Houldsworth Valley Primary Academy

FGM POLICY

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1. INTRODUCTION

This policy provides information about female genital mutilation (FGM) and what action they should take to safeguard girls and young women who they believe may be at risk of being, or have already been, harmed. FGM is extremely traumatic, can be fatal, and has significant short and long term medical and psychological implications. It is illegal in the United Kingdom, and therefore is a child protection issue.

FGM has been a criminal offence in the UK since the Prohibition of Female Circumcision Act 1985 was passed. The Female Genital Mutilation Act 2003 replaced the 1985 Act and made it an offence 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 the practice is legal. Further information about the Act can be found in **Home Office Circular 10/2004**.

2. POLICY CONTEXT

The Every Child Matters Agenda requires all agencies to take responsibility for safeguarding and promoting the welfare of every child/young person. This is to enable them to:

- Be healthy.
- Stay safe.
- Enjoy and achieve.
- Make a positive contribution.
- Achieve economic well-being.

Therefore professionals and volunteers from all agencies have a statutory responsibility to safeguard girls / young women from being abused through FGM.

3. POLICY STATEMENT

At Houldsworth Valley Primary Academy we recognise that whilst there is no intent to harm a girl/ young woman through FGM, the practice directly causes serious short and long term medical and psychological complications. Consequently **it is a physically abusive act**.

It is our aim to prevent the practice of FGM in a way that is culturally sensitive and with the fullest consultations with community representatives and professional agencies.

All staff and certain agencies should be alert to the possibility of FGM, and their policy should include a preventative strategy that focuses upon education, as well as the protection of girls/young women at risk of significant harm. The following principles should be adhered to:

- The safety and welfare of the girl/young woman is paramount.
- All agencies and staff, including volunteers, will act in the interest of the rights of the girl/ young woman, as stated in the UN Convention on the Rights of the Child (1989).
- All decisions or plans for the girl/young woman should be based on thorough assessments which are sensitive to the issues of age, race, culture, gender, religion. Stigmatisation of the girl / young woman or their specific community should be avoided.
- All agencies should work in partnership with members of affected local communities, to develop support networks and education appropriate programmes.

4. FEMALE GENITAL MUTILATION

4.1 Definition

The World Health Organisation (WHO) states that female genital mutilation (FGM) 'comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons' (WHO, 2008). FGM is also known as female circumcision, but this is incorrect as circumcision means 'to cut' and 'around' (Latin), and it is quite dissimilar to the male procedure. It can also be known as female genital cutting. The Somali term is 'Gudnin' and in Sudanese it is 'Tahur'. FGM is not like male circumcision. It is very harmful and can cause long-term mental and physical suffering, menstrual and sexual problems, difficulty in giving birth, infertility and even death. The average age for FGM to be carried out is about 14 years old. However it can vary from soon after birth, up until adulthood.

4.2 Prevalence

FGM is much more common than most people realise. In 2004 it was estimated that there were approximately 80,000 girls and women in the UK who have undergone genital mutilation and a further 7,000 girls under 17 were at risk (Department of Health). Current figures are unknown, as although there has been a rise in immigration to the UK during this period since 2004, educational programmes against FGM may have had an impact on reducing incidence.

A study by FORWARD estimated prevalence of FGM in England and Wales as at least 66,000 in 2001 with 24,000 girls under the age of 15 being at risk (Dorkenoo, 2007). One study (Williams et al, 1998) found that 70% of unmarried Somali girls aged 16-22 living in London had experienced FGM, and that the vast majority of those had it carried out before arriving in the UK.

Morison et al, (2004), detailing experiences and attitudes to FGM among London based Somalis aged 16-22 years, found that age on arrival to the UK had a significant impact on whether girls were circumcised. Only 42% of girls who arrived in the UK before the age of 6 were circumcised, compared with 91% of girls who arrived after the age of 11.

FGM is traditionally practised in sub-Saharan Africa, but also in Asia or the Middle East. Those African countries where it is most likely to be practised include Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Guinea, Mali, Sierra Leone, Somalia and Sudan. This does not mean that it is legal in these countries. There are a range of responses by individual nations: from still being legal, to being illegal but not upheld, to outright bans that are adhered to.

Girls and women from the Democratic Republic of Congo, Ghana, Niger, Tanzania, Togo, Uganda and Yemen are less likely to undergo FGM. But within these countries there are particular ethnic communities were prevalence is higher. It should also be remembered that girls and young women who are British citizens but whose parents were born in countries that practiced FGM, may also be at risk.

4.3 Legal Position

FGM has been illegal in the UK since the Female Circumcision Prohibition Act 1985. This made it illegal for a person to excise, infibulate (sew together the labia majora) or otherwise mutilate the whole or any part of a girl/young woman's labia majora, labia minora or clitoris. It is also an offence

for anyone to assist a girl/young woman to mutilate her own genitalia. The only exception is for operations for specific physical and mental health reasons, undertaken by registered medical or nursing practitioners.

The Female Genital Mutilation Act 2003 strengthened the 1985 Act, by making it an offence to take UK nationals and those with permanent UK residence, overseas for the purpose of circumcision, to aid and abet, counsel, or procure the carrying out of FGM. It also makes it illegal for anyone to circumcise girls or women for cultural or non-medical reasons. The 2003 Act increases the maximum penalty for committing or aiding the offence from 5 years to 14 years in prison.

Local authorities can apply to the courts for various orders, such as an Emergency Protection Order, under the Children Act 1989, to prevent a girl/young woman being taken abroad for the purposes of genital mutilation. In emergency situations consideration should also be given to the use of Police Protection. However these expire after 72 hours, so further provisions would have to be considered after this.

4.4 Cultural Context

The issue of FGM is very complex. Despite the obvious harm and distress it can cause, many parents from communities who practice FGM believe it important in order to protect their cultural identity.

FGM is often practiced within a religious context. However, neither the Koran nor the Bible supports the practice of FGM. As well as religious reasons, parents may also say that undergoing FGM is in their daughter's best interests because it:

- Gives her status and respect within the community.
- Keeps her virginity/chastity.
- Is a rite of passage within the custom and tradition in their culture.
- Makes her socially acceptable to others, especially to men for the purposes of marriage.
- Ensures the family are seen as honourable.
- Helps girls and women to be clean and hygienic.

4.5 Main Forms of FGM

The World Health Organisation has classified four main types of FGM:

1. 'Clitoridectomy which is the partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, rarely, the prepuce (the fold of skin surrounding the clitoris) as well.
2. Excision which is the 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 which is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, and sometimes outer, labia, with or without removal of the clitoris.
4. Other types which are all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area' (WHO FGM Fact Sheet, 2008).

4.6 The FGM Procedure

The procedure is usually carried out by an older woman in the community, who may see conducting FGM as a prestigious act as well as a source of income.

The procedure usually involves the girl / young woman being held down on the floor by several women. It is carried out without medical expertise, attention to hygiene or an anaesthetic. Instruments used include un-sterilised household knives, razor blades, broken glass and stones. The girl/young woman may undergo the procedure unexpectedly, or it may be planned in advance.

4.7 Consequences of FGM

Many people may not be aware of the relation between FGM and its health consequences; in particular the complications affecting sexual intercourse and childbirth which occur many years after the mutilation has taken place.

Short term health implications include:

- Severe pain and shock.
- Infections.
- Urine retention.
- Injury to adjacent tissues.
- Fracture or dislocation as a result of restraint.
- Damage to other organs.
- Death.

Depending on the degree of mutilation, it can cause severe haemorrhaging and result in the death of the girl/young woman through loss of blood.

Long term health implications include:

- Excessive damage to the reproductive system.
- Uterus, vaginal and pelvic infections.
- Infertility.
- Cysts.
- Complications in pregnancy and childbirth.
- Psychological damage.
- Sexual dysfunction.
- Difficulties in menstruation.
- Difficulties in passing urine.
- Increased risk of HIV transmission.

4.8 Signs and Indicators

Some indications that **FGM may have taken place** include:

- The family comes from a community that is known to practice FGM, especially if there are elderly women present in the extended family.

- A girl/young woman may spend time out of the classroom or from other activities, with bladder or menstrual problems
- A long absence from school or in the school holidays could be an indication that a girl/young woman has recently undergone an FGM procedure, particularly if there are behavioural changes on her return (this may also be due to a forced marriage) - see **Safeguarding Children and Young People from Forced Marriage Procedure.**
- A girl/young woman requiring to be excused from physical exercise lessons without the support of her GP.
- A girl/young woman may ask for help, either directly or indirectly.
- A girl/young woman who is suffering emotional/psychological effects of undergoing FGM, for example withdrawal or depression.
- Midwives and obstetricians may become aware that FGM has taken place when treating a pregnant woman/young woman.

Support for a girl or young woman who may have undergone FGM can be obtained from the **Agency for Culture and Change Management** (Tel: 0114 272 8780).

Some indications that **FGM may be about to take place** include:

- A conversation with a girl/young woman where they may refer to FGM, either in relation to themselves or another female family member or friend.
- A girl/young woman requesting help to prevent it happening.
- A girl/young woman expressing anxiety about a 'special procedure' or a 'special occasion' which may include discussion of a holiday to their country of origin.
- A boy may also indicate some concern about his sister or other female relative.

Support for a girl or young woman who may be about to undergo FGM can be obtained from the **Agency for Culture and Change Management** (Tel: 0114 272 8780).

5. ACTION TO TAKE IF WORKERS BELIEVE A CHILD IS AT RISK OF FGM

Any information or concern that a girl/young woman is at risk of, or has undergone FGM should result in an immediate referral to Suffolk Police and Customer First.

In an emergency - do not delay - ring 999.

FGM places a girl/young woman at risk of significant harm and will therefore be initially investigated under Section 47 of the Children Act 1989 by Children's Social Care and Suffolk Police.

If a girl/young woman is thought to be at risk of FGM, **workers should be aware of the need to act quickly** - before she is abused by undergoing FGM in the UK, or taken abroad to undergo the procedure.

An interpreter must be used in all interviews with the family if their preferred language is not English. The interpreter must be female.

6. STRATEGY MEETING/DISCUSSION

Once a referral has been received for either a girl/young woman who is at risk or has undergone FGM, a Strategy Meeting/Discussion must be convened within **two working days**. This should involve representatives from the police, Children's Social Care Services, and education. Relevant

health care providers or voluntary/community/faith organisations with specific expertise (for example FGM, domestic violence and/or sexual abuse) should also be invited. Consideration should also be given to inviting a legal advisor.

The Strategy Meeting/Discussion must first establish if the parents and/or girl/young woman have had access to information about the harmful aspects of FGM. If not, the parents/girl/young woman should be offered the opportunity of educational/preventative programmes before any further action is considered.

Every attempt should be made to work with parents on a voluntary basis to prevent abuse of FGM occurring. The investigating team should ensure that parental co-operation is achieved wherever possible, including the use of community organisations and/or community leaders to facilitate the work with parents/family. However, if it is not possible to reach an agreement, the first priority is protection of the girl/young woman.

7. GIRLS/YOUNG WOMEN IN DANGER

If the parents cannot satisfactorily guarantee that they will not proceed with the mutilation and the Strategy Meeting/Discussion decides that as such the child/young woman is in immediate danger, then an Emergency Protection Order should be sought.

The primary focus is to prevent the child undergoing any form of FGM, rather than removal from the family.

If the girl/young woman has already undergone FGM, the Strategy Meeting/Discussion will need to consider whether to continue enquiries or whether to assess the need for support services. Consideration should be given to establish, if there are any younger sisters, and an assessment may be needed to determine if there are any risks to younger siblings. If any legal action is being considered, legal advice must be sought.

8. CHILD PROTECTION CONFERENCE

A Child Protection Conference should only be considered necessary if there are unresolved child protection issues, once the initial investigation and assessment have been completed.

9. IF A GIRL/YOUNG WOMAN HAS ALREADY UNDERGONE FGM

Where FGM has been practiced, a referral should be made to Children's Social Care Services or Suffolk Police. A Strategy Meeting/Discussion should consider how, where and when the procedure was performed and its implications for the girl/young woman. Suffolk Police and the Safeguarding Team will take a lead role in the investigation of this serious crime, working to common joint investigative practices and in line with strategy agreements.

A girl/young woman who has undergone FGM should be seen as a Child in Need and offered services as appropriate. The Strategy Meeting should consider the need for medical assessment and/or therapeutic services for her.

The risk to other female children in the family and extended family must be considered at the Strategy Meeting and a referral made to Children's Social Care Services or Police as appropriate.

If the woman is the mother of a female child or has the care of female children, a multi-agency meeting needs to be held to identify the most appropriate way of informing parents of the legal and health implications of FGM and assessing the potential risk to female children in the family.

10. THE ROLE OF HEALTH PROFESSIONALS IN RESPONDING TO FGM

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. In such a situation they should be aware of the risk of FGM in relation to:

- Any younger siblings.
- Daughters she has or daughters she may have in the future.
- Any female members in her extended family.

GP's should be alert to the possibility that girls/young women within at risk communities may present to them with health issues. This may be due to having already undergone FGM, and they may be experiencing menstrual or sexual problems for example, or want support. Alternatively they may be very concerned that they will soon have to undergo FGM and may turn to their GP for help. However, they may find such issues extremely difficult to discuss. The GP should spend time, therefore and ask questions about presenting health issues to ascertain the exact nature of the problem.

After childbirth, a girl/woman who has been DE infibulated/defibulated (a surgical procedures to open up the scar tissue to restore the normal vaginal opening, commonly called a 'reversal') may request, and continue to request when refused, re-infibulation. This should be treated as a child protection concern, as the girl/woman's apparent reluctance to comply with UK law and/or consider that the process is harmful, raises concerns in relation to girl child/ren she may already have or may have in the future.

Professionals should consult with their agency's nominated safeguarding children adviser and with Children's Social Care Services about making a referral to them.

All girls/women who have undergone FGM (and their boyfriends/partners or husbands) must be told that re-infibulation is against the law and will not be done under any circumstances. Each woman should be offered counselling to address how things will be different for her afterwards.

See also the British Medical Association guidance: **FGM: Caring for Patients and Child Protection**.