

**MULTI-AGENCY
PRACTICE
GUIDELINES:
FEMALE GENITAL
MUTILATION**

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CHAPTER ONE

PURPOSE OF THE GUIDELINES

1.1 Aims

This document seeks to provide advice and support to frontline professionals who are responsible for safeguarding children and protecting adults from the abuses associated with female genital mutilation (“FGM”). As it is unlikely that any single agency will be able to meet the multiple needs of someone affected by FGM, this document sets out a multi-agency response and strategies to encourage agencies to co-operate and work together.

This document sets out:

- how to identify a girl (including an unborn girl) or young woman who may be at risk of being subjected to FGM and how to respond appropriately to protect her;
- how to identify when a girl or young woman has been subjected to FGM and how to respond appropriately to support her; and
- measures that can be implemented to prevent, and ultimately eradicate, the practice of FGM.

FGM is a form of child abuse and violence against women and girls and should, therefore, be dealt with as part of existing child and adult safeguarding structures, policies and procedures.

1.2 Audience

The guidelines in this document are aimed at all frontline professionals and volunteers within agencies that work to:

- safeguard children and young people from abuse; or
- safeguard adults from abuse.

This includes, but is not limited to, Health and Social Care (“HSC”) staff and other health professionals, police officers, staff in HSC Children’s Services and teachers and other educational professionals. The information may also be relevant to non-governmental organisations and voluntary organisations working directly with girls and women at risk of FGM, or dealing with its consequences.

1.3 The status of the guidelines

These guidelines are practice guidelines and are designed to be educative and provide advice. They are not a substitute for existing statutory guidance, such as *Co-operating to Safeguard Children (2003)*, *the Regional Child Protection Policy and Procedures* or *Safeguarding Vulnerable Adults – Regional Adult Protection Policy and Procedural Guidance*.

Existing bodies and organisations should ensure that their agencies work effectively using existing policies and procedures to tackle this issue. This includes, but is not limited to, the Police Service of Northern Ireland (“PSNI”), the HSC Board, the Public Health Agency, HSC Trusts and the Safeguarding Board for Northern Ireland (“SBNI”).

1.4 Coverage of the Guidelines

These guidelines, which are designed for application in Northern Ireland, have been adapted from the guidelines which apply in England and Wales.¹

¹http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/97857/FGM.pdf

For information about the Scottish Government’s work to prevent and tackle FGM visit:
<http://www.scotland.gov.uk/Topics/People/Equality/violence-women/MinorityEthnicIssuesPages/FemaleGenitalMutilation>

1.5 Principles supporting the Guidelines

The following principles should be adopted by all agencies in relation to identifying and responding to girls (and unborn girls) and women at risk of, or who have experienced, FGM and their parent(s):

- The safety and welfare of the child is paramount.
- Regard should be had to the United Nations Convention on the Rights of the Child (1989).
- FGM is illegal in the UK (for more information, see Section 2.3).
- FGM is not a matter that can be left to be decided by personal preference – it is illegal, abusive and an extremely harmful practice. Professionals should not let fears of being branded ‘racist’ or ‘discriminatory’ weaken the protection afforded to vulnerable girls and women.
- Accessible, acceptable and sensitive health, education, police, social care and voluntary sector services must underpin interventions.
- Some FGM practising families do not see it as an act of abuse (for more information, see Section 2.8). However, FGM has severe and significant physical and mental health consequences, both in the short and long term (see Section 2.10), and must not be excused, accepted or condoned.

- Engagement with families and communities will be required to achieve the long-term abandonment and eradication of FGM.

CHAPTER TWO

UNDERSTANDING THE ISSUES AROUND FGM

Summary

- It is **illegal** in the UK to subject a girl or young woman to FGM or to assist a non-UK person to carry out FGM overseas. For the purposes of the criminal law in Northern Ireland, FGM is the mutilation of the labia majora, labia minora or the clitoris.
- FGM is prevalent in 28 African countries, as well as parts of the Middle East and Asia.
- It has been estimated that, in the UK, over 20,000 girls under the age of 15 are at risk of FGM each year and that 66,000 women are living with the consequences of FGM, although the true extent is unknown, due to the hidden nature of the crime.
- FGM is practised by families for a variety of complex reasons, but often in the mistaken belief that it is for the benefit of the girl or woman.
- FGM constitutes a form of child abuse and violence against children and women and has severe long-term and short-term physical and psychological consequences.

2.1 Definition

FGM involves procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. The practice is medically unnecessary, extremely painful and has serious health consequences, both at the time when the mutilation is carried out and in later life.

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.

2.2 Types of FGM

FGM has been classified by the World Health Organization into four types:

- Type 1 – Clitoridectomy: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in

- Type 4 – Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterising the genital area.

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 or adolescence, just before marriage or during the first pregnancy. However, the majority of cases of FGM are thought to take place between the ages of 5 and 8 and therefore girls within that age bracket are at a higher risk.

2.3 UK legislation

FGM is illegal in the UK. Anyone found guilty of an FGM offence - or of aiding and abetting such an offence - faces a penalty of up to 14 years in prison, a fine, or both.

In England, Wales and Northern Ireland, the practice is illegal under the Female Genital Mutilation Act 2003². Under the 2003 Act, a person is guilty of an offence if s/he excises, infibulates or otherwise mutilates the whole or any part of a girl's or woman's labia majora, labia minora or clitoris. The Act does not prevent necessary operations performed by a registered medical practitioner on physical and mental health

² In Scotland it is illegal under the Prohibition of Female Genital Mutilation (Scotland) Act 2005. In the Republic of Ireland it is illegal under the Criminal Justice (Female Genital Mutilation) Act 2012.

grounds or an operation performed by a registered medical practitioner or midwife or a person undergoing training with a view to becoming a medical practitioner or midwife on a girl who is in labour or has just given birth for purposes connected with the labour or birth (these exceptions are set out in section 1(2) and (3) of the Act). It is also an offence to assist a girl or woman to mutilate her own genitalia.

It is an offence for anyone (regardless of their nationality and residence status) to perform FGM in the UK or to assist a girl to perform FGM on herself in the UK. Provided that the mutilation takes place in the UK, the nationality or residence status of the victim is irrelevant.

2.4 FGM taking place overseas

It is an offence under the 2003 Act for a UK national or permanent UK resident to perform FGM, or to assist a girl to perform FGM on herself, outside the UK. It is also an offence to assist FGM carried out abroad by anyone (including foreign nationals), although in some cases the offence is limited to the situation where the victim is a UK national or permanent UK resident. This would cover taking a girl abroad to be subjected to FGM. The exceptions set out in sections 1(2) and (3) of the 2003 Act also apply to this offence. Under the Children (Northern Ireland) Order 1995 an application can be made to the court for various orders to prevent a child being taken abroad for mutilation – see Chapter 5 of these guidelines for more information.

2.5 International prevalence of FGM

FGM is a deeply rooted tradition, widely practised mainly among specific ethnic populations in Africa and parts of the Middle East and Asia, which serves as a complex form of social control of women's sexual and reproductive rights. The World Health Organisation estimates that between 100 and 140 million girls and women worldwide have experienced female genital mutilation and around 3 million girls undergo some form of the procedure each year in Africa alone. FGM has also been documented in communities in **Iraq, Israel, Oman, the United Arab Emirates, the Occupied Palestinian Territories, India, Indonesia, Malaysia and Pakistan.**

2.6 Prevalence of FGM in the UK

It is difficult to estimate the prevalence of FGM in the UK because of the hidden nature of the crime. However, in England and Wales, a study³ based on 2001 census data suggested that:

- over 20,000 girls under the age of 15 could be at high risk of FGM in England and Wales each year;
- nearly 66,000 women in England and Wales are living with the consequences of FGM.

It is possible that, due to population growth and immigration from practising countries since 2001, FGM is significantly more prevalent than these figures suggest. There is likely to be an uneven distribution of cases of FGM around the UK, with more occurring in those areas of the UK with larger communities from the practising countries (see Section 2.5) – found by the same study to be London, Cardiff, Manchester, Sheffield, Oxford, Northampton, Birmingham, Crawley, Reading, Slough and Milton Keynes.

However, in all areas authorities and professionals must be aware of, and actively prevent and tackle, FGM.

2.7 Names for FGM

FGM is known by a number of names, including 'female genital cutting', 'circumcision' or 'initiation'. 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 practising communities, largely because they are English terms.

See Appendix B for terms used for FGM in different languages.

³ FORWARD (2007) *A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales.*

2.8 Cultural underpinnings and motives of FGM

FGM is a complex issue, with a variety of explanations and motives given by individuals and families who support the practice.

Reasons given for practising FGM:

- It brings status and respect to the girl.
- It preserves a girl's virginity/chastity.
- It is part of being a woman.
- It is a rite of passage.
- It gives a girl social acceptance, especially for marriage.
- It upholds the family honour.
- It cleanses and purifies the girl.
- It gives the girl and her family a sense of belonging to the community.
- It fulfils a religious requirement believed to exist.
- It perpetuates a custom/tradition.
- It helps girls and women to be clean and hygienic.
- It is cosmetically desirable.
- It is believed to make childbirth safer for the infant.

FGM is often seen as a natural and beneficial practice by a loving family who believe that it is in the girl's or woman's best interests. This also limits a girl's incentive to come forward to raise concerns or talk openly about FGM – reinforcing the need for all professionals to be aware of the issues and risks of FGM. It is

because of these beliefs that girls and women who have not undergone FGM can be considered by practising communities to be unsuitable for marriage.

Despite the harm it causes, many women from FGM-practising communities consider FGM normal to protect their 'cultural identity'. As a result of the belief systems of the cultural groups who practise FGM, many women who have undergone FGM believe they appear more attractive than women who have not undergone FGM. 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.

Infibulation (Type 3) is strongly linked to virginity and chastity, and used to safeguard girls from sex outside marriage and from having sexual feelings. In some cultures, it is considered necessary at marriage for the husband and his family to see the wife 'closed' and, in some instances, both mothers will take the wife to be cut open enough to be able to have sex. Although FGM is practised by secular communities, it is most often claimed to be carried out in accordance with religious beliefs. However, FGM predates Christianity, Islam and Judaism, and the Bible, Koran, Torah and other religious texts do not advocate or justify FGM. Despite this, religion is sometimes given as a justification for FGM.

For example, some people from Muslim communities argue that the Sunna (traditions or practices undertaken or approved by the prophet Mohammed) recommend that women undergo FGM, and some women have been told that having FGM will make them 'a better Muslim'. However, senior Muslim clerics at an international conference on FGM in Egypt in 2006 pronounced that FGM is not Islamic, and the London Central Mosque has spoken out against FGM on the grounds that it constitutes doing harm to oneself or to others, which is forbidden by Islam.

Some views of people from FGM practising communities⁴

"I cannot trust her if she is not circumcised"

"Female circumcision in our country has many beneficial aims like to keep the honour of the girl. But generally circumcision is not good because there is a difference between circumcised women and uncircumcised women"

"Yes I am happy to marry an uncircumcised woman"

"The right time to open my circumcision is at night-time of marriage"

2.9 FGM procedure

It is believed that FGM happens to British girls in the UK as well as overseas (often in the family's country of origin). Girls of school

age who are subjected to FGM overseas are thought to be taken abroad at the start of the school holidays, particularly in summer, in order for there to be sufficient time for them to recover before returning to their studies.

FGM is usually carried out by the older women in a practising community, for whom it is a way of gaining prestige and can be a lucrative source of income. The arrangements for the procedure usually include the child being held down on the floor by several women and the procedure carried out without medical expertise, attention to hygiene or anaesthesia. The instruments used include unsterilised household knives, razor blades, broken glass and stones. The girl may often not be expecting the procedure, exacerbating the trauma that is experienced.

2.10 Consequences of FGM

Many men and women in practising communities can be unaware of the relationship between FGM and its harmful health and welfare consequences (see below), particularly the longer-term complications affecting sexual intercourse and childbirth.

2.10.1 Short-term implications for a girl's health and welfare

The short-term consequences following a girl undergoing FGM can include:

- severe pain;

⁴ Quotes taken from interviews conducted by midwife and FGM specialist Comfort Momoh MBE

- emotional and psychological shock (exacerbated by having to reconcile being subjected to the trauma by loving parents, extended family and friends);
- haemorrhage;
- wound infections, including tetanus and blood-borne viruses (including HIV and Hepatitis B and C);
- urinary retention;
- injury to adjacent tissues;
- fracture or dislocation as a result of restraint;
- damage to other organs;
- death.

2.10.2 Long-term implications for a girl's or woman's health and welfare

The longer-term implications for women who have been subjected to FGM Types 1 and 2 are likely to be related to the trauma of the actual procedure, while health problems caused by FGM Type 3 are severe. World Health Organisation research has shown that women who have undergone FGM of all types, but particularly Type 3, are more likely to have complications during childbirth.

The long-term health implications of FGM can include:

- chronic vaginal and pelvic infections;
- difficulties with menstruation;
- difficulties in passing urine and chronic urine infections;
- renal impairment and possible renal failure;
- damage to the reproductive system, including infertility;
- infibulation cysts, neuromas and keloid scar formation;
- complications in pregnancy and delay in the second stage of childbirth;
- pain during sex and lack of pleasurable sensation;
- psychological damage, including a number of mental health and psychosexual problems such as low libido, depression, anxiety and sexual dysfunction; flashbacks during pregnancy and childbirth;
- substance misuse and/or self-harm;
- increased risk of HIV and other sexually transmitted infections;
- death during childbirth.

2.10.3 Psychological and mental health problems

Case histories and personal accounts taken from women indicate that FGM is an extremely traumatic experience for girls and women, which stays with them for the rest of their lives. Young women receiving psychological counselling in the UK report feelings of betrayal by parents, incompleteness, regret and anger.⁵ There is increasing awareness of the severe psychological consequences of FGM for girls and women, which can become evident in mental health problems.

The results from research⁶ in practising African communities are that women who have undergone FGM have the same levels of Post Traumatic Stress Disorder ("PTSD") as adults who have been subjected to early childhood abuse, and that the majority of the women (80 per cent) suffer from affective (mood) or anxiety disorders. The fact that FGM is 'culturally embedded' in a girl's or woman's community appears not to protect her against the development of PTSD and other psychiatric disorders.

Professionals, particularly those in the health sector, should ensure that mental health support is made available to assist girls and women who have undergone FGM.

⁵ Haseena Lockhat (2004) *Female Genital Mutilation: Treating the Tears*, London: Middlesex University Press

⁶ Behrendt, A. et al (2005) Posttraumatic Stress Disorder and Memory Problems after Female Genital Mutilation, *American Journal of Psychiatry* 162:1000–1002, May.

CHAPTER THREE

IDENTIFYING GIRLS AND WOMEN AT RISK

Professionals in all agencies and individuals and groups need to be alert to the possibility of a girl or a woman being at risk of FGM or already having undergone FGM. There are a range of potential indicators that a child or young person may be at risk.

Victims of FGM are likely to come from a community that is known to practice FGM – see Section 2.5 for relevant countries.

Provided the FGM takes place in the UK, the nationality or residence status of the victim is irrelevant.

Professionals should also note that the girls and women at risk of FGM may not yet be aware of the practice or the fact that it might be applied to them. Sensitivity should always be shown when approaching the subject.

3.1 Specific factors which may heighten a girl's or woman's risk of being affected by FGM

There are a number of factors in addition to a girl's or woman's community that could increase the risk that she will be subjected to FGM:

- The position of the family and the level of integration within UK society – it is believed that communities less integrated into British society are more likely to carry out FGM.
- Any girl born to a woman who has been subjected to FGM must be considered to be at risk, as must other female children in the extended family.

- Any girl who has a sister who has already undergone FGM must be considered to be at risk, as must other female children in the extended family.
- Any girl withdrawn from personal, social or health education may be at risk as a result of her parents wishing to keep her uninformed about her body and rights.

3.2 Indications that FGM may be about to take place soon

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 or adolescence, at marriage or during the first pregnancy. However, the majority of cases of FGM are thought to take place between the ages of 5 and 8 and therefore girls within that age bracket are at a higher risk.

It is believed that FGM happens to British girls in the UK as well as overseas (often in the family's country of origin). Girls of school age who are subjected to FGM overseas are thought to be taken abroad at the start of the school holidays, particularly in the summer holidays, in order for there to be sufficient time for them to recover before returning to their studies.

There can also be clearer signs when FGM is imminent:

- It may be possible that families will practise FGM in the UK when a female family elder is around, particularly when she is visiting from a country of origin.
- A professional may hear reference to FGM in conversation, for example a girl may tell other children about it. (See Appendix B for commonly used terms in different languages).
- A girl may confide that she is to have a 'special procedure' or to attend a special occasion to 'become a woman'.

- A girl may request help from a teacher or another adult if she is aware or suspects that she is at immediate risk.
- Parents may state that they or a relative will be taking the child out of the country for a prolonged period.
- A girl may talk about a long holiday to her country of origin or another country where the practice is prevalent (see Section 2.5 for the nationalities which traditionally practise FGM).

3.3 Indications that FGM may have already taken place

It is important that professionals look out for signs that FGM has already taken place so that:

- the girl or woman affected can be offered help to deal with the consequences of FGM (see Section 2.10);
- enquiries can be made about other female family members who may need to be safeguarded from harm;
- criminal investigations into the perpetrators, including those who carry out the procedure, can be considered, with a view to prosecuting those who break the law and protecting others from harm.

There are a number of indications that a girl or woman has already been subjected to FGM:

- A girl or woman may have difficulty walking, sitting or standing.
- A girl or woman may spend longer than normal in the bathroom or toilet due to difficulties urinating.
- A girl may spend long periods of time away from a classroom during the day with bladder or menstrual problems.

CHAPTER FOUR

GOOD PRACTICE TO FOLLOW IN ALL CASES

4.1 Duty to safeguard

Safeguarding girls at risk of harm through FGM poses specific challenges because the families involved may give no other cause for concern, for example with regard to their parenting responsibilities or relationships with their children. However, there remains a duty on all professionals to act to safeguard girls at risk and it should always be remembered that:

1. FGM is an illegal act which is performed on a female, regardless of age.
2. Girls and young women at risk of FGM are entitled to be protected.
3. Girls and young women are at risk if a relative has undergone FGM, as FGM can be an inter-generational practice.
4. A girl may be removed from the country to undergo FGM.

4.1.1 An illegal act being performed on a female, regardless of age

In addition to the legislation specifically criminalising FGM (see Section 2.3), professionals must abide by other relevant laws such as the Children (Northern Ireland) Order 1995 and the Human Rights Act 1998 (Article 3 of the European Convention on Human Rights is particularly relevant (prohibition on torture or inhuman or degrading treatment or punishment)).

The UN Convention on the Rights of the Child, which the UK has ratified, also applies and makes clear that any person below the age of 18 has the right to protection from activities or events that may cause them harm and that they need special safeguards and care, including appropriate legal protection.

Professionals have a responsibility to ensure that families know that FGM is illegal, and should ensure that families know that the authorities are actively tackling the issue. This knowledge alone may deter families from having FGM performed on their children, and save girls and women from harm.

4.1.2 The need to safeguard girls and young women at risk of FGM

Article 66 of the Children (Northern Ireland) Order 1995 allows, in certain circumstances for the making of inquiries into a child's circumstances and places a duty on certain persons to assist with those inquiries. The purpose of the inquiries is to determine whether action is required to safeguard or promote the child's welfare.

A HSC Trust should exercise its powers under Article 66 if it has reason to believe that a child or young girl is likely to be subjected to, or has been subjected to, FGM.

Where a child or young girl appears to be in immediate danger of FGM, consideration should be given to legal interventions (see Chapter 5).

4.1.3 The risk to girls and young women where a relative has undergone FGM

Where professionals believe that a girl has undergone FGM, they must also consider the risks to other girls and women who may be related to her or living with/in the charge of her family. This is because it is recognised that FGM can be an inter-generational practice.

4.1.4 Situations where a girl may be removed from the country to undergo FGM

As described in Sections 2.3 and 2.4, it is unlawful to perform FGM, or to assist a girl or woman to perform FGM on herself, in Northern Ireland. It is an offence for UK nationals or permanent UK residents to perform FGM, or to assist a girl to perform FGM on herself, abroad. It is also an offence for a UK national or permanent resident to assist a non-UK person to perform a relevant act of FGM (as defined in section 3(2) of the Female Genital Mutilation Act 2003) abroad – this would cover taking a girl abroad to be subjected to FGM. However, there may be instances where the exact risk of this occurring is not known, but one parent – or a professional – may be concerned enough to alert professionals. In certain circumstances a prohibited steps order or wardship order can be used to prevent a girl being removed from the country – Chapter 5 sets out the possible legal interventions in more detail.

4.2 Talking about FGM

FGM is a complex and sensitive issue, which should be approached with care.

When talking about FGM, professionals should:

- ensure that a female professional is available to discuss the issues, if the girl or woman would prefer this;

- make no assumptions;
- give the girl time to talk and be willing to listen;
- create an opportunity for the individual to disclose;
- see the girl on her own in private;
- be sensitive to the intimate nature of the subject;
- be sensitive to the fact that the girl may remain loyal to her 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 girl is at risk of being subjected to the procedure;
- take detailed notes;
- use simple language and ask straightforward questions;
- use terminology that the girl will understand, e.g. she is unlikely to view the procedure as 'abusive';
- avoid loaded or offensive terminology such as 'mutilation' (see Appendix B for terms used in different languages which may be useful);
- use value-neutral terms which are understandable, such as:
 - “Have you been closed?”
 - “Were you circumcised?”
 - “Have you been cut down there?”
- be direct, as indirect questions can be confusing and may only serve to reveal any underlying embarrassment or discomfort that you or the girl 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?”
- give the message that the girl can come back to you if she wishes;

- give 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.

An accredited female interpreter may be required. Any interpreter should be appropriately trained in relation to FGM and should not be a family member, known to the individual, or someone with influence in the girl's community. This is because girls or women may feel embarrassed to discuss sensitive issues in front of such people and there is a risk that personal information may be passed on to others in their community and place them in danger.

Furthermore, there is a risk that interpreters who are from the family or who are from the individual's community may deliberately mislead professionals and/or encourage the girl to drop the complaint and submit to the wishes of her community or family.

Women often recount feelings of great distress and humiliation due to the responses they receive from professionals when it is revealed that they have been subjected to FGM. They describe looks of horror, inappropriate and insulting questions, and feelings of shame from being made to feel 'abnormal'. Such negative reactions from professionals are caused by a lack of awareness or understanding of the issue, but can be devastating to a woman who has been subjected to FGM. These stories of negative experiences may reach the communities that practise FGM and could build barriers to the

effective care and prevention of FGM, and deter women and girls from seeking treatment or support.

Asking the right questions in a straightforward and sensitive way is key to establishing an understanding and securing the exchange of information which is needed to ensure that the girl or woman, and her family members, are given the care, protection and safeguarding they need.

Remember:

- Girls/women may wish to be interviewed by a professional of the same gender.
- Girls/women may not want to be seen by a professional from their own community.
- Alerting the girl's or woman's family to the fact that she is disclosing information about FGM may place her at risk of harm.
- Develop a safety and support plan in case the girl/woman is seen by someone 'hostile' at or near the department, venue or meeting place, e.g. prepare another reason why she is there.

- If the girl/woman insists on being accompanied during the interview, e.g. by a teacher or advocate, ensure that the accompanying person understands the discussions are confidential and must not be disclosed, especially to the girl or woman's family (see Section 4.6 for more details about disclosure).
- Some girls/women may require an authorised accredited interpreter, who speaks their dialect.
- Do not assume that families from practising communities will want their girls/ women to undergo FGM.

4.3 Things to be aware of in dealing with cases of FGM

For many people, prosecuting their family is something they simply will not consider. If the girl or woman is from overseas, fleeing potential FGM and applying to remain in the UK as a refugee is a complicated process and may require professional immigration advice.⁷ Many individuals, especially women, may be extremely frightened by contact with any statutory agency, as they may have been told that the authorities will deport them and/or take their parents or children from them.

Professionals need to be extremely sensitive to these fears when dealing with a victim or

potential victim from overseas, even if they have indefinite leave to remain or a right of abode, as they may not be aware of their true immigration position. These circumstances make them particularly vulnerable.

In such instances professionals should always seek informed legal advice.

If it is discovered that a girl/woman is in breach of immigration rules (for example if she has overstayed her visa), remember that she may also require medical treatment, or be the victim of a crime and be traumatised as a result. Guidelines on NHS treatment for overseas visitors can be found at –

www.nhs.uk/NHSEng/aboutNHSservices/uk-visitors/Pages/accessing-nhs-services.aspx

Do not allow any investigation of a girl/woman's immigration status to impede police enquiries into whether an offence may have been committed against her or her children. UK Border Agency officials and local police officers should discuss how any two simultaneous investigations may work.

4.4 Medical examinations

In some cases, it may be necessary to arrange a medical examination for emotional or physical conditions. In other cases, a girl/woman may require attention to injuries for evidential purposes. In either circumstance, it may not

⁷ (see www.ukba.homeoffice.gov.uk/asylum for more information about the asylum application process).

be advisable to call or visit a medical practitioner from the local community, as this may threaten the security of the girl/woman.

It is advisable in all cases where injuries are apparent to encourage the girl/woman to have those injuries documented for future reference.

Remember:

- The examination of a child or young person should be in accordance with the safeguarding children procedures and should normally be carried out by a consultant paediatrician, preferably with experience of dealing with cases of FGM.

4.5 Making enquiries

In general, enquiries should be undertaken by police officers with assistance from social workers. However, there may be occasions when professionals may wish to make informal enquiries before involving police if, for example, a girl has been absent from school for a prolonged period. In these circumstances, it is important not to reveal that the enquiries are related to FGM as this may increase the risk to the girl or woman. If the fact that the enquiries relate to FGM needs to be shared, this should only be shared with professionals aware of the need to handle such information appropriately. If enquiries by professionals produce information which may lead to the identification, apprehension or

prosecution of a person for an offence, that information must be reported to the PSNI (see section 5 of the Criminal Law Act (Northern Ireland) 1967 which sets out the penalties for concealing known or suspected offences).

4.6 Disclosure and confidentiality

To safeguard children and young people as required by UK law, it may be necessary to give information to people working in other agencies or departments. For some professionals, this can pose dilemmas when it involves going beyond the normal boundaries of confidentiality. Nonetheless, both law and policy allow for disclosure where it is in the public interest or where a criminal act may have been perpetrated. There may also be the perception that passing on information can damage the relationship of trust built up with families and communities. However, it is crucial that the focus is kept on the best interests of the girl/woman, as required by law.

Guidance about disclosure and when confidentiality can be breached is available in the following publications:

- *Co-operating to Safeguard Children* (2003)
- Nursing and Midwifery Council's *advice on confidentiality* (2009)

- General Medical Council's guidance (2009) *Confidentiality*
- National Police Improvement Agency on behalf of the Association of Chief Police Officers (2010) *Guidance on the Management of Police Information*.⁸

Referrals to other professionals or agencies should be conducted using existing and agreed procedures and arrangements.

4.7 A victim-centred approach

Whatever a girl or woman's circumstances, they have rights that should always be respected, such as the right to personal safety and to be given accurate information about their rights and choices. Professionals should listen to the girl/woman and respect her wishes as far as possible. However, there may be times when a girl/woman wants to take a course of action which may put her at risk. On these occasions, professionals should explain all the outcomes and risks to the individual and follow the prescribed child or adult protection procedures.

Professionals should also be clear that FGM is a criminal offence in

⁸ See Appendix D for links to these documents

the UK and must not be permitted or condoned.

4.8 Forced marriage and FGM

There have been reports of cases where girls/women have been subjected to both FGM and forced marriage. If you are concerned about an individual who may be at risk of both practices you can contact the UK Government's Forced Marriage Unit for advice on 020 7008 0151 (Monday – Friday, 9am – 5pm) or 020 7008 1500 (in emergencies outside these hours - ask for the Global Response Centre).⁹

A 24 hour helpline, which specialises in responses to FGM, has been set up by the NSPCC, in association with a number of voluntary and professional groups, including FGM charities. The helpline is staffed by counsellors who are specially trained in child protection. They can offer advice and support and can assist with referrals to statutory agencies and other services.

The helpline number is:

0800 0283550.

Emails can be sent to:

fgmhelpline@nspcc.org.uk

⁹ There is statutory guidance on how to deal with forced marriage see: <http://www.dfpni.gov.uk/the-right-to-choose-forced-marriage.pdf>

CHAPTER FIVE

LEGAL INTERVENTIONS

FGM is illegal in the UK (see Sections 2.3 and 2.4 for more details) and is a clear and severe form of child abuse and violence against women. Professionals should intervene to safeguard and protect girls and women who may be at risk of FGM or who have been affected by it.

This Chapter does not set out new policies, procedures or requirements for the police and other statutory authorities. Rather, it highlights the relevant existing statutory procedures which may be used in cases of FGM, namely –

- police protection;
- emergency protection orders;
- care or supervision orders;
- inherent jurisdiction;
- applications for wardship; and
- repatriation.

5.1 Police protection

HSC Children's Services may approach the police and ask for their assistance in undertaking a joint investigation. The way in which this is to be handled should be covered by locally agreed procedures¹⁰ and in accordance with *Co-operating to Safeguard Children*. A joint approach may be particularly useful where it is thought that a girl or young woman is at immediate risk of FGM.

Where there is reasonable cause to believe that a child or young person, under the age of 18 years, is at risk of significant harm, a police officer may remove the child or young person from the parent and take her into police protection

for up to 72 hours (see Article 65(1)(a) of the Children (Northern Ireland) Order 1995).

The police must inform HSC Children's Services and may ask them to assist in finding safe and secure accommodation for the girl or young woman. HSC Children's Services should commence child protection inquiries (see Article 66 of the Children (Northern Ireland) Order 1995). If no protective orders are put in place within the 72 hour period (HSC Children's Services may apply for an emergency protection order (see Section 5.2) at any point within the 72 hours if the child or young person is still considered to be at risk of significant harm), the child or young person must be released from police protection and returned to her parent or carer.

¹⁰ e.g. The Protocol for Joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse – Northern Ireland (April 2013)

HSC Children's Services must assist the police, if requested to do so, by arranging a placement for the child or young person in a place of safety, taking into account risk management and safety planning.

Remember:

- police officers have power, under Article 19(1)(e) of the Police and Criminal Evidence (Northern Ireland) Order 1989, to enter and search any premises in order to protect life or prevent injury.
- police officers can also prevent the removal of a child or young person from a hospital or other safe place in which the child or young person is accommodated (see Article 65(1)(b) of the Children (Northern Ireland) Order 1995).
- the parents may ask for contact with the child or young person who is under police protection. This does not have to be granted if, in the opinion of the designated officer, it is not in the best interests of the child or young person (i.e. if it would place the child or young person in danger). The designated officer should maintain a record of his/her decision and the rationale for that decision.
- the local Public Protection Unit (child abuse investigation unit) must be informed of any child or young person under police protection.
- a girl or woman may wish to see a police officer of the same gender.
- the girl or woman may, or may not, want to see a police officer from her own community – try to give her the choice.
- in all cases, ensure that the child protection register has been checked. and establish whether the child/young person may be looked after by the HSCT or otherwise known to the HSCT.
- the police do not have parental responsibility with respect to the child or young person while she is under police protection, but they can do what is reasonable in the circumstances for the purpose of safeguarding or promoting her welfare.
- the police cannot make any decisions for the child or young person beyond the 72 hour period.

5.2 Emergency Protection Orders

If it is not considered appropriate to take a girl or young woman into police protection, or if the situation cannot be resolved during the 72 hours of police protection, an emergency protection order (“EPO”) should be considered by the relevant HSCT.

The application can be made by anyone, but in practice it is usually made by HSC Children’s Services.

An EPO –

- authorises the applicant to remove the girl and keep her in safe accommodation;
- will only be granted to safeguard the girl’s welfare;
- lasts for up to eight days (this includes any period in police protection), but may be extended on one occasion for up to seven days.

If the person applying for an EPO is anyone other than HSC Children’s Services, HSC Children’s Services must be informed and must then undertake Article 66 inquiries (see section 4.1.2 above). HSC Children’s Services have the power, having consulted with the applicant and the child or young person, to take over the EPO and responsibility for the child or young person (see the Emergency Protection Orders (Transfer of Responsibilities) Regulations (Northern Ireland) 1996, SR 1996 No. 435).

An application may be made to court for an EPO without giving notice to the parents if this is necessary to protect the child or young person. In exceptional cases, where the application is particularly urgent, it can be made by telephone.

Remember:

- an EPO is open to challenge by the child/young person, the child’s or young person’s parents or any person with parental responsibility.
- once an EPO is made, the applicant shares parental responsibility with the parents but can only exercise that responsibility so far as is required to safeguard or promote the welfare of the child or young person.
- HSC Children’s Services do not need to release details of where the child or young person is living if this is necessary to protect her.
- if it is necessary to protect the child or young person, the court should be asked for an order which states that there be no contact (or only restricted contact) during the period of the EPO.

- HSC Children’s Services are, in certain circumstances, under a duty to make child protection inquiries (under Article 66 of the Children (Northern Ireland) Order 1995). One of those circumstances is when a child or young person living in their area is the subject of an EPO.
- the harm, or likelihood of harm, is attributable to (among other things) the care given to the child or young person, or likely to be given to them if the order were not made, not being what it would be reasonable to expect a parent to give to a child or young person.

For further information on court orders see The Children (Northern Ireland) Order 1995: Guidance and Regulations, Volume 1: Court Orders.¹¹

5.3 Care Orders and Supervision Orders

Sometimes, an EPO is followed by an application for a care order or a supervision order (see Article 50 of the Children (Northern Ireland) Order 1995). Without such an application, the EPO will lapse and the applicant will no longer have parental responsibility.

A court will only make an interim care order or an interim supervision order under Article 57 of the Children (Northern Ireland) Order 1995 if it is satisfied that there are reasonable grounds to believe that the following threshold criteria are met:

- the child or young person concerned is suffering, or is likely to suffer, significant harm; and

Note: the term ‘significant harm’ should be taken to include all forms of abuse – physical, sexual and emotional, and all forms of ill treatment that are not physical.

It is the court’s responsibility to decide whether an order is necessary to protect the child or young person and what sort of order is the most appropriate.

Article 50(4) of the Children (Northern Ireland) Order 1995 provides that no care order or supervision order may be made with respect to a young person who has reached the age of 17 (or 16 in the case of a young person who is married).¹²

The advantage of a care order over a supervision order is that it allows greater protection to be offered to the child or young person, as the applicant may obtain an order that there be no contact with the family and may conceal the whereabouts of the child or young person if that is

¹¹ <http://www.dhsspsni.gov.uk/children-order-guidance-regulations>

¹² There is statutory guidance on how to deal with forced marriage see: <http://www.dfpni.gov.uk/the-right-to-choose-forced-marriage.pdf>

necessary to ensure adequate protection.

When a care order or supervision order is not available due to the age of the young person, HSC Children's Services should be aware of the opportunities presented by a ward of court order. This is available for children/young people of up to 18 years old and, while social services themselves cannot have a young person 'warded' without leave of the court, the young person or an adult friend or advocate can apply for wardship and various directions can be attached, as required. Very commonly, for a child or young person in fear of being taken abroad, the directions will relate to surrendering passports to the court so that the child or young person may not leave the jurisdiction without the court's permission (see Section 5.5 for further information on wardship).

Remember:

- A care order gives parental responsibility to the applicant/designated authority, who can then decide the extent to which others with parental responsibility may meet that responsibility. A care order places the designated authority under a duty to receive the child or young person into its care in order to safeguard and promote the child's or young person's welfare. Young people are not able to apply for a care order on their own behalf.

- A care order cannot be made once a young person has reached the age of 17 or, in the case of a married person, 16.¹³
- If a care order is granted, it lasts until the young person reaches the age of 18, unless it is discharged before then. It is a criminal offence to remove a child or young person who is subject to a care order from the UK, without the express consent of the designated authority (and every other person who has parental responsibility), or the court.
- When a care order is not appropriate, wardship may still be an option (see Section 5.5).

The parents may agree to the child or young person being accommodated by the designated authority in an attempt to forestall the authority's application for an order. The accommodation provided must adequately protect the child or young person. When a child or young person is accommodated on a voluntary basis, the designated authority will not share parental responsibility and may be forced to disclose to the parents where the child or young person is living. It may be the case that a care order or wardship can offer greater protection to the child or young person.

¹³ See footnote 11

If there is a relative or adult whom the child or young person can trust, that person could apply for a residence order with respect to the child or young person. This can be done as a freestanding application or within the care proceedings. Again, the question is likely to arise as to whether such an order will provide adequate protection to the child or young person. Although the residence order holder would share parental responsibility, the parents would retain their parental responsibility and would know where the child or young person was living. However, the residence order holder could also apply for a prohibited steps order or a specific issue order to keep the whereabouts of the child or young person undisclosed.

It is possible for an authority to acquire a supervision order (on the same criteria as a care order) to accompany a residence order. A supervision order places a duty on the supervisor to advise, assist and befriend the supervised child or young person. Such an order could provide much needed backup to a residence order holder, although it would not give the designated authority parental responsibility. If the child or young person is not in care, the designated authority could, with the leave of the court, obtain a prohibited steps order under Article 8 of the Children (Northern Ireland) Order 1995. Such an order could prohibit the parents from removing the child or young person from the country without the permission of the court. However, it would not confer parental responsibility on the designated authority. Following

a prohibited steps order, further steps should be taken by HSC Children's Services, education professionals and the police to monitor the continuing wellbeing and safety of the child or young person if they remain in the family home.

5.4 Inherent jurisdiction

There will be cases where a care order is not appropriate, possibly because of the age of the young person. HSC Children's Services may ask the court to exercise its inherent jurisdiction to protect the young person. Any interested party can apply to have a young person up to the age of 18 made a ward of court.

For the purposes of obtaining protection for a child or young person, there is little difference between wardship and the other orders made in the exercise of the inherent jurisdiction of the High Court. Orders made under the inherent jurisdiction are flexible and wide ranging and an order may be sought where there is a real risk of a girl or young woman being subjected to FGM. Where there is a fear that a girl or young woman may be taken abroad for the purpose of FGM, an order for the surrender of her passport may be made, as well as an order that the child or young person may not leave the jurisdiction without the court's permission.

Orders for the immediate return of the child or young person can be obtained. These orders can be enforced against family members or extended family members.

5.5 Applications for wardship

Once a young person has left the country, there are fewer legal options open to police, HSC Children's Services, other agencies or persons to recover the young person and bring her back to the UK. One course of action is to seek the return of the young person to the jurisdiction of Northern Ireland by making her a ward of court.

An application for wardship is made to the Family Division of the High Court and may be made by any interested person, including HSC Children's Services, if they have permission under Article 173 of the Children (Northern Ireland) Order 1995. Once the order is obtained, the cooperation of the authorities in the country to which the child or young person has been taken can be sought. Without such cooperation, it may be difficult to locate and return the child or young person.

5.6 Repatriation

When a British national seeks assistance at a British Embassy or High Commission overseas and wishes to return to the UK, the Foreign and Commonwealth Office (FCO) will do what it can to assist or repatriate the individual. Sometimes the FCO may ask the police or HSC Children's Services for assistance when a British

national is being repatriated to the UK from overseas.

In cases concerning FGM, the victim may be extremely traumatised and frightened. They may have been held against their will for many months or years. They may have suffered emotional and physical abuse. Sometimes they will have risked their life to escape and their family may go to considerable lengths to find them. This makes all victims extremely vulnerable when they return to the UK. Unfortunately, due to the urgency of the situation, the FCO may not be able to give the police or HSC Children's Services much, if any, notice of the person's arrival.

In some instances the FCO will only be able to assist a repatriation with the assistance and support of UK agencies – for example, in the case of the repatriation of a minor in very limited circumstances where certain criteria are met.

Remember:

- The FCO cannot pay for a repatriation. It will normally ask the person or trusted friends to fund the cost of repatriation. In some cases, repatriation has been funded by schools or social services. However, this should never delay the process of getting the individual to safety.

- The FCO can facilitate a British national's return to the UK by providing emergency travel documents, in some exceptional circumstances helping to arrange flights and, where possible, by helping to find temporary safe accommodation while the person is overseas.
- The FCO or social services may ask the police to meet the person on arrival, in case family members try to abduct them at the airport.

CHAPTER SIX

GUIDELINES FOR HEALTH PROFESSIONALS

Professionals should be familiar with the full relevant clinical guidance when dealing with any case of suspected FGM. Details of publications can be found in Appendix D.

6.1 How health professionals can make a difference

Health professionals have a key role and must recognise the possibility that FGM may occur, intervene to prevent girls and women from being harmed and provide support to victims of FGM. However, investigations and enquires about any criminal offence are the responsibility of the police and social services, and should not be conducted by health professionals.

While the overarching legal issue related to FGM is its illegality, professionals must also ensure that they provide care and support that is consistent with safeguarding law and policy. Professionals should be familiar with *Co-operating to Safeguard Children* (2003) and the appropriate provisions in the Children (Northern Ireland) Order 1995.

It is essential to refer to, and work with, others such as teachers, HSC Children's Services and the police where necessary (see Section 4.6 for details on referrals to appropriate agencies and breaching confidentiality). Both law and policy allow for disclosure to safeguard a child/ young person from harm, where it is in the public

interest or where a criminal act has been perpetrated.

Awareness of FGM, the communities involved (see Section 2.5) and the indicators of risk (see Chapter 3) is an important starting point in ensuring provision of the support and interventions needed. In addition to the specific steps set out below, all professionals are encouraged to:

- inform/raise awareness among their colleagues about the issues surrounding FGM, including these guidelines;
- include black and ethnic minority women's issues (such as FGM) within domestic violence training;
- circulate and display copies of FGM leaflets and posters (see Appendix D for details);
- deal with FGM in a sensitive and professional manner, and be sufficiently prepared so that they do not exhibit

signs of shock, confusion, horror or revulsion when treating an individual affected by FGM (see Section 4.2 for advice on how to talk about FGM);

- always consider other girls and women in the family/extended family who may be at risk of FGM when dealing with a particular case;
- ensure that mental health issues are considered when supporting girls and women affected by FGM.

6.2 General practitioners and practice nurses

General practitioners (GPs) and practice nurses are well placed to identify girls and women in need of treatment to deal with the consequences of FGM (see Section 2.10), as well as to identify and protect those who may be at risk.

GPs and practice nurses are encouraged to consider a number of areas:

- A question about FGM should be asked when a routine patient history is being taken from girls and women from communities that traditionally practise FGM (see Section 2.5).
- Information about FGM should be made part of any 'welcome pack' given to a practice's new patients (see Appendix D for details of materials available).

- Consider the risk of FGM being performed on girls and women overseas when vaccinations are requested for an extended break.

6.3 Health visitors, school nurses, community children's nurses and community paediatricians

The position of health visitors, school nurses, community children's nurses (CCNs) and community paediatricians means that they are well placed to identify those at risk of FGM and those who have already been affected, and to act. Health visitors, in particular, work closely with families in their homes, and have a key role in terms of health promotion and education from an early age in a girl's life. This may include helping and supporting families to explore ways of breaking the cycle of FGM. Health visitors, school nurses and CCNs are also well placed to collaborate in support and referral as part of multi-professional teams.

Community child health professionals can intervene to tackle FGM in a number of ways:

- Health visitors visiting a mother known to have undergone FGM should ensure that the family is aware of its illegality in the UK, and consider whether any girls in the family need safeguarding.

- School nurses, CCNs and community paediatricians may be in a position of trust and may receive disclosures from girls and young women (or their friends) that lead them to suspect that they are at risk. They should be prepared and able to talk about the subject professionally and sensitively (see Section 4.2).
- The presence of FGM should be considered even if a woman has had previous vaginal births. This should be addressed as early as possible during pregnancy or, if a woman is admitted who is already in labour, it is important to check for any re-suturing.

6.4 Obstetricians, midwives and neonatal staff

Obstetricians or midwives may become concerned about a girl or woman being at risk while attending at a birth. When there is concern that a child or young person may be at risk of FGM, information should be shared on an interagency basis in keeping with *Co-operating to Safeguard Children* (2003) and the *Regional Child Protection Policy and Procedures*. A number of practical actions can be taken to support those at risk of FGM:

- At the antenatal booking, the process of history taking should identify women who have undergone FGM.
- The appropriate care pathway for the woman during pregnancy, delivery and postnatal care should be developed by the midwives and obstetricians with the woman.
- When a woman who has undergone FGM gives birth to a daughter, she should be provided with clear information that FGM is illegal in the UK and should not be performed on her daughter. It is important that this is done in a sensitive manner as the woman may have been a victim of enforced FGM and may be distressed at the suggestion that she would do the same to her daughter (see Section 4.2 for more details on talking about FGM).
- The type of FGM (see Section 2.2) should be clearly recorded on the woman's medical records, including a detailed description of the genitals, identifying the presence/absence and condition of each structure.

- FGM should be documented in the antenatal notes but if for any reason this is not the case, it should be done post-natally before the transfer home after delivery.
- The woman's health visitor and GP should be informed that she has undergone FGM so they can ensure that she receives any required medical and mental health support, reinforce the messages about the illegality of the practice, and safeguard her daughters and other female family members.

6.5 Other healthcare Professionals

Children and young people are cared for across health services within both children's and adult services, and in specialist areas such as gynaecology, sexual and reproductive health and genitourinary services.

All health professionals must be aware of the issues around FGM (see Chapter 2). They must be able to recognise when girls or young women may be at risk of FGM or have already had FGM performed on them (see Chapter 3). They must also proactively work with other agencies to protect girls and young women who may be at risk.

6.6 Clinical issues and procedures

Health professionals, particularly obstetricians and midwives, need to be aware of how to care for women and girls who have undergone FGM, particularly when giving birth.

Professionals should be familiar with the full, relevant clinical guidance when dealing with any case of suspected FGM. Details of publications can be found in Appendix D.

Some women/girls seek help because they wish to undergo deinfibulation before marrying, or may be experiencing problems conceiving because of difficulties with penetration. Often known as 'reversal', deinfibulation involves opening the scar tissue that covers the vaginal introitus and the urethral meatus surgically. Although best performed when not pregnant, women may need reversal to be done during pregnancy or as an emergency, for example during a miscarriage. This is because products of conception, such as blood clots and fetal tissue, can be retained behind scar tissue and may lead to serious infection.

All women who have undergone Type 3 FGM (infibulation) should be informed that deinfibulation is an option and be informed about the benefits of this. Women should be referred to a service with the relevant skilled and experienced healthcare professionals to carry out the procedure.

The FGM National Clinical Group has produced an educational DVD which clearly instructs and shows doctors, midwives and nurses how to undertake deinfibulation. This can be ordered from the group's website: www.fgmnationalgroup.org

6.7 Re-suturing or reinfibulation

Re-suturing, often known as reinfibulation or closing, should never be performed because it is illegal for any professional to do this in the UK.

This may mean that careful discussions have to be held with the woman, her partner and family to explain the law and why reinfibulation has to be refused. Women may themselves request reinfibulation for social reasons or because they have known nothing else. It is necessary to follow up with the woman during the post-natal period, as reinfibulation may be performed illegally at this point. Support, information and counselling continue to be very important.

Healthcare professionals who participate in FGM or reinfibulation will be breaking the law and would also be answerable to the respective professional registers.

For women who have undergone deinfibulation, health professionals should communicate equally the disadvantages of infibulation and the benefits of not being reinfibulated after childbirth:

- It is more hygienic.

- It means that sex will be much more comfortable and better once both partners get used to it.
- It will make future births much easier and less risky.
- It increases the likelihood of conception.
- It reduces the risk of complications in future pregnancies and the subsequent chance of perinatal death.

Once girls and women know all the facts and the benefits of not undergoing reinfibulation, most are happy not to do so. However, health professionals should not assume that this means that the woman will be more able to resist the pressure from her community to subject any daughter(s) she may have to FGM; **therefore steps must be taken to protect the daughter(s) as well as any female children in the family or extended family.**

6.8 Counselling

All girls or women who have undergone FGM should be offered counselling to address how things will be different for her afterwards. The woman should be offered counselling sessions, taking into account that she may not want to make the arrangements for these while her boyfriend, partner, husband or other family members are present.

Professionals should be aware that there may be coercion and control involved, which may have repercussions for the girl or

woman. Boyfriends, partners and husbands should also be offered counselling.

CHAPTER SEVEN

GUIDELINES FOR POLICE SERVICE

7.1 How police officers can make a difference

FGM is not a matter that can be left to be decided by personal preference or tradition; it is an extremely harmful practice. FGM is child abuse, a form of violence against women and girls, and is against the law, with a maximum prison sentence of 14 years.

By virtue of Article 3 of the Criminal Attempts and Conspiracy (NI) Order 1983, it is also 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.

Officers should not let fears of being branded 'racist' or insensitive to cultural traditions weaken their investigative strategy. Although officers should consider and research cultural matters around this issue, FGM investigations should be robust, with a view to upholding the law.

Criminal investigations should follow the PSNI's Service Procedure: "Police response to Female Genital Mutilation" and those for child protection investigations. Accordingly, offences of FGM should be investigated in line with the procedures set out in the "Protocol for Joint Investigation by Social Workers & Police Officers of

Alleged & Suspected Cases of Child Abuse- Northern Ireland" (April 2013).¹⁴

The procedures in this section apply, in particular, to officers and staff in:

- Public Protection Units;
- Rape Crime Units; and
- Youth Diversion Officers and teams which work, deal with, or come into contact with, children and young people.

7.2 Initial steps when a girl may be at risk of FGM

If an officer or member of police staff believes that a girl may be at risk of undergoing FGM an immediate referral must be made to the Child Abuse Investigation Unit in the District Public Protection Unit (PPU).

The PPU will take immediate steps to protect the girl from harm and preserve evidence and, where appropriate, will investigate any

¹⁴ Further, reference may be made to a number of guidance documents which have been produced by the Association of Chief Police Officers ("ACPO").

offences or refer the investigation to the District Crime Manager and/or the relevant D/Superintendent, Crime Operations in line with current policies and protocols, particularly the PSNI Service Procedure 'The Police Response to Female Genital Mutilation'.

Honour based violence (“HBV”) is a generic term which covers all “honour crimes”, including forced marriage and FGM. The PSNI Service Procedure: “Police Response to HBV” must also be closely referenced when dealing with FGM.

Even if it is outside core hours, appropriate protection measures must be put in place. The PPU will, in turn, make an immediate referral to the relevant HSC Children’s Services team. If any officer believes that the girl could be at immediate risk of significant harm, consideration should be given to the use of the police protection powers under Article 65 of the Children (Northern Ireland) Order 1995 (see Section 5.1).

Officers should carry out the following actions:

- Complete appropriate checks, e.g. child protection register.
- Refer to local HSC Children’s Services (unless they were the referrer).
- Inform District Intelligence Unit.
- Complete the relevant risk assessment/ management plans.

- Inform the relevant Contact Management Centre of the crime report, ensuring that the incident is flagged in accordance with PSNI procedures.
- Inform the Duty Inspector.
- Ensure that the on-call Superintendent 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.

7.2.1 Next steps when a girl may be at risk of FGM

In accordance with Article 66 of the Children (Northern Ireland) Order 1995, every referral with regard to FGM must generate a strategy meeting with the police, HSC Children’s Services, health professionals (school nurse, health visitor, or community/hospital paediatrician as appropriate) and the referrer (e.g. school) as soon as possible (**and in any case within three working days**). The minutes of the meeting and the decisions taken should be recorded, in line with relevant procedures.

The parents must be informed of the law and the dangers of FGM. This can be done by representatives from school, HSC Children’s Services, health professionals and/or the police. It is the duty of all professionals to

consider every possible way of securing parental co-operation, including the use of community organisations to facilitate the work with the parents and other family members.

If there is any suggestion or suspicion that the family still intends to subject the 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 Article 65 of the Children (Northern Ireland) Order 1995 and remove the girl to a place of safety (see Section 5.1). In addition, HSC Children's Services should consider the use of a prohibited steps order and/or emergency protection order (see Section 5.2). The welfare of other children within the family, in particular female siblings, should be reviewed and any appropriate actions taken. 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 the girl and any other siblings.

7.3 Initial steps when a girl is thought to have already undergone FGM

If any police officer or member of police staff is made aware that a girl has already undergone FGM, the duty inspector must be informed and an immediate referral should be made to the local PPU.

If this is outside the core hours, the Duty Inspector (or on-call Senior Investigating Officer) must manage the initial phase of the investigation and ensure that appropriate protection measures are put in place. The PPU will, in turn, make an immediate referral to the relevant HSC Children's Services.

Officers should carry out the following actions:

- Complete the appropriate checks, e.g. child protection register;
- Refer to local HSC Children's Services (unless they were the referrer)
- Inform District Intelligence Unit.
- Complete the relevant risk assessment and management plans.
- Inform the relevant Contact Management Centre of the crime report, ensuring that the incident is flagged in accordance with PSNI procedures.
- Inform the Duty Inspector.
- Ensure that the on-call Superintendent is made aware of the referral;
- Consider whether this could be a critical incident and deal with the matter accordingly.

The investigative strategy should aim to identify and investigate the excisors (people who carry out FGM for payment or otherwise), with a view to identifying further victims, assisting prosecutions and closing down networks.

7.3.1 Next steps when a girl is thought to have already undergone FGM

If it is believed or known that a girl has undergone FGM, an initial strategy meeting must be held as soon as possible (**and in any case within three working days**) to discuss the implications for the girl and the co-ordination 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 for the girl. Police action will, therefore, need to be in partnership with other agencies/ organisations. This should also be used as an opportunity to assess the need for support services, such as counselling, and medical assistance, as appropriate.

Police may wish to seek prosecutorial or pre-charge advice from the Public Prosecution Service ("PPS), where appropriate, in respect of any potential criminal investigation/proceedings.

A child protection case conference must be held **within fifteen working days** of the initial referral.

7.4 Conducting interviews about FGM

As with all criminal investigations, children and young people should

be interviewed under the relevant procedure/guidelines¹⁵, with a view to obtaining the best possible evidence for use in any prosecution. Consent should be obtained to record the interview and for allowing the use of the interview in family and/or criminal courts. In addition, information gained from the interview process will enable a risk assessment to be conducted as to the risk to any other children or siblings. See Section 4.2 for more information on talking about FGM with those affected.

7.5 Medical examinations

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.

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 girl or young woman, is offered and that appropriate referrals are made as necessary.

¹⁵ Such as the "Protocol for Joint Investigations by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse – Northern Ireland 2004" and "Achieving Best Evidence in Criminal Proceedings (Northern Ireland): Guidance for Vulnerable or Intimidated Witnesses, including Children".

Where a child refuses to be interviewed or undergo medical examination, assistance should be sought from an intermediary or community organisation.

Consideration should also be given to the need for legal protective measures, including the possible need for a wardship application.

7.2.6 Steps when an adult female has undergone FGM

If any police officer or member of 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 should include an assessment of the individual's vulnerability.

This meeting should also discuss any potential risk to any girls within the family (and extended family) and consider initial and core UNOCINI assessments of those girls. It should also consider providing support services for the woman/girls, including counselling and medical assistance.

The investigative strategy should consider identifying and investigating any excisors (and those who assist or facilitate excision) in the UK (people who carry out FGM for payment or otherwise), with a view to identifying further victims, assisting prosecutions and closing down networks.

CHAPTER EIGHT

GUIDELINES FOR HEALTH AND SOCIAL CARE CHILDREN'S SERVICES

All children's social care professionals should work in accordance with the guidelines in *Co-operating to Safeguard Children (2003)* and *Regional Child Protection Policy and Procedures (2005)*

8.1 How HSC Children's Services can make a difference

HSC Children's Services have a clear duty to safeguard children and must, therefore, work to prevent FGM taking place, and offer support to any girls affected by the practice.

FGM is not a matter that can be left to be decided by personal preference – it is an extremely harmful practice. Professionals should not let fears of being branded 'racist' or 'discriminatory' weaken the protection required by vulnerable girls and women.

HSC Children's Services have safeguarding protocols and procedures for helping children and young people who are facing abuse. Every office should, as part of its domestic violence and safeguarding children protocols, have multi-agency policies and procedures that include handling cases where FGM is alleged or known about.

Once concerns are raised about FGM, consideration should also be given to possible risks to other

children in the family and practising community. Professionals should be alert to the fact that any female child 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.

8.2 Strategy meeting

On receipt of a referral, a strategy meeting must be convened as soon as possible (and in any case within three working days), and should involve representatives from the police, HSC Children's Services, education professionals, and health services. Health providers or voluntary organisations with specific expertise – for example on FGM, domestic violence and/or sexual abuse – may be invited; and the need for legal advice should be considered.

The strategy meeting must first establish whether the parents or girl have had access to information about the harmful aspects of FGM and the law in the UK. If not, they should be given appropriate information regarding the law and harmful consequences of FGM.

If required an interpreter, who is 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. See Section 4.2 for more details.

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 of achieving parental co-operation, including the use of community organisations and/or community leaders (whose views on FGM are known and approved) to facilitate the work with the family. However, the child's interests are always paramount, and any agreement reached must be carefully monitored and enforced.

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 (see Chapter 5 for details of options). The primary focus is to prevent the child undergoing any form of FGM, rather than removal of the child from the family.

8.3 Steps when a girl is at immediate risk of FGM

If the strategy meeting decides that the girl is in immediate danger of FGM and/or professionals consider that her parents will proceed with performing FGM, then an EPO should be sought (see Section 5.2).

8.4 Steps when a girl has already undergone FGM

A strategy meeting should be convened as soon as possible (and, in any case, within two working days). The strategy meeting will consider how, where, when and by whom the procedure was performed and the implications of this. The strategy meeting will need to consider carefully whether to continue enquiries or whether to assess the need for support services. If there is evidence of any criminal act having taken place (for example, if the FGM took place in the UK or was performed or assisted by a British resident overseas), legal advice must be sought and a criminal investigation conducted.

A second strategy meeting should take place within ten working days of the referral. This meeting must evaluate the information collected in the enquiry and recommend whether a child protection conference is necessary to make a decision about whether the girl continues to be at risk of significant harm and needs further protection, and possibly to agree a child protection plan.

Consideration should always be given to the additional needs that a victim of FGM may have as there is a likelihood that the child/young person may have already been subject to threats and/or coercion and may have suffered emotional abuse/trauma. The need for counselling and medical help should be assessed and the needs of other female siblings/family members, who may be at risk, should also be considered.

CHAPTER NINE

GUIDELINES FOR SCHOOLS, COLLEGES AND UNIVERSITIES

9. 1 How staff can make a difference

Girls who are threatened with or who have undergone FGM may withdraw from education, restricting their educational and personal development. They may feel unable to go against the wishes of their parents and consequently may suffer emotionally. 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 attendance, 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 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.

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 where support and counselling are provided routinely. Students need to know that they will be listened to and their concerns taken seriously.

Schools, colleges and universities can create an 'open' and supportive environment by:

- circulating and displaying materials about FGM (see Appendix D for details);
- displaying relevant information, e.g. details of the NSPCC's Helpline and ChildLine services, Careline, the 24 hour Domestic Violence Helpline and appropriate black and minority ethnic women's groups (see Appendix C 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;

- informing/raising awareness about issues around FGM with colleagues – as well as including appropriate training in continuing professional development;
- 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 (see Appendix C);
- making materials such as books and DVDs available (see Appendix D);
- introducing FGM into the school curriculum within relevant classes, such as personal, social or health education.

9.2 What to do when you are concerned that a student may be at risk of, or has undergone, FGM

Staff may be concerned about a student because they are exhibiting some of the signs described in Sections 3.1 and 3.2. Alternatively, a student may approach a member of staff

because she is concerned that she is at risk, or to disclose that she has undergone FGM. A student may also approach staff to voice concern in relation to another student whom she/he believes may be at risk of FGM.

All efforts should be made to establish the full facts from the student at the earliest opportunity. Once the full facts have been established, the member of staff should be able to decide on the level of response required. If there is an indication that the child or young person is at risk of FGM or has undergone FGM, or she has expressed fears of reprisals or violence, the information must be shared with both the police and HSC Children's Services.

Staff should:

- talk about FGM in a professional and sensitive manner, in line with Section 4.2;
- explain that FGM is illegal in the UK and that the student will be protected by the law;
- liaise with the designated teacher with responsibility for safeguarding children;

- recognise and respect the student's wishes, where possible. However, child welfare must be paramount. FGM is child abuse and against the law. If a member of staff believes that the student is at risk of FGM, or has already undergone FGM, the police and HSC Children's Services must be informed even if this is against the student's wishes. If you do take action against the student's wishes, you must inform her of the reasons why and maintain a record of this decision and the rationale for it;
- activate local safeguarding procedures and local protocols for multi-agency liaison with the police and children's or adults' social care;
- ensure that the student is informed of the immediate and long-term health consequences of FGM to encourage her to seek and accept medical assistance;
- refer the student, with her consent, to appropriate medical help, counselling and local and national support groups (see Appendix C for details);
- ensure that safeguarding and protection is considered for any female family members.

Staff should not:

- decide that it is not their responsibility to follow up the allegation;
- treat such allegations merely as a domestic issue;
- ignore what the student has told them or dismiss out of hand the need for immediate protection;
- approach the student's family or those with influence within the community, in advance of any enquiries by the police, adult or children's social services, either by telephone or letter.

It is not the role of teachers, lecturers and staff to investigate allegations of abuse of a student and therefore, if the student is under 18 years, all referrals should be made in accordance with the relevant safeguarding children guidance. These referrals will usually be to HSC Children's Services or the police.

Remember:

- the student may not wish to be referred to a social worker, police officer or a guidance/ pastoral/ head teacher from her own community.

- consult other professionals, particularly an experienced manager/colleague or the local Police Protection Unit.
- speaking to the student's parents about the action you are taking may place the student at risk of emotional and/or physical harm. Therefore, do not approach the family as they may deny the allegations, feign co-operation, expedite any travel arrangements and hasten their plans to carry out the procedure.

9.3 What to do when a student stops attending school

If a teacher, lecturer or other member of staff suspects that a student has been removed from, or prevented from, attending education as a result of FGM, a referral should be made to the local social services and the police.

Staff may consider speaking to the student's friends to gather information – although they should not reveal that FGM is suspected, as this may get back to the family which may hasten any plans to perform the procedure.

Remember:

- there may be occasions when an education welfare officer or teacher visits the family in the UK to find out why the student is not

attending school or college. The family may tell the teacher that the student is being educated overseas. Sometimes, the family may suggest that the teacher speaks to the student on the telephone.

- if this occurs, the teacher should refuse to speak on the telephone and (if the student is a British national) insist that the student is presented at the nearest British Embassy or High Commission. There have been occasions when students have not been able to talk freely over the telephone or a different individual has spoken to the teacher.

Staff should not:

- remove the student from the school register without first making enquiries and/or referring the case to the police and local social services; or
- dismiss the student as taking unauthorised absence.

CHAPTER TEN

REDUCING THE PREVALENCE OF FGM

Wherever possible, all professionals should actively seek and support ways to reduce the prevalence of FGM in practising communities in the UK. This is not a straightforward process as cultural practices, such as FGM, have been ingrained for many generations, and require extensive work to change attitudes in order to address the issues thoroughly and effectively.

10.1 The role of Safeguarding Board for Northern Ireland

The Safeguarding Board oversees how agencies and organisations work and work together to ensure the safeguarding and the promotion of the welfare of children. In particular, it seeks to ensure that relevant agencies work in an inclusive, co-ordinated and consistent way to identify and prevent maltreatment or the impairment of a child's health or development. It has, therefore, a crucial role to play with regard to FGM and the drive to eliminate the practice.

10.2 Professional learning requirements

Raising awareness about the socio-cultural, ethical/legal, sexual health and clinical care implications involved in FGM is essential. Education and training must be provided for all health and social care professionals who may

work with affected women and girls and with their families. It is also important to consider the issues of ethnicity, custom, culture and religion in a sensitive manner.

Single agency, inter-agency and inter-disciplinary training will help to ensure that staff who have responsibility for child protection work are acquainted with child protection procedures in relation to FGM and are confident working with preventative programmes relating to FGM.

It is recommended that FGM should be a part of all staff training on safeguarding. Any programme of training around FGM should include the following:

- Overview of FGM (what it is, when and where it is performed).
- Socio-cultural context, including the perception of FGM as a religious obligation.
- Facts and figures.
- UK FGM and child protection law.
- FGM complications.
- Safeguarding children – principles to follow when FGM is suspected or has been performed.

- Roles of different professionals.

See Appendix D for details of materials available to professionals.

10.3 Working with communities to eliminate FGM

So-called cultural practices, such as FGM, can be deeply embedded in communities and so working towards their abandonment must be a 'bottom-up', community-led approach.

When dealing with individual cases, professionals should explore ways of resolving problems about the continuation of this practice in ways that involve individuals and families with their full participation. Education of male partners, families and community leaders can also be key to reducing the number of girls and women who suffer in the future. All community members should be encouraged to report any suspected cases of FGM, and the various anonymous means for doing this (see Appendix C) should be highlighted for those unwilling to provide their details to the authorities.

All professionals are encouraged to actively consider how best this could be done as part of existing work and engagement with practising communities, and how new initiatives could be established.

APPENDIX A

GLOSSARY OF TERMS USED

Adult

'Adult' means a person aged 18 years or over.

Girl, child, children and young people

'girl'/ 'child' means a person who has not reached her 18th birthday. This includes young people aged 16 and 17 who are living independently. Their status and entitlement to services and protection under the Children (Northern Ireland) Order 1995 is not altered by the fact that they are living independently.

Child abuse and neglect

Throughout this document, the recognised categories of maltreatment as set out in *Co-operating to Safeguard Children (2003)* and the *Regional Child Protection Policy and Procedures (2005)* have been used.

These are:

- physical abuse
- emotional abuse
- sexual abuse
- neglect

Child in need

Children who are defined as being 'in need' under Article 17 of the Children (Northern Ireland) Order 1995 are those who are unlikely to achieve or maintain, or to have the opportunity of achieving or

maintaining, a reasonable standard of health or development, or whose health or development will be significantly impaired, without the provision of services, plus those who are disabled. The authorities and other bodies have a duty to safeguard and promote the welfare of children in need.

Deinfibulation

See 'Infibulation'.

Domestic violence

The government defines domestic violence as: "threatening behaviour, violence or abuse (psychological, physical, verbal, sexual, financial or emotional) inflicted on one person by another where they are or have been intimate partners or family members, irrespective of gender or sexual orientation."¹⁶

This includes issues of particular concern to black and minority ethnic (BME) communities such as so called 'honour-based violence', **female genital mutilation (FGM)** and forced marriage."

Forced marriage

A forced marriage is a marriage in which one or both spouses do not (or, in the case of some adults with learning or physical disabilities, cannot) consent to the marriage and duress is involved. Duress can include physical, psychological,

¹⁶ The definition of domestic violence is under review and may be amended.

financial, sexual and emotional pressure.

Infibulation

Infibulation (Type 3 FGM) is the 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. **Deinfibulation** is the procedure to 're-open' a vaginal opening. **Reinfibulation** (also known as re-suturing) is the procedure to narrow a vaginal opening after it has been deinfibulated for childbirth, for example. Reinfibulation is illegal in the UK – see Section 6.7.

Reinfibulation or re-suturing

See 'Infibulation'.

Significant harm

The Children (Northern Ireland) Order 1995 introduced the concept of 'significant harm' as the threshold that justifies compulsory intervention in family life in the best interests of children and young people. It places a duty on authorities to make enquiries, with a view to deciding whether they should take action to safeguard or promote the welfare of a child who is suffering, or likely to suffer, significant harm.

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APPENDIX B

TERMS USED FOR FGM IN OTHER LANGUAGES

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

APPENDIX C

RELEVANT ORGANISATIONS

Northern Ireland Health and Social Care (HSC) Trusts - Gateway Services for Children's Social Work

Belfast HSC Trust Telephone (for referral) 028 9050 7000

Areas Greater Belfast area

Further Contact Details (for ongoing professional liaison)

Greater Belfast Gateway Team 414 Ormeau Road Belfast, BT7 3HY

Website <http://www.belfasttrust.hscni.net/>

Out of Hours Emergency Service (after 5pm each evening at weekends, and public/bank holidays)

028 90565444

SouthEastern HSC Trust Telephone (for referral) 0300 1000 300

Areas Lisburn, Dunmurry, Moira, Hillsborough, Bangor, Newtownards, Ards Peninsula, Comber, Downpatrick, Newcastle and Ballynahinch

Further Contact Details (for ongoing professional liaison)

Greater Lisburn Gateway Team

Stewartstown Road Health Centre 212 Stewartstown Road Dunmurry
Belfast, BT17 0FG

Tel: 028 90602705 Fax: 028 90629827

North Down Gateway Team

James Street Newtownards, BT23 4EP

Tel: 028 91818518 Fax: 028 90564830

Down Gateway Team

Children's Services 81 Market Street Downpatrick, BT30 6LZ

Tel: 028 44613511 Fax: 028 44615734

Website <http://www.setrust.hscni.net/>

Out of Hours Emergency Service (after 5pm each evening at weekends, and public/bank holidays)

028 90565444

Northern HSC Trust Telephone (for referral) 0300 1234 333

Areas Antrim, Carrickfergus, Newtownabbey, Larne, Ballymena, Cookstown, Magherafelt, Ballycastle, Ballymoney, Portrush and Coleraine

Further Contact Details (for ongoing professional liaison)

Central Gateway Team

Unit 5A, Toome Business Park Hillhead Road Toomebridge, BT41 3SF
Tel: 028 7965 1020 Fax: 028 7965 1036

South Eastern Gateway Team

The Beeches 76 Avondale Drive Ballyclare, BT39 9DB
Tel: 028 93340165 Fax: 028 9334 2531

Northern Gateway Team

Coleraine Child Care Team 7A Castlerock Road Coleraine, BT51 3HP
Tel: 028 7032 5462 Fax: 028 7035 7614

Website <http://www.northerntrust.hscni.net/>

Out of Hours Emergency Service (after 5pm each evening at weekends, and public/bank holidays)

028 94468833

Southern HSC Trust Telephone (for referral) 0800 7837 745

Areas Craigavon, Banbridge, Dromore, Lurgan, Portadown, Gilford, Armagh, Coalisland, Dungannon, Fivemiletown, Markethill, Moy, Tandragee, Ballygawley, Newry City, Bessbrook, Annalong, Rathfriland, Warrenpoint, Crossmaglen, Kilkeel, Newtownhamilton

Further Contact Details (for ongoing professional liaison)

Craigavon/Banbridge Gateway Team

Brownlow H&SS Centre 1 Legahory Centre Craigavon , BT65 5BE
Tel: 028 38343011 Fax: 028 38324366

Newry/Mourne Gateway Team

Dromalane House Dromalane Road Newry, BT35 8AP
Tel: 028 30825000 Option 1 Fax: 028 30825016

Armagh /Dungannon Gateway Team

E Floor South Tyrone Hospital Carland Road Dungannon, BT71 4AU
Tel: 028 87713506 Fax: 028 87713671

Central Gateway Team

Gosford Place The Mall West Armagh, BT61 9AR
Tel: 028 37415285 Fax: 028 37522544

Website <http://www.southerntrust.hscni.net/>

Out of Hours Emergency Service (after 5pm each evening at weekends, and public/bank holidays)
028 38334444

Western HSC Trust Telephone (for referral) 028 7131 4090

Areas Derry, Limavady, Strabane, Omagh and Enniskillen

Further Contact Details (for ongoing professional liaison)

Derry Gateway Team

Whitehill, 106 Irish Street Derry, BT47 2ND
Tel: 028 71314090 Fax: 028 71314091

Omagh Gateway Team

Tyrone and Fermanagh Hospital 1 Donaghane Road Omagh, BT79 ONS
Tel: 028 66344103 Fax: n/a

Enniskillen Gateway Team

2 Coleshill Road Enniskillen BT747HG
Tel: 028 66344103 Fax: n/a

Website <http://www.westerntrust.hscni.net/>

Out of Hours Emergency Service (after 5pm each evening at weekends, and public/bank holidays)
028 71345171

Police Service of Northern Ireland

Domestic Abuse Officers are available in all districts 0845 600 8000

Helplines

ChildLine

24-hour Helpline for children: 0800 1111

www.childline.org.uk

National Society for the Prevention of Cruelty to Children (NSPCC) Helpline

Free phone 0808 800 5000

help@nspcc.org.uk

NSPCC Helpline,
Weston House,
42 Curtain Road,
London,
EC2A 3NH

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

NSPCC FGM helpline: 0800 0283550.

E'mails can be sent to fgmhelpline@nspcc.org.uk

24 Hour Domestic & Sexual Violence Helpline
Call: 0808 802 1414
Email Support: 24hrsupport@dvhelpline.org
Text support to 07797 805 839

Freephone from all landlines and mobiles. Translation service available.

Black Association of Women Step Out (BAWSO) 02920 644633
24-hour Helpline: 0800 731 8147 www.bawso.org.uk

UK Government

Foreign and Commonwealth Office: www.fco.gov.uk/fgm

Other organisations

Children's Law Centre: 028 90 245704

info@childrenslawcentre.org

<http://childrenslawcentre.org/>

Northern Ireland Commissioner for Children and Young People: 028 9031 161

info@niccy.org

<http://www.niccy.org>

Northern Ireland Council for Ethnic Minorities: 028 9023 8645

<http://www.nicem.org.uk/>

Women's Aid Federation Northern Ireland: 028 9024 9041

Local Women's Aid Advice Centres

- Antrim, Ballymena, Carrickfergus, Larne and Newtownabbey 028 2563 2163
- Belfast and Lisburn 028 9066 6049
- Causeway 028 7035 6573
- Cookstown and Dungannon 028 8676 9300
- Craigavon and Banbridge 028 3834 3256
- Fermanagh 028 6632 8898
- Foyle 028 7128 0060
- Newry, Mourne, South Down and South Armagh 028 3025 0765
- North Down and Ards 028 9127 3196
- Omagh 028 8224 1414

Agency for Culture and Change Management UK (ACCM UK):
info@accmuk.com

Agency for Cultural Change and Management – Sheffield:
www.accmsheffield.org

Birmingham Against FGM: 0121 303 8200

cypfcomms@birmingham.gov.uk

Bristol FGM Network:
www.bristol.nhs.uk/Patients/BCH/default.asp

Council for Ethnic Minority Communities & FGM Northamptonshire:
www.fgmnorthamptonshire.btik.com

Equality Now: 020 7839 5456
www.equalitynow.org

FGM National Clinical Group:
www.fgmnationalgroup.org/index.htm

Foundation for Women's Health Research & Development (FORWARD): 020 8960 4000

www.forwarduk.org.uk

Iranian and Kurdish Women's Rights Organisation (IKWRO): 020 7920 6460
www.ikwro.org.uk

London Black Women's Health and Family Support: www.bwhafs.com

Manor Gardens Health Advocacy Project, North London: 020 7281 7694

www.manorgardenscentre.org

Teesside African Health Community:

www.tahc.co.uk

APPENDIX D

MATERIALS AVAILABLE ABOUT FGM

Guidance and guidelines for Professionals

The following list is not intended to be an exhaustive list of all applicable publications. Professionals should consult the relevant professional bodies and agencies for the up-to-date guidance.

- *Association of Chief Police Officers Guidance on Investigating Child Abuse and Safeguarding Children (2nd Edition)*

www.ceop.police.uk/Documents/ACPOGuidance2009.pdf

- National Police Improvement Agency on behalf of the Association of Chief Police Officers (2010) *Guidance on the Management of Police Information*.

www.acpo.police.uk/documents/information/2010/201004/INFMOP101.pdf

- DHSSPS: *Co-operating to Safeguard Children (2003)*

www.dhsspsni.gov.uk/co-operating_to_safeguard_children_may_2003.pdf

- Regional Child Protection Committee: *Regional Child Protection Policy and Procedures (2005)*

www.dhsspsni.gov.uk/acpcregionalstrategy.pdf

- British Medical Association (2006) *Female Genital Mutilation – Caring for Patients and Child Protection*

<http://bma.org.uk>

- General Medical Council (2006) *Raising Concerns about Patient Safety*

[www.gmc-uk.org/
Raising_and_acting_on_concerns_about_patient_safety_Final.pdf_47223556.pdf](http://www.gmc-uk.org/Raising_and_acting_on_concerns_about_patient_safety_Final.pdf_47223556.pdf)

- General Medical Council (2012) *Protecting children and young people: the responsibilities of all doctors*

www.gmc-uk.org/guidance/ethical_guidance/13257.asp

- General Medical Council (2007) *0–18 Years: Guidance for All Doctors*

www.gmc-uk.org/guidance/ethical_guidance/children_index.asp

- General Medical Council (2008) *Consent: Patients and Doctors Making Decisions Together*

www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp

- General Medical Council (2009) *Confidentiality*

www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp

- HM Government (2006) *What To Do If You Are Worried A Child Is Being Abused*

www.gov.uk/government/publications/what-to-do-if-youre-worried-a-child-is-being-abused

- HM Government (2010) *Call to End Violence against Women and Girls*

www.gov.uk/government/publications/call-to-end-violence-against-women-and-girls

- Nursing and Midwifery Council (2008) *The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives*

[www.nmc-uk.org/Documents/Standards/
nmcTheCodeStandardsOfConductPerformanceAndEthicsForNursesandMidwives
_TextVersion.pdf](http://www.nmc-uk.org/Documents/Standards/nmcTheCodeStandardsOfConductPerformanceAndEthicsForNursesandMidwives_TextVersion.pdf)

- Nursing and Midwifery Council: Advice on Confidentiality

www.nmc-uk.org/Nurses-and-midwives/Advice-by-topic/Advice/A/Confidentiality

- Royal College of Nursing (2006) *Female Genital Mutilation – An RCN Educational Resource for Nursing and Midwifery Staff*

www.rcn.org.uk/data/assets/pdf_file/0012/78699/003037.pdf

- Royal College of Obstetricians and Gynaecologists (2009) *Green-top Guideline No. 53 – Female Genital Mutilation and its Management*

www.rcog.org.uk/files/rcog-corp/GreenTop53FemaleGenitalMutilation.pdf

The FGM National Clinical Group has produced an educational DVD which clearly instructs and shows doctors, midwives and nurses how to undertake de-infibulation. This can be ordered from the group's website:

www.fgmnationalgroup.org

The UK Government's Department of Health has also produced a DVD about FGM, which can be ordered by emailing violence@dh.gsi.gov.uk

Information about the UK Government's strategy to eradicate violence against women and girls can be found at www.homeoffice.gov.uk/crime/violence-against-women-girls

Clinical guidance on FGM developed by Leeds Teaching Hospital Trust (LTHT) is available from the LTHT Haamla Service.

Government-produced leaflets and posters

Professionals, civil society partners and members of the public can download copies of the UK government's leaflet and poster about FGM from www.fco.gov.uk/fgm

Hard copies can be requested via fgm@fco.gov.uk

Books about FGM

- Waris Dirie, *Desert Flower* (ISBN 9780688158231)
- Layli Miller Bashir and Fauziya Kassindja, *Do They Hear You When You Cry?* (ISBN 9780553505634)
- Alice Walker, *Possessing the Secret of Joy* (ISBN 9780671789428)

Films about FGM

- Mooladé (2004)
- Fire Eyes (2004)
- Africa Rising (2009)

Research about FGM in the UK

- FORWARD (2007) *A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales*
- FORWARD (2009) *FGM is Always with Us: Experiences, Perceptions and Beliefs of Women Affected by Female Genital Mutilation in London: Results from a PEER Study*

APPENDIX E

Below is a list and contact details of hospitals and clinics in the UK offering specialist female genital mutilation health services.

African Well Women's Clinic - Guy's & St Thomas's Hospital

8th Floor - c/o Antenatal Clinic
Lambeth Palace Rd
London SE1 7EH
Tel: 020 7188 6872
Mobile: 07956 542 576
Open: Mon-Fri 9am - 4pm
Contact: Ms. Comfort Momoh MBE comfort.momoh@gstt.nhs.uk

African Well Women's Clinic - Antenatal Clinic - Central Middlesex Hospital

Acton Lane
Park Royal
London NW10 7NS
Tel: 020 8965 5733 or 020 8963 7177
Open: Friday 9am - 12pm
Contact: Kamal Shehata Iskander kamal.shehataiskander@mwlh.nhs.uk or
Jacky Deehan jacqueline.deehan@nwlh.nhs.uk

African Well Women's Clinic - Antenatal Clinic - Northwick Park & St Mark's Hospitals

Watford Road
Harrow
Middlesex HA1 3UJ
Tel: 020 8869 2870
Open: Friday 9am-5pm
Contact: Jeanette Carlsson

African Women's Health Clinic - Whittington Hospital

Level 5, Highgate Hill
London N19 5NF
Tel: 020 7288 3482 ext. 5954
Mobile: 0795 625 7992
Open: Last Wednesday of each month, 9am-5pm
Contacts: Joy Clarke joy.clarke@whittington.nhs.uk or Shamsa Ahmed

Women's and Young People's Service - Sylvia Parkhurst Health Centre - Mile End Hospital (3rd Floor)

Bancroft Road
London E1 4DG
Tel: 020 7377 7898 or 020 7377 7870
Open: Mon-Thursday 12pm- 8pm; Friday 9.30am-5.30pm
Contact: Dr. Geetha Subramanian geetha.subramanian@thpct.nhs.uk

African Women's Clinic - University College Hospital

Clinic 3; Elizabeth Garrett Anderson Wing Euston Road London, NW1 2BU
Tel 0845 155 5000

Open: Monday afternoon 2-5pm

Contact: Maligaye Bikoo maligaye.bikoo@uclh.nhs.uk

Multi-Cultural Antenatal Clinic - Liverpool Women's Hospital

Crown Street

Liverpool L8 7SS

Tel: 0151 702 4085 or 0771 751 6134

Open: Monday-Friday, 8.30am-4.30pm

Contact: Barbara Valjelo barbara.valjelo@lwh.nhs.uk

St Mary's Hospital - Gynaecology & Midwifery Departments

Praed Street

London W1 1NY

Tel: 020 7886 6691 / 020 7886 1443

Open: 9am- 5pm

Contacts: Judith Robbins or Sister Hany foong.han@imperial.nhs.uk

Birmingham Heartlands Hospital - Princess of Wales Women's Unit - Labour Ward

Bordesley Green East

Birmingham, B9 5SS

Tel: 0121 424 3909 / 07817534274

Open: Thursday and Friday

Contact: Alison Hughes alison.hughes@heartofengland.nhs.uk

African Women's Clinic - Women and Health

4 Carol Street

Camden, London NW1 OHU

Tel: 020 7482 2786

Open: Mon-Thurs 10am-8.30pm; Friday: 10am-5pm

Contact: Maligaye Bikoo maligaye.bikoo@uclh.nhs.uk

Acton African Well Woman Centre - Acton Health Centre

35-61 Church Road London, W3 8QE Tel: 0208 383 8761 or 07956001065

Open: Mon, Tues, Thurs: 8.30am-6.30pm; Weds: 8.30am-4pm; Fri: 8.30am-8pm (closed every day from 1-2pm)

Contact: Juliet Albert (Midwife) Juliet.albert@nhs.net or Hayat Arteh (Health Advocate) Hayat.arteht@nhs.net

Charlotte Keel Health Centre - Minority Ethnic Women's and Girls' Clinic

Seymour Road

Easton

Bristol, BS5 0UA

0117 902 7111

Open: Drop-in - last Wednesday of every month, 9.30am-12pm

Contact: Dr Hilary Cooling

Labour Ward, City Campus - Nottingham University Hospitals

Hucknall Road

Nottingham, NG5 1PB

Tel: 0115 969 1169 ext 55124 / 55127

Open: Monday, 13.30-17.00; Tuesday, 9-12

Contact: Carol McCormick carol.mccormick@nuh.nhs.uk

West London African Women's Hospital Clinic

Gynaecology and Antenatal Clinics Chelsea and Westminster Hospital 369

Fulham Road, London, SW10 9NH Tel: 0203 315 3344

fgmwestlondon@nhs.net

West London African Women's Community Clinic

West London Centre for Sexual Health Charing Cross Hospital (South Wing)

Fulham Palace Road London, W6 8RF Tel: 0203 315 3344

fgmwestlondon@nhs.net