Warwickshire FGM Procedures April 2017

Note: These procedures are based on the current Tri.x published procedures with appendix being based on guidance specific to Warwickshire.

Contents

1. Definition and Key Facts

- Female genital mutilation (FGM) includes procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons;
- The procedure has no health benefits for girls and women;
- Procedures can cause death, severe bleeding, wound infection and problems urinating, and later cysts, Hepatitis B, HIV and infertility as well as complications in childbirth and increased risk of new born deaths;
- More than 125 million girls and women alive today have been cut in the 29 countries in Africa and the Middle East where FGM is concentrated;
- FGM is mostly carried out on young girls sometime between infancy and age 15;
- FGM is a violation of the human rights of girls and women and is considered as torture under Article 3 of the European Convention on Human Rights.

FGM is recognised internationally as a violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women. It is nearly always carried out on minors and is a violation of the rights of children. The practice also violates a person's rights to health, security and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death.

Female genital mutilation is classified into four major types:

- **Type 1**: Clitoridectomy: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris);
- **Type 2**: Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina);
- **Type 3**: Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris;
- **Type 4**: Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, tattoos, incising, scraping and cauterizing the genital area.
  (World Health Organisation, 2014)

Breast Ironing

Breast ironing, also known as breast flattening, is the pounding and massaging of a pubescent girl's breasts using hard or heated objects, to try to make them stop developing or to disappear. Although not explicitly considered currently under legislation, Practitioners need to be aware of this potential practice and act in the best interest of protecting the child/young person and follow local safeguarding

procedures. Breast Ironing is typically carried out by the girl's mother with the belief that she is protecting the girl from sexual harassment and rape, prevent early pregnancy that would tarnish the family name, or to allow the girl to pursue education rather than be forced into early marriage. It is mostly practiced in parts of Cameroon. Breast ironing is extremely painful and can cause tissue damage. Other possible health impacts include breast infections, the formation of abscesses, malformed breasts or the eradication of one or both breasts. The practice ranges dramatically in its severity, from using heated leaves to press and massage the breasts, to using a scalding grinding stone to crush the budding gland. Due to the range of this activity, health consequences vary from benign to acute.

2. Serious Crime Act 2015 and Related Guidance

A number of legislative changes on FGM were introduced by the Serious Crime Act 2015, which was given royal assent on 3 March 2015.

The act introduces measures to enhance the protection of vulnerable children and others, including strengthening the law to tackle female genital mutilation (FGM) and domestic abuse.

The Act brings in new provisions to tackle FGM by:

- Extending the extra-territorial reach of the offences in the Female Genital Mutilation Act 2003 so that they apply to habitual as well as permanent UK residents;
- Introducing a new offence of failing to protect a girl from risk of FGM;
- Granting lifelong anonymity to victims;
- Bringing in a civil order (FGM protection orders) to protect potential victims;
- Introducing a duty on regulated professionals in England & Wales, which includes, healthcare professionals, teachers and social care workers, to notify the Police of known cases of FGM carried out on a girl under 18 (Mandatory Reporting of Female Genital Mutilation information) [1]
- Introducing a new offence of failing to protect a girl from the risk of genital mutilation. This offence is against:
    a. Those persons with parental responsibility with whom the child has frequent contact; and
    b. Those persons who are aged over 18 years who have assumed responsibility for the child in the manner of a parent (note – this will include foster carers).

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/573782/FGM_Mandatory_Reporting_-_procedural_information_nov16_FINAL.pdf

In addition there are two international conventions, which contain 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 of Rights of the child.
- The UN Convention on the Elimination of ALL Forms of Discrimination against Women

Related Guidance

Mandatory reporting of female genital mutilation: procedural information (Issued October 2015)

Get a female genital mutilation protection order (updated 20 October 2015)

Amendment

Serious Crime Act 2015: Factsheet - Female genital Mutilation

3. Professional Response & Processes - Identifying a Child/Young Person Under 18 Years who has been Subject to FGM

Please use the FGM safeguarding risk assessment tool in Appendix 6, FGM Safeguarding & Risk Assessment Tool. The aim of the risk assessment tool is to have a structured approach to aid an initial assessment of risk, and then support the on-going assessment of individuals who are potentially subject to or at risk of FGM (using parts 1 to 3). Please follow the process map below:

Warwickshire process map 1

This process map is intended to inform professionals of the processes and procedures that need to be followed when an under 18 year old female is identified as at risk of FGM or has undergone FGM.

4. Professional Response & Processes - Identifying a Child/Young Person Under 18 Years Who is at Risk of FGM

Please use the FGM safeguarding risk assessment tool in Appendix 6, FGM Safeguarding & Risk Assessment Tool. The risk assessment tool is to have a structured approach to aid an initial assessment of risk, and then support the on-going assessment of individuals who are potentially subject to or at risk of FGM (using parts 1 to 3). Please follow the process map below:

Warwickshire process map 2

This process map is intended to inform professionals of the processes and procedures that need to be followed when an under 18 year old female is identified as at risk of FGM or has undergone FGM.

5. Identifying an Under 18's or Over 18 who has Undergone FGM

Please use the FGM safeguarding risk assessment tool in Appendix 6, FGM Safeguarding & Risk Assessment Tool. The aim of the risk assessment tool is to have a structured approach to aid an initial assessment of risk, and then support the on-going assessment of individuals who are potentially subject to or at risk of FGM (using parts 1 to 3). Please follow the process map below:

Warwickshire process map 3

This process map is intended to inform professionals of the processes and procedures that need to be followed when an under 18 year old or over 18 female has undergone FGM.

6. Professionals Response to Concerns

Summary

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 Children's Social Care in line with the Referrals Procedure of the LSCB Inter-agency procedures.

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.

Concern that a child is at risk of FGM

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.

School nurses in schools are also in a position to identify FGM or receive a disclosure about it at opportunistic drop sessions at schools (see **Mandatory Reporting of Female Genital Mutilation - procedural information**).

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 the Referrals Procedure. The completed FGM Safeguarding Risk Assessment Tool should accompany the referral.

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 undergone FGM

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 of FGM (Appendix 3: Signs that a Girl may be at risk of FGM or has undergone FGM?);
- A parent/other adult, a child or other children disclosing that the child has been subjected to FGM.

A professional, volunteer or community group member who has information or suspicions that a child has been subjected to FGM should consult with their agency or group's Designated Child Protection Adviser (if they have one) and make a referral in line with referral procedure.

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 using the referrals procedure and to the local Health Service.

Health - NHS Actions

Health professionals such as midwives, obstetricians, gynaecologists, general practitioners and paediatricians are most likely to encounter a girl or woman who has been subjected to FGM. They should be aware of the risks to:

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

Since April 2014, all acute Hospital Trusts to record:

- If a patient has had Female Genital Mutilation;
- If there is a family history of Female Genital Mutilation;
- If a Female Genital Mutilation-related procedure has been carried out on a patient;
- Type of FGM;
- If the patient has been re-sutured.

Since October 2015 all Hospital Trusts have been required to report this data centrally to the centrally to the Health and social care information centre (HSCIC) (identified only by a patients NHS number) a monthly basis. This is the first stage of a wider ranging programme of work in development to improve the way in which the NHS will respond to the health needs of girls and women who have suffered Female Genital Mutilation and actively support prevention.

Pregnancy and childbirth

Women who have had female genital mutilation should be identified through sensitive enquiry and referred for antenatal examination to the Urogynaecology Consultant in line with Antenatal guidance. Health Practitioners, including Midwives and Health Visitors should consider commencing a CAF (Common Assessment Framework) as part of the early help offer.

Midwifery Services

If FGM is identified in the ante natal or post natal period the midwife should complete the FGM assessment tool. If a positive response is gained, referral to social care/Police as appropriate. If the patient is clear she does not support FGM activity the conversation must be clearly recorded in relevant documentation.

Maternity services should inform health visitor colleagues of any FGM cases

Counselling regarding re-infibulation

All girls/women who have undergone FGM, as well as their partners or husbands; and in the case of girls under 18, her parents, should be informed that re-infibulation is illegal and will not be done under any circumstances.

Counselling sessions should be offered and arranged, taking into account that the woman may not want to make the arrangements about it when her partner or husband or other family members are present. Consideration should be given to offering counselling to partners and husbands.

Mandatory Reporting of FGM

From 31st October 2015, Regulated health, social care professionals and teachers must report cases of FGM to the **Police** via 101 or in writing if:

- A girl under 18 tells them they've had FGM;
- They see physical signs that a girl has had FGM.

This applies to all registered professionals in NHS, Primary Care and Private Healthcare settings.

A failure to report the discovery in the course of their work could result in a referral to their professional body and a criminal charge being brought against them.

For further information, see **Information Standards Board for Health and Social Care Female Genital Mutilation Prevalence Dataset Standard Specification**.

See **Fact sheet on mandatory reporting of female genital mutilation (GOV.UK)**.

7. Protection and Action to be Taken by Local Authority Children's Social Care

If there are suspicions that a girl under the age of 18 years may have undergone FGM or is at risk of FGM professionals must still report the issue by following their internal safeguarding procedures.

Where concerns about the welfare and safety of a child or young woman have come to light in relation to FGM, a referral to Children's Social Care should be made in accordance with the referral procedure.

Children's Social Care will investigate (initially) via the completion of a Children & Families Assessment under Section17 of the Children Act 1989. If it is considered that the threat of FGM is imminent then urgent legal advice must be sought and a Strategy Meeting must be convened as a matter of urgency to consider section 47 enquiries being undertaken.

If a referral is received concerning one child, consideration must be given as to whether female siblings are at similar risk.

Once concerns are raised about FGM there should also be consideration of possible risk to other female children in the practicing community. Professionals should be alert to the fact that any one of the female children amongst these could be identified as being at risk of FGM and will then need to be responded to as a child in need or a child in need of protection.

Section 47 Enquiries – Strategy Meeting

As a result of the Children & Families Assessment (Section 17 of the Children Act 1989), a Strategy Meeting may be convened. It should be convened within two working days (but in some cases, depending upon the outcome of the Children & Families (C&F) assessment, the meeting may need to take place immediately), and should involve representatives from Police, Children's Social Care, Education, Health and any voluntary services that could provide specialist information and advice regarding FGM. Health providers or voluntary organisations with specific expertise must be invited; and consideration may also be given to inviting a legal advisor.

In addition to the issues considered at all Strategy Meetings, the meeting should also establish:

- How best to approach the family and seek their co-operation;
- Whether the child's parents are well informed about the harmful aspects of FGM and the law in the UK;
- If the parents are not well informed, how could they best be provided with appropriate information;
- Whether a medical examination is required and if so, for what purpose;
- What action may be necessary in response to any attempt to remove the child from the UK.

An interpreter appropriately trained in all aspects of FGM should be used in all interviews with the family. A female interpreter should be used where possible and must not be a family relation.

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 (and other children's) wellbeing and safety is paramount at all times and therefore careful consideration must be given not to inform the wider community of this should increase the risks to the child(ren)

If no agreement with the parents is reached, the first priority is the protection of the child and the least intrusive legal action should be taken to ensure the child's safety.

No evidence of risk

If the Children and Family assessment and the Strategy Meeting concludes that there is no clear evidence of risk to a child, Children's Social Care will:

- Consult with the child's GP about this conclusion and invite him/her to notify social care immediately if any further concerns are raised about the risk of FGM;
- Notify appropriate professionals involved with the family of the outcome of the enquiries made;
- Inform the family and the referrer that the enquiry has been concluded; and
- Offer the family any appropriate support services.

Child at risk of genital mutilation

If, the outcome of the Children and Family Assessment or the Section 47 enquiries identifies that a child is at risk of female genital mutilation, the social worker must:

- Seek immediate legal advice to consider which Orders may be the most appropriate to safeguard the child. If there is an imminent risk of harm then consideration needs to be given as to whether there is a need to seek an Emergency Protection Order to safeguard the child or in the alternative whether a FGM Protection Order should be sought to prevent the child being removed from the UK;
- Notify the parents that FGM is a criminal act in England & Wales and ensure that the parents are provided with comprehensive information about the law surrounding Female Genital Mutilation;
- Give consideration to a convene a child protection conference to determine whether threshold is met for a CP plan.

If a child protection conference concludes that the child needs to be subject to a child protection plan, female genital mutilation is normally regarded as a form of physical, rather than sexual abuse.

If the child has already undergone genital mutilation

If the family's primary language is not English, a female interpreter where possible, must assist at any interview with them and ideally the interpreter should be appropriately trained in relation to FGM. The interpreter must not be a family member.

In this situation any action taken should focus on:

- Any available information about how, when and where the procedure was performed;
- Obtaining any additional information which may assist the Police in their enquiries in respect of any possible criminal prosecution;
- How to address any concerns for the welfare of the child who has undergone the procedure, including, but not limited to, any health implications;
- The implications for any other children in the family, including the extended family;
- The family's need for support services;
- The family's willingness to co-operate with the agencies concerned; gaining written agreement from the family that they will not let any additional female children undergo the procedure;
- Health education and other work with the family to reduce the risk to other members of the family;
- Support the family may need in the face of community pressure;
- Community reaction to the child and family;
- If there are any other safeguarding concerns about the care of the child whether a child protection conference should be convened. At the Strategy Meeting consideration needs to be given to the risks to any other female children in the family.

Second Strategy Meetings should be the exception and should therefore not be seen as part of a normal process. However, if deemed necessary, the 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 the Child Protection Conference Procedure.

If it appears that no other children are at risk:

Children's Social Care Services will take no further action other than to consider any of the physical and emotional concerns for the child who has undergone the procedure; In the event any additional needs are identified consideration should be given to either continued support to meet those needs by the relevant early help agency with Early Help Single Assessment or signposting to universal services.

Children's Social Care will notify the child's GP and midwifery services to invite them to notify them if any changes in the situation give rise to further concerns, e.g. the mother giving birth to further girls.

The Police

After a report has been made to the Police by any regulated professional; the Police will consult with Children's Social Care and a decision will then be made whether any Police action is necessary to ensure the child is safeguarded.

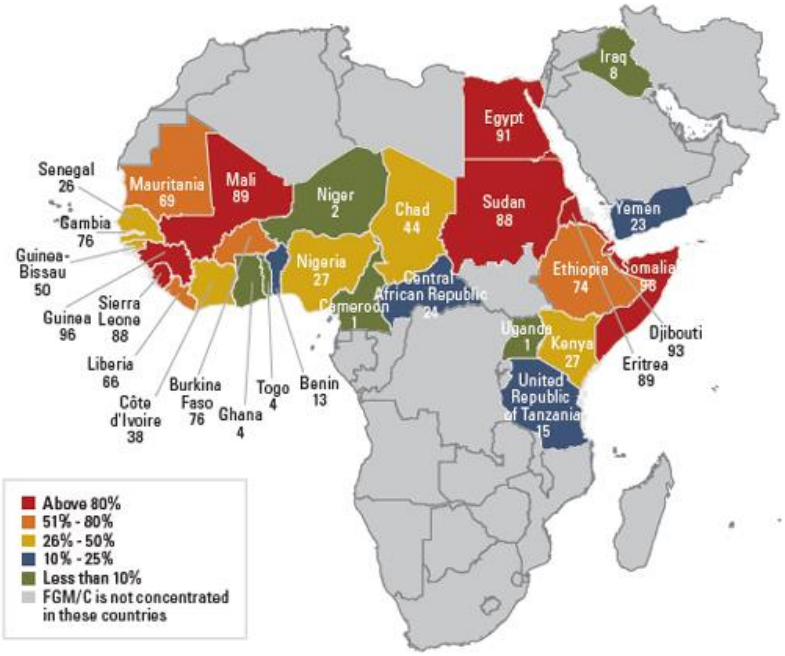
FGM is considered a serious crime and the Child Abuse Investigation Unit (CAIU) will take a lead role in any investigation necessary. The Police recognises the need for an effective investigative response to what is regarded as an extremely severe form of child abuse, recognising the immediate and long term pain, suffering and risks to health associated with this practice.

Appendix 1: FGM Prevalence Globally, Nationally and in Warwickshire

The World Health Organization (WHO) estimates that between 100 and 140 million girls and women worldwide have been subjected to FGM and there are an estimated 3 million girls in Africa at risk of undergoing the procedure every year. One or more types of FGM are practiced in more than 28 African countries and also by ethnic groups in the southern part of the Arabian Peninsula and along the Persian Gulf. UK communities that are at risk of FGM include Somali, Kenyan, Ethiopian, Sierra Leonean, Sudanese, Egyptian, Nigerian, Eritrean, Yemeni, Kurdish and Indonesian women and girls.

The most common types of FGM are excision of the clitoris (Type 1), and excision of the clitoris and labia minora (Type 2) — accounting for up to 80% of all cases. The most extreme type is infibulation (Type 3), which constitutes about 15% of all procedures, but is practised among as many as 90% of women from Somalia, Djibouti and Northern Sudan.

Percentage of Girls and Women aged 15 – 49 years who have undergone FGM by country



Percentage distribution of ages at which girls have undergone FGM (as reported by their mothers) (UNICEF 2013).

The number of women with FGM in the United Kingdom has increased, largely as a consequence of migration. Many women and girls will have experienced FGM before arrival in the UK and the following estimates have been made on the basis of census data and prevalence studies in practicing countries. Studies published in 2015 estimate that approximately 103,000 women aged 15 to 49 living in England who have been subjected to FGM and approximately 24,000 aged over 50.

It also estimates that there are 1343 Women in **Warwickshire** who come from practising countries. Of these women it is estimated that 155 have FGM, distributed across the county as follows:

North Warwickshire:	3
Nuneaton and Bedworth	34
Rugby	52
Stratford U Avon	18
Warwick	48

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

It must be emphasised that these are estimates only and there can be no absolute confidence about the prevalence of FGM in the UK. Furthermore, there can be no confident assumption about the impact of migration on continuation or otherwise of FGM. Some think that there may be less pressure on communities to sustain the practice in the UK whilst the alternative view – that there could be increased pressure to sustain traditional practices – is held by others.

Appendix 2: Cultural Underpinnings of FGM

Parents who support the practice of female genital mutilation say that they are acting in the child's best interests. The reasons they give include that it:

- Brings status and respect to the girl;
- Preserves a girl's virginity/chastity;
- Is part of being a woman;
- Is a rite of passage;
- Gives a girl social acceptance especially for marriage;
- Upholds the family honour;
- Gives the girl and her family a sense of belonging to the community;
- Fulfils a religious requirement mistakenly believed to exist;
- Perpetuates a custom/tradition;
- Helps girls and women to be clean and hygienic;
- Is cosmetically desirable; and
- Is mistakenly believed to make childbirth safer for the infant.

It is because of these beliefs that girls and women who have not undergone FGM are often considered by practising communities to be unsuitable for marriage. Women who have attempted to resist exposing their daughters to FGM report that they and their families were ostracised by their community and told that nobody would want to marry their daughters.

Appendix 3: Signs that a Girl may be At Risk of FGM or has Undergone FGM?

Suspicions may arise in a number of ways that a child is being prepared for FGM to take place abroad. These include;

- Knowing that the family belongs to a community in which FGM is practised;
- Knowing the family is making preparations for the child to take a holiday, arranging vaccinations or planning absence from school;
- The child may talk about a special procedure/ceremony that is going to take place or becoming a woman.

Indicators that FGM may already have occurred include:

- Prolonged absence from school or other activities;
- Noticeable behaviour change on return from absence;
- Bladder or menstrual problems;
- Difficulty sitting still;
- Looking uncomfortable;
- Complain about pain between their legs;
- Talk of something somebody did to them that they are not allowed to talk about.

Appendix 4: Consequences of FGM on Women and Girls

The chart below shows how genital cutting affects girls and woman throughout their lives.

Appendix 5: Agencies Offering Help and Advice

Help and support

If you, or a child you know is in immediate danger, you should contact the **Police** by calling **999 in an emergency.**

If there is no immediate danger or you need advice or information, you should call the Warwickshire Multi-Agency Safeguarding Hub (MASH) on 01926 414144 or the Police on 101**.**

Non-urgent advice for British nationals abroad can be obtained from the **Foreign & Commonwealth Office Helpline** on 020 708 1500.

Other organisations that can help:

NSPCC FGM helpline:
Tel: 0800 028 3550 (free, anonymous and 24/7) or
Email: **fgmhelp@nspcc.or.uk**.

Childline
Tel: 0800 1111 (24 hour helpline for children)
Website: **www.childline.org.uk**

Warwickshire Multi-Agency Safeguarding Hub (MASH)
Tel: 01926 414144

Email: **mash@warwickshire.gcsx.gov.uk**

Website: **www.warwickshire.gov.uk/MASH**

Refuge Domestic Abuse Support Service

Tel: 0808 2000 247 (Freephone)

ROSA – Rape and Sexual Abuse Support

Tel: 01788 551151 Website: www.rosasupport.org.uk

Safeline

Tel: 0808 800 5008. Website: www.safeline.org.uk

Celestinecelest Community Organisation – Not for profit. Support around FGM to Warwickshire and Coventry Residents.
Tel: 07517 227 911 Website: www.celestinecelest.org

Appendix 6: FGM Safeguarding & Risk Assessment Tool

Click here for FGM Safeguarding and Risk Assessment Tool.

Appendix 7: Female Genital Mutilation Protection Order (FGMPO)

An application can be made to the Court for a FGM Protection Order. The application can be made by the girl who is to be protected or by a relevant third party (such as a Local Authority).

The orders are in place to keep those at risk of FGM safe from another person. You can apply for a protection order even if you (or the person you know) are already a victim of FGM, e.g so that the victim can't be prevented from returning to the UK.

People who are victims do not need to reveal their identity or pay to apply for a Protection Order.

How to apply

Download and fill in an **application form (FGM001)**.

You'll also need to fill in:

- form (FGM006) if you're applying for someone else
- form (C8) if you don't want your address, or the address of the person you're applying for, to be shared with the respondent

See the government website for more details at www.gov.uk/female-genital-mutilation-protection-order

Contact Citizens Advice if you need help with your application. You can also ask a solicitor to apply for you and you might be able to get legal aid.

Going to the Court hearing

You will be asked to go to a hearing. The Court will tell you when and where it will happen. It will be held in private.

You might need to give evidence at the hearing. The court can make special arrangements if your worried about seeing the respondent.

If the Court agrees you need a protection order, they'll decide whether to give you a permanent or temporary order. They might ask you to provide more information before making a decision.

What happens next

You'll need to give ('serve') the protection order to the police, and to anyone else named in the order. You can give it to them yourself or the court can do it for you.

If someone breaks your protection order

You can contact the police or apply to get the respondent arrested if they don't follow the restrictions set out in your protection order.

Appendix 8: Talking about FGM

FGM is a complex and sensitive issue that requires professionals to approach the subject carefully. When talking about FGM, professionals should:

- ✓ Ensure that a female professional is available to speak to if the girl or woman would prefer this.
- ✓ Make no assumptions.
- ✓ Give the individual time to talk and be willing to listen.
- ✓ Create an opportunity for the individual to disclose, seeing the individual on their own in private.
- ✓ Be sensitive to the intimate nature of the subject.
- ✓ Be sensitive to the fact that the individual may be loyal to their parents.
- ✓ Be non-judgemental (pointing out the illegality and health risks of the practice, but not blaming the girl or woman).
- ✓ Get accurate information about the urgency of the situation if the individual is at risk of being subjected to the procedure.
- ✓ Take detailed notes.
- ✓ Record FGM in the patient's healthcare record, as well as details of any conversations.
- ✓ Use simple language and ask straight forward questions such as:

- "In some countries, there is a practice in which a girl may have part of her genitals cut. Have you ever heard about this practice?"
- "Have you been closed?"
- "Were you circumcised?"
- "Have you been cut down there?"
- "Have you yourself ever been circumcised/had your genitals cut?"
- "What do you call this practice (that you had)?"
- "Do you think female circumcision should continue?"
- "Does your husband and his family think that female circumcision should be continued?"
- "Do your female relatives think that female circumcision should be continued?"

- ✓ Be direct, as indirect questions can be confusing and may only serve to compound any underlying embarrassment or discomfort that you or the patient may have. 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 to pass urine?"
- "Do you have any pelvic pain or menstrual difficulties?"
- "Have you had any difficulties in childbirth?"

FGM can be named differently in other languages/countries and has different meanings associated with these terms. Some of the language and terms used are listed below:

Country	Term used	Language	Meaning

	for FGM		
EGYPT	Thara	Arabic	Deriving from the Arabic word ‘tahar’ meaning to clean/purify
	Khitan	Arabic	Circumcision – used for both FGM and male circumcision
	Khifad	Arabic	Deriving from the Arabic word ‘khafad’ meaning to lower (rarely used in everyday language)
ETHIOPIA	Megrez	Amharic	Circumcision/cutting
	Absum	Harrari	Name giving ritual
ERITREA	Mekhnishab	Tigregna	Circumcision/cutting
KENYA	Kutairi	Swahili	Circumcision – used for both FGM and male circumcision
	Kutairi was ichana	Swahili	Circumcision of girls
NIGERIA	Ibi/Ugwu	Igbo	The act of cutting – used for both FGM and male circumcision
	Sunna	Mandingo	Religious tradition/obligation – for Muslims
SIERRA LEONE	Sunna Soussou Religious tradition/obligation – for Muslims	Sunna Soussou Religious tradition/obligation – for Muslims	Sunna Soussou Religious tradition/obligation – for Muslims
	Bondo	Temenee/Mandingo /Limba	Integral part of an initiation rite into adulthood – for non-Muslims
	Bondo/Sonde	Mendee	Integral part of an initiation rite into adulthood – for non-Muslims
SOMALIA	Gudiniin	Somali	Circumcision used for both FGM and male circumcision
	Halalays	Somali	Deriving from the Arabic word ‘halal’ ie. ‘sanctioned’ – implies purity. Used by Northern & Arabic speaking Somalis.
	Qodiin	Somali	Stitching/tightening/sewing refers to infibulation
SUDAN	Khifad	Arabic	Deriving from the Arabic word ‘khafad’ meaning to lower (rarely used in everyday language)
	Tahoor	Arabic	Deriving from the Arabic word ‘tahar’ meaning to purify
CHAD – the	Bagne		Used by the Sara Madjingaye

Ngama			
Sara subgroup	Gadja		Adapted from ‘ganza’ used in the Central African Republic
GUINEA-BISSAU	Fanadu di Mindjer	Kriolu	‘Circumcision of girls’
GAMBIA	Niaka	Mandinka	Literally to ‘cut /weed clean’
	Kuyango	Mandinka	Meaning ‘the affair’ but also the name for the shed built for initiates
	Musolula Karoola	Mandinka	Meaning ‘the women’s side’/‘that which concerns women’

Appendix 9: Other Resources for health, schools and other professionals.

Health

Below are links to helpful resources and information about FGM for health professionals.

Resources from government:

- information about FGM at NHS Choices
- eLearning for Healthcare e-learning modules for healthcare professionals
- FGM risk and safeguarding: guidance for professionals
- patient information leaflet
- FGM enhanced dataset: implementation summary for GP practices (PDF, 357KB)
- commissioning services to support women and girls with FGM: guidance
- information on mandatory reporting for health professionals

Resources from other sources:

- FGM educational resource for nursing and midwifery staff produced by the Royal College of Nursing
- Maternity guidelines for women affected by FGM from Barking, Havering and Redbridge University Hospitals NHS Trust
- 'Tackling FGM in the UK': a report and set of recommendations for identifying, recording and reporting FGM, produced by a coalition of royal colleges, trade unions and Equality Now
- Medical questionnaire produced by Bolton NHS Foundation Trust, currently used when FGM is identified within their NHS services
- FGM National Clinical Group resource targeted at specialists, practitioners and educators in the UK and abroad, giving an overall context of FGM and its current standing within healthcare and political arenas

Early Years, Schools, Colleges and Universities

It's up to schools, colleges and universities to decide exactly how they address FGM, taking account of the numbers of pupils from relevant communities. They can, however, create an open and supportive environment. For example by raising awareness through learning in sex and relationship education within personal, social, and health education (PSHE). Listed below are some helpful resources and information about FGM for schools and teachers.

Resources from government:

- Keeping children safe in education: statutory guidance for schools and colleges
- Working together to safeguard children: England
- Working together to safeguard children: Wales
- Statutory framework for the early years foundation stage: sets the standards for learning, development and care for children from birth to 5 years old.

Resources from other sources:

- the film ‘Best of British’ by Values vs Violence looks at personal choices and values and community cohesion issues, and is aimed at sixth form and university students
- a DVD for secondary school staff on how to tackle FGM issues is available from Integrate Bristol, a charity that works towards equality and integration
- infant and primary schools ‘Dotcom’ learning programme – a range of resources led by a fun, friendly character called Dot who helps children learn how to value themselves and others, be aware of the choices they make and do the right thing
- infant and primary schools: effective sex and relationship education within PSHE can help pupils keep themselves safe from harm through building their confidence to ask for help, learning that their body belongs to them and giving them the language to describe private parts of their body. The Sex Education Forum and PSHEAssociation have advice and guidance on effective teaching and learning in sex and relationship education and PSHE.

Further FGM support materials are also available, including:

- Key Stage 3 (Y7) lesson plan produced by Islington Council to raise awareness of the practice of FGM and provide information on how and where young people can get help
- the FGM Fact File: Interactive Teaching Resource: a teaching resource by the Foundation for Women’s Health Research and Development (FORWARD) - see ‘Training’ section below - for use in secondary schools (Y9-11) as part of personal, social and health education. It aims to raise young people’s awareness of FGM, help them realise that it is a form of abuse, and make them aware of who and where they can go to for help. There is also a teachers pack to support the resource.

Leaflets

These materials are designed to help classroom teachers and professionals raise awareness of FGM, and explore the stigma and common issues that often surround it.

Resources from government:

- ‘Statement opposing FGM’ available in multiple languages
- ‘The facts’ leaflet

The following resources from other sources can be found under FGM support materials:

- FGM frequently asked questions: a campaigner’s guide for young people, produced by FORWARD

- ‘I Have Rights’, produced by the Iranian and Kurdish Women’s Rights Organisation (IKWRO)
- ‘Voices of women’, by Birmingham and Solihull Women’s Aid FGM Project
- Guidance for schools, produced by Project Azure and the Metropolitan Police Service

Further resources from other sources:

- ‘What is FGM?’ (PDF, 928KB), produced by 28TooMany
- Female genital mutilation: information sheet produced for the Greater Manchester area
- Email the Kurdish and Middle Eastern Women’s Organisation in Britain for their handbook for professionals
- Email BAWSO for their FGM booklet for families