

Smithdown Primary School

Female Genital Mutilation (FGM)

Safeguarding Training 2016-2017

**Understanding FGM**

**Key points:**

 • FGM is illegal in the UK. For the purpose of the criminal law in England and Wales, FGM is mutilation of the labia majora, labia minor or clitoris.

 • FGM is an unacceptable practice for which there is no justification. It is child abuse and a form of violence against women and girls.

 • FGM is prevalent in 30 countries. These are concentrated in countries around the Atlantic coast to the Horn of Africa, in areas of the Middle East, and in some countries in Asia.

• It is estimated that 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 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.

• FGM is a deeply embedded social norm, practised by families for a variety of complex reasons. It is often thought to be essential for a girl to become a proper woman, and to be marriageable. The practice is not required by any religion.

**What is FGM?**

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.

**FGM is illegal**.

It is child abuse and a form of violence against women and girls and should therefore be treated as such. It should be addressed using existing structures, policies and procedures designed to safeguard children and vulnerable adults. All bodies to which this guidance applies need to work effectively with one another, and with other relevant organisations to address FGM.

**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; and

• Type 4 – Other: all other harmful procedures to the female genitalia for nonmedical purposes, e.g. pricking, piercing, incising, scraping and cauterising the genital area. The extent to which the WHO classifications of FGM come within the ambit of the criminal law.

**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, Oman, The United Arab Emirates, The Occupied Palestinian Territories, India, Indonesia, Malaysia, Pakistan and Saudi Arabia. It has also been identified in parts of Europe, North America and Australia.

**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 estimated that approximately 60,000 girls aged 0-14 were born in England and Wales to mothers who had undergone FGM 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 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. 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.

**Protective Legislation**

FGM has been a criminal offence in the UK since The **Prohibition of Female Circumcision Act 1985.** The Act was repealed by **The FGM Act 2003** and closed a loophole which enabled victims to be taken outside of the jurisdiction for the purposes of FGM, without sanction. **The FGM Act 2003** made it unlawful for UK nationals or permanent UK residents to carry out FGM abroad, or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where FGM is legal. The legislation was designed to prevent families and carers from taking girls abroad to undergo the procedure. The Act increased the maximum penalty for being found guilty of FGM from 5 to 14 years imprisonment. The **FGM Act 2003** also made it a criminal offence to re-infibulate following an FGM procedure.

There are new legislative measures being brought through the **Serious Crime Act 2015** which will strengthen the legislative framework around tackling FGM. The changes include introducing ‘habitual UK resident’ rather than ‘permanent UK resident’, and introducing FGM Protection Orders (similar to Forced Marriage Protection Orders).

FGM is considered to be a form of child abuse (it is categorised under the headings of both **Physical Abuse** and **Emotional Abuse**). 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.

FGM is also an abuse of female adults usually categorized under honour based violence and domestic abuse definitions. Where a female adult is also defined as an **Adult at risk**, additional support mechanisms would be available through local social care teams and adult safeguarding processes.

Private law remedies can be used as a form of legal protection. For example a **Prohibited Steps Order** under Section 8 Children Act 1989 can be used to prevent a child being taken abroad or from having the procedure. A Non Molestation Order under Part IV of the Family Law Act 1996 may also be used as protection for the child or adult. The Domestic Violence Crime and Victims Act 2004 make the breach of a Non Molestation Order a criminal offence.

It may be possible for victims of FGM to claim compensation from the **Criminal Injuries Compensation Authority**. The injuries must be reported to the police. The Police have [**Police Protection**](http://trixresources.proceduresonline.com/nat_key/keywords/police_protection.html) powers where there is reasonable cause to believe that a child or young person, under the age of 18 years, is at risk of [**Significant Harm**](http://trixresources.proceduresonline.com/nat_key/keywords/significant_harm.html). A police officer may (with or without the cooperation of social care) remove the child from the parent and use the powers for ‘police protection’ (section 46 of the Children Act 1989) for up to 72 hours.

The Local Authority has further powers under Section 44 of the Children Act 1989. Under this section, the Local Authority may apply for an [**Emergency Protection Order**](http://trixresources.proceduresonline.com/nat_key/keywords/emerge_prot_order.html) (EPO). The Order authorizes the applicant to remove the girl and keep her in safe accommodation for up to 8 days. This Order is often sought to ensure the short term safety of the child.

**Communities**

Working with Communities to End FGM due to so-called ‘cultural practices’, will be a challenge. It can be deeply embedded in practising communities and working to end them requires both top down direction and a community-led approach. Some of the ways organisations and professionals can help to end FGM include: • involving individuals and families in discussions about how FGM can be ended within their family and wider community; • talking to all groups, including men, boys and community leaders about FGM and its consequences; • encouraging individuals to report suspected cases of FGM, and highlighting the anonymous means for doing this, such as the NSPCC helpline, for those unwilling to provide information to the authorities and • signposting to organisations that can provide support and advice to those who wish to end the practice within their family or community.

**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; and • 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.

**Religion**

**However, FGM predates Christianity, Islam and Judaism, and the Bible, Koran, Torah and other religious texts do not advocate or justify FGM.** Muslim scholars have condemned the practice and are clear that FGM is an act of violence against women. Furthermore, scholars and clerics have stressed that Islam forbids people from inflicting harm on others and therefore most will teach that the practice of FGM is counter to the teachings of Islam. However, many communities continue to justify FGM on religious grounds. This is evident in the use of religious terms such as “sunnah” that refer to some forms of FGM (usually Type I).

FGM is not practised amongst many Christian groups except for some Coptic Christians of 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.

FGM has also been practiced amongst some Bedouin Jews and Falashas (Ethiopian Jews) and again is not supported by Judaic teaching or custom.

**Short-Term Consequences of FGM**

The immediate/short-term consequences of FGM can include: • severe pain; • shock; • haemorrhage; • 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. **The highest maternal and infant mortality rates are in FGM-practicing regions.**

**The actual number of girls who die as a result of FGM is not known. However, in areas of Sudan where antibiotics are not available, it is estimated that one-third of the girls undergoing FGM will die.**

**Risk Factors**

The most significant factor to consider when deciding whether a girl 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. 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; • 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

 **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 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 is reluctant to undergo any medical examinations; • a girl asks for help, but is not be explicit about the problem; and/or • a girl talks about pain or discomfort between her legs.

**School Responsibility (Child Protection Policy)**

‘Section 5B of the Female Genital Mutilation Act 2003 (as inserted by section 74 of the Serious Crime Act 2015) places a statutory duty upon teachers along with regulated health and social care professionals in England and Wales, to report to the police where they discover (either through disclosure by the victim or visual evidence) that FGM appears to have been carried out on a girl under 18. Those failing to report such cases will face disciplinary sanctions. It will be rare for teachers to see visual evidence, and they should not be examining pupils, but the same definition of what is meant by “to discover that an act of FGM appears to have been carried out” is used for all professionals to whom this mandatory reporting duty applies. Information on when and how to make a report can be found at- ‘Mandatory reporting of female genital mutilation procedural information’ Teachers must personally report to the police cases where they discover that an act of FGM appears to have been carried out. Unless the teacher has a good reason not to, they should also still consider and discuss any such case with the school or college’s designated safeguarding lead and involve children’s social care as appropriate. The duty does not apply in relation to at risk or suspected cases (i.e. where the teacher does not discover that an act of FGM appears to have been carried out, either through disclosure by the victim or visual evidence) or in cases where the woman is 18 or over. In these cases, teachers should follow local safeguarding procedures.’ DFE 2016 The school will also consult the government guidance Multi-agency statutory guidance on female genital mutilation (revised 2016).

**Terms Used for FGM In Other Languages**

Country Term used for FGM Language CHAD – the Ngama Sara subgroup Bagne Gadja EGYPT Thara Arabic Khitan Arabic Khifad Arabic ETHIOPIA Megrez Amharic Absum Harrari ERITREA Mekhnishab Tigregna GAMBIA Niaka Mandinka Kuyango Mandinka Musolula Karoola Mandinka GUINEA-BISSAU Fanadu di Mindjer Kriolu IRAN Xatna Farsi KENYA Kutairi Swahili Kutairi was ichana Swahili NIGERIA Ibi/Ugwu Igbo didabe fun omobirin / ila kiko fun omobirin Yoruba SIERRA LEONE Sunna Soussou Bondo Temenee Bondo/Sonde Mendee Bondo Mandinka Bondo Limba SOMALIA Gudiniin Somali Halalays Somali Qodiin Somali SUDAN Khifad Arabic Tahoor Arabic TURKEY Kadin Sunneti Turkish

**Useful Contacts:**

**Third Sector Agencies Working With FGM**

**Foundation for Women’s Research and Development (FORWARD)**
Tel: 0208 960 4000
Email: **forward@forwarduk.org.uk**

**The NSPCC 24hour helpline to protect children and young people affected by FGM**Tel: 0800 028 3550

**NESTAC - Drop in groups across the North West for girls and women affected by FGM**
Tel: 01706 868993
Mob: 07862 279289
Email: **peggy@nestac.org**

**Childline**
24 hour helpline for children: 0800 1111

**National 24 hour Domestic Violence Helpline**
24-hour Helpline: 0808 2000 247

**Statutory Agencies Working with FGM**

**Local Authority referral points for children across Merseyside**

**Merseyside Police**

Family Crime Investigation Unit at Wirral BCU

**Multi-Cultural Antenatal Clinic – Liverpool Women's Hospital**
Crown Street
Liverpool L8 7SS
Tel: 0151 702 4180 or 0151 702 4178
Mobile: 07717 516134
Open: Monday-Friday 8.30am-4.30pm
Contact: Ronnie Gilbertson or Joanne Topping