

FGM: WHAT IT IS, WHEN AND WHERE IT IS PERFORMED

FGM is a deep-rooted cultural practice which involves the cutting or removal of external female genitalia. FGM has been classified by the World Health Organisation into four types. The terminology for FGM varies between communities. Victims and witnesses may not recognise terminology which is not used within their own community. People living in communities where FGM is practised may not view the procedure as a form of mutilation and may not understand the term or may consider it offensive. Victims and witnesses may refer to holding a ceremony, celebration or party in their honour, or becoming a woman. Terminology and questions that may be better understood includes: Circumcision – ‘Have you been circumcised?’ ‘Is circumcision practised in your community?’ Cut – ‘Have you been cut down there?’ ‘Have you been closed?’ Are you ‘clean’?

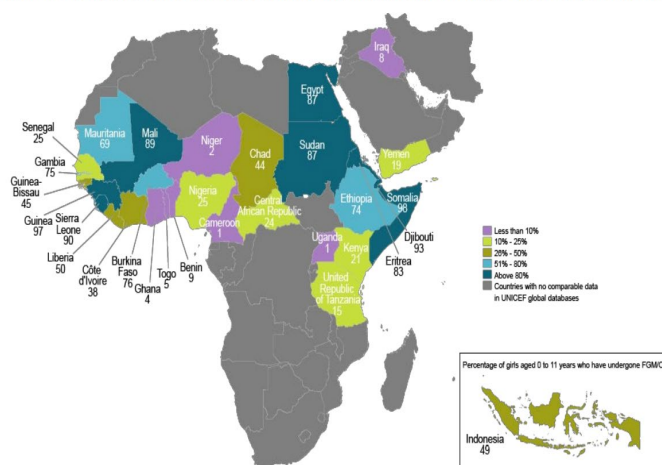
FGM is usually conducted by traditional excisors either in the country of origin or also now in the UK although there is also an increasing trend of medicalised FGM overseas and in the UK black market.

The age at which FGM is carried out varies enormously according to the community. The procedure may be carried out shortly after birth, during childhood or adolescence, just before marriage or during a woman's first pregnancy. In the UK, research suggests it is most often conducted on girls aged 5-8 or 5-10 years old. Where school age girls are taken overseas for FGM to be carried out, it most often occurs during summer school holidays, allowing them time to recover before returning to school.

Approximately 103,000 women aged 15-49 and approximately 24,000 women aged 50 and over who have migrated to England and Wales are estimated to be living with the consequences of FGM. The Government suggests, approximately 10,000 girls aged under 15 who have migrated to England and Wales are likely to have undergone FGM.

While FGM is concentrated in certain countries across Africa and the Middle East (eg Iraq, Yemen). FGM is documented in Colombia, Iran, Israel, Oman, United Arab Emirates, Occupied Palestinian Territories, India, Indonesia, Malaysia, Pakistan and Saudia Arabia. It occurs in practicing migrant communities in the UK, Europe, North America and Australia.

Figure 1: Percentage of girls and women aged 15-49 who have undergone FGM in Africa, the Middle East, and Indonesia



Source: UNICEF global databases, 2016, based on DHS, MICS and other nationally representative surveys, 2004-2015.

WHY IS FGM PERFORMED

There are numerous complex, interrelated reasons for FGM-performing communities to carry out FGM. FGM may be performed to control a woman's sexuality e.g. to reduce sexual desire, prevent premarital sex, preserve virginity and curtail marital infidelity. The clitoris may also be removed to enhance a woman's femininity and improve hygiene. In some communities, FGM is a rite of passage from childhood to adulthood, symbolising that a girl is now a woman, and is ready to fulfil her role as wife and begin reproduction. In communities where most women are cut, family, peers, and community members create an environment where the practice is normalised and acceptable and non-conformity has significant social consequences including family or community isolation. Whilst religion may be cited as a reason, there is no religious basis for the procedure and no religion advocates FGM.

Women who have undergone FGM may themselves play an important role in socialising girls to undergo FGM, often to avoid ostracisation from the community. In some communities FGM is seen as a natural and beneficial practice carried out by a loving family who believe it is in a girl's best interests. As a result, it cannot be assumed that parents or girls are likely to come forward and discuss the issue with frontline professionals, such as teachers, social workers or medical practitioners.

THE POTENTIAL CONSEQUENCES OF FGM

The health consequences of the practice vary depending on multiple factors such as the medical experience of the excisor, and the medicalised or non-medicalised context in which FGM is performed. Health complications include severe pain, shock, excessive bleeding, difficulty in passing urine, menstrual problems, infections (sepsis), HIV, psychological consequences such as post-traumatic stress, repeated FGM, birth complications, pain during sexual intercourse, infertility and in rare cases, death.

IDENTIFYING FGM

INDICATORS THAT A GIRL MAY BE AT RISK OF FGM:

- The girl's mother was subjected to FGM.
- The girl's sister is believed to have already undergone FGM.
- The girl has a father and/or mother who comes from a community known to practise FGM;
- The family indicate there are strong levels of influence by elders and/or elders are involved in bringing up female children
- Female family elders are visiting from an FGM-prevalent country.
- The girl talks about a special ceremony/'becoming a woman'.
- The girl talks about or a long holiday overseas for a prolonged period to a country where FGM is prevalent.
- Parents seek to withdraw their daughter from learning about FGM at school.
- The girl may disclose concerns that she could be cut to a teacher or school friend.
- Community or family has limited integration into Western society.
- The family is not engaging with professionals.

INDICATORS THAT A GIRL HAS UNDERGONE FGM:

- Discomfort or difficulty walking, sitting or standing.
- Spending longer in the toilet than usual due to difficulties urinating.
- Frequent bladder or menstrual problems.
- Prolonged or repeated absence from school.
- Noticeable change in behaviour, i.e. withdrawn or depressed.
- Reluctance to undergo normal medical examinations.
- A girl may confide in a professional or friend.

Note many of these indicators do not, on their own, indicate a risk/occurrence of FGM ie changed behaviour may be due to hormonal changes, parental marital difficulties, bereavements etc; many migrant families will return to countries of origin for extended stays; parents may mistrust professionals.

THE UK LAW ON FGM AND CHILD PROTECTION

FEMALE GENITAL MUTILATION ACT 2003 (FGMA):

It is illegal to perform FGM in England and Wales, or to assist anyone to carry out FGM outside the UK on a UK resident. Anyone with parental responsibility who has frequent contact with a girl and any other adult who is fulfilling a parental role may commit an offence of failing to protect a girl from FGM if they are aware that a girl is at significant risk of FGM and do not take reasonable steps to protect the girl.

Under Section 5B regulated health and social care professionals and teachers (qualified teachers and persons who are employed or engaged to carry out teaching work in schools and other institutions) in England and Wales must notify the police where, in the course of their work, they discover that an act of FGM appears to have been carried out on a girl aged under 18 (see further below). Upon receipt of such notification the police will conduct enquiries into any alleged offence. The Crown Prosecution Service (CPS) will decide whether a person should be charged with a criminal offence.

Where a local authority becomes aware that a girl is at risk of or has undergone FGM they may apply for a female genital mutilation protection order, a civil order which may be made for the purposes of protecting a girl. The court can make an order which prohibits, requires, restricts or includes any other term it considers appropriate to stop or change the behaviour or conduct of anyone who is seeking to or has already arranged for a girl to be subjected to FGM. The court can, for example, order the surrender of passports or other travel documents, including the passport/travel documentation of the girl to be protected; prohibit parents from taking their daughter abroad or prohibit parents or others from entering into any arrangements in the UK or overseas for FGM to be performed on the person. Breach of an FGMPo is a criminal offence with a maximum penalty of up to five years' in prison. Breach may also be treated as a contempt of court, punishable by up to two years' imprisonment, a fine, or both.

SAFEGUARDING OBLIGATIONS:

FGM is a child protection issue. The case of B and G (Children) (No 2) confirms that all types of FGM (including Type 4) constitute "significant harm" for the purposes of the Children Act 1989. Professionals should, therefore, have regard to their wider safeguarding responsibilities as detailed in Working Together to Safeguard Children and Keeping Children Safe in education when they identify a risk or occurrence of FGM.

WHAT TO DO WHEN FGM IS SUSPECTED OR DISCOVERED.

IF FGM IS SUSPECTED:

Where indicators of FGM are identified (ie a concerning disclosure is made by a girl from a community which practices FGM talking about a special celebration) then the DSL should be informed. The DSL may wish to consider discussing concerns with parents but should consider first carefully whether this would jeopardise safety or any criminal investigation. If the child is not at imminent risk of FGM then the DSL should inform children's social care. If there is an imminent risk of FGM or a person leaving the country so that FGM can take place, the police should be contacted on 999. If in doubt, advice should be sought from the DSL or from the Police or Children's Social Care about what to tell the woman / family in these circumstances.

IF FGM IS DISCOVERED:

Teachers in England and Wales must make a report to the police where, in the course of their professional duties, they (a) are informed by a girl under 18 that an act of FGM has been carried out on her; or (b) observe physical signs which appear to show that an act of FGM has been carried out on that girl and they have no reason to believe the act was necessary for the girl's physical or mental health or for purposes connected with labour or birth.

Reports should be made as soon as possible after FGM is discovered. Best practice is for reports to be made by the close of the next working day. A longer timeframe than the next working day may, however, be appropriate in exceptional cases where, for example, a professional has concerns that a report to the police is likely to result in an immediate safeguarding risk to the girl or their sibling and where consultation with colleagues or other agencies is necessary. This duty cannot be delegated to a school's DSL - teachers must personally report to the police cases where they discover that an act of FGM appears to have been carried out. The school must also make safeguarding children referral.

Other teaching staff are not subject to the s5B notification duty but still have a general responsibility to report cases of FGM, in line with wider safeguarding frameworks. If they become aware that FGM has been carried out on a girl under 18, they should share inform their designated safeguarding lead and follow their organisation's safeguarding procedures.

REFERENCES/FURTHER READING

- HM Government, 'Multi-agency statutory guidance on female genital mutilation' (2020)
<https://www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation>
- HM Government 'Mandatory reporting of female genital mutilation: procedural information' (2020)
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- Newcastle Safeguarding Children Partnership, 'Female Genital Mutilation Multi-Agency Practice Guidance' (2022)
<https://newcastlesafeguardingchildren.org.uk/wp-content/uploads/2024/11/24-FGM-Multiagency-Guidance-2022.pdf>
- Department of Education, 'Keeping Children Safe in Education' (2024)
https://assets.publishing.service.gov.uk/media/66d7301b9084b18b95709f75/Keeping_children_safe_in_education_2024.pdf
- College of Policing, 'Female Genital Mutilation' (2021)
<https://www.college.police.uk/tags/female-genital-mutilation>