



London

Female Genital Mutilation

Resource Pack

Supported by:

London Safeguarding Children Board
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'It is a terrible experience which leaves deeply emotional and psychological problems. It is midwives who usually carry out the operation in the presence of grandmothers and other women like aunts. Sometimes the mothers are too scared to come in. It could occur in the midwife's house or sometimes the midwife goes to the girl's house. If it happens at the midwife's home, it is possible there will be a long queue of girls operated, one girl after the other. The girls enter the room with grandmothers and aunts. They fix the girls legs down and put clothes in her mouth to prevent her from crying. They caution her not to cry aloud, this way, they do not scare the other girls. This happens when girls are about six or seven years old. After the procedure they receive anti-tetanus vaccination and an antiseptic for washing. Some girls die afterwards and this is common in the villages'.

'There is a woman who cannot forget. She always talks about the picture of the tray, the instruments, the cotton and the smell of dettol on that day. Til today when that woman smells dettol, she vomits. She saw all women like enemies on that day and can never forget'.

FGM is always with us (Forward, 2009)¹

¹ *FGM is always with us - experiences perceptions and beliefs of women affected by female genital mutilation in London (Forward, 2009). <http://www.forwarduk.org.uk/news/news/563>*

Contents

Acknowledgments	7
Foreword	8
Section A: Overview	10
A1. Background	11
1.1 Introduction.....	11
1.2 This guidance	11
1.3 Underlying principles	12
1.4 Definition.....	12
A2. Facts about Female Genital Mutilation (FGM)	14
2.1 Prevalence.....	14
2.2 Risk factors.....	15
2.3 The short and long term consequences for children and women subjected to FGM	15
2.4 Why the practice continues	16
2.5 Religion and FGM.....	17
A3. The legislative framework	17
3.1 National legislation	17
3.2 International legislation and agreements.....	18
3.3 Female Genital Mutilation Act 2003.....	18
3.4 Child protection and FGM.....	19
Section B: Practice guidelines for professionals	20
B1 The London procedure for safeguarding children at risk of abuse through FGM	22
1.1 Summary	22
1.2 Professional response	22
1.3 Professionals and volunteers from all agencies responding to concerns.....	23
1.4 Education / leisure and community and faith groups.....	24
1.5 Health	24
1.6 The police	25
1.7 LA children’s social care.....	25
1.8 The role of Local Safeguarding Children Boards).....	27
1.9 Information sharing.....	27

B2	FGM factsheet for schools	28
B3	Multi-agency training powerpoint	28
B4	Metropolitan Police Service Standard Operation Procedures (SOPs)	29
4.1	Introduction	29
4.2	Initial steps.....	29
4.3	Next steps.....	29
4.4	When a child has already undergone FGM	30
4.5	Child Abuse Investigation Team Officers.....	30
4.6	Achieve Best Evidence (ABE) interview	31
4.7	Medical examination.....	31
4.8	The FGM investigative flow chart	33
B5	Guidance for health professionals	34
5.1	Introduction	34
5.2	Early identification of FGM	34
5.3	Knowledge of risk factors	34
5.4	Interpreters	34
5.5	Making enquiries and asking questions.....	35
5.6	A framework for discussion	35
5.7	Issues to consider.....	36
5.8	Critical referral pathway for the holistic care of women with FGM.....	36
5.9	Critical stages	36
B6	De-infibulation guidelines	38
6.1	Introduction	38
6.2	Ante-partum	38
6.3	Intra-partum	38
6.4	Post-partum	38
6.5	A visual example of the de-infibulation process.....	39
B7	FGM National Clinical Group – reversal DVD	39
B8	Ante-natal guidelines	40
8.1	Introduction	40
8.2	Obstetric assessment	40
8.3	Intra-partum care guidelines	40
8.4	Induction of labour (IOL).....	40
8.5	Management of gynaecological examinations.....	41
8.6	Post natal guidelines	41
B9	Examples of FGM audit tools	42
B10	Electronic fields for hand-held records	42

Section C: Working with families and community groups 44

- C1 Female Genital Mutilation / circumcision: what you need to know 45**
- C2 Information services and support guide for young people in the UK 47**
- C3 Arabic / Somali poster: stop female circumcision 47**
- C4 Stop FGM Now DVD 47**

Section D: Support organisations and key resources 49

- D1 London based FGM specialist health services 50**
- D2 London based community and voluntary sector support and specialist FGM services 52**
- D3 Selected specialist health services for women outside the London area 54**
- D4 Links to key resources 55**
 - 4.1 Legislation55
 - 4.2 Guidance and procedures55
 - 4.3 Research55
 - 4.4 Awareness raising resources56
 - 4.5 FGM literature.....56
 - 4.6 Glossary56

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Foreword

Baroness Ruth Rendell CBE

The welfare of children must be the primary concern of all of us. Children come first. What kind of a society would have it otherwise? Yet a serious form of child abuse - Female Genital Mutilation - continues in the UK and has until recently continued unchecked in spite of two acts of parliament making it illegal and carrying heavy penalties on perpetrators.

FGM, as I shall call it, is illegal and, however well-intentioned, constitutes child cruelty as well as being a grave violation of the human rights of girls and women. In all circumstances where FGM is practised on a child it is a violation of a child's right to life, her right to her bodily integrity and her right to health.

Communities who perpetuate this practice do so in the belief that it is in the girl's best interests. It can be said that parents commit these cruel and damaging acts out of love for their daughters. Such parents are often unaware that that FGM is illegal and extremely harmful to a girl's health and it is this which has helped to make combating FGM a formidable task.

The World Health Organisation estimates that between a hundred and a hundred and forty million girls and women have experienced FGM worldwide and up to three million girls undergo some form of the procedure each year. In the UK research indicates that over 20,000 girls under the age of 15 are potentially at risk of FGM in England and Wales, a large proportion of them in London.

It has been illegal in this country since the Female Circumcision Act of 1985. Since then, in 2003, the Female Genital Mutilation Act was passed, a measure which, among other things, made it a criminal offence to take a child out of this country in order to have mutilation carried out abroad. Increasing awareness of this abuse in our midst is starting to have a positive impact and many groups are working hard to educate children and their parents in their own communities. Health professionals are learning to recognise the signs of FGM in women, notably in pregnancy, while teachers are becoming aware of the symptoms in a child at risk of mutilation. For instance, has the girl become withdrawn and nervous? Does she speak of the

promised 'holiday' to her parents' country of origin? Improvements in training and procedures are giving educators, doctors, midwives and nurses the confidence needed to safeguard the child and prevent what amounts to abuse, however well-intentioned.

However, those encountering FGM for the first time can still be shocked and upset, unsure of how to react. It is often the cultural undertones which impede them. FGM is an important part of an age-old tradition, pre-dating the world's major religions, and most people in our present-day world and this country have learned the importance of respecting another culture. They also have feelings that in interfering they may be acting in a racist way. As a former MP told me of the 1985 Act of Parliament, 'Some people felt that this is going back to the days of white men telling black men what to do.'

But all should understand that FGM is a cruel practice, often leading to a lifetime of pain, terrible difficulties in giving birth and needless daily discomfort. It is therefore crucial that the large volume of work that has been carried out in specific local areas is made easily accessible to all; this resource pack is a vital step in doing that. With clear guidance on how to respond to a child who may be at risk of FGM, the means to help professionals raise the issue with community groups and how to approach the subject in a sensitive manner, while always emphasising the legal and damage to health implications of FGM, the pack will be a valuable resource for all who want to put an end to the practice.

More needs to be done. The pack should be seen as the latest step in the process which began to the 1985 Act and was continued in 2003. It is now up to us all, health professionals, teachers, community activists and everyone who cares about the health and happiness of children, to put an end to FGM once and for all.

Baroness Ruth Rendell CBE

November 2009

Section A: Overview

A1. Background	11
1.1 Introduction	11
1.2 This guidance	11
1.3 Underlying principles	12
1.4 Definition.....	12
A2. Facts about Female Genital Mutilation (FGM)	14
2.1 Prevalence.....	14
2.2 Risk factors.....	15
2.3 The short and long term consequences for children and women subjected to FGM	15
2.4 Why the practice continues	16
2.5 Religion and FGM.....	17
A3. The legislative framework	17
3.1 National legislation	17
3.2 International legislation and agreements	18
3.3 Female Genital Mutilation Act 2003.....	18
3.4 Child Protection and FGM	19

A1. Background

1.1 Introduction

- 1.1.1 In 2007, the London Safeguarding Children Board (the London Board) published the *London Procedure for Safeguarding Children at Risk of Abuse through Female Genital Mutilation (the London FGM procedure)*² – a multi-agency child protection procedure designed to assist Local Safeguarding Children Boards and frontline professionals in preventing young girls being subjected to FGM.
- 1.1.2 The London Board launched the procedures at a full day FGM conference in 2007, providing a unique opportunity for delegates to participate and gain a clearer understanding of the issues which surrounds FGM³.
- 1.1.3 At the conference, a number of delegates highlighted that, although a large number of resources and guidance documents have been developed across London and the UK, it can be difficult for professionals to know what tools exist and how to access them.
- 1.1.4 In response, the London Board convened an expert steering group to collate existing information into a resource pack to help professionals and community groups working with FGM.
- 1.1.5 This pack was commissioned by the London Board, and is intended to supplement but not replace or take priority over advice or codes of conduct produced by employers or national bodies. It is a resource that should complement existing professional procedures, protocols and guidance which relate to specific roles, responsibilities or professional practices.

1.2 This guidance

- 1.2.1 This resource pack provides information and guidance for people who may encounter women or girls at risk of, or having undergone, female genital mutilation (FGM). This may include frontline professionals in all agencies and their managers, individuals in London's local communities and community groups such as faith and leisure groups. The pack includes resources on:
 - Identifying when a child may be at risk of being subjected to FGM and responding appropriately to protect the child;
 - Identifying when a child has been subjected to FGM and responding appropriately to support the child; and
 - Measures which can be implemented to prevent and ultimately eliminate the practice of FGM.
- 1.2.2 The pack draws on a large number of tools and guidelines which professionals may choose to adopt in their own local area, including information leaflets, details of support services and training resources.
- 1.2.3 Section A provides an overview of the FGM in the UK, including a definition, some facts and figures and the legislative framework
- 1.2.4 Section B collates procedures, guidelines and flowcharts for professionals. This includes information on implementing a system of routine questioning for FGM at midwifery units, standard operating procedures for the Metropolitan Police Service and

² *London procedure for safeguarding children at risk of abuse through female genital mutilation* (London Board, 2007): <http://www.londonscb.gov.uk/fgm>

³ <http://www.londonscb.gov.uk/fgm>

multi-agency safeguarding guidance. The section aims to help professionals to identify and support families who may need to protect their daughters from abuse through FGM and routinely collect information in order to inform the delivery of better care and service provision for girls at risk of or subjected to FGM.

- 1.2.5 Section C provides information for professionals to use when raising awareness with individuals, communities and organisations.
- 1.2.6 Section D draws together links to a wide range of resources for people interested in finding out more in this area, and contains a list of FGM specialist health services and other useful organisations.
- 1.2.7 This resource pack should be read in conjunction with the London FGM procedure⁴.

1.3 Underlying principles

- 1.3.1 FGM is considered child abuse in the UK and a grave violation of the human rights of girls and women. In all circumstances where FGM is practised on a child it is a violation of the child's right to life, their right to their bodily integrity, as well as their right to health. The UK Government has signed a number of international human rights laws against FGM, including the UN Convention on the Rights of the Child.
- 1.3.2 Any agency identifying, supporting or responding to children / families subjected to FGM should act on the basis that:
 - The safety and welfare of the child is paramount;
 - The rights of the child, as detailed by the UN convention of 1989, are complied with;
 - All decisions and plans for families affected by FGM should be based on good quality assessments and be sensitive to issues of race, culture, gender, religion and sexuality and avoid as far as possible stigmatising families of practising communities;
 - Wherever possible, members of local communities should be involved in preventative work to empower individuals and groups to develop strong local support systems.

1.4 Definition

- 1.4.1 The World Health Organisation (WHO) defines female genital mutilation as: "all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons"⁵.
- 1.4.2 Female genital mutilation is classified into four major types:

⁴ *London procedure for safeguarding children at risk of abuse through female genital mutilation* (London Board, 2007)

⁵ *Eliminating female genital mutilation: an interagency statement* (WHO, 2008):
http://www.unifem.org/attachments/products/fgm_statement_2008_eng.pdf

- Type 1, **Clitoridectomy**: 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.
- 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 and sometimes outer labia, with or without removal of the clitoris.
- Type 4, **Other**: All other harmful procedures to the female genitalia for non-medical purposes for example, pricking, piercing, incising, scraping and cauterising the genital area. Type 4 is noted by professionals to be common among practising communities, however, it is also the type that often goes unnoticed and therefore not recorded.



TYPE 1: Clitoris removed



TYPE 2: Clitoris and labia minora removed



TYPE 3: All external genitalia removed... and...



TYPE 3: an artificial barrier created

Type 4 involves too many variations to illustrate, if there is any doubt regarding the normal autonomy of a vagina, an FGM specialist should be consulted.

- 1.4.3 FGM is known by a number of names, including female genital cutting or circumcision. The term female circumcision is unfortunate because it is anatomically incorrect and gives a misleading analogy to male circumcision. The names 'FGM' or 'cut' are increasingly used at the community level, although they are still not always understood by individuals in practicing communities, largely because they are English terms. The Somali term for FGM is 'Guddniin' and the Sudanese word for FGM is 'Tahur'.

A2. Facts about Female Genital Mutilation (FGM)

2.1 Prevalence

- 2.1.1 FGM is practiced in more than 28 countries in Africa and in some countries in Asia and the Middle East. African countries where FGM is most practised are Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, the Gambia, Guinea, Mali, Sierra Leone, Somalia and the Sudan⁶. There is also a high incidence of women affected by FGM from communities such as Iraq, Kurdistan and Pakistan.
- 2.1.2 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.
- 2.1.3 London has substantial populations from FGM practicing countries.
- 2.1.4 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.
- This is reflected in the increase in the estimated percentages of all maternities which were to women with FGM from 1.06 per cent in 2001 to 1.43 per cent in 2004.
- 2.1.5 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.
- 2.1.6 These estimates highlight the need not only to enhance health care for girls and women who have already undergone FGM, but also for systematic activity to break the chain of continued practice in the next generation. Despite the limitations of these estimates, they suggest that the numbers of women living in England and Wales with FGM are substantial and increasing.
- 2.1.7 See <http://www.forwarduk.org.uk/key-issues/fgm/research> to download a copy of this research.

⁶ *Eliminating female genital mutilation: an interagency statement* (WHO, 2008)

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)

2.2 Risk factors

- 2.2.1 Those who are affected by FGM may be British citizens born to parents from FGM practising communities or women 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 students¹⁰.
- 2.2.2 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;
 - 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;
- 2.2.3 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, as pointed out by FORWARD, 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.
- 2.2.4 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 anymore'.¹¹

2.3 The short and long term consequences for children and women subjected to FGM

- 2.3.1 Short term consequences of 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.
- 2.3.2 Infections are common, particularly as the procedure is generally carried out in unhygienic conditions and/or with instruments that are not sterilised.
- 2.3.3 In some cases, potential fatal septicaemia and tetanus may occur.
- 2.3.4 Discomfort and pain during/after sexual intercourse and recurrent infection may lead to infertility.
- 2.3.5 Long term consequences may include abscesses, painful cysts, keloids, which can cause problems during pregnancy and childbirth. Also, cysts on the scar can develop into abscesses and can be very painful.

¹⁰ *Female genital mutilation fact sheet* (Government Equalities Office, 2009): <http://www.equalities.gov.uk/pdf/Female%20Gential%20MutilationFACTSHEET.pdf>

¹¹ *FGM is always with us* (Forward, 2009)

- 2.3.6 Other long term complications may include infertility and difficulties in menstruation. Urinary retention is also a frequent complication, especially when the skin is stitched over the urethra. FGM is often attributed to causing chronic urine infections.

'Harmful effects and complications arise from circumcision, especially the pharaonic type, which has a lot of complications – emotional, psychological and health problems. A woman suffers these complications from circumcision throughout her life'.¹²

- 2.3.7 FGM can also cause significant psychological damage, such as mental health and psychosexual problems which may include depression, anxiety and sexual dysfunction
- 2.3.8 Women may feel angry, depressed and suffer from post traumatic stress disorder
- 2.3.9 There is increasing awareness of the severe psychological consequences of FGM for girls and women which become evident in mental health problems.

'You have the feeling that you have not been allowed to have something you should have by nature. It is something to do with pleasure... You hear about this pleasure, but you have never felt it, you don't know what it is, how would you know?'¹³

2.4 Why the practice continues

- 2.4.1 The WHO¹⁴ cites a number of reasons for the continuation of FGM, such as:

- Custom and tradition
- A mistaken belief that FGM is a religious requirement (see section 2.5. below)
- 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

- 2.4.2 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 girls¹⁵.

- 2.4.3 International data shows a close relationship between women's ability to exercise control over their lives and their belief that FGM should end¹⁶.

¹² *FGM is always with us* (Forward, 2009)

¹³ *FGM is always with us* (Forward, 2009)

¹⁴ *Eliminating female genital mutilation: an interagency statement* (WHO, 2008)

¹⁵ *Eliminating female genital mutilation: an interagency statement* (WHO, 2008)

¹⁶ *Female genital mutilation / cutting: A statistical exploration* (Unicef, 2005):
http://www.unicef.org/publications/files/FGM-C_final_10_October.pdf

'Reasons to circumcise are traditional. It is associated with identity. It is a societal identity not for the person, a cultural identity the Somali must keep. Some people know of the health problems and have difficult experiences with delivery and other things: although they have problems, they still believe in it. It should be done'.¹⁷

2.5 Religion and FGM

- 2.5.1 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 people from inflicting harm on others and therefore the practice of FGM is counter to the teachings of Islam.
- 2.5.2 FGM is practiced 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.
- 2.5.3 FGM may also take place amongst some Bedouin Jews and Falashas (Ethiopian Jews).

A3. The legislative framework

3.1 National legislation

- 3.1.1 In England, Wales and Northern Ireland all forms of FGM are illegal under the Female Genital Mutilation Act 2003¹⁸ and in Scotland it is illegal under the Prohibition of FGM (Scotland) Act 2005¹⁹. See [section A, 3.3. Female Genital Mutilation Act](#) for more information.
- 3.1.2 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 NSF²⁰ and is supported by the Children Act 2004²¹, requires all agencies to take responsibility for safeguarding and promoting the welfare of every child to enable them to:
- Be healthy
 - Stay safe
 - Enjoy and achieve
 - Make a positive contribution
 - Achieve economic well-being
- See www.everychildmatters.gov.uk/ for more information.

¹⁷ *FGM is always with us* (Forward, 2009)

¹⁸ <http://www.opsi.gov.uk/ACTS/acts2003/20030031.htm>

¹⁹ <http://www.opsi.gov.uk/legislation/scotland/acts2005/20050008.htm>

²⁰ *National Service Framework for Children, Young People and Maternity Services:*
<http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/ChildrenServicesInformation/fs/en>

²¹ <http://www.opsi.gov.uk/acts/acts2004/20040031.htm>

- 3.1.3 Working within this policy framework, professionals and volunteers from all agencies have a statutory responsibility to safeguard children from being abused through FGM.
- 3.1.4 Under the Children Act 1989²², local authorities can apply to the Courts for various Orders to prevent a child being taken abroad for mutilation.

3.2 International legislation and agreements

- 3.2.1 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 Child²³
 - The UN Convention on the Elimination of All Forms of Discrimination against Women²⁴
- 3.2.2 These conventions have been strengthened by two world conferences: the International Conference on Population and Development (ICPD, Cairo, September 1994) and the World Conference on Women (Beijing 1995).

3.3 Female Genital Mutilation Act 2003

- 3.3.1 Section 1 - A person is guilty of an offence if he/she excises, infibulates or otherwise mutilates the whole or any part of a girl's labia majora, labia minora or clitoris.
- 3.3.2 Section 2 - A person is guilty of an offence if he/she aids, abets, counsels or procures a girl to carry out FGM on herself
- 3.3.3 Section 3 - Makes it an offence for a person in the UK to aid, abet, counsel or procure the performance outside the UK of FGM that is carried out by a person who is not a UK National or permanent resident. For example, a person who arranges by telephone from England for his UK national daughter to have FGM carried out abroad by a foreign national (who does not live permanently in the UK), commits an offence.
- 3.3.4 Section 4 - Extends sections 1, 2 and 3 of the Act so that any of the prohibited acts done outside the UK by a UK national or permanent UK resident will be an offence under UK law and triable in the courts of England, Wales and Northern Ireland. (Scotland has separate legislation – the Prohibition of Female Genital Mutilation (Scotland) Act 2005).
- 3.3.5 Section 8 of the Accessories and Abettors Act 1861 makes it an offence for a person in the UK or a UK national or permanent UK resident outside the UK to aid, abet, counsel or procure a UK national or permanent UK resident to carry out FGM outside the UK. For example, if a person in the UK advises his UK national brother over the telephone how to carry out FGM abroad, he is guilty of an offence.
- 3.3.6 The effects of the extension of section 2 is that it is an offence for a UK national or permanent UK resident outside the UK to aid, abet, counsel or procure a person of any nationality to carry out FGM on herself wherever it is carried out.
- 3.3.7 The effects of the extension of section 3 is that it is an offence for a UK national or permanent UK resident outside the UK to aid, abet, counsel or procure a foreign national (who is not a permanent UK resident) to carry out FGM outside the UK on a

²² http://www.opsi.gov.uk/acts/acts1989/Ukpga_19890041_en_1.htm

²³ <http://www.unhchr.ch/html/menu3/b/k2crc.htm>

²⁴ <http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm>

UK national or permanent UK resident. For example, a permanent UK resident who takes his permanent UK resident daughter to the doctor's surgery in another country so that FGM can be carried out is guilty of offence.

3.3.8 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.

3.3.9 The penalty for FGM is up to 14 years imprisonment and/or a fine on conviction on Indictment; and up to 6 months imprisonment and/or a fine (not exceeding the statutory maximum) on summary conviction.

Note: Under the Act the term 'girl' includes 'woman'. Therefore any female on whom FGM is carried out comes within the definition of 'girl' regardless of her age.

3.4 Child protection and FGM

3.4.1 FGM is considered to be a form of child abuse (it is categorised under the headings of both physical abuse and emotional abuse) as it is illegal and is performed on a child who is unable to resist or give informed consent. Working Together to Safeguard Children (HM Government 2006)²⁵, 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 LA 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 procedure²⁶, community organisations and community leaders / faith leaders should be approached to assist in facilitating work with parents / family members.
- A local authority may exercise its power under s47 of the Children Act 1989 if it has reason to believe that a child has suffered, or is likely to experience FGM.
- The Common Assessment Framework (CAF) may be a useful tool and can be requested by individuals or professionals if there are concerns about the child.

²⁵ <http://www.everychildmatters.gov.uk/resources-and-practice/IG00060/>

²⁶ *London procedure for safeguarding children at risk of abuse through female genital mutilation* (London Board, 2007)

Section B: Practice guidelines for professionals

B1	The London procedure for safeguarding children at risk of abuse through FGM	22
1.1	Summary	22
1.2	Professional response	22
1.3	Professionals and volunteers from all agencies responding to concerns	23
1.4	Education / leisure and community and faith groups	24
1.5	Health	24
1.6	The police	25
1.7	LA children’s social care	25
1.8	The role of Local Safeguarding Children Boards	27
1.9	Information sharing	27
B2	FGM factsheet for schools	28
B3	Metropolitan Police Service Standard Operation Procedures (SOPs)	29
3.1	Introduction	29
3.2	Initial steps	29
3.3	Next steps	29
3.4	When a child has already undergone FGM	30
3.5	Child Abuse Investigation Team Officers	30
3.6	Achieve Best Evidence (ABE) interview	31
3.7	Medical examination	31
3.8	The FGM investigative flow chart	33
B4	Guidance for health professionals	34
4.1	Introduction	34
4.2	Early identification of FGM	34
4.3	Knowledge of risk factors	34
4.4	Interpreters	34
4.5	Making enquiries and asking questions	35
4.6	A framework for discussion	35
4.7	Issues to consider	36
4.8	Critical referral pathway for the holistic care of women with FGM	36
4.9	Critical stages	36
B5	De-infibulation guidelines	38
5.1	Introduction	38
5.2	Ante-partum	38

5.3	Intra-partum	38
5.4	Post-partum	38
5.5	A visual example of the de-infibulation process.....	39
B6	FGM National Clinical Group – educational DVD	39
B7	Ante-natal guidelines.....	40
7.1	Introduction.....	40
7.2	Obstetric assessment.....	40
7.3	Intra-partum care guidelines.....	40
7.4	Induction of labour (IOL).....	40
7.5	Management of gynaecological examinations.....	41
7.6	Post natal guidelines	41
B8	Examples of FGM audit tools.....	42
B9	Electronic fields for hand-held records	42

B1 The London procedure for safeguarding children at risk of abuse through FGM

1.1 Summary

1.1.1 The London procedure for safeguarding children at risk of abuse through FGM was developed by the London Safeguarding Children Board to assist professionals, volunteers and individuals who may come across FGM. The procedures provide guidance for frontline professionals and their managers in all agencies, and individuals in London's community, faith and interest groups to:

- Identify when a child may be at risk of being subjected to FGM and responding appropriately to protect the child;
- Identify when a child has been subjected to FGM and responding appropriately to support the child;
- Outline measures which can be implemented to prevent and ultimately eliminate the practice of FGM.

1.1.2 The procedure contains detailed guidance on identifying children who may be at risk of abuse through FGM, and outlines the specific roles and responsibilities of all agencies which may come into contact with a child or family affected by FGM.

1.1.3 The procedure contains appendices with visual guides and signposts, which include:

- Appendix 1: Multi-agency child protection decision making and action flowchart
- Appendix 2: Decision-making and action flowchart for health professionals;
- Appendix 3: Decision-making and action flowchart for professionals in LA education and schools and professionals and volunteers in the voluntary sector;
- Appendix 4: Decision-making and action flowchart for professionals in LA children's social care.

1.1.4 The London FGM procedure is available to download from www.londonscb.gov.uk/fgm/, and key sections are reproduced below.

1.2 Professional response (section 7)

1.2.1 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

1.2.2 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.

1.2.3 The appropriate response to FGM is to follow usual child protection procedures to ensure:

- Immediate protection and support for the child/ren; and
- That the practice is not perpetuated.

- 1.2.4 An appropriate response to a child suspected of having undergone FGM, as well as a child at risk of undergoing FGM, could include:
- Arranging for an interpreter if this is necessary and appropriate;
 - Creating an opportunity for the child to disclose, seeing the child on their own;
 - Using simple language and asking straightforward questions;
 - Using terminology that the child will understand (e.g. the child is unlikely to view the procedure as abusive);
 - Being sensitive to the fact that the child will be loyal to their parents;
 - Giving the child time to talk;
 - Getting accurate information about the urgency of the situation, if the child is at risk of being subjected to the procedure;
 - Giving the message that the child can come back to you again.
- 1.2.5 An appropriate response by professionals who encounter a girl or woman who has undergone FGM includes:
- Arranging for a professional interpreter and not agreeing to friends/family members interpreting on their behalf;
 - Being sensitive to the intimate nature of the subject;
 - Making no assumptions;
 - Asking straightforward questions;
 - Being willing to listen;
 - Being non-judgemental (condemning the practice, but not blaming the girl / woman);
 - Understanding how she may feel in terms of language barriers, culture shock, that she, her partner, her family are being judged;
 - Giving 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.

1.3 Professionals and volunteers from all agencies responding to concerns (section 10)

- 1.3.1 Any information or concern that a child is at immediate risk of, or has undergone, female genital mutilation should result in a child protection referral to LA children's social care in line with section 6. Referral and assessment in the London Child Protection Procedures²⁷
- 1.3.2 Where a child is thought to be at risk of FGM, practitioners should be alert to the need to act quickly – before the child is abused through the FGM procedure in the UK or taken abroad to undergo the procedure.
- 1.3.3 See Appendix 1 in the London FGM procedure for Multi-agency Child Protection Decision-making and Action Flowchart²⁸.

²⁷ *London Child Protection Procedures* (London Board, 2007)

²⁸ *Safeguarding children at risk of abuse through FGM* (London Board, 2007)

1.4 Education / leisure and community and faith groups (section 10.2)

Concerns that a child is at risk of abuse through FGM

- 1.4.1 Teachers, other school staff, volunteers and members of community groups may become aware that a child is at risk of FGM through a parent/other adult, a child or other children disclosing that:
- The procedure is being planned;
 - An older child in the family has already undergone FGM.
- 1.4.2 School nurses are in a particularly good position to identify FGM or receive a disclosure about it.
- 1.4.3 A 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 designated child protection adviser (if they have one) and should make an immediate referral to LA children's social care, in line with section 6. Referral and assessment in the London Child Protection Procedures²⁹.
- 1.4.4 The referral should not be delayed in order to consult with the designated child protection adviser, a manager or group leader, as multi-agency safeguarding intervention needs to happen quickly.
- 1.4.5 If there is a concern about one child, consideration must be given to whether siblings are at similar risk. Once concerns are raised about FGM there should also be consideration of possible risk to other children in the practicing community.

Concerns that a child has already been abused through FGM

- 1.4.6 Teachers, other school staff, volunteers and members of community groups may become aware that a child has been subjected to FGM through:
- A child presenting with the signs and symptoms described above;
 - A parent / other adult, a child or other children disclosing that the child has been subjected to FGM.
- 1.4.7 A professional, volunteer or community group member who has information or suspicions that a child has been subjected to FGM should act in line with 1.4.3, above.
- 1.4.8 If the child appears to be in acute physical and/or emotional distress, they should make an immediate referral to LA children's social care in line with section 6. Referral and assessment in the London Child Protection Procedures³⁰.
- 1.4.9 If there is a concern about one child, the child's siblings and the children in the extended family should be considered to be at risk.
- 1.4.10 Once concerns are raised about FGM in relation to one child / family, there should also be consideration of possible risk to other children in the practicing community.

1.5 Health (section 10.3)

Concerns in relation to a mother who has undergone FGM

- 1.5.1 Health professionals encountering a girl or woman who has undergone FGM should be alert to the risk of FGM in relation to her:
- Younger siblings;

²⁹ *London Child Protection Procedures* (London Board, 2007), www.londonscb.gov.uk/procedures/

³⁰ *London Child Protection Procedures* (London Board, 2007)

- Daughters or daughters she may have in the future;
 - Extended family members.
- 1.5.2 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.
- 1.5.3 Health visitors are in a good position to reinforce information about the health consequences and the law relating to FGM. Currently FGM is not always provided on post-natal discharge reports and is not recorded routinely in health visiting records. Health visitors should seek to record this information wherever possible.
- 1.5.4 If a girl or woman who has been de-infibulated requests re-infibulation after the birth of a child, where the child is female, or there are daughters in the family, health professionals should consult with their designated child protection adviser and with LA children's social care about making a referral to them.
- 1.5.5 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 girl child/ren she may already have or may have in the future. Professionals should consult with the designated child protection adviser and with LA children's social care about making a referral to them.
- 1.5.6 If the girl or woman is a mother or prospective mother, her child/ren or unborn child should be considered at risk of significant harm. The health professional should consult with their designated child protection adviser and should make an immediate referral to LA children's social care, in line with section 6. Referral and assessment in the London Child Protection Procedures³¹.
- 1.5.7 If the girl or woman has the care of female children, these children should be considered children at risk of significant harm, the designated child protection adviser should be consulted and a referral made to LA children's social care, as above.
- 1.5.8 See also FGM: Caring for patients and child protection (BMA, July 2006)³²

1.6 The police

- 1.6.1 See [section B4. Metropolitan Police Service Standard Operation Procedures, below](#).

1.7 LA children's social care (section 11)

- 1.7.1 LA children's social care will investigate (initially) under Section 47 of the Children Act (1989).
- 1.7.2 If a referral is received concerning one child, consideration must be given to whether siblings are at similar risk.
- 1.7.3 Once concerns are raised about FGM there should also be consideration of possible risk to other child in the practicing community. Professionals should be alert to the fact that any one of the girl children amongst these could be identified as being at risk of

³¹ *London Child Protection Procedures* (London Board, 2007)

³² http://www.bma.org.uk/images/FGMJuly06_tcm41-146715.pdf

FGM and will then need to be responded to as a child in need or a child in need of protection.

Strategy meeting

- 1.7.4 On receipt of a referral a strategy meeting must be convened within two working days, and should involve representatives from police, LA children's social care, education, health and voluntary services. Health providers or voluntary organisations with specific expertise (e.g. FGM, domestic violence and/or sexual abuse) must be invited, and consideration may also be given to inviting a legal advisor (in line with section 6. referral and assessment in the London Child Protection Procedures³³).
- 1.7.5 The strategy meeting must first establish if either parents or the child has had access to information about the harmful aspects of FGM and the law in the UK. If not, the parents / child should be given appropriate information regarding the law and harmful consequences of FGM.
- 1.7.6 An interpreter and, if possible, a community advocate, appropriately trained in all aspects of FGM, must be used in all interviews with the family. A female interpreter should be used, who is not a family relation.
- 1.7.7 Every attempt should be made to work with parents on a voluntary basis to prevent the abuse. It is the duty of the investigating team to look at every possible way that parental co-operation can be achieved, including the use of community organisations and/or community leaders to facilitate the work with parents / family. However, the child's interests are always paramount.
- 1.7.8 If no agreement is reached, the first priority is protection of the child and the least intrusive legal action should be taken to ensure the child's safety.
- 1.7.9 The primary focus is to prevent the child undergoing any form of FGM, rather than removal of the child from the family.

Children at immediate risk of harm

- 1.7.10 If the strategy meeting decides that the child is in immediate danger of mutilation and parents cannot satisfactorily guarantee that they will not proceed with it, then an emergency protection order should be sought.

If a child has already undergone FGM

- 1.7.11 A strategy meeting must be convened within two days. The strategy meeting will consider how, where and when the procedure was performed and the implication of this.
- 1.7.12. If the child has already undergone FGM, the strategy meeting will need to consider carefully whether to continue enquiries or whether to assess the need for support services. If any legal action is being considered, legal advice must be sought.
- 1.7.13 A second strategy meeting should take place within ten working days of the referral, with the same chair. This meeting must evaluate the information collected in the enquiry and recommend whether a child protection conference is necessary, in line with section 7. Child protection conferences in the London Child Protection Procedures³⁴.
- 1.7.14 A girl who has already undergone FGM should not normally be subject to a child protection conference or made subject of a child protection plan unless additional child protection concerns exist. However, she should be offered counselling and medical help. Consideration must be give to any other female siblings at risk.

³³ *London Child Protection Procedures* (London Board, 2007)

³⁴ *London Child Protection Procedures* (London Board, 2007)

1.7.15 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.

1.8 The role of Local Safeguarding Children Boards (section 12)

1.8.1 Local Safeguarding Children Boards (LSCBs) duties and responsibilities include promoting activity amongst local agencies and in the community to:

- Identify and prevent maltreatment or impairment of health or development, and ensure children are growing up in circumstances consistent with safe and effective care;
- Safeguard and promote the welfare of groups of children who are potentially more vulnerable than the general population;
- Increase understanding of safeguarding children issues in the professional and wider community, promoting the message that safeguarding is everybody's responsibility.

1.8.2 The LSCB should undertake initiatives in relation to FGM which fulfil these duties and responsibilities.

1.8.3 LSCBs should ensure that single agency and inter-agency training on safeguarding and promoting welfare is provided in order to meet local needs (i.e. that staff who have responsibility for child protection work are acquainted with child protection procedures in relation to FGM and are confident working with local preventative programmes relating to FGM).

1.8.4 London's LSCBs may consider developing and supporting a centralised virtual team of experts to advise professionals on the prevention of FGM in the community and the appropriate professional response to individual cases.

1.9 Information sharing (section 13)

1.9.1 Professionals in all agencies need to be confident and competent in sharing information appropriately both to safeguard children from being abused through FGM and to enable children and women who have been abused through FGM to receive physical and emotional and psychological help.

1.9.2 Professionals in all agencies should share information in line with Section 3. Information sharing, in the London Child Protection Procedures³⁵

³⁵ *London Child Protection Procedures* (London Board, 2007)

B2 FGM factsheet for schools

- 2.1 The Government Equalities Office (GEO) has published a factsheet about Female Genital Mutilation (FGM), which has been sent to frontline safeguarding and education professionals. GEO developed the factsheet in partnership with the Department of Health and the Department for Children Schools and Families (DCSF).
- 2.2 The factsheet aims to raise awareness about FGM. It explains what FGM is, who is most likely to be affected by it and why some communities wrongly justify this practice. It also provides guidance on how to identify those at risk and where to find information, services and useful organisations.
- 2.3 The factsheet was launched at the end of June 2009 by the Minister for Women and Equality, Maria Eagle MP, and was disseminated to schools via a DCSF newsletter. The factsheet was launched just before the holidays in order to highlight that this is a time when girls are at particular risk of being taken overseas to undergo FGM.
- 2.4 The factsheet is available to download from <http://www.equalities.gov.uk/pdf/Female%20Genital%20MutilationFACTSHEET.pdf>

B3 Multi-agency training powerpoint

- 3.1 The Metropolitan Police Service Project Azure team have produced a short training powerpoint as part of their "Summer is for Fun" awareness raising campaign, which can be used for a range of audience. The powerpoint is available to download at http://www.met.police.uk/scd/specialist_units/fgm_azure_training.ppt
- 3.2 See also [section C4. Stop FGM Now DVD](#) for a related DVD, which can be used to raise awareness with professionals and also community groups

B4 Metropolitan Police Service Standard Operation Procedures (SOPs)

4.1 Introduction

- 4.1.1 The Metropolitan Police are charged with safeguarding children and making London safe for children and young people. This section reproduces the police Standard Operating Procedures for dealing with all incidents of Female Genital Mutilation³⁶.
- 4.1.2 The procedures apply in particular to officers and staff in the following roles:
- Child Abuse Investigation Command;
 - Community Safety Units;
 - Missing Persons Teams;
 - Sapphire Units.
 - All police officers and police staff who in the course of their duty deal or come into contact with children and young people.
- 4.1.3 These SOPs are to be read in conjunction with the London FGM procedure (see [section B1, above](#)) and the current London Child Protection Procedures³⁷.

4.2 Initial steps

- 4.2.1 If officers or members of police staff believe that a child may be at risk of undergoing FGM, an immediate referral should be made to their local Child Abuse Investigation Team (CAIT). If this is outside the core hours, the SCD Reserve Desk must be made aware of any concerns. The CAIT will in turn make an immediate referral to the local LA children's social care team.
- 4.2.2 If any officer believes that the child could be at immediate risk of significant harm they should consider the use of Police Protection Powers under S46 Children's Act 1989.
- 4.2.3 Officers should carry out the following actions:
- Complete appropriate checks;
 - Complete a MERLIN entry;
 - Complete risk assessment and management plans;
 - Complete a Crime Report using Flag "PG";
 - Inform their supervisor, who must be at least the rank of Inspector (CAIT Officers should ensure that the on-call Supt. is made aware of the referral);
 - All officers and staff must consider whether this could be a Critical Incident and deal with the matter accordingly.

4.3 Next steps

- 4.3.1 As a Section 47 Children's Act investigation, EVERY referral with regard to FGM must generate a strategy meeting with police, LA children's social care, health (school

³⁶ *An aid to FGM investigators: Metropolitan Police Service Standard Operation Procedures (SOPs)* (Met Police, 2008)

³⁷ *London Child Protection Procedures* (London Board, 2007)

nurse, health visitor, or community / hospital paediatrician as appropriate) and the referrer (e.g. school) as soon as practicable (and in any case within 48 hours).

- 4.3.2 Ensure that minutes are taken at the meeting and decisions are recorded on Form 3542 (Substantive Strategy / Planning Meeting record).
- 4.3.3 The first consideration should be informing the parents of the law and the dangers of FGM. This can be done by representatives from schools, LA children's social care, health professionals and/or police. It is the duty of all professionals to look at every possible way that parental co-operation can be achieved, including the use of community organisations to facilitate the work with the parents/family.
- 4.3.4 If there is any suggestion that the family still intend 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 s46 Children Act 1989 and removing her to a place of safety. In addition, LA children's social care should consider the use of a Prohibitive Steps Order or Emergency Protection Order.
- 4.3.5 The welfare of other children within the family, in particular female siblings, should be reviewed.
- 4.3.6 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 child and any other siblings.

4.4 When a child has already undergone FGM

- 4.4.1 If any police officer or police staff is made aware that a child has already undergone FGM, an immediate referral should be made to their local Child Abuse Investigation Team (CAIT). If this is outside the core hours, the **SCD** Reserve Desk must be made aware of any concerns. The CAIT will in turn make an immediate referral to the local LA children's social care team.
- 4.4.2 Officers should carry out the following actions:
 - Complete appropriate checks;
 - Complete a MERLIN entry;
 - Risk assessment and management plans;
 - Refer to LA children's social care (unless they were the referrer);
 - Complete a Crime Report using the flag "PG";
 - All Officers must inform their supervisor, who must be at least the rank of Inspector;
 - CAIT Officers should ensure the on-call Supt. is made aware of the referral;
 - All Officers and staff must consider whether this could be a Critical Incident and deal the matter accordingly.

4.5 Child Abuse Investigation Team Officers

- 4.5.1 If it is believed or known that a child has undergone FGM, a strategy meeting must be held as soon as practicable (and in any case within 48 hours) 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, thus police action will 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.

4.6 Achieve Best Evidence (ABE) interview

- 4.6.1 As with all criminal investigations, children and young people should be interviewed under the relevant procedures / guidelines (e.g. ABE) to obtain the best possible evidence for use in any prosecution. Consent should be obtained allowing the use of the interview in both family and/or criminal courts. Additionally information gained from the interview process will enable a risk assessment to be conducted as to the risk to any other children / siblings.

4.7 Medical examination

- 4.7.1 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 (Section 3 Specialist FGM being present during any such examination). 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 child or young person is offered and appropriate referrals made as necessary. Where a child refuses to be interviewed or undergo medical examination, assistance should be sought from an intermediary or community organisation.
- 4.7.2 A girl or young person that has already undergone FGM should be offered counselling and medical help as appropriate. Police officers may want to refer to the CPS guidance document entitled *Provision of Therapy for Child Witnesses Prior to a Criminal Trial*³⁸
- 4.7.3 A second strategy meeting should take place within 10 working days of the initial referral.
- 4.7.4 The Investigative Strategy should consider identifying established excisors (people who carry out FGM for payment or otherwise) and investigating these individuals with a view to identifying further victims and closing down these networks within the Metropolitan Police Service and beyond, where children in London are affected.

Adult female undergone FGM

- 4.7.5 If any police officer or police staff is made aware that an adult female has undergone FGM, a multi-agency meeting must be convened to consider the risks to the woman. This meeting should discuss any potential risk to any girls within the family (and extended family) and consider initial and core assessments of those girls. It should also consider providing supportive services for the woman, including counselling and medical assistance.

Issues relevant to Investigation of Offences

- 4.7.6 The reasons behind FGM are complex, and can vary from community to community. However, despite the very severe health consequences, parents and others who have this done to their daughters do not intend it as an act of abuse. They genuinely believe that it is in the girl's best interests to conform to their prevailing traditional practice.
- 4.7.7 FGM is firmly embedded in the culture of the practising communities who may resent what they perceive as the imposition of external cultural values on them. The act of

³⁸ <http://www.cps.gov.uk/publications/prosecution/therapychild.html>

FGM constitutes significant harm and is physically and emotionally abusive. FGM is not a matter that can be left to be decided by personal preference or tradition; it is an extremely harmful practice which violates the most basic human rights.

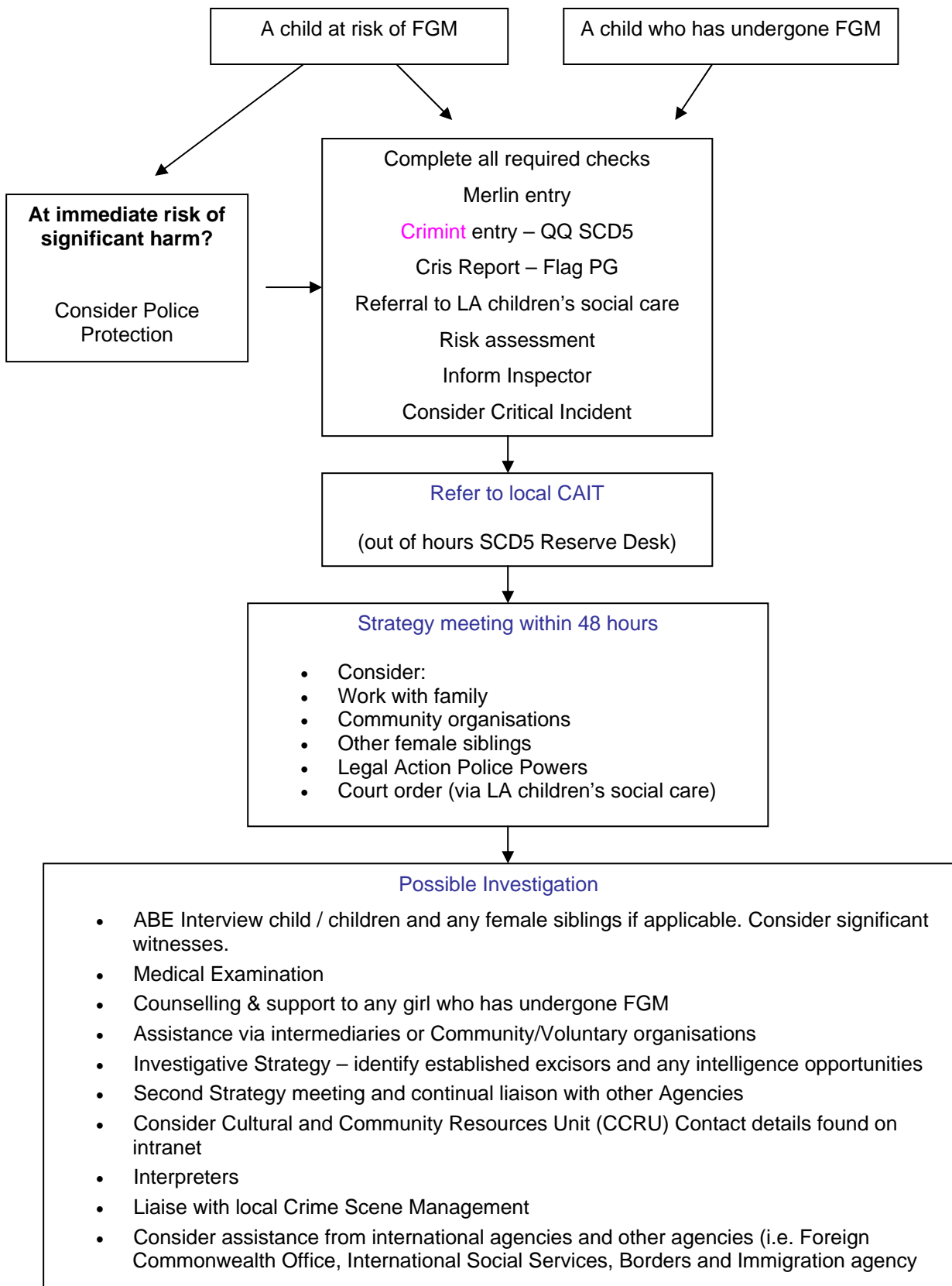
- 4.7.8 FGM is child abuse and against the law. Officers should not let fears of being branded racist weaken their investigative strategy. Although officers should consider and research cultural matters around this issue, FGM investigation should be robust and enforce the law.

Information Sharing

- 4.7.9 Professionals in all agencies should share information in line with section 4. Information sharing in the London Child Protection Procedures³⁹.

³⁹ *London Child Protection Procedures* (London Board, 2007)

4.8 The FGM investigative flow chart⁴⁰



⁴⁰ Project Azure, 2007

B5 Guidance for health professionals

5.1 Introduction

5.1.1 FGM is a crime and all health professionals including health visitors, midwives, school nurses, practice nurses, GP's, paediatricians, hospital doctors, sexual health practitioners and therapists have the responsibility to:

- Recognise the sensitivity and complexity of issues relating to FGM;
- Provide support, information and advice for communities that practice FGM in the context of the UK legislation, child protection intervention, human rights and health outcomes;
- Identify, refer and provide sensitive and appropriate care to women and girls who are at risk of FGM or who have undergone FGM;
- Form networking links and work in partnership with local communities, local statutory and voluntary organisations to share and disseminate information.

5.2 Early identification of FGM

5.2.1 Early identification and referring is the responsibility of all health professionals including the practice nurse, health advisers, sexual health nurses and doctors – for further information please see the London FGM procedure, appendix 2, which contains clear guidance and decision making flowcharts for Health professionals⁴¹.

5.2.2 Early identification is critical to the delivery of effective maternity care, the implementation of effective preventative strategies and the protection of girls. The booking meeting is the most appropriate time to enquire about a woman's FGM status as an integral part of routine history taking.

5.3 Knowledge of risk factors

5.3.1 The single most important risk factor determining whether a woman is circumcised is her country of origin. Any woman who comes from an FGM practicing country falls within the at risk group, sensitive enquiry must be made in to the FGM status of **all women** identified as **at risk**.

5.4 Interpreters

5.4.1 If possible, it is advisable that a professional female interpreter be used for woman known to have limited English. This will reduce misunderstanding; increase the likelihood of identification of FGM and any additional physical, psychological, social concerns. Use of family members is not advised as they may influence decisions and inhibit true expression of the woman's feelings.

5.4.2 Always brief / debrief the interpreter, explain the purpose of the meeting, ensure she understands the issue and is happy to talk about FGM. We must remain aware that she may have experienced FGM, thus have difficulty discussing it. Alternatively, she may view FGM as a valuable practice, hindering the interpretation process.

5.4.3 Check the woman is happy to continue with the chosen interpreter, as communities affected by FGM are often small and therefore interpreters may be known socially by the woman. The importance of confidentiality should be stressed to all parties.

⁴¹ *Safeguarding children at risk of abuse through female genital mutilation* (London Board, 2007)

5.5 Making enquiries and asking questions

5.5.1 Midwives often find broaching this subject difficult, uncomfortable and fear offending the woman. This is indeed a delicate task and must be approached sensitively, in the presence of a relationship based on mutual trust and respect.

5.6 A framework for discussion

5.6.1 The meeting should begin with a discussion around other issues, for example: the purpose of the meeting; ask what her needs might be and how they can be best met.

5.6.2 Reiterate the confidential nature of midwifery care.

5.6.3 Acknowledge that you are aware of traditional practices in her home country in which the genitals of girls are circumcised / cut.

5.6.4 Explain these practices can cause many complications in pregnancy / childbirth and therefore it is important you know if she has been circumcised to ensure delivery of safe / effective care.

5.6.5 Use a sensitive line of questioning with value neutral terms understandable to the woman, such as:

- “Have you been closed?”
- “Were you circumcised?”
- “Have you been cut down there?”

5.6.6 Be direct, as indirect questions can be confusing and only serve to reveal any underlying embarrassment or discomfort you may have.

5.6.7 If any confusion remains, ask leading questions such as:

- ‘Do you experience any pains or difficulties during intercourse?’
- “Do you have any problems passing urine?”
- “How long does it take?”
- “Do you have any pelvic pain / menstrual difficulties?”
- “Have you had any difficulties in childbirth”?

5.6.8 Women often report feelings of great distress and humiliation due to the response they receive when their circumcision is revealed. They describe looks of horror, inappropriate and insulting questions and their shame from being made feel abnormal. Such reactions are usually related to lack of understanding and can devastate a woman. These negative experiences will reach the community and will only serve to build barriers to effective care and prevention of FGM.

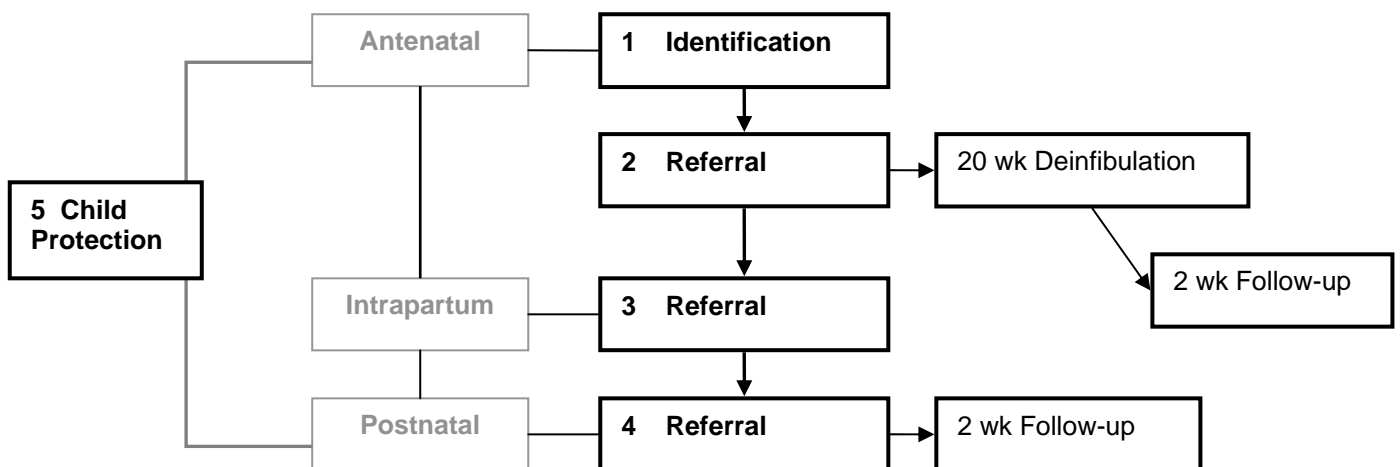
‘Sometimes when circumcised women go to the hospital, the nurses call each other to see the circumcised woman. This is an unhappy experience for many women. The nurses ask a lot of questions and they stare⁴²’.

⁴² FGM is always with us (Forward, 2009).

5.7 Issues to consider

- **Do** determine how she refers to the procedure and out of respect, adopt that terminology throughout care.
- **Do** show genuine interest in her values, beliefs, life experiences. Listen attentively, allow time to gauge how she feels about her FGM and respond appropriately. Some women are very proud of their circumcision, which gives a sense of virtue, beauty and identity. Others reflect on FGM as an extremely negative experience and a traumatic attack on their body.
- **Do** be mindful of her social context and current concerns. There may be more pressing issues that need to be broached first (e.g. bereavement, family separation, resettlement issues). Show you care, that you're interested in her, not just the state of her genitals.
- **Do not** use the term mutilation as this can be offensive and alienate the woman.
- **Do not** project feelings of disgust, shock, anger or pity. Such reactions may reflect your own western value judgements and can cause embarrassment. Women must be provided with culturally sensitive, non judgemental care and be treated with compassion and respect.
- **Do not** examine FGM unless good cause to do so - examinations must be kept to a minimum.

5.8 Critical referral pathway for the holistic care of women with FGM⁴³



5.9 Critical stages⁴⁴

5.9.1 This section should be read with reference to the diagram at 5.8, above.

1. Identification must take place at the booking meeting. Early identification is critical to the delivery of effective care
2. Referral to lead midwife / consultant for surgical, psychological, social assessment and development of planned care. Where necessary, women with

⁴³ *Female Genital Mutilation (FGM) Clinical Guidelines* (N. Clark, Leeds Teaching Hospital Trust, 2007)

⁴⁴ *Female Genital Mutilation (FGM) Clinical Guidelines* (N. Clark, Leeds Teaching Hospital Trust, 2007)

Type III FGM deemed will be offered deinfibulation as close to 20 weeks gestation as possible. A follow-up appointment will be made at 2 weeks to assess healing.

4. In labour, women already reviewed by a lead midwife will have a detailed plan for delivery documented in the hand held notes. Women who remain unidentified until delivery or those who elected intrapartum deinfibulation, should be refer to midwife / consultant for review. Women with Type III FGM intact, deinfibulation by anterior midline incision, extending no further than the urethra may be performed in the first or second stage, according to parity, integrity of scar tissue and accessibility to the vagina.
4. On discharge from hospital the community midwife, HV. GP should be informed. Record should include information such as, FGM status, deinfibulation / repair, child protection concerns and preventative education provided.

B6 De-infibulation guidelines⁴⁵

6.1 Introduction

6.1.1 De-Infibulation involves cutting the scar tissue upwards until the urethral meatus is visible which as formed where the remnants of the labia majora has been stitched together, thus exposing the vaginal opening allowing enough room for the tissue to stretch over the baby's head (Newman 1996 and Easton 1994). The raw edges on either side are then over-sewn with an absorbable suture material which dissolves quickly (Forward, 1997 – MaCaffrey 1995). This procedure can be performed on women who are not pregnant.

6.2 Ante-partum

- 6.2.1 De-infibulation must be performed between 20 – 32 weeks gestation allowing for the scar to be fully healed prior to delivery.
- 6.2.2 Local anaesthetic should be offered although a spinal anaesthetic or general anaesthetic should be considered;
- 6.2.3 Women whose preference is for de-infibulation in labour must have her request respected and granted.

6.3 Intra-partum

- 6.3.1 If FGM is identified during labour, de-infibulation can be performed in the first stage of labour rather than the second stage. In such cases delivery of the baby must be by a qualified midwife and not a student as this will reduce the risk of further trauma.
- 6.3.2 Local anaesthesia / epidural can be offered, however, epidural is recommended
- 6.3.3 When de-infibulation has been performed an **intact perineum must be aimed for** especially when the head is approaching as the perineum of women with type III is relaxed and can rupture easily.
- 6.3.4 When an episiotomy is indicated, a medial lateral episiotomy should be performed
- 6.3.5 On NO account should a bilateral episiotomy be performed

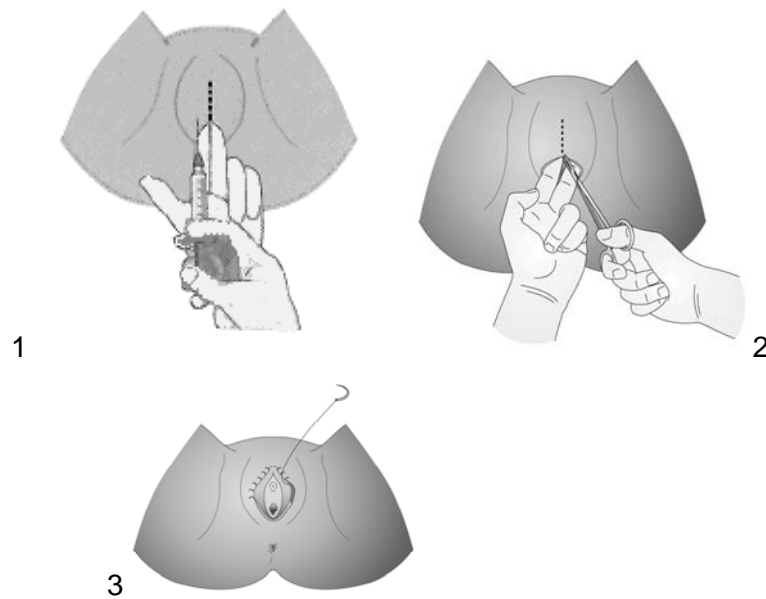
6.4 Post-partum

- 6.4.1 Re-infibulation is against the law and must never be performed
- 6.4.2 Care of the perineum must be observed and advised
- 6.4.3 Discuss with the women and family the potential of FGM for the female child and the legal consequences
- 6.4.4 The health visitor must be informed that the female child may be at risk
- 6.4.5 Information leaflets for support groups must be given to the women and family

'There was a woman who was suffering from bleeding and pain. When she went to the GP, he told her it was normal. He did not know how to treat her. She kept going several times and at last they opened her'⁴⁶.

⁴⁵ Joy Clarke – Lead FGM Specialist Midwife / Whittington Hospital

6.5 A visual example of the de-infibulation process⁴⁷



B7 FGM National Clinical Group – reversal DVD

- 7.1 In January 2010, the FGM National Clinical Group will launch an educational DVD which clearly instructs and shows doctors, midwives and nurses how to undertake a reversal operation.
- 7.2 This DVD will be available to download free of charge at <http://www.fgmnationalgroup.org/>.

'I sometimes find coping with FGM difficult and found it hard to talk to my mother about the health difficulties and pain I was experiencing. Nevertheless, after getting de-infibulated in London, I have found that I have become a stronger and more confident person'⁴⁸.

Needs a reference

⁴⁶ *FGM is always with us* (Forward, 2009).

⁴⁷ *Female Genital Mutilation (FGM) Clinical Guidelines* (N. Clark, Leeds Teaching Hospital Trust, 2007)

⁴⁸ *Reference needed*

B8 Ante-natal guidelines⁴⁹

8.1 Introduction

8.1.1 Women with FGM need specialist care in pregnancy and childbirth. All women must be referred to a lead consultant / midwife for a physical, psychological, social needs assessment. Always cite reason for referral for example:

- to anticipate / eliminate obstetric risks associated with FGM;
- to assess need for deinfibulation;
- for provision of additional support.

8.1.2 FGM in pregnancy and childbirth significantly increases maternal morbidity and foetal morbidity / mortality. In the UK, however, with early identification, timely referral and appropriate management of care, many of FGM's complications can be prevented. It is therefore essential that FGM is identified at the beginning of pregnancy or ideally pre-pregnancy.

8.2 Obstetric assessment

8.2.1 Depending on the degree / type of FGM (see [section A, 1.4. Definitions](#)), the integrity of scar tissue will be assessed and a mutual plan of care formulated and documented in the hand held notes. This will reduce the need for repeat examination, enable identification of physical complications and facilitate anticipation of obstetric complications.

8.2.2 Where deemed necessary, women with Type III FGM will be offered deinfibulation as close to 20 wk gestation as possible. This will allow adequate time for healing before labour, permit access to the introitus / urethra enabling access for routine care during labour and reduce obstetric risks associated with FGM.

8.2.3 A follow-up appointment will be made at 2 wk to assess healing.

8.3 Intra-partum care guidelines

8.3.1 The delivery suite:

- Women already reviewed by a senior obstetric and specialist lead will have a detailed plan for delivery documented in her hand held notes.
- Women who remain unidentified until labour or those who elected intrapartum deinfibulation refer to lead consultant/midwife for full physical assessment and delivery plan.
- Inform coordinating midwife.
- Care must be provided by an experienced midwife.

8.4 Induction of labour (IOL)

8.4.1 Many women from FGM practicing communities are avidly opposed to induction of labour. This is reflected in the fact that many women do not attend 40 week appointments for fear of being induced. It is essential that professionals explain clearly the process of IOL, indications for and reasoning behind IOL for example:

⁴⁹ *Female Genital Mutilation (FGM) Clinical Guidelines* (N. Clark, Leeds Teaching Hospital Trust, 2007)

- Caesarean;
 - Risk of stillbirth.
- 8.4.2 From 42 weeks, women who decline IOL should be offered increased monitoring consisting of twice weekly CTG and ultrasound for AFI.

8.5 Management of gynaecological examinations

- Where possible, a female practitioner should conduct the examination;
- Any examination may be challenging and traumatic;
- Protocols similar to those used when performing a first pelvic check on an adolescent will be useful;
- Use smallest speculum available angle instruments carefully to minimise pressure / friction on anterior scar tissue;
- Record accurately and in detail any findings, type / extent of FGM, complications identified. Simple diagrams are useful to convey findings.

8.6 Post natal guidelines

8.6.1 The postnatal period is traditionally an important time for women affected by FGM where they are cared for closely by female relatives. Women in the host culture often feel isolated due to the lack of this support network. Increased postnatal visits and referral to local support groups may be necessary as well as additional information and support on areas such as:

- Preventative education;
- Genital hygiene;
- Passing urine can be very painful - the use of a water bidet may help to ease the pain. If very painful and where appropriate, local aesthetic gel (e.g. Instillagel) may be used.
- Ensure regular / adequate analgesia.
- Advise re pelvic floor exercises.
- Observe regularly (and always prior to discharge) for adequate healing, signs of infection.
- Diet
- contraception
- Cervical smear
- Continue preventative education

8.6.2 Prior to hospital discharge:

- Inform community midwife, health visitor, GP.
- Clearly record on discharge notes relevant information (e.g. FGM status, perineal trauma, deinfibulation, repair, child protection concerns, preventative education provided).
- If intrapartum deinfibulation or extensive perineal / vaginal trauma, make 2 wk referral to lead consultant to assess healing.

B9 Examples of FGM audit tools

- 9.1 A number of hospitals now have detailed audit tools for FGM. Please see www.londonscb.gov.uk/fgm/ to download samples of audit tool templates provided by the Chelsea and Westminster and Queen Charlotte Hospital. These templates can be used as they stand or can be modified and/or adapted accordingly.

B10 Electronic fields for hand-held records

- 10.1 This sample of an electronic field for hand held records template was provided by Hillingdon Hospital for adaptation and/or modification accordingly.

Questionnaire : AN Booking medical/surgical history : User IP Address : 127.0.0.1 - Microsoft Internet Explorer

WHITE, Vanessa 02427477 Notes Delivered: 05/06/2009

Pathway Alert Summary

Question	Answer
1 Interpreter Required	No
2 Refugee/Asylum Status	No
3 Medical/Surgical History	Pulmonary embol / thrombos
4 Psychological Problems	No
5 Operations	No
6 Anaesthetic Complications	No
7 Anaesthetic Review	No
8 Gynae Problems/Operations	No
9 Last Smear	Within last two years
10 Result of Last Smear	Normal
11 Blood Transfusion(s)	No
12 Vaginal Infections/Ever	No
13 Anaemia/Blood Disorders	No
14 Atypical Antibodies	Not Known
15 FGM	Yes
16 FGM Reversal	Yes
17 Smoker	No - never smoked
18 Partner or family member smoke	No

Has a reversal been discussed

Yes

No

Next Finalize Close

2008 Sep 11 Oct Nov 14 Dec Jan Feb Mar Apr May Jun 5 5 Today 18

Yes ... Saved. Local intranet

Questionnaire : AN Booking medical/surgical history : User IP Address : 127.0.0.1 - Microsoft Internet Explorer

WHITE, Vanessa 02427477 Notes Delivered: 05/06/2009

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6 Anaesthetic Complications	No
7 Anaesthetic Review	No
8 Gynae Problems/Operations	No
9 Last Smear	Within last two years
10 Result of Last Smear	Normal
11 Blood Transfusion(s)	No
12 Vaginal Infections/Ever	No <input type="button" value="No"/>
13 Anaemia/Blood Disorders	No
14 Atypical Antibodies	Not Known
15 FGM	Yes
16 FGM Reversal	Yes
17 Smoker	No - never smoked
18 Partner or family member smoke	No

Has the mother ever had an FGM?

No

Yes

Next [Message] [Refresh] Finalize Close

2008 Sep 11 Oct Nov 14 Dec Jan Feb Mar Apr May Jun 5 5 Today 18

Yes ...Saved. Local intranet

Section C: Working with families and community groups

C1	Female Genital Mutilation / circumcision: what you need to know	45
C2	Information services and support guide for young people in the UK	47
C3	Arabic / Somali poster: stop female circumcision	47
C4	Stop FGM Now DVD	47

'From very early parents tell their children about FGM, as they explain to them that it is part of our religion and if they do not get circumcised they will not be good Muslims. As such they convince the younger generations to getting circumcised'.

'People here know the law and the view of the Government on female circumcision. Some support this position whilst some feat it. In the past people used to take their daughters during the holidays to circumcise them, now they can't do that. The question now is really what about our daughters' future? How can we protect them and their honour without circumcision?'

'People who do not want to circumcise have many reasons behind stopping it, the most important being the physical, mental and bodily harm that it causes. For bodily harm, the circumcised woman becomes disfigured in her sexual organs. With regard to physical harm, the woman can have illnesses. Some chronic infections which she suffers until the last day she lives. Sometimes death might occur due to the way the gruesome operation was conducted'.

FGM is always with us (Forward, 2009)⁵⁰

⁵⁰ *FGM is always with us (Forward, 2009).*

C1 Female Genital Mutilation / circumcision: what you need to know⁵¹

- 1.1 This information leaflet was produced by Waltham Forest PCT for professionals to use when talking about FGM with parents, families and community groups. The key information from the leaflet is reproduced below, and the fully formatted leaflet is available at www.londonscb.gov.uk/fgm/.



Female Genital Mutilation (FGM), also known as female circumcision, is widely practiced in more than 28 African countries, parts of the Middle East, some parts of Asia and in parts of various other countries.

It is not required by any religion and is practiced by Christians, Muslims, Jews and all different faiths in a wide range of communities and cultures.

The UK Law

FGM is against the law in the UK under the Female Genital Mutilation Act 2003 and is a form of child abuse. It is a very serious crime and carries a penalty of 14 years in prison. It is also an offence to take a female child out of the UK for that purpose or to arrange it.

When FGM has occurred after January 2004 the Police will need to be informed.

What is FGM?

There are different types of female circumcision depending on the area or community that practices it. The World Health Organisation describes:

Type I

Removal of the hood of the clitoris with or without removal of part or the entire clitoris

⁵¹ Waltham Forest PCT – full leaflet available at www.londonscb.gov.uk/fgm/

Type II

Removal of part or the entire clitoris with removal of part or all of the small labia. After healing a small scar will cover the upper part of the vulval area

Type III

The most severe form of FGM which usually involves the removal of part or the entire clitoris and the small labia. The two sides are stitched or pulled together with thorns leaving a very small vaginal opening for the passage of urine or menstrual blood. This is often called infibulation

Type IV

The stretching or pulling of the clitoris and/or labia: burning of the clitoris and surrounding tissue: scraping of the tissue around the vaginal opening or cutting or the vagina. Also introduction of herbs into the vagina to cause bleeding or tighten or narrow it.

FGM / circumcision is dangerous to health

Short term problems include severe pain, difficulty passing urine, bleeding, infection and death.

For some types **long term** problems include difficulty passing urine and long painful periods. For type iii there may be a long scar which can make sex and childbirth difficult. Recurrent infections can lead to infertility.

Women may also feel angry, depressed and suffer from post traumatic stress disorder.

Where to get help

Medical help and information about the reversal procedure / help with painful periods and difficulty passing urine and psychological support can be obtained through your GP and practice nurse.

Pregnancy

If you are pregnant please speak to your midwife who will be able to advise and support you with any concerns you may have.

In addition parents and children can access these services via the health visitor and school nurse.

Young people can access help from their teachers, college staff or any health professionals.

List of local support organisations

The leaflet then lists support organisations available around Waltham Forest – please substitute these with your own local services.

C2 Information services and support guide for young people in the UK⁵²

- 2.1 The guide is produced as a resource for use in schools by young people and adults who work with young people. It provides basic information on FGM and related health and social issues.
- 2.2 It aims to increase awareness of the law and about child protection issues and also offers ideas for helping girls at risk of FGM. The guide provides information of specialist health and support services in the UK.
- 2.3 It discusses the following issues:
- What female genital mutilation is and who is at risk;
 - What role religion plays in FGM;
 - Some of the myths about FGM;
 - What the health effects are;
 - Access to specialist services;
 - What can be done if you are worried that someone is at risk and what happens if you report it.
- 2.4 The full guide is available to download at <http://www.forwarduk.org.uk/news/news/564>

'I didn't want to talk about it (FGM) ...but when I found out about the information I found more confidence to go out there and tell people. You can't be shy about it because you know you're stopping a bad thing and you might save your sister. If I know the information I'm more confident to speak out'.

Young Somali male

Needs a reference – not from the Forward Study⁵³

C3 Arabic / Somali poster: stop female circumcision

- 3.1 The Metropolitan Police Service have produced an awareness raising poster around female genital mutilation, in Arabic and Somali – available for download at http://www.met.police.uk/scd/specialist_units/fgm_poster.pdf.

C4 Stop FGM Now DVD

- 4.1 As part of the Metropolitan Police Services' campaign against FGM, the Project Azure team has produced a short DVD explaining the brutal effects of FGM.
- 4.2 The DVD can be used in work with communities, medical and education practitioners to raise awareness of the issue of FGM and the criminal consequences of its practice,

⁵² Forward, 2009: <http://www.forwarduk.org.uk/news/news/564>

⁵³ Needs a reference.

and copies are available from the Project Azure team (see http://www.met.police.uk/scd/specialist_units/fgm_reward.htm)

- 4.3 The film is also available to view at the Met Police's YouTube channel: <http://www.youtube.com/user/metpolicesservice>

Section D: Support organisations and key resources

D1	London based FGM specialist health services	50
D2	London based community and voluntary sector support and specialist FGM services	52
D3	Selected specialist health services for women outside the London area.....	54
D4	Links to key resources	55
4.1	Legislation	55
4.2	Guidance and procedures	55
4.3	Research	55
4.4	Awareness raising resources	56
4.5	FGM literature.....	56
4.6	Glossary	56

'FGM is unjustifiable. It was my mother who subjected me to this horrible thing. My father was against circumcision, but when he went away on business I was taken to the country and an old woman cut me. I do not want any woman to go through this. I would not let anybody cut my child'.

Needs a reference – not from the Forward Study⁵⁴

⁵⁴ Needs a reference

D1 London based FGM specialist health services

- 1.1 Health professionals at these specialist clinics have extensive experience in dealing with FGM and understand the cultural reasons behind FGM. They are not there to judge but to help.
- 1.2 Girls and women who have experienced FGM can access the specialist health care services listed to discuss and address the health related problems associated with FGM.
- 1.3 Some specialist clinics provide a deinfibulation service, which is a simple procedure to open up the scar tissue caused by the closing of the vagina in Type 3 FGM.
- 1.4 Girls and women do not need a referral from their GP / midwife to benefit from the specialist services listed below. They can visit whenever it is convenient for them.

- **Acton African Well Women Centre, Mill Hill Surgery**
111 Avenue Road
Acton, W3 8QH
020 8383 8761

- **African Well Women's Clinic / Antenatal Clinic, Central Middlesex Hospital**
Acton Lane, Park Royal
London, NW10 7NS
020 8963 7177 / 020 8965 5733

- **African Well Women's Clinic, Guy's and St. Thomas' Hospital**
8th floor c/o Ante-natal clinic
Lambeth Palace Road
London, SE1 7EH
020 8188 6872 / 07956 542 576

- **African Well Women's Clinic / Antenatal Clinic, Northwick Park & St Marks Hospital**
Watford Road, Harrow
Middlesex, HA3 1UJ
020 8869 2870

- **African Well Women's Clinic, Whittington Hospital**
Level 5
Highgate Hill
London, N19 5NF
020 7288 3482 ext 5954 / 07956 257 992

- **African Well Women's Service, ONEL**
 Community Services, Oliver Road
 Polyclinic, 75 Oliver Road
 E10 5LG
 020 8430 7382 / 7381
- **African Women's Clinic, University College London**
 Clinic 3, Elizabeth Garrett Anderson Wing
 University College
 235 Euston Road
 London, NW1 2BU
 08451 555 000 ext 2531
- **African Women's Clinic, Camden**
 Women & Health
 4 Carol Street, Camden
 London, NW1 OHU
 020 7482 2786
- **Chelsea and Westminster Gynaecology and Midwifery Department**
 3rd Floor
 369 Fulham Road
 London, SW10 9NH
 020 7751 4488
- **St. Mary's Hospital, Gynaecology & Midwifery Department**
 Praed Street
 London, W2
 020 7886 6691 / 020 7886 1443
- **Women's and Young People's Services, Sylvia Pankhurst Health Centre**
 Mile End Hospital
 Bancroft Road
 London, E1 4DG
 020 7377 7898 / 020 7377 7870

D2 London based community and voluntary sector support and specialist FGM services

- **AFRUCA (Africans United Against Child Abuse)**
Unit 3D/F Leroy House
436 Essex Road, London, N1 3QP
020 7704 2261
www.afruca.org
- **Black Women's Health and Family Support**
1st Floor, 62 Russia Lane,
London, E2 9LU
020 8980 3503
www.bwhafs.com
- **British Somali Community**
Star House, 104 – 108 Grafton Road
London, NW5 4BD
020 7485 2963
www.britishtosomali.org
- **Community Partnership Advisor Project**
Voluntary Action Camden, 293 – 299 Kentish Town Road
London, NW5 2TJ
020 7284 6575
- **Eritrean Community in the UK**
266/268 Holloway Road
London, N7 6NE
020 7700 7995
www.ericomuk.org.uk
- **Ethiopian Health Support Association**
Priory House, Kingsgate Place
London, NW6 4TA
020 7419 1972
www.ethsa.co.uk

- **FGM National Clinical Group**
 c/o Institute of Womens Health,
 University College London Hospital NHS Trust, 2nd Floor West,
 250 Euston Road,
 London, NW1 2PG
info@fgmnationalgroup.org
www.fgmnationalgroup.org
- **FORWARD**
 Unit 4
 765-767 Harrow Road
 London, NW10 5NY
 020 8960 4000
www.forwarduk.org.uk
- **Iskwaran Somali Mental Health Project**
 Unit 51 - The Design Works
 Park Parade, Harlesden
 London, NW10 4HT
 020 8838 6163
- **Waltham Forest Somali Women's' Association**
 Greenleaf Road
 Walthamstow, E17
 020 8503 7121
- **Somali Welfare Association**
 33 Ladbroke Grove
 London, W10 5AA
 020 8968 1195
www.somwa.org
- **Project Azure**
 Metropolitan Police Child Abuse Investigation Command
Scd5mailbox-azure@met.police.uk
 020 7161 2888

D3 Selected specialist health services for women outside the London area

- **Birmingham**

Princess of Wales Women's Unit Labour Ward
Birmingham Heartlands Hospital
Bordesley Green East
Birmingham, B9 5SS
0121 424 0730 or 0798 981 4207

- **Bristol**

Minority Ethnic Women's & Girls Clinic
Charlotte Keel Health Centre
Seymour Road, Easton
Bristol, BS5 0UA
0117 902 7100

- **Leeds**

FGM Clinic
St. James's University Hospital (St.JUH)
Antenatal Clinic, Level 4 Gledhow Wing
Leeds, LS9 7TF

- **Liverpool**

Multi-Cultural Antenatal Clinic
Liverpool Women's Hospital
Crown Street
Liverpool, L8 7SS
0151 702 4085 or 0771 751 6134

- **Nottingham**

Labour Ward City Campus
Nottingham University Hospitals
Hucknall Road
Nottingham, NG5 1PB
0115 969 1169 / 55127

D4 Links to key resources

4.1 Legislation

- 4.1.1 Female Genital Mutilation Act 2003
<http://www.opsi.gov.uk/ACTS/acts2003/20030031.htm>
- 4.1.2 Prohibition of FGM (Scotland) Act 2005
<http://www.opsi.gov.uk/legislation/scotland/acts2005/20050008.htm>
- 4.1.3 Children Act 2004
<http://www.opsi.gov.uk/acts/acts2004/20040031.htm>
- 4.1.4 Children Act 1989
http://www.opsi.gov.uk/acts/acts1989/Ukpga_19890041_en_1.htm
- 4.1.5 The UN Convention on the Rights of the Child
<http://www.unhcr.ch/html/menu3/b/k2crc.htm>
- 4.1.6 The UN Convention on the Elimination of All Forms of Discrimination against Women
<http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm>

4.2 Guidance and procedures

- 4.2.1 London procedure for safeguarding children at risk of abuse through female genital mutilation (London Board, 2007)
<http://www.londonscb.gov.uk/fgm/>
- 4.2.2 London Child Protection Procedures (London Board, 2007)
www.londonscb.gov.uk/procedures/
- 4.2.3 An aid to FGM investigators: Metropolitan Police Service Standard Operation Procedures (SOPs) (Met Police, 2008)
http://www.met.police.uk/scd/specialist_units/fgm_sop.doc
- 4.2.4 Eliminating female genital mutilation: an interagency statement (WHO, 2008)
http://www.unifem.org/attachments/products/fgm_statement_2008_eng.pdf
- 4.2.5 Female Genital Mutilation (FGM) Clinical Guidelines (N. Clark, Leeds Teaching Hospital Trust, 2007)
- 4.2.6 FGM: Caring for patients and child protection (BMA, July 2006)
http://www.bma.org.uk/images/FGMJuly06_tcm41-146715.pdf
- 4.2.7 Working Together to Safeguard Children (HM Government 2006)
<http://www.everychildmatters.gov.uk/resources-and-practice/IG00060/>
- 4.2.8 National Service Framework for Children, Young People and Maternity Services
<http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/ChildrenServicesInformation/fs/en>

4.3 Research

- 4.3.1 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>
- 4.3.2 FGM is always with us - experiences perceptions and beliefs of women affected by female genital mutilation in London (Forward, 2009)
<http://www.forwarduk.org.uk/news/news/563>

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

4.4 Awareness raising resources

- 4.4.1 Female genital mutilation fact sheet (Government Equalities Office, 2009)
<http://www.equalities.gov.uk/pdf/Female%20Gential%20MutilationFACTSHEET.pdf>
- 4.4.2 Met Police training powerpoint
http://www.met.police.uk/scd/specialist_units/fgm_azure_training.ppt
- 4.4.3 Information services and support guide for young people in the UK
<http://www.forwarduk.org.uk/news/news/564>
- 4.4.4 Arabic / Somali poster: stop female circumcision
http://www.met.police.uk/scd/specialist_units/fgm_poster.pdf
- 4.4.5 Stop FGM Now film
<http://www.youtube.com/user/metpoliceservice>
- 4.4.6 FGM: What you need to know leaflet (Waltham Forest PCT)
<http://www.londonscb.gov.uk/fgm/>

4.5 FGM literature

- 4.5.1 Dirie, W., *Desert Flower* (William Morrow Pub, 1998)
- 4.5.2 Dorkenoo, E., *Cutting the Rose: Female Genital Mutilation - The Practice and Its Prevention* (Minority Rights Publications, 2005)
- 4.5.3 Lockhat, H., *Treating the Tears* (Middlesex University Press, 2004)
- 4.5.4 Momoh, C. (ed)., *Female Genital Mutilation* (Radcliffe, 2005)

4.6 Glossary

- **Clitoridectomy**
Refers to the excision of the clitoris
- **Clitoris**
Tissue richly supplied with nerves – making it the most sensitive part of the body
- **De-infibulation**
The surgical procedure to open up the closed vagina
- **Excision**
Refers to the removal of the clitoral hood, with or without removal of part or all of the clitoris
- **Labia majora / minora**
Outer / inner lips that allow a woman the elasticity required when giving birth
- **Pharonic infibulation**
Refers to FGM Type 3
- **Prepuce / hood of clitoris**
Surrounds and protects the head of the clitoris
- **Re-infibulation**
The re-stitching of FGM