding appropriately to protect them
- identifying when a girl or woman has had FGM and procedures for responding appropriately to support them

FGM is a criminal offence – it is child abuse and a form of violence against women and girls, and therefore should be treated as such. Cases should be dealt with following existing child and adult safeguarding policies and procedures.

Principles underpinning the guidance and procedure:

- The safety and welfare of the child is paramount
- All agencies act in the interests of the child as stated in the UN Convention on the Rights of the Child (1989)
- FGM is illegal in the UK
- FGM is an extremely harmful practice - responding to it cannot be left to personal choice
- Accessible, high quality and sensitive health, education, police, social care and voluntary sector services must underpin interventions
- as FGM is often an embedded social norm, engagement with families and communities plays an important role in contributing to ending it; and
- All decisions or plans should be based on good quality assessments in line with Working Together to Safeguard Children 2018

Chapter 2: Understanding FGM

Definition

FGM is a procedure where the female genital organs are injured or changed and there is no medical reason for this. It is frequently a very traumatic and violent act for the victim and can cause harm in many ways. The practice can cause severe pain and there may be immediate and/or long-term health consequences, including mental health problems, difficulties in childbirth, causing danger to the child and mother; and/or death.

The age at which FGM is carried out varies enormously according to the community. The procedure may be carried out shortly after birth, during childhood or adolescence, just before marriage or during a woman's first pregnancy.

Types of FGM

FGM has been classified by the World Health Organisation (WHO) 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

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

International prevalence of FGM

FGM is a deeply rooted practice, widely carried out mainly among specific ethnic populations in Africa and parts of the Middle East and Asia. It serves as a complex form of social control of women's sexual and reproductive rights. The exact number of girls and women alive today who have undergone FGM is unknown, however, UNICEF estimates that over 200 million girls and women worldwide have undergone FGM.

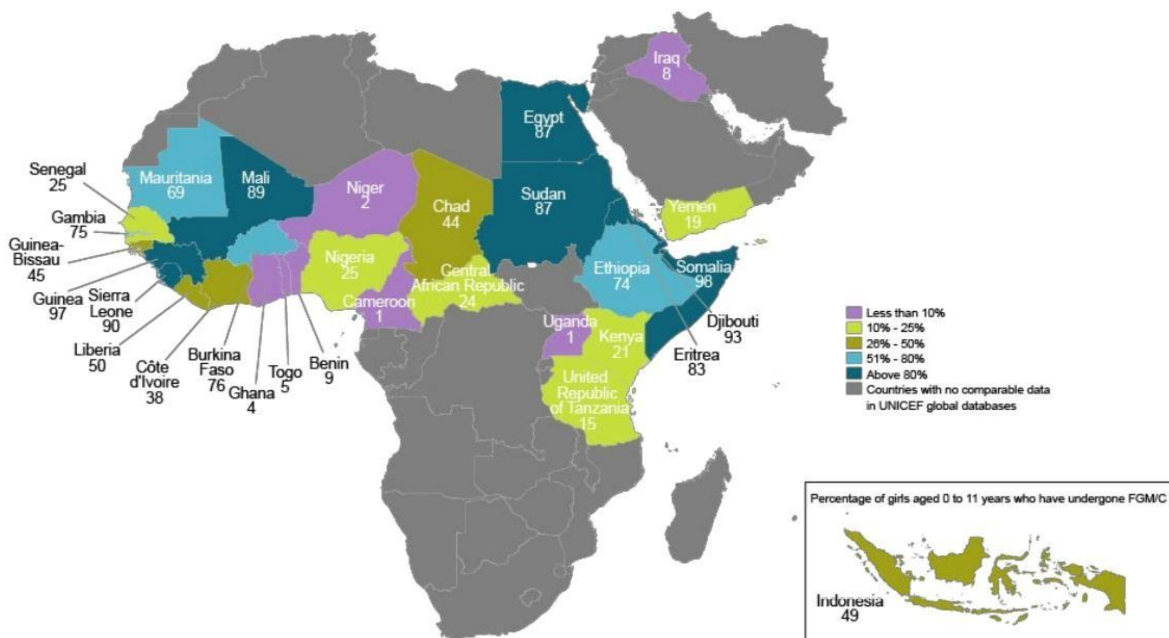
While FGM is concentrated in countries around the Atlantic coast to the Horn of Africa, and areas of the Middle East like Iraq and Yemen, it has also been documented in communities in:

- Colombia
- Iran

- Israel (within the Bedouin community and within the immigrant Ethiopian Jewish community in its country of origin)
- Oman
- The United Arab Emirates
- The Occupied Palestinian Territories
- India
- Indonesia
- Malaysia
- Pakistan
- Saudi Arabia

It has also been identified in parts of Europe, North America and Australia

Figure 1: Percentage of girls and women aged 15-49 who have undergone FGM in Africa, the Middle East, and Indonesia



Notes: In Liberia, girls and women who have heard of the Sande society were asked whether they were members; this provides indirect information on FGM since it is performed during initiation into the society. Data for Indonesia refer to girls aged 0 to 11 years since prevalence data on FGM among girls and women aged 15 to 49 years is not available.
Source: UNICEF global databases, 2016, based on DHS, MICS and other nationally representative surveys, 2004-2015.

Percentage of girls and women aged 15-49 who have undergone FGM in Africa, the Middle East, and Indonesia

Africa

- Benin – 9%
- Burkina Faso – 76%
- Cameroon – 1%
- Central African Republic – 24%
- Chad – 44%

- Côte d'Ivoire – 38%
- Djibouti – 93%
- Egypt – 87%
- Eritrea – 83%
- Ethiopia – 74%
- Gambia – 75%
- Ghana – 4 %
- Guinea – 97%
- Guinea-Bissau – 45%
- Kenya – 21%
- Liberia – 50%
- Mali – 89%
- Mauritania – 69%
- Niger – 2%
- Nigeria – 25%
- Senegal – 25%
- Sierra Leone – 90%
- Somalia – 98%
- Sudan – 87%
- Togo – 5%
- Uganda – 1%
- United Republic of Tanzania – 15%

Middle East
- Iraq – 8%
- Yemen – 19%

Asia
- Indonesia – 49%

For more information please see Multi–agency Statutory Guidance on Female Genital Mutilation April 2020

Prevalence of FGM in England and Wales

The prevalence of FGM in England and Wales is difficult to estimate because of the hidden nature of the crime.

However, a 2015 study[1] estimated that:
- approximately 60,000 girls aged 0-14 were born in England and Wales to mothers who had undergone FGM (see Appendix 2 for risk factors); and
- approximately 103,000 women aged 15-49 and approximately 24,000 women aged 50 and over who have migrated to England and Wales are living with the

[1] 2 Macfarlane A, Dorkenoo E. (2015) Prevalence of Female Genital Mutilation in England and Wales: National and local estimates. London: City University London and Equality Now http://openaccess.city.ac.uk/12382/

consequences of FGM. In addition, approximately 10,000 girls aged under 15 who have migrated to England and Wales are likely to have undergone FGM

Prevalence of FGM at a local level

The 2015 study reported that no local authority area in England and Wales is likely to be free from FGM entirely. Regional breakdowns of these prevalence estimates show that while urban areas, and specifically London, have the highest estimated prevalence, every area is likely to be affected in some way. It should also be noted that women and girls from affected communities living in low prevalence areas may be more isolated and in greater need of targeted support. NHS Digital publishes quarterly statistics on the profile of patients treated within the National Health Service in England who are identified through their treatment as having had FGM.

Names for FGM

FGM is known by a variety of names, including 'female genital cutting', 'circumcision' or 'initiation'. The term 'female circumcision' is anatomically incorrect and misleading in terms of the harm FGM can cause. The terms 'FGM' or 'cut' are increasingly used at a community level, although they are not always understood by individuals in practising communities, largely because they are English terms. See Appendix 3 for advice about how to talk about FGM.

FGM and other forms of Violence Against Women and Girls

FGM is a form of violence against women and girls which is, in itself, both a cause and consequence of gender inequality. Whilst FGM may be an isolated incident of abuse within a family, it can be associated with other behaviours that discriminate against, limit or harm women and girls. These may include other forms of honour-based abuse (e.g. forced marriage) and domestic abuse.

There have been reports of cases where individuals have been subjected to both FGM and forced marriage. If a professional has a concern about an individual who may be at risk of forced marriage, they should consult the multi-agency practice guidelines on handling cases of forced marriage[2]. Further information about FGM, including the motives for and consequences of it, can be found in Appendix 1.

[2] http://www.gov.uk/forced-marriage#guidance-for-professionals

Chapter 3: The Law in England and Wales

Key points

FGM is illegal in England and Wales under the Female Genital Mutilation Act 2003.

As amended by the Serious Crime Act 2015, the Female Genital Mutilation 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.

In England and Wales, criminal and civil legislation on FGM is contained in the Female Genital Mutilation Act 2003 ("the 2003 Act").

Female Genital Mutilation Act 2003

Under section 1(1) of the 2003 Act, 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 minora or clitoris. Section 6(1) of the 2003 Act provides that the term "girl" includes "woman" so the offences in sections 1 to 3 apply to victims of any age.

Other than in the excepted circumstances set out in sections 1(2) and (3), it is an offence for any person (regardless of their nationality or residence status) to:

- perform FGM in England or Wales (section 1 of the 2003 Act)
- assist a girl to carry out FGM on herself in England or Wales (section 2 of the 2003 Act) and
- assist (from England or Wales) a non-UK national or UK resident to carry out FGM outside the UK on a UK national or UK resident21 (section 3 of the 2003 Act)

Provided that the FGM takes place in England or Wales, the nationality or residence status of the victim is irrelevant.

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).

Failing to protect a girl from risk of FGM

Section 3A of the 2003 Act 22provides for an offence of failing to protect a girl from the risk of FGM. This means that if an offence under section 1, 2 or 3 of the 2003 Act is committed against a girl under the age of 16, each person who is responsible for the girl at the time the FGM occurred could be liable under the offence.

The term “responsible” covers two classes of person:

- a person who has “parental responsibility” for the girl and has “frequent contact” with her and
- a person aged 18 or over who has assumed (and not relinquished) responsibility for caring for the girl “in the manner of a parent”

Extra-territorial offences

Section 4(1) of the 2003 Act extends sections 1 to 3 to extra-territorial acts so that it is also an offence for a UK national or UK resident to:

- perform FGM outside the UK (sections 4 and 1 of the 2003 Act)
- assist a girl to perform FGM on herself outside the UK (sections 4 and 2 of the 2003 Act) and
- assist (from outside the UK) a non-UK national or UK resident to carry out FGM outside the UK on a UK national or UK resident (sections 4 and 3 of the 2003 Act)

The extra-territorial offences are intended to cover taking a girl abroad to be subjected to FGM. By virtue of section 1(4) of the 2003 Act, the exceptions set out in sections 1(2) and (3) also apply to the extra-territorial offences.
Section 4(1A) of the 2003 Act provides that an offence under section 3A can be committed wholly or partly outside the UK by a person who is a UK national or UK resident.

Other offences

Under provisions of the law which apply generally to criminal offences it is also an offence to:

- aid, abet, counsel or procure a person to commit an FGM offence
- encourage or assist a person to commit an FGM offence
- attempt to commit an FGM offence
- conspire to commit an FGM offence

Any person found guilty of such an offence faces the same maximum penalty as for the offences under the 2003 Act.

Exemptions

In strict anatomical terms, there is little to distinguish some of the procedures involved in carrying out FGM from those involved in carrying out legitimate surgery. The 2003 Act therefore contains general exemptions for:

- a surgical operation performed by a registered medical practitioner which is necessary for a girl’s physical or mental health
- an operation performed by a registered medical practitioner or midwife (including a person undergoing training with a view to becoming a medical practitioner or midwife) on a girl who is in labour or has just given birth, for purposes connected with the labour or birth

For further information on the law and legal interventions see Chapter 3 and Annex E in the statutory guidance.

FGM Protection Orders

An FGMPO is a civil order which may be made for the purposes of protecting a girl against the commission of an FGM offence – that is, protecting a girl at risk of FGM - or protecting a girl against whom an FGM offence has been committed. In deciding whether to make an order a court must have regard to all the circumstances of a case including the need to secure the health, safety and well-being of the potential or actual victim. The court can make an order which prohibits, requires, restricts or includes any other such other terms as it considers appropriate to stop or change the behaviour or conduct of those who would seek to subject a girl to FGM or have already arranged for, or committed, FGM.

Examples of the types of orders the court might make are:

- to protect a victim or potential victim at risk of FGM from being taken abroad
- to order the surrender of passports or any other travel documents, including the passport/travel documentation of the girl to be protected
- to prohibit specified persons ('respondents') from entering into any arrangements in the UK or overseas for FGM to be performed on the person to be protected
- to include terms which relate to the conduct of the individuals named in the order both inside and outside of England and Wales and
- to include terms which cover individuals who are, or may become involved in other respects (or instead of the original respondents) and who may commit or attempt to commit FGM against a girl

Orders may also be made against people, who are not named in the application. This is in recognition of the complexity of the issues and the numbers of people who might be involved in the wider community.

An application for an FGMPO can be made to the High Court or the family court by the person to be protected (the victim), or a "relevant third party" (a person or body specified, or in a class specified by the Lord Chancellor for this purpose) without the leave of the court. Local authorities have been specified as a "relevant third party". An application can also be made by 'any other person' with the leave of the court. In deciding whether to grant leave, the court must have regard to all the circumstances, including the applicant's connection with, and knowledge of, the circumstances of the girl.

A court can also make an FGMPO without application being made to it in certain family proceedings. In addition, a criminal court can also make an FGMPO, without application, in criminal proceedings for a genital mutilation offence where the person who would be a respondent to any proceedings for an FGMPO is a defendant in the criminal proceedings. An FGMPO can be made in such criminal proceedings to protect a girl at risk, whether or not they are the victim of the offence in relation to the criminal proceedings. For example, the younger sister of the victim of a genital mutilation offence could also be protected by the court in criminal proceedings. An application for a FGMPO is not an alternative to the work of the police and CPS in investigating and prosecuting crimes. Crimes may be investigated and offenders prosecuted at the same time as an application is made for an FGMPO or an order is in force.

An FGMPO may be made for a specified period or until varied or discharged.

The applicant or the court must serve the order on the police, including the local police station of the girl being protected.

When local authorities have obtained a FGMPO or are aware that one is in place, it is essential that they work closely with the victim and the relevant support service, if there is one, to ensure it offers the level of protection that was envisaged. Links need to be established with other agencies, in particular the police, to ensure ongoing support is available to victims as needed.

Where an agency has obtained an FGMPO it should consider which, if any, other agencies need to be aware of the FGMPO, i.e. those not served with a copy of the order by the court, and whether it is necessary for that information to be shared in order to secure the protection of the girl at risk. Care should, however, be exercised in sharing information, particularly if it could have the adverse effect of leading to either reprisals for the victim and/or other members of their family.

Breach of an FGMPO is a criminal offence with a maximum penalty of up to five years' imprisonment. As an alternative to prosecution, a breach of an FGMPO may be dealt with by the civil route as a contempt of court, punishable by up to two years' imprisonment, a fine, or both.

FGM Mandatory Reporting Duty

The FGM mandatory reporting duty is a legal duty provided for in the FGM Act 2003 (as amended by the Serious Crime Act 2015). The legislation requires regulated health and social care professionals and teachers in England and Wales to make a report to the police 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

For the purposes of the duty, the relevant age is the girl's age at the time of the disclosure/identification of FGM (i.e. it does not apply where a woman aged 18 or over discloses she had FGM when she was under 18).

Complying with the duty does not breach any confidentiality requirement or other restriction on disclosure which might otherwise apply.

The duty is a personal duty which requires the individual professional who becomes aware of the case to make a report; the responsibility cannot be transferred. The only exception to this is if you know that another individual from your profession has already made a report; there is no requirement to make a second.

The duty does not apply in relation to at risk or suspected cases or in cases where the woman is over 18. In these cases, you should follow local safeguarding procedures. For more

information, please see Working Together to Safeguard Children and/or the multi-agency statutory guidance on FGM. Where there is a risk to life or likelihood of serious immediate harm, professionals should report the case immediately to police, including dialling 999 if appropriate.

Professionals should make the report as soon after the case has been discovered. Best practice is within 1 working day.

The duty only applies in cases where the victim discloses. If someone else, such as a parent or guardian, discloses that a girl under 18 has had FGM, a report to the police is not mandatory. However, in these circumstances disclosures should still be handled in line with wider safeguarding responsibilities If there are suspicions that a girl under the age of 18 years may have undergone FGM or is at risk of FGM professionals must still report the issue by following their internal safeguarding procedures. Professionals must share the information about their concerns, potential risk and/or the actions which are to be taken. Next steps should be discussed with the safeguarding lead and if necessary a Children's Services referral made.

The Home Office has produced guidance Mandatory Reporting of Female Genital Mutilation – procedural information to support this duty and a fact sheet on the New Duty for Health and Social Care Professionals and Teachers to Report Female Genital Mutilation (FGM).

Chapter 4: Working Together to Tackle FGM

What to do if you are worried about a child in relation to FGM

If any professional suspects that a girl has undergone FGM their named/designated safeguarding lead must be made aware and an immediate referral should be made to the Children's Services. For those professionals subject to mandatory reporting this will include a referral to the police. See Mandatory Reporting Duty section above.

When a girl is suspected to have already undergone FGM, all professionals should:
- document this in their notes;
- complete relevant risk assessment; and
- follow the Children's MARS Policy and Procedure Assessing Need and Providing Help

For further information on safeguarding adults, other family members and women and girls from overseas, see Annex D in the statutory guidance. Additional considerations for NHS staff, police staff and schools, colleges and universities can be found in can also be found in Annex D.

If Children's Services and/or the police have reason to believe that a child is likely to suffer or has suffered FGM, Children's Services will liaise with the police and determine the next course of action. This may result in a strategy discussion being convened which should include the relevant health professionals and, if the child is of school age, a school representative also any others involved with the child/family or deemed appropriate.

The strategy discussion will make a decision will be whether the child or young person, the unborn child, or sibling of a child in questions has suffered or is likely to suffer significant harm as a consequence of FGM. If so, a section 47 enquiry will be initiated which could be undertaken jointly with the police.

When undertaking an assessment/section 47 enquiry:
- Consider if the procedure has already been performed how, where and when the procedure was performed and the implication of this
- Children's Services and/or the police will liaise with the Child Sexual Assault Assessment Service where it is believed that FGM has already taken place to enable a medical assessment to take place
- Consider whether a criminal act has taken place and liaise with the police and where necessary take legal advice
- Where a child appears to be in immediate danger of FGM, legal advice should be sought and consideration should be given, for example, to seeking an FGM Protection Order, an Emergency Protection Order or a Prohibited Steps Order, making it clear to the family that they will be breaking the law if they arrange for the child to have the procedure
- Consider the need for support services
- If concerns are substantiated, consider whether a child protection plan is necessary
- The child's interests are always paramount, and any agreement must be carefully monitored and enforced by all agencies

Where a child has been identified as having suffered, or being likely to suffer, significant harm, it may not always be appropriate to remove the child from an otherwise loving family environment. Parents and carers may genuinely believe that it is in the girl's best interest to conform to their prevailing custom. Professionals should work in a sensitive manner with families to explain the legal position around FGM in the UK. The families will need to understand that FGM and re-infibulation (the process of resealing the vagina after childbirth) is illegal in the UK and that if they are insistent upon carrying out the practice, relevent health professionals and Children's Services must be informed that a female child may be at risk of significant harm.

Interpretation services should be used if English is not spoken or well understood, and the interpreter should not be an individual who is known to the family.

Where a child appears to be in immediate danger of mutilation, legal advice should be sought and consideration should be given, for example, to seek an FGM Protection Order, an Emergency Protection Order or a Prohibited Steps Order, making it clear to the family that they will be breaking the law if they arrange for the child to have the procedure.

Appendix 1: Risk

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 practising FGM. In addition, it is important to consider whether FGM is known to be practised in her community or country of origin.

The age at which girls undergo FGM varies enormously according to the community. The procedure may be carried out when the girl is new-born, during childhood or adolescence, at marriage or during a first pregnancy.

Given the hidden nature of FGM, individuals from communities where it takes place may not be aware of the practice. Women and girls who have undergone FGM may not fully understand what FGM is, what the consequences are, or that they themselves have had FGM. Given this context, discussions about FGM should always be undertaken with appropriate care and sensitivity (see Appendix 3).

It is believed that FGM may happen to girls in the UK as well as overseas. Girls of school age who are subjected to FGM overseas are likely to be taken abroad (often to the family's country of origin) at the start of the school holidays, particularly in the summer, in order for there to be sufficient time for her to recover before returning to school.

There are a number of factors in addition to a girl's or woman's community, country of origin and family history that could indicate she is at risk of being subjected to FGM. Potential risk factors may include:

- a female child is born to a woman who has undergone FGM
- a female child has an older sibling or cousin who has undergone FGM
- a female child's father comes from a community known to practise FGM
- the family indicate that there are strong levels of influence held by elders and/or elders are involved in bringing up female children
- a woman/family believe FGM is integral to cultural or religious identity
- a girl/family has limited level of integration within UK community
- parents have limited access to information about FGM and do not know about the harmful effects of FGM or UK law
- a girl confides to a professional that she is to have a 'special procedure' or to attend a special occasion to 'become a woman'
- a girl talks about a long holiday to her country of origin or another country where the practice is prevalent
- parents state that they or a relative will take the girl out of the country for a prolonged period
- a parent or family member expresses concern that FGM may be carried out on the girl
- a family is not engaging with professionals (health, education or other)
- a family is already known to social care in relation to other safeguarding issues
- a girl requests help from a teacher or another adult because she is aware or suspects that she is at immediate risk of FGM

- a girl talks about FGM in conversation, for example, a girl may tell other children about it – it is important to take into account the context of the discussion
- a girl from a practising community is withdrawn from Personal, Social, Health and Economic (PSHE) education or its equivalent
- a girl is unexpectedly absent from school
- sections are missing from a girl's Red book and/or
- a girl has attended a travel clinic or equivalent for vaccinations / anti-malarials

This is not an exhaustive list of risk factors. There may be additional risk factors specific to particular communities. For example, in certain communities FGM is closely associated to when a girl reaches a particular age.

If any of these risk factors are identified professionals will need to consider what action to take. If unsure whether the level of risk requires referral at this point, professionals should discuss with their named/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.

Indicators that FGM may have already taken place

It is important that professionals look out for signs that FGM has already taken place so that:

- the girl or woman receives the care and support she needs to deal with its effects
- enquiries can be made about other female family members who may need to be safeguarded from harm and/or
- criminal investigations into the perpetrators, including those who carry out the procedure, can be considered to prosecute those who have broken the law and to protect others from harm

There are a number of indications that a girl or woman has already been subjected to FGM:

- a girl or woman asks for help
- a girl or woman confides in a professional that FGM has taken place
- a mother/family member discloses that female child has had FGM
- a family/child is already known to social services in relation to other safeguarding issues
- a girl or woman has difficulty walking, sitting or standing or looks uncomfortable
- a girl or woman finds it hard to sit still for long periods of time, and this was not a problem previously

- a girl or woman spends longer than normal in the bathroom or toilet due to difficulties urinating
- a girl spends long periods of time away from a classroom during the day with bladder or menstrual problems
- a girl or woman has frequent urinary, menstrual or stomach problems
- a girl avoids physical exercise or requires to be excused from physical education (PE) lessons without a GP's letter
- there are prolonged or repeated absences from school or college
- increased emotional and psychological needs, for example withdrawal or depression, or significant change in behaviour
- a girl or woman is reluctant to undergo any medical examinations
- a girl or woman asks for help, but is not be explicit about the problem and/or
- a girl talks about pain or discomfort between her legs.

This is not an exhaustive list of indicators. If any of these indicators are identified professionals will need to consider what action to take.

If unsure what action to take, professionals should discuss with their named/designated safeguarding lead.

Appendix 2: Talking About FGM

Key points

- Supporting women and girls who have undergone FGM demands sensitivity and compassion on the part of the professional
- Sometimes it will not be clear that FGM is the origin of the individual's problem/s
- Professionals may experience strong emotions when dealing with FGM – it is important they discuss this with a colleague or supervisor
- Important points to consider when talking to women or girls affected by FGM include: ensuring that the conversation is not interrupted, giving the individual time to speak, only asking one question at a time, and remaining non-judgmental
- When developing written or visual materials for either individuals or the public, care must be taken to ensure the materials are appropriate, and developing them in consultation with survivors and affected communities is recommended

Introduction to Talking about FGM

Good communication is essential when talking to individuals who have had FGM, may be at risk of FGM, or are affected by the practice.

Professionals should ensure that they enquire sensitively about FGM. The topic of FGM may arise in a variety of settings, including a GP's surgery as part of a medical consultation, a home environment during a health visitor's post-natal visit, or at school. Conversations may take place with the girl or woman who may be affected by FGM, a parent or other family member. How the conversation is opened and the language used will vary according to the setting and who the conversation is with, however, the key principles set out below should apply in all cases.

Talking about FGM can be difficult and upsetting. Professionals may wish to speak with their supervisor if they are affected by what they have heard.

It is important to acknowledge and understand the motives, demographics and consequences of FGM. Equally, it is important that professionals take the time to think about their own concerns, feelings and values, so they can discuss FGM with clarity and confidence. A lack of awareness may mean that a professional is unable to relate to the girl or woman/their family, which may lead to a failure to discuss the issue appropriately and result in distress for the girl or woman.

If, as a result of talking about FGM with an individual or family, a professional identifies that a girl is at risk of FGM or has undergone FGM, then appropriate action should be taken.

Preparing to speak to individuals and families

Adhering to key standards will enable professionals to hold conversations in a sensitive and appropriate way. These include:

- making the care of women and girls affected by FGM the primary concern, treating them as individuals, listening and respecting their dignity
- working with others to protect and promote the health and well-being of those in their care, their families and carers, and the wider community and
- being open and honest, acting with integrity and upholding the reputation of the profession

When initiating a conversation about FGM, professionals should:

- ensure that the conversation is opened sensitively
- be aware of the specific circumstances of the individual when a discussion about FGM needs to take place and
- be non-judgmental

Creating and maintaining a good rapport with the girl or woman is essential. This can be achieved by:

- allowing the girl or woman to speak - actively listening, gently encouraging, and seeking the girl or woman's permission to discuss sensitive areas
- not being afraid to ask about FGM, using appropriate and sensitive language. It is not unusual for women to report that professionals have avoided asking questions about FGM, and this can lead to a breakdown in trust. If a professional does not give a girl or woman the opportunity to talk about FGM , it can be very difficult for a girl or woman to bring this up herself
- asking only one question at a time – it can be difficult to think through the answers to several questions at the same time
- making sure there is appropriate time to listen; a girl or woman may relate information she has not disclosed previously. Interrupting her story part way through because of a lack of time is likely to cause distress and may either damage the relationship with her, or affect her relationship with professionals in future and
- preparing by understanding what written materials are available to support conversations, and what other community and third-sector organisations are able to offer support and additional information within the area

It is important that professionals understand the appropriate language to use and maintain a professional and non-judgmental approach to engage with the individual effectively in what may be a challenging and upsetting situation.

Professionals should:

- ensure sensitive language is used and that the girl or woman's wishes, culture and values are recognised and respected
- be aware that different communities may have different terms for FGM
- remember that women or girls may not be aware that they have had FGM
- professionals may need to explain that FGM is the cause of symptoms and
- consider some of the following ways to start a discussion about FGM:
    - "I can see in your notes from the obstetrician or midwife that you have been cut. Could you tell me a bit more about this?"
    - "I know that (some) women in your country have been cut. How do you feel about this? Could you tell me a bit more?"

- "You have talked about your cutting and the traditions in your country. Is there anything else you want to tell me about this?"
- "How do you, and how does your partner, feel about female genital cutting? How do the people around you feel about this? Are you still in touch with relatives in your country? How do they feel about it? At what age is it usually performed?"

Professionals have a responsibility to ensure women and families understand that FGM is illegal in the UK, and to explain the harmful consequences it can have.

Using Translators

An accredited female interpreter may be required. Any interpreter should ideally be appropriately trained in relation to FGM, and in all cases should not be a family member, not be known to the individual, and not be someone with influence in the individual's community. Care must be taken to ensure that an interpreter is available at services supporting women with FGM, as this is likely to be required for many appointments relating to FGM.

Appendix 3: Background on FGM

Cultural underpinnings and motives of FGM

FGM is a complex issue, and individuals and families who support it give a variety of justifications and motivations for this. However, FGM is a crime and child abuse, and no explanation or motive can justify it. The justifications given may be based on a belief that, for example, it:

- brings status and respect to the girl
- preserves a girl's virginity/chastity
- is part of being a woman
- is a rite of passage
- gives a girl social acceptance, especially for marriage
- upholds the family "honour"
- cleanses and purifies the girl
- gives the girl and her family a sense of belonging to the community
- fulfils a religious requirement believed to exist
- perpetuates a custom/tradition
- helps girls and women to be clean and hygienic
- is aesthetically desirable
- makes childbirth safer for the infant
- rids the family of bad luck or evil spirits

FGM is a traditional practice often carried out by a family who believe it is beneficial and is in a girl or woman's best interests. This may limit a girl's motivation to come forward to raise concerns or talk openly about FGM – reinforcing the need for all professionals to be aware of the issues and risks of FGM.

Infibulation (Type 3) is strongly linked to virginity and chastity, and used to 'protect' girls from sex outside marriage and from having sexual feelings. In some cultures, it is considered necessary at marriage for the husband and his family to see her 'closed' and, in some instances, both mothers will take the girl to be cut open enough to be able to have sex.

Although FGM is practised by secular communities, it is most often claimed to be carried out in accordance with religious beliefs. However, FGM predates Christianity, Islam and Judaism, and the Bible, Koran, Torah and other religious texts do not advocate or justify FGM.

Medicalisation of FGM

Some who support the practice have sought to eliminate risks of infection (by, for example, carrying it out in a medical environment) in order to legitimise FGM. However, in addition to the immediate risks associated with FGM being carried out, it can have serious and harmful long-term psychological and physical effects, regardless of how the procedure was done.

Consequences of FGM

Men and women in practising communities may be unaware of the potential harmful health and welfare consequences of FGM, some of which are set out below.

Immediate/short-term consequences of FGM
The immediate/short-term consequences of FGM can include:

- severe pain
- shock
- hemorrhage
- wound infections
- urinary retention
- injury to adjacent tissues
- genital swelling and/or
- death.

Long-term consequences of FGM
The long-term consequences of FGM can include:

- genital scarring
- genital cysts and keloid scar formation
- recurrent urinary tract infections and difficulties in passing urine
- possible increased risk of blood infections such as hepatitis B and HIV
- pain during sex, lack of pleasurable sensation and impaired sexual function
- psychological concerns such as anxiety, flashbacks and post-traumatic stress disorder
- difficulties with menstruation (periods)
- complications in pregnancy or childbirth (including prolonged labour, bleeding or tears during childbirth, increased risk of caesarean section) and
- increased risk of stillbirth and death of child during or just after birth

Appendix 4: Further guidance and sources of support

A comprehensive list of guidance, resources and helpline information can be found in Annex H and I in the statutory guidance.

Sources of support

North Lincolnshire Children's Services
If a child is at risk of significant harm, North Lincolnshire Children's Services should be contacted on the Single Point of Contact on 01724 296500 or out of office hours on 01724 296555.

North Lincolnshire Adult's Services
If you have concerns about an adult with care and support needs, North Lincolnshire Adult's Services can be contacted on 01724 297000.

Humberside Police
Emergency: 999
Non-Emergency: 101
Further information and advice is available on Humberside Police website

The Blue Door
The Blue Door is a specialist service who provide support to anyone that has experienced domestic abuse and sexual violence in North and North East Lincolnshire and those who have experienced rape and serious sexual offences in Hull and the East Riding of Yorkshire through a variety of advocacy, outreach workers, groups and programmes.

Office Telephone: 01724 841947
Helpline: 0800 197 47 87
Further information and referral forms are available from The Blue Door's website

The Halo Project
The Halo project is a national charity that supports victims of honour based abuse, forced marriages and female genital mutilation by providing appropriate advice and support to victims.

01642 683045
0808 178 8424 Freephone
www.haloproject.org.uk

Somali Development Services
SDS provides support to the Somali community and provides education, advocacy and advice and guidance.

0116 285 5888
https://www.somdev-services.com/index.php/fgm/

My Sister's Place
My Sister's Place is an independent specialist service for women aged 16 or over and have experienced or are experiencing domestic abuse

01642 241864
www.mysistersplace.org.uk

The Agency for Culture and Change Management (ACCM)
ACCM is an independent charity whose primary role is to lobby for and communicate the effects of legislation concerning FGM and other harmful traditional practices in the UK.

01234 356910
www.accmuk.com

The Foundation of Women's Health Research and Development (FORWARD)
FORWARD is the African women-led women's rights organisation working to end violence against women and girls. They provide information, advice and one to one support for those affected by FGM.

0208 960 4000 ext 1
www.forwarduk.org.uk

NSPCC FGM Helpline
0800 028 3550
fgm.help@nspcc.org.uk

NSPCC website

Further guidance

- Multi–agency Statutory Guidance on Female Genital Mutilation April 2020
- Female Genital Mutilation and its Management (Green-top Guideline No. 53)
- Female Genital Mutilation – Home Office
- Mandatory Reporting of Female Genital Mutilation – procedural information
- Female Genital Mutilation Risk and Safeguarding – Guidance for Professionals (Department of Health)