



Female Genital Mutilation Strategy

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The MSCB Multi-Agency FGM Strategy sets out Merton's Strategic Response to the Issue of FGM. We are indebted to Wandsworth LSCB and Merton Public Health for the Work on FGM. We are also grateful to Lorraine Beckford (Merton CCG) for her outstanding work in researching international responses to FGM and providing support on the equality and diversity impact assessment of this strategy.

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Introduction

Female Genital Mutilation (FGM) is a form of physical abuse and violence against women and girls. It is a harmful cultural practice with devastating health consequences for girls and women. It is also a violation of a girl's human rights and bodily integrity. FGM is illegal in England and Wales under the **Female Genital Mutilation Act 2003** ("the 2003 Act") as amended by **the Serious Crime Act 2015**. FGM comprises all procedures involving partial or total removal of the external female genitalia for non-medical reasons.

Goals of Merton Safeguarding Children Board FGM Strategy

- To create community awareness and to engage with local communities on the prevention of FGM
- To ensure that all multi-agency partners are aware of their statutory responsibilities and are fulfilling them.
- To ensure that there are safe pathways to protect women and girls who have had or who are at risk of FGM
- To provide multi-agency guidance for local safeguarding partners and an effective safeguarding response to the issue of FGM.
- To ensure that services are in place to optimise future reproduction and sexual function, psychological health and better quality of life for survivors of FGM

Please note that Mandatory Reporting of FGM by registered professionals came into force on the 31st October 2015.

Scope

This strategy applies to girls and young women between the ages of 0-18 years old. Women 18 year old and above are addressed as part of Merton's Violence Against Women and Girls (VAWG) Strategy 2016-2018.

Equality Impact Assessment

The FGM Strategy document is drafted in full compliance with the requirements of the Equality Act 2010. The strategy fully reflects the need to protect women and girls from the harmful physical and psychological impact of FGM. Merton Safeguarding Childrens Board can confirm that all providers of public services have given due regard to:-

- Elimination of unlawful discrimination, harassment and victimization and all other conduct prohibited in the Serious Crime Act 2015,
- Advancing equality of opportunity between women and girls who share a protected characteristic and those who do not,
- To ensure all public services are informed of, and comply with statutory legislation to report suspected or at risk incidences of FGM to the Police in compliance with of the Serious Crime Act 2015
- And to foster good relations between people who share a protected characteristic, and those who do not including confronting prejudice and promotion of understanding.

MSCB Priorities

Priority 1: Protection

To identify, support and protect women and girls who may be at risk of FGM by creating awareness and ensuring access to provision. We work to ensure that all girls and young women are safeguarded from this form of physical abuse. We are also aware that the harm caused by FGM includes emotional and psychological harm in the immediate and longer term.

Priority 2: Provision

To ensure that women who have undergone FGM and girls at risk of FGM have access to specialist services for information, advice, support, health care and therapeutic support to overcome the physical effects and psychological trauma of FGM. Our goal is to ensure that all women and girls who are at risk of or have experienced FGM are appropriately supported.

Priority 3: Prevention

To improve awareness of FGM as a safeguarding issue that causes significant harm to women and girls. MSCB recognises that FGM can be a culturally sensitive issue; we want to work with communities to support them to have a clear understanding of the need to end FGM. We will do this by highlighting the fact that FGM is illegal; that it is harmful physically and emotionally and is therefore a form of physical abuse and violence against women and girls. The MSCB wants to ensure that all communities in the Merton area understand that there is a need to work with agencies and services to ensure that FGM is prevented.

1.1 What is FGM?

The World Health Organisation (WHO) defines FGM as

All procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.¹

It's estimated that up to 3 million girls undergo FGM worldwide every year, with approximately 100 to 140 million girls and women estimated to have experienced the practice.²

¹ UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNIFEM, World Health Organisation (WHO)(2008) *Eliminating Female genital mutilation: An interagency statement*. Geneva: WHO

² Ibid.

There are four types of FGM as classified by the WHO. These are shown in Table 1.

Type I	Clitoridectomy: Partial or total removal of the clitoris and/or the prepuce
Type II	Excision: Partial or total removal of the clitoris and the labia minora, with or without removal of the labia majora
Type III	Infibulation: Narrowing of the vaginal orifice with creation of a covering seal by cutting and repositioning the labia minora and/or the labia majora, with, or without excision of the clitoris
Type IV	All other harmful procedures to female genitalia for non-medical purposes, for example pricking, piercing, incising, scraping, cauterisation and so-called, 'designer vaginas'.

Table 1 FGM classification

The age at which FGM is performed varies depending on local practices, with some communities and ethnic groups carrying out the practice on babies and infants while others see it as a 'rite of passage' when a girl gets older.

1.2 FGM and Religion

Female Genital Mutilation is not a religious requirement or obligation. While religion is often cited as justification for the practice, it predates Judaism, Christianity and Islam and has been denounced by senior Muslim clerics in recent years. FGM, including a symbolic prick to the clitoris, has no link with Islam and is neither a requirement nor a 'Sunna' in Islam. Globally most Muslims do not practise FGM. FGM is a cultural or traditional practice.

1.3 Why is FGM Practiced?

FGM tends to be seen as a cultural custom or a rite of passage and there is frequently a great deal of external pressure associated with carrying it out, with significant social consequences for those who refuse to comply. Although FGM is practiced by secular communities, it is most often claimed to be carried out in accordance with religious beliefs. In addition to giving religious reasons for subjecting their daughters to FGM, parents say they are acting in a child's best interests because it:

- Brings status and respect to the girl;
- Preserves a girl's virginity / chastity;
- Is a rite of passage;
- Gives a girl social acceptance, especially for marriage;
- Upholds the family honour;
- Helps girls and women to be clean and hygienic.
- increasing sexual pleasure for men
- reduction of women's sexual desire.³

1.4 FGM as a Form of Physical and Emotional Abuse

FGM represents a form of physical and emotional abuse. It is a violation of a girl's bodily integrity and her human rights. The practice has no known health benefit and causes both short and long term significant harm to women and girls.

³ Local Government Association (2015) *Female Genital Mutilation (FGM): A Councillor's Guide*. London, LGA

In the short term, FGM can result in

- Severe pain,
- Emotional and physical shock,
- Haemorrhaging
- Infections
- Damage to other organs.

Longer term consequences are equally significant and include

- Chronic infections,
- Renal impairment,
- Damage to the reproductive system,
- Complications in pregnancy and childbirth,
- Psychological issues and long-term psychological trauma.
- Increased risk of acquiring and transmitting sexually transmitted infections.

In extreme cases, FGM can result in death; for example, some girls die from blood loss or infection as a direct result of the procedure.

1.5 Risk factors for FGM

a. Risk to the child must be considered if:

- Any female child is born to a woman who has undergone FGM
- Any female child whose older sibling has undergone FGM must be considered at immediate risk.
- Risk to other children in the woman's or child's household must also be considered.⁴

b. Increased risk factors for FGM?

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

c. Indicators that FGM may already have occurred include

- Prolonged absence from school or other activities with noticeable behaviour change on return,
- Girls with bladder or menstrual problems.
- Some children find it difficult to sit still and look uncomfortable, or
- Girls may complain about pain between their legs, or
- Girls talking about something somebody did to them that they are not allowed to talk about.

d. Additional Risk Factors

- The position of the family and the level of integration within UK society
- Girls who are withdrawn from PHSE lessons

⁴ RCM, RCN, RCOG, Equality Now, UNITE (2013) *Tackling FGM in the UK: Intercollegiate Recommendations for identifying, recording and Reporting*, p. 15, London: Royal College of Midwives

d. What to do

- Talk to them about your concerns, but use simple language and straightforward questions;
- Be sensitive and let them know that they can talk to you again;
 - a) if FGM is suspected consult your organisation's designated child protection lead
 - b) if you consider that there is a risk of FGM make a referral to MASH on 0208 545 4226/4227.
 - c) If FGM is discovered or disclosed by a regulated professional⁵ (e.g. social worker, teacher or health professional) report it to the police on 101 (see section 2.ii of this strategy and Appendix 1 for guidance on the Mandatory Reporting Duty)
- You can access help and support anonymously from the NSPCC FGM Helpline on 0800 028 3550 or email: fgmhelp@nspcc.org.uk
- If someone is at imminent risk of FGM, you should contact the police (999) immediately.

⁵ The roles and responsibilities of specific professionals are outlined in detail under 2.ii; 4.1 and Appendix 1

2.i The Legal Framework and National policy context

a. Legislation: England and Wales

FGM is illegal in the UK. In England, Wales and Northern Ireland, civil and criminal legislation on FGM is contained in the **Female Genital Mutilation Act 2003** (the act). In Scotland, FGM legislation is contained in the **Prohibition of Female Genital Mutilation (Scotland) Act 2005**. The Female Genital Mutilation Act 2003 was amended by sections 70-75 of the **Serious Crime Act 2015**.

b. Criminal law in England and Wales

Under section 1 of the act, a person is guilty of an FGM offence if they excise, infibulate or otherwise mutilate the whole or any part of a girl's or woman's labia majora, labia minora or clitoris. To excise is to remove part or all of the clitoris and the inner labia (lips that surround the vagina), with or without removal of the labia majora (larger outer lips). To infibulate is to narrow the vaginal opening by creating a seal, formed by cutting and repositioning the labia.

c. Offences of FGM

It is an offence for any person (regardless of their nationality or residence status) to:

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

If the mutilation takes place in England or Wales, the nationality or residence status of the victim is irrelevant.

(a) Failing to protect a girl from risk of FGM

Section 72 of the 2015 Act inserts new section 3A into the 2003 Act; this creates a new offence of failing to protect a girl from FGM. This will mean that if an offence of FGM under sections 1, 2 or 3 is committed against a girl under the age of 16, each person who is responsible for the girl at the time the FGM occurred could be guilty of an offence. The maximum penalty for the new offence is seven years' imprisonment or a fine or both.⁶

(b) FGM taking place abroad

It is an offence for a UK national or UK resident (even in countries where FGM is not an offence) to:

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

⁶ To be "responsible" for a girl, the person will either have parental responsibility for the girl (such as mothers, fathers married to the mothers at the time of birth and guardians) and have frequent contact with her, or where the person is aged 18 or over they will have assumed responsibility for caring for the girl "in the manner of a parent", for example family members to whom parents might send their child during the summer holidays.

An offence of failing to protect a girl from risk of FGM can be committed wholly or partly outside the UK by a person who is a UK national or UK resident. The extra-territorial offences of FGM are intended to cover taking a girl abroad to be subjected to FGM.

(c) Penalties for the offence of FGM

Any person found guilty of an offence under sections 1, 2, 3 of the act faces up to 14 years' imprisonment, a fine or both. Any person found guilty of an offence under section 3A of the act, faces up to 7 years' imprisonment, a fine or both.

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

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

Any person found guilty of such an offence faces the same maximum penalty for these offences under the act.

(d) FGM protection orders

Under section 5A and schedule 2 of the act provision is made for FGM protection orders. An FGM protection order is a civil law measure which provides a means of protecting actual or potential victims from FGM. Applications for an FGM protection order can be made to the High Court or family court in England and Wales with the purpose of protecting a girl or woman against the commission of a genital mutilation offence or protecting a girl or woman where such an offence has been committed.

The act also:

- guarantees lifelong anonymity for victims of FGM (section 4A of the act)
- places a mandatory duty on health and social care professionals and teachers to notify the police where they discover FGM has been carried out on a girl under 18 years of age during the course of their work (section 5A of the act)
- provides for statutory guidance on FGM (section 5C of the act).

2.ii Mandatory Reporting Duty (see Appendix 1 for Procedural Guidance on the Mandatory Reporting Duty)

Section 74 inserts new section 5B into the 2003 Act which creates a new mandatory reporting duty requiring specified regulated professionals in England and Wales to make a report to the police. The duty applies where, in the course of their professional duties, a professional discovers that FGM appears to have been carried out on a girl aged under 18 (at the time of the discovery).

The duty applies where the professional either:

- is informed by the girl that an act of FGM has been carried out on her, or
- observes physical signs which appear to show an act of FGM has carried out and has no reason to believe that the act was necessary for the girl's physical or mental health or for purposes connected with labour or birth.

The duty applies to professionals working within healthcare or social care, and teachers. It therefore covers:

- Professionals regulated by a body overseen by the Professional Standards Authority (with the exception of the Pharmaceutical Society of Northern Ireland). This includes doctors, nurses, midwives, and, in England, social workers,
- Teachers,

The duty does not apply where a professional has reason to believe that another individual working in the same profession has previously made a report to the police in connection with the same act of FGM. For these purposes, professionals regulated by a body which belongs to the Professional Standards Authority are considered as belonging to the same profession.

The duty is a personal duty which requires the individual professional who becomes aware of the case to make a report; the responsibility cannot be transferred.⁷

An FGM notification is to be made to the chief officer of police for the area in which the girl resides; the notification -

- must identify the girl and explain why the notification is made;
- must be made before the end of one month from the time when the person making the notification first discovers that an act of female genital mutilation appears to have been carried out on the girl;
- the notification may be made orally or in writing.

⁷ *Mandatory Reporting of Female Genital Mutilation* – procedural information, Home Office, 2015

3. Prevalence of FGM

3.1 Global context

FGM is currently practised in up to 29 African countries as well as some countries in Asia and the Middle East, including Iraq, Israel, Oman, the United Arab Emirates, the Occupied Palestinian Territories, India, Indonesia, Malaysia and Pakistan. Large-scale migration has resulted in the practice spreading to other parts of the world.

Where FGM occurs, prevalence varies widely within and between countries depending on the different communities and ethnic groups in each area, as indicated in the map below.⁸ Research shows that women from high prevalence countries are a higher risk of FGM (see Table 2)

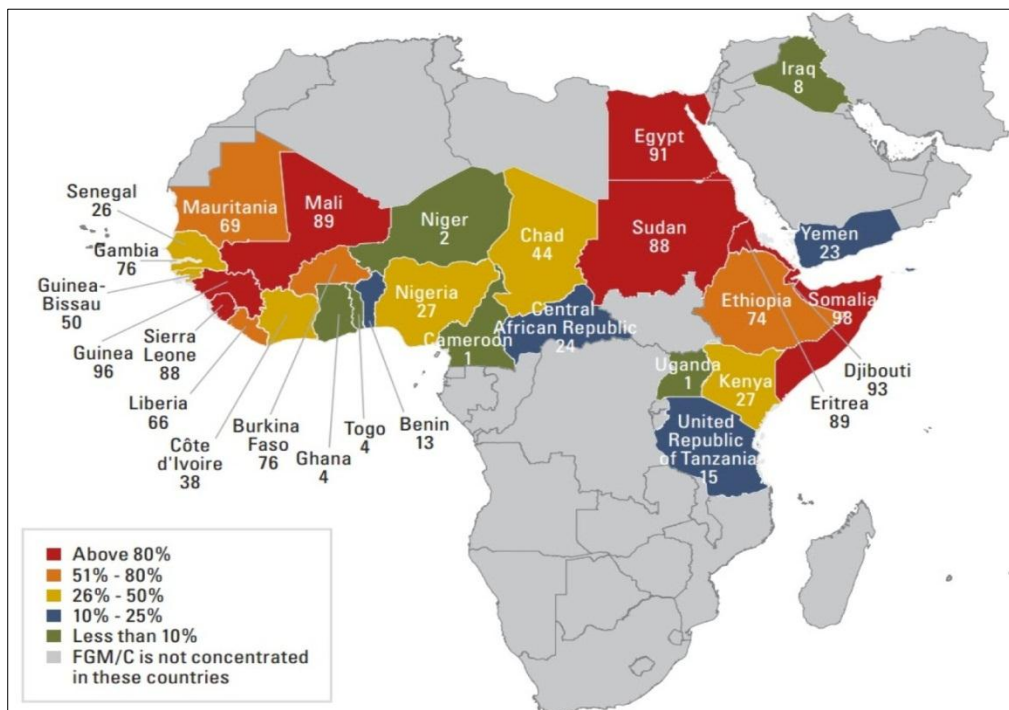


Figure 1 map from UNICEF shows the prevalence of FGM in the female population ages 15 to 49. Unicef© 2015

While the WHO has witnessed a recent trend in the medicalisation of FGM in some countries, the practice remains recognised as a human rights violation with long-term complications even where the procedure itself is safer. FGM remains a significant concern globally as population increases mean that the actual number of women and girls experiencing FGM will continue to rise.⁹

⁸ UNICEF (2013) Female Genital Mutilation / Cutting: A statistical overview and exploration of the dynamics of change. New York, UNICEF

⁹ UNICEF (2014) Female genital mutilation / cutting: what might the future hold? New York, UNICEF

3.2 The Prevalence of FGM in the UK

	Prevalence and Type of FGM	Practicing Countries
1	Almost universal FGM, over 30% FGM, Type III (infibulation)	Sudan (north), Somalia, Eritrea, Djibouti
2	High national prevalence of FGM, Types I and II (Clitoridectomy and excision)	Egypt, Ethiopia, Mali, Burkina Faso, Gambia, Guinea, Sierra Leone
3	Moderate national prevalence of FGM, Types I and II (Clitoridectomy and excision)	Central African Republic, Chad, Cote d'Ivoire, Guinea Bissau, Iraq (Kurdistan), Kenya, Liberia, Mauritania, Nigeria, Senegal, Yemen
4	Low national prevalence of FGM, Types I and II (Clitoridectomy and excision)	Benin, Cameroon, Ghana, Niger, (Democratic Republic of Congo), United Republic of Tanzania, Togo, Uganda

Table 2: Categorisation of countries by FGM type and prevalence, London and Merton

Until very recently, robust data on the prevalence of FGM has not previously been available in the UK; however steps have been taken to provide local areas with information to support strategic planning in the response to FGM.

		Merton	London	England
Estimated numbers of women with FGM, 2011	0-14	60	5,035	9,517
	15-49	628	64,342	101,552
	50+	255	17,569	23,576
	Total	942	86,947	134,645
Estimated prevalence per 1000 population, 2011	0-14	3.4	6.7	2.1
	15-49	11.4	28.2	8.0
	50+	9.0	15.8	2.4
	Total	9.3	21.0	5.0
Number of women born in FGM practicing countries resident in England, 2011	0-14	158	11,811	24,733
	15-49	2,622	164,079	278,877
	50+	1,584	74,480	124,190
	Total	4,364	250,370	427,800
Estimated numbers of maternities to women with FGM, 2005-2013		545	60,618	97,525
Estimated % of maternities to women with FGM, 2005-2013		1.84	5.34	1.65
Estimated numbers of girls born to women with FGM, 2005-2013		264	30,839	49,797
Estimated % of girls born to women with FGM, 2005-2013		1.73	5.25	1.62

Table 3: FGM prevalence estimates, Merton, London and England, Source: Macfarlane & Dorkenoo, 2015

The data shows that London is estimated to have a significantly higher proportion of women and girls with FGM than England as a whole. It is estimated that 65% of the number of women with FGM in England are found in London. Similarly 62% of the estimated number of girls born to women with FGM between 2005 and 2013 were born in London. The estimate of FGM prevalence in Merton and

the estimated percentage of girls born to women with FGM can be seen to be much closer to that of England than London.

Figures 1 and 2 compare Merton estimates with both geographical and statistical comparators. It is clear that while Merton estimates are more than double that of the three boroughs with the lowest prevalence, the estimates are significantly lower than most other comparator boroughs and only slightly higher than England estimates.

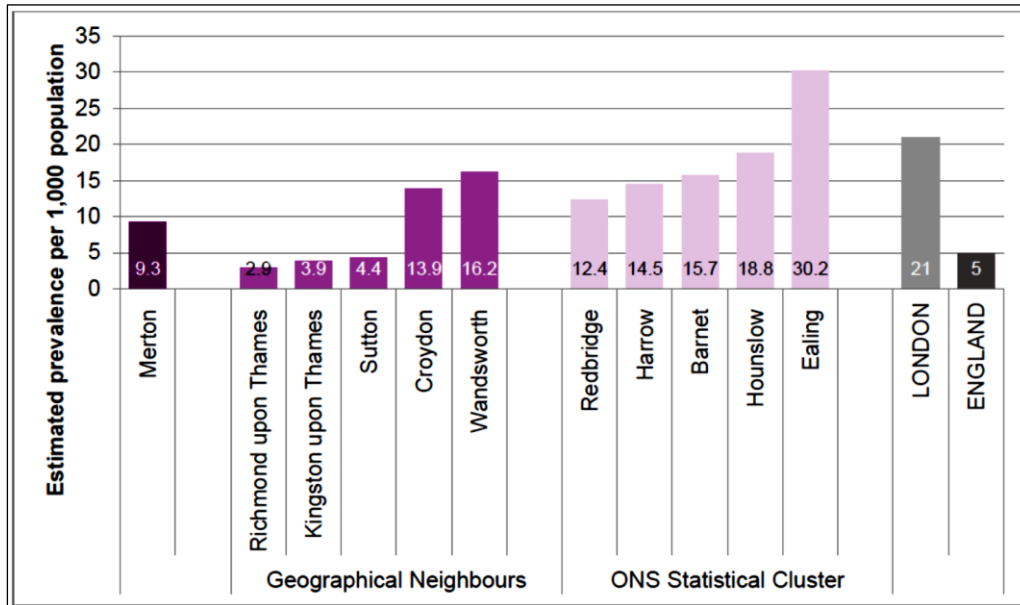


Figure 1: Estimated prevalence of FGM per 1,000 population, Merton and comparators, 2011, source: Macfarlane & Dorkenoo, 2015

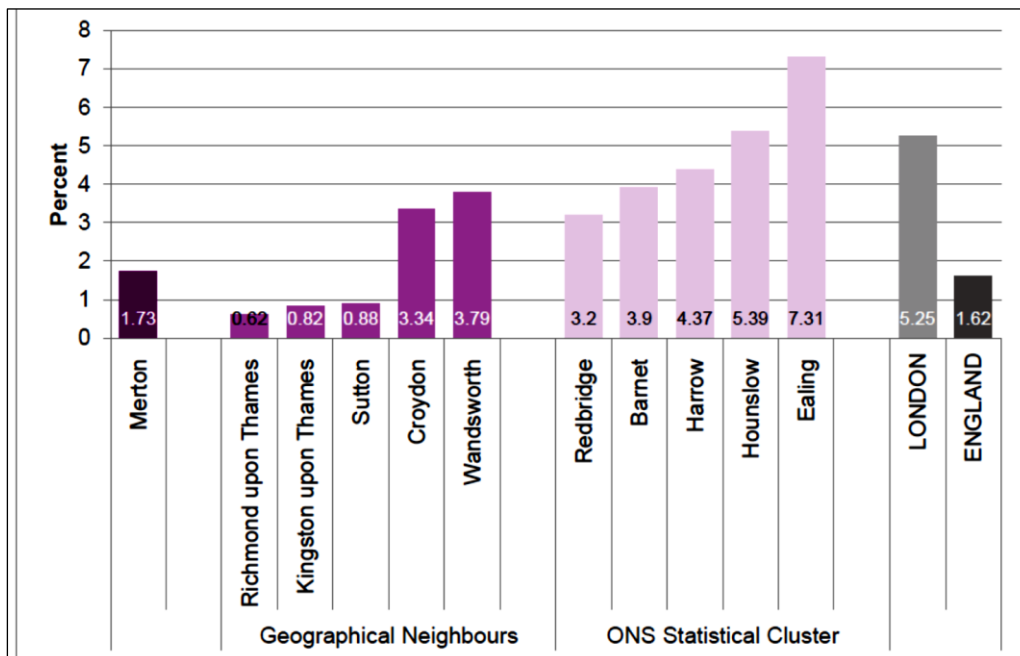


Figure 2: Estimated percentages of girls born to women with FGM, Merton and comparators, 2005-2013

3.3 What does the at risk population look like in Merton?

Data from the 2011 Census helps to show the numbers of Merton residents born in each FGM practising country. Table 4 below displays this data using the FGM classification system. Note that the data was only available at population level; therefore in order to give an indication of the female population only numbers in the table represent 50% of the total population. Table 5 shows cases of FGM reported by Acute Trusts across England, London and hospitals in Kingston, Epsom and St Helier and St George's NHS Trusts.

FGM country classification <small>(see Table 1 for definitions)</small>	Country of Birth	Number of Merton Residents <i>Estimations based on 2011 Census</i>	
High prevalence of type III	Eritrea	32	291
	Djibouti	0	
	Somalia	243	
	Sudan	16	
High prevalence of types I & II	Ethiopia	34	307
	The Gambia	18	
	Guinea	8	
	Mali	*	
	Sierra Leone	124	
	Egypt	123	
	Burkina	*	
Moderate prevalence of types I & II	Central African Republic	0	1,533
	Chad	*	
	Iraq	206	
	Ivory Coast	48	
	Kenya	510	
	Liberia	40	
	Mauritania	*	
	Nigeria	695	
	Guinea-Bissau	*	
	Senegal	5	
	Yemen	29	
Low prevalence of types I & II	Cameroon	27	2,033
	Congo (Democratic Republic)	53	
	Benin	*	
	Ghana	1,372	
	Niger	*	
	Togo	8	
	Uganda	417	
	Tanzania	156	

Table 4: Merton populations born in FGM practising countries, 2011 Census, Source: 2011 ONS Census

Region or Acute Trust	Newly identified cases of FGM, Sept 2014 – March 2015	Active caseload, end of March 2015
England	3,963	3,164
London	2,040	1,783
Epsom and St Helier University Hospitals NHS Trust	Information not available	Information not available
Kingston Hospital NHS Foundation Trust	10	Information not available
St George's Healthcare NHS Foundation Trust	126	14

Table 5: Cases of FGM reported by Acute Trusts by region and Trust, Sept 2014 – March 2015

4 Guidance on Tackling FGM locally

4.1 Safeguarding

The MSCB will also work with partners to ensure that local safeguarding procedures are reviewed to include the handling of cases where FGM is alleged or known about or where an FGM risk may be identified. In addition to the guidance in 1.5.d, the MSCB guidelines for tackling FGM include the following;

- **Health professionals** – FGM is not an issue that can be decided on by personal preference – it is an illegal, extremely harmful practice and a form of child abuse and violence against women and girls. As FGM is a form of child abuse, professionals have a statutory obligation under national safeguarding protocols (e.g. Working Together to Safeguard Children 2015) to protect girls and women at risk of FGM.

Each NHS organisation will have local safeguarding protocols and procedures for helping children and young people who are at risk of or facing abuse.

Each Acute Trust's policies and procedures should consider the characteristics around FGM, ensuring that the response to FGM includes the sharing of information with multi-agency partners throughout the girl's childhood, and that if, or when, the risk facing the girl changes (which may mean it escalates or even becomes less immediate), this is identified and consideration is given as to whether or not a change in subsequent safeguarding actions are required. It must always be remembered that fears of being branded 'racist' or 'discriminatory' must never weaken the protection that professionals are obliged to provide to protect vulnerable girls and women.

One specific consideration when putting in place safeguarding measures against FGM is that the potential risk to a girl born in the UK can usually be identified at birth, because through

the ante-natal care and delivery of the child, NHS professionals can and should have identified that the mother has had FGM.

However FGM can be carried out at any age throughout childhood, meaning **that identifying FGM at birth can mean that any safeguarding measures adopted may have to be in place from birth to 18 years old, that is, over the course of the girl's childhood.** This is a significantly different timescale and profile compared with many of the other forms of harm, against which the safeguarding framework provides protection. This difference in approach should be recognised when putting in place policies and procedures to protect against FGM.¹⁰

- **Police officers** – The Metropolitan Police Service aims to:
 - identify, support, and protect victims or potential victims of FGM
 - Work with support networks to ensure victims or potential victims feel safe
 - Find those involved in FGM and bring them to justice
 - Provide guidance and advice where FGM is suspected
 - Deliver awareness training to a range of audiences
 - Increase public awareness
 - Engage with and establish strong links with practicing communities
 - Help and support by signposting to experts in the field¹¹

- **Children's social care**¹²
 - 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 Merton MASH team in line with Referral and Assessment Procedure.¹³
 - 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.
 - On receipt of a referral, a strategy meeting / discussion must be convened within two working days, and should involve representatives from the police, Merton children's social care, education, health and third sector services. Health providers (e.g. GP Surgeries, Clinics, Hospitals, Health Visitors, School Nurses etc.,) or third sector 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.

¹⁰ *Female Genital Mutilation Risk and Safeguarding Guidance for professionals*, FGM Prevention programme team, Department of Health, © Crown copyright 2015, 2903800 March 2015, produced by Williams Lea for the Department of Health

¹¹ Project Azure is the MPS response to female genital mutilation, through training, prevention work, pro-activity and community partnerships. see <http://content.met.police.uk/Article/Female-genital-mutilation/1400009693144/1400009693144>

¹² *London Child Protection Procedures 2015*,

¹³ *Ibid.* See also [Referral and Assessment Procedure, Referral criteria](#), which provides guidance on the difference in LA children's social care between section 47 / assessment.

- 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 interest is always paramount.
- **Schools, colleges and universities¹⁴** – All schools have a responsibility to educate children to reduce their risk and ensure that any concerns they have are appropriately referred. Schools' and colleges' statutory safeguarding responsibilities are set out in *Keeping Children Safe in Education*, published in July 2015 and *Multi-Agency Practice Guidelines: Female Genital Mutilation* published 2014. Statutory safeguarding responsibilities apply to FGM as to any other risk.
 - Schools and Educational establishments should aim to create an 'open environment' where students feel comfortable and safe to discuss the problems they are facing – an environment where FGM can be discussed openly, and support and counselling are provided routinely. Students need to know that they will be listened to and their concerns taken seriously.
 - Schools' and colleges' statutory safeguarding responsibilities are set out in *Keeping Children Safe in Education*, published on July 2015. These apply to FGM as to any other risk.
 - Staff may become aware of a student because she appears anxious, depressed and emotionally withdrawn. They may be presented with a sudden decline in her performance, aspirations or motivation. There may be occasions when a student comes to school or college but then absents herself from lessons, possibly spending prolonged periods in the bathroom.
 - Students who fear they may be at risk of FGM can often come to the attention of, or turn to, a teacher, lecturer or other member of staff before seeking help from the police or social services. Sometimes the student's friends report it to staff. Teachers, lecturers and other members of staff are in an ideal position to identify and respond to a victim's needs at an early stage.
 - It is for schools and colleges to decide exactly how they address this issue, taking account of the numbers of pupils from relevant communities.
 - They can, however, create an 'open' and supportive environment by some or all of the following:
 - circulating and displaying materials about FGM.
 - displaying relevant information, e.g. details of the NSPCC's Helpline and ChildLine services, Careline, National Domestic Violence Helpline and appropriate black and minority ethnic women's groups (see Appendix D for more information).
 - ensuring that a private telephone is made available should students need to seek advice from the above organisations or other relevant groups discreetly.

¹⁴ *Multi-Agency Practice Guidelines: Female Genital Mutilation* p. 14 ff. Crown copyright 2014 and *Keeping Children Safe in Education* 2015

- raising awareness of FGM among staff – including appropriate training in continuing professional development, where relevant.
- ensuring that the designated member of staff with responsibility for safeguarding children is well versed in the issues around FGM.
- referring students to an education welfare officer, a child protection lead, pastoral tutor, learning mentor or school counsellor as appropriate.
- encouraging young people to access appropriate advice, information and support
- making materials such as books and DVDs available .
- introducing FGM into the school curriculum within relevant classes in order to educate children to reduce safeguarding risks, such as:
 - Personal, Social Health and Economic Education (PSHE)
 - Sex and relationship education (SRE), having regard to relevant statutory guidance;
 - Science, particularly in ensuring accurate naming of body parts as required by the curriculum programme of study
 - Citizenship

4.2 Services for girls and women who have undergone FGM

There are a range of dedicated services for women with female genital mutilation who provide support with regards to both mental and physical health. The MSCB will work with partners in health to ensure that there is a thorough healthcare assessment of women and girls where FGM is found or suspected.

In addition to health interventions there are opportunities for a multi-agency safeguarding response where a need is identified; this includes working with agencies such as the police and social services in order to fully meet the needs of girls who have undergone or are at risk of FGM.

These services will focus on two specific aspects of care;

- Provision of sensitive and appropriate services for survivors of FGM
- Safeguarding girls at risk of FGM

MSCB will ensure that there is effective and coordinated multi-agency work within local agencies; ensuring that these services are consistent with local strategies and multi-agency processes.

4.3 Role of local partnerships in tackling FGM

Safeguarding is everyone’s business. FGM is a form of physical abuse; it is illegal. The MSCB will work proactively to safeguard and promote the welfare of children at risk of FGM. We will do this in partnership with communities, multi-agency partners and voluntary organisations to raise awareness of this issue and reduce the prevalence of FGM in the Merton area.

The MSCB will work with partners to ensure that single agency and inter-agency training is provided to all relevant staff on safeguarding in relation to FGM, including socio-cultural, ethical and legal issues as well as complications and the roles of different professionals.

The MSCB will work with communities to encourage the abandonment of FGM. This will involve the establishment of Community Champions who will raise awareness and support local communities. This should include work with the wider family when individual cases arise and education of male partners and community leaders. It will also involve encouraging community members to report suspected cases and highlighting anonymous ways of doing this as a means of increasing the level of information gathered.

4.4. What are we currently doing in Merton?

Pathways exist for safeguarding referrals to Children's Social Care/MASH from all relevant organisations;

- Maternity services
- Health visiting
- GPs
- Education
- Voluntary services

4.5. What are we going to do?

Priority 1: Protection

We will work to increase the numbers of girls who are identified as being at risk of FGM and to ensure that they are protected and supported.

Priority 2: Provision

We will work to ensure women who have undergone FGM and girls at risk have access to specialist services for information, advice and support. We recognise that support may include medical interventions to correct the physical harm done to women by FGM and/or therapeutic interventions to address the psychological and mental health of women and girls who have experienced trauma as a result of FGM.

Priority 3: Prevention

MSCB recognises that FGM can be a culturally sensitive issue; we want to work with communities to support them to take ownership of FGM as a safeguarding issue.

The MSCB will seek to work in partnership with local communities and voluntary organisations to identify and train Community Champions who will be able to engage in discussion and debate with community elders and others to ensure that there is awareness and recognition of the need to safeguard women and girls from FGM. It has been found that "...Effective programs focus on supporting dialogue and debate within the community, and engaging with community members as peers and as leaders rather than as passive subjects."¹⁵

6. Governance

¹⁵ *Best Practice guide for working with communities affected by FGM/C, The National Female Genital Mutilation/Cutting Awareness, Copyright ©2014 Multi-Cultural Centre for Women's Health*

The FGM Strategy and its implementation is to be monitored by the Policy Sub-Group of the Board

7. Training Strategy

We also want to ensure that is trained to fulfil their statutory responsibilities with regards to FGM. The focus of the FGM strategy is to improve the awareness of frontline staff and managers to effectively prevent FGM and to provide appropriate support to women and girls who may have suffered FGM. Designated Safeguarding Lead Briefs, MSCB Cascade Briefings, we will provide materials to equip teams to receive training with their organisation.

8. Implementation Plan

See attached draft.

9. Communication Plan

The goal of the MSCB to reduce the incidences of FGM by raising awareness of FGM amongst children, young people, families and communities to help address attitudes and myths about FGM.

- (a) *For Professionals* – the MSCB will provide a multi-agency FGM Briefing Pack which will include copies of the strategy; a PowerPoint Presentation, links to key websites.
- (b) *For targeted Community groups* – the MSCB will engage the support of community based organisations and groups to address the issue of FGM in Local Communities.
- (c) *For children and Families* – the MSCB will ensure that children and families have access to information, advice and support regarding the issue of FGM with clear sign-posting for medical and therapeutic support.
- (d) *General Awareness Raising* – the MSCB will dedicate web space where information can be found and accessed on FGM. The MSCB will also participate, where possible, in International Zero Tolerance of FGM Day on 6 February

Appendix 1: Mandatory Reporting Procedural Guidance¹⁶

Section 5B of the **Female Genital Mutilation Act 2003** (the act)¹⁷ introduced a mandatory reporting duty which requires regulated health and social care professionals and teachers in England and Wales to report ‘known’ cases of FGM in girls under 18 years of age which they identify in the course of their professional work to the police. **This duty applies from 31 October 2015.**

‘Known’ cases are those where either a girl informs the person that an act of FGM – however described – has been carried out on her, or where the person observes physical signs on a girl appearing to show that an act of FGM has been carried out and the person has no reason to believe that the act was, or was part of, a surgical operation within section 1(2)(a) or (b) of the FGM Act 2003.

The legislation requires regulated health and social care professionals and teachers in England and Wales to make a report to the police where, in the course of their professional duties, they either:

- are informed by a girl under 18 that an act of FGM has been carried out on her; or
- observe physical signs which appear to show that an act of FGM has been carried out on a girl under 18 and they have no reason to believe that the act was necessary for the girl’s physical or mental health or for purposes connected with labour or birth.

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

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

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

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

Visually identified cases – when you might see FGM

The duty applies to cases you discover in the course of your professional work.

If you do not currently undertake genital examinations in the course of delivering your job, then the duty does not change this. Most professionals will only visually identify FGM as a secondary result of undertaking another action.

For healthcare professionals, if, in the course of your work, you see physical signs which you think appear to show that a child has had FGM, this is the point at which the duty applies – the duty does

¹⁶ *Mandatory Reporting of Female Genital Mutilation – procedural information*, Home Office, Crown Copyright 2015

¹⁷ As inserted by section 74 of the Serious Crime Act 2015

not require there to be a full clinical diagnosis confirming FGM before a report is made, and one should not be carried out unless you identify the case as part of an examination already under way and are able to ascertain this as part of that. Unless you are already delivering care which includes a genital examination, you should not carry one out.

For teachers and social workers, there are no circumstances in which you should be examining a girl. It is possible that a teacher, perhaps assisting a young child in the toilet or changing a nappy, may see something which appears to show that FGM may have taken place. In such circumstances, the teacher must make a report under the duty, but should not conduct any further examination of the child.

Verbally disclosed cases

If you are a relevant professional and a girl discloses to you that she has had FGM (whether she uses the term 'female genital mutilation' or any other term or description, e.g. 'cut') then the duty applies. If, in the course of delivering safe and appropriate care to a girl you would usually ask if she has had FGM, you should continue to do so.

The duty applies to cases directly disclosed by the victim; if a parent, guardian, sibling or other individual discloses that a girl under 18 has had FGM, the duty does not apply and a report to the police is not mandatory. Any such disclosure should, however, be handled in line with wider safeguarding responsibilities - in England, this is likely to include referral to children's social services, and in Wales the disclosure must be immediately referred to the local authority.

Timeframe for reports

Reports under the duty should be made as soon as possible after a case is discovered, and best practice is for reports to be made by the close of the next working day, unless any of the factors described below are present. You should act with at least the same urgency as is required by your local safeguarding processes.

In order to allow for exceptional cases, a maximum timeframe of one month from when the discovery is made applies for making reports. However, the expectation is that reports will be made much sooner than this.

Making a report

Where you become aware of a case, the legislation requires you to make a report to the police force area within which the girl resides. The legislation allows for reports to be made orally or in writing.

When you make a report to the police, the legislation requires you to identify the girl and explain why the report is being made. While the requirement to notify the police of this information is mandatory and overrides any restriction on disclosure which might otherwise apply, in handling and sharing information in all other contexts you should continue to have regard to relevant legislation and guidance, including the Data Protection Act 1998 and any guidance for your profession. The provisions of the Data Protection Act 1998 do not prevent a mandatory report to the police from being made.

It is recommended that you make a report orally by **calling 101**, the single non-emergency number.

When you call 101, the system will determine your location and connect you to the police force covering that area. You will hear a recorded message announcing the police force you are being connected to. You will then be given a choice of which force to be connected to – if you are calling with a report relating to an area outside the force area which you are calling from, you can ask to be directed to that force.

You should be prepared to provide the call handler with the following information:

- explain that you are making a report under the FGM mandatory reporting duty
- your details:
 - name
 - contact details (work telephone number and e-mail address) and times when you will be available to be called back
 - role
 - place of work
- details of your organisation's designated safeguarding lead:
 - name
 - contact details (work telephone number and e-mail address)
 - place of work
- the girl's details:
 - name
 - age/date of birth
 - address
- if applicable, confirm that you have undertaken, or will undertake, safeguarding actions, as required by the English or Welsh version of Working Together to Safeguard Children as appropriate.

Record keeping

Throughout the process, you should ensure that you keep a comprehensive record of any discussions held and subsequent decisions made, in line with standard safeguarding practice. This will include the circumstances surrounding the initial identification or disclosure of FGM, details of any safeguarding actions which were taken, and when and how you reported the case to the police (including the case reference number). You should also ensure that your organisation's designated safeguarding lead is kept updated as appropriate.

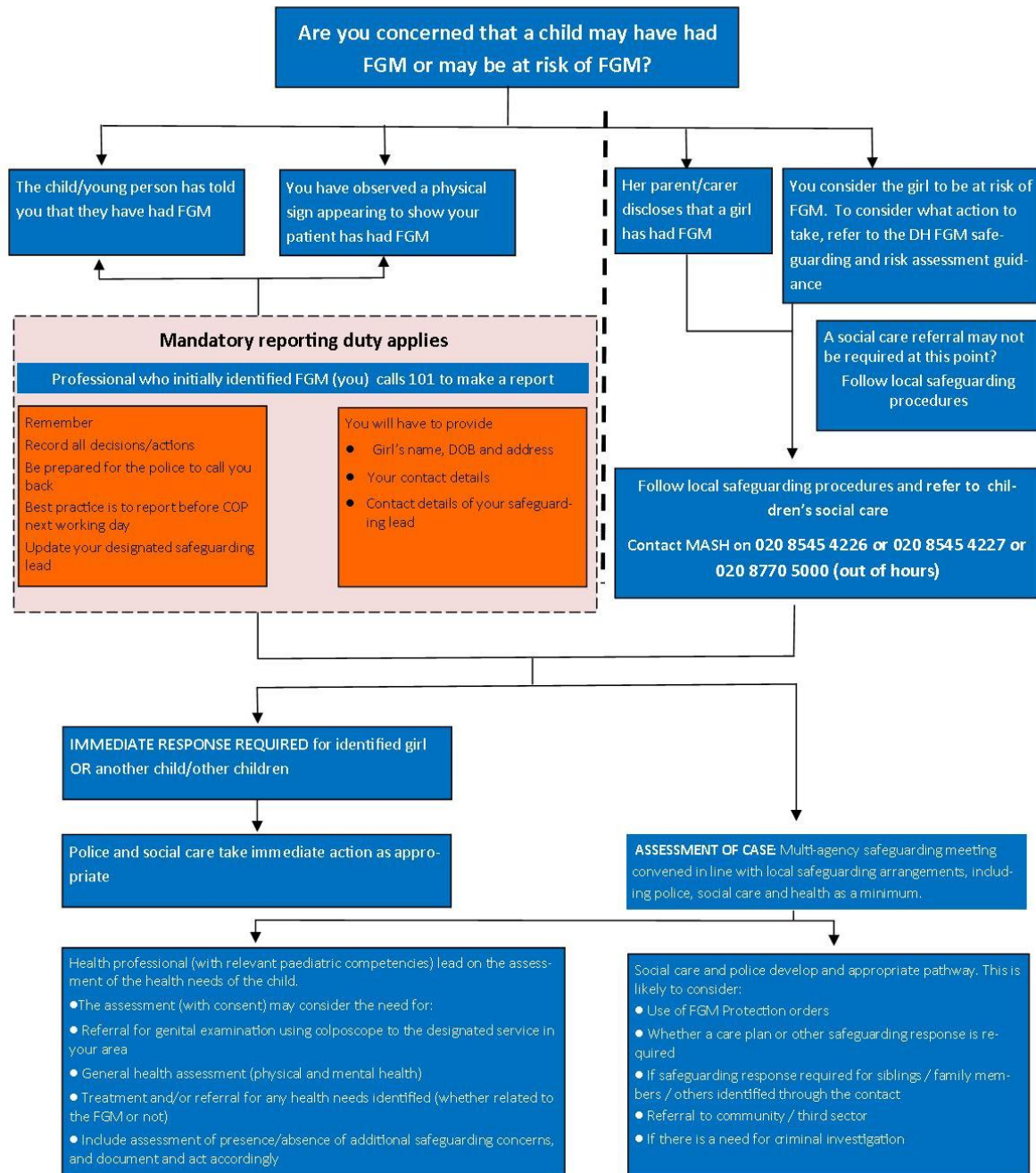
Appendix 2: Traditional Terms for FGM (adapted from Department of Health Female Genital Mutilation Risk and Safeguarding Guidance for professionals)

Country	Term used for FGM	Language	Meaning
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	Tigreña	Circumcision/cutting
KENYA	Kutairi	Swahili	Circumcision – used for both FGM and male circumcision
	Kutairi was	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
	Bondo	Temenee/ Mandingo/	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' i.e. '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 Ngama	Bagne		Used by the Sara Madjingaye
Sara subgroup	Gadja		Adapted from 'ganza' used in the Central African Republic
GUINEA-BISSAU	Fanadu di	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	Mandinka	Meaning 'the women's side'/'that which concerns women'

Appendix 3: Adapted from Department of Health Guidance

FGM Mandatory Duty & Intervention Flow Chart



If a girl appears to have been recently cut or you believe she is at imminent risk, act immediately – this may include phoning 999.

REMEMBER: Mandatory reporting is only one part of safeguarding against FGM and other abuse. Always ask your local safeguarding lead if in doubt.

Appendix 4: ORGANISATIONS WORKING ON ISSUES ON AROUND FGM

POLICE SERVICE

Metropolitan Police Service / Project Azure 020 7161 2888

UK GOVERNMENT <https://www.gov.uk/female-genital-mutilation>

HELPLINES

National Society for the Prevention of Cruelty to Children (NSPCC) FGM Helpline 24 –hour Helpline.
Free phone 0800 028 3550 www.nspcc.org.uk/fgm

Black Association of Women Step Out (BAWSO)

24-hour Helpline: 0800 731 8147 www.bawso.org.uk

Integrate Bristol <http://integratebristol.org.uk/>

24-hour helpline on **0800 028 3550**.

ChildLine 24-hour Helpline for children: 0800 1111 www.childline.org.uk

National Domestic Violence Helpline 24-hour Helpline: 0808 2000 247
www.nationaldomesticviolencehelpline.org.uk

NSPCC British Sign Language Helpline for deaf or hard-of-hearing callers ISDN videophone: 020 8463 1148 Webcam: nspcc.signvideo.tv (available Monday – Friday, 9 am – 5 pm, in English language only) Text: 0800 056 0566

OTHER ORGANISATIONS

28 Too Many <http://28toomany.org/>

Africans Unite Against Child Abuse (AFRUCA) <http://www.afruca.org/>

Agency for Culture and Change Management UK (ACCM UK) <http://www.accmuk.com/>

Birmingham & Solihull Women’s Aid <http://bswaid.org/>

Daughters of Eve: <http://www.dofeve.org/>

Foundation for Women’s Health Research & Development (FORWARD)
<http://www.forwarduk.org.uk/>

Halo Project <http://www.haloproject.org.uk/>

Manor Gardens Health Advocacy Project <http://www.manorgardenscentre.org/>

Petal App. <http://petals.coventry.ac.uk/>

The Maya Centre www.mayacentre.org.uk

For more organisations and local services, please visit

<https://www.gov.uk/female-genital-mutilation>