Female Genital Mutilation (FGM)

Multi-agency Practice Guidance

February 2022 (reviewed Feb 2026)

This guidance is for all professionals working with children and families

Definition – FGM comprises all procedures involving partial or total removal of the external female organ or other injury to the female organs for non-medical reasons. It has no health benefits and harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue, and hence interferes with the natural function of the girls and women's bodies. The practice causes severe pain and has several immediate and long-term health consequences, including difficulties in childbirth also causing danger to the child.

The World Health Organisation has classified 4 types:

- Type 1 – Clitoridectomy: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris)

- Type 2 – Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are the 'lips' that surround the vagina)

- Type 3 – Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris

- Type 4 – Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, 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 new-born, during childhood or adolescence, just before marriage or during the first pregnancy. It usually happens between infancy to

adolescence and is commonly performed on girls between the ages of 5 and 8 years and therefore girls within that age bracket are at a higher risk.

FGM is a criminal offence, a form of violence against women and girls and a violation of human rights, as outlined by UNICEF:

“FGM is condemned by a number of international treaties and conventions, as well as by national legislation in many countries. Article 25 of the Universal Declaration of Human Rights states that “everyone has the right to a standard of living adequate for health and well-being,” and this statement has been used to argue that FGM violates the right to health and bodily integrity. With FGM considered as a form
of violence against women, the UN Convention on the Elimination of All Forms of Discrimination against Women can be invoked. Similarly, defining it as a form of torture brings it under the rubric of the Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment. Moreover, since FGM is regarded as a traditional practice prejudicial to the health of children and is, in most cases, performed on minors, it violates the Convention on the Rights of the Child.”

The guidance is to provide professionals an understanding of FGM, the considerations and action required to safeguard girls and women who they believe may be at risk of or have already been harmed through FGM. Professionals have a statutory obligation under national safeguarding protocols (e.g. Working Together to Safeguard Children) to protect girls and women at risk of FGM. FGM will be dealt with through existing Newcastle Safeguarding Child Protection and Adult Safeguarding Procedures.

The Law – Female Genital Mutilation (FGM) refers to procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. FGM has been illegal in the United Kingdom (UK) since The Prohibition of Female Circumcision Act 1985, with the law being strengthened in 2003 making it illegal to aid, abet, counsel or procure a non-UK national to carry out FGM on girls (who are British nationals or permanent residents of the UK) abroad, whether or not it is lawful in that country.

The Serious Crime Act 2015 extended the offences related to FGM in England and Wales to include: making parents/carers responsible for failing to prevent their child being subjected to FGM, granting life-long anonymity to victims of FGM, introducing a new FGM protection order. Crucially, it also created a new statutory duty – mandatory reporting – on health care professionals, social workers and teachers who must report to the police cases of FGM or suspected FGM involving girls under the age of 18.
FGM is categorised under the definition of violence against women and girls and is included in the ‘Freedom from Violence and Abuse: a cross-government strategy to build a safer society for women and girls Volume 1 Strategy’ December 2025 Freedom from Violence and Abuse: a cross-government strategy to build a safer society for women and girls Volume 1 Strategy

In communities where FGM is practiced it is usually carried out by older women who have no medical training. The procedure is justified as: –

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

The charity Forward describes FGM as a 'Complex Social Norm' as women and girls are told that it guarantees:

- Love and Acceptance;
- Status and Recognition;
- Female Identity;
- Public and Private Belonging;
- Access to Privileges;

Whilst they are told that 'non-conformity' means:

- Shame and Ridicule;
- Isolation and Exclusion;
- Rejection and Stigma;
- Abuse and Harm: Physical, Emotional, Psychological and Economic Retribution;

FGM can lead to both short term and long term health risks. Short term risks may include severe pain, excessive bleeding, shock, infection, urine retention, tissue damage, fracture and dislocation and death. Long term risks may include difficulties with menstruation, increased risk of infertility, cysts and abscesses, scar tissue, complication in pregnancy and child birth, sexual dysfunction (extremely painful penetration, lack of desire, arousal, or climax), severe psychological trauma and chronic pain.

The most significant factor to consider when deciding whether a girl or woman may be at risk of FGM is whether her family has a history of practising FGM. In addition, it is important to consider whether FGM is known to be practised in her community or country of origin.

There are 3 significant risk factors for FGM when professionals are considering who is potentially at risk:

- a female child is born to a woman who has undergone FGM;
- a female child has an older sibling or cousin who has undergone FGM;
- a female child who has a father who comes from a community known to practise FGM;

The following indicators need to be taken into consideration when staff are considering whether FGM could take place:

- A family comes from a community where FGM is practiced
- a woman/family believe FGM is integral to cultural or religious identity;
- the family indicate that there are strong levels of influence held by elders and/or elders are involved in bringing up female children;
- a girl talks about a long holiday to her country of origin or another country where the practice is prevalent e.g. Africa or the Middle East
- parents state that they or a relative will take the girl out of the country for a prolonged period;
- a girl confides to a professional that she is to have a 'special procedure' or to attend a special occasion to 'become a woman';
- a girl talks about FGM in conversation, for example, a girl may tell other children about it – it is important to take into account the context of the discussion;

Staff may also need to consider:

- a girl/family has limited level of integration within UK community;
- parents have limited access to information about FGM and do not know about the harmful effects of FGM or UK law;
- a family is not engaging with professionals (health, education or other);
- a family is already known to social care in relation to other safeguarding issues;
- a girl from a practising community is withdrawn from Personal, Social, Health and Economic (PSHE) education or its equivalent; • a girl is unexpectedly absent from school;
- sections are missing from a girl's Red book;

Remember: this is not an exhaustive list of risk factors and there may be additional risk factors specific to particular communities; for example, in certain communities FGM is closely associated to when a girl reaches a particular age.

FGM risk assessment template FGM Professional Guidance Forms

If staff do recognise or have concerns relating to risk factors, they need to be aware of what action it is appropriate to take.

There are 4 key actions: -

- Enquiry, National flagging risk via FGM-IS, and submitting Enhanced Data Set for Health
- Recording and Information Sharing
- Safeguarding Referral
- Mandatory Reporting of Children who have been subjected to FGM to the Police

Safeguarding girls at risk of harm through FGM poses specific challenges because the families may give no other cause for concern (such as parenting responsibilities or relationships with their children). Family members may believe FGM is the right thing to do and consider it is in the child's best interest, and adults may find it difficult to understand why the authorities should intervene in what they see as a cultural practice specific to their way of life. The family situation may be compounded by those who wish girls to be ritually cut when others disagree.

It is important to promote understanding and to protect girls and women from the practice through a continuing programme of education and awareness-raising. This needs to include explaining why FGM is considered to be a violation of human rights, and the connection between the procedures and the long-term effects on the body and the emotions.

One specific consideration when putting in place safeguarding measures against FGM is that the potential risk to a girl born in the UK can usually be identified at birth, because through the antenatal care and delivery of the child, NHS professionals can and should have identified that the mother has had FGM. However, FGM can be carried out at any age throughout childhood, meaning that identifying FGM at birth can have the consequence that any safeguarding measures adopted may have to be in place for more than 16 years over the course of the girl's childhood. This is a significantly different timescale and profile compared with many of the other forms of harm against which the safeguarding framework provides protection.

Enquiry, National flagging risk via FGM-IS, and submitting Enhanced Data Set for Health

Routine enquiry about FGM is in place in the ante-natal setting and with the Health Visiting service; selective enquiry should be in place in other health settings. Initiating the conversation can be challenging for many professionals and so framing it in the context of "Do you or your partner come from a community where cutting or female circumcision is practiced?" followed by "have you ever been cut or had any form of surgery or piercings?" may be a useful opening question to encourage further discussion. It is important to allow time for the girl or woman to speak given the sensitivity of the issue and be aware that by doing so she may be disclosing information which she has been told by her family or community must not be discussed. It is also important to consider that communities may not use or

recognise the term ‘FGM’ but instead use specific terminology that is commonly used within their communities or first language. For example, ‘Female Cutting’ or ‘Female Circumcision’.

The Female Genital Mutilation Information Sharing (FGM-IS), is a national IT system for health that allows clinicians across England to note on a girl's record within the NHS Summary Care Record application (an existing part of a child’s electronic record) that they are potentially at risk of FGM.

Further information about this process can be found at: Female Genital Mutilation - Information Sharing - NHS England Digital

Recording and Information Sharing

The importance of sharing information between practitioners and between agencies in relation to girls potentially at risk of FGM, and in relation to discussions held with family members around safeguarding, must not be under-estimated; this information is vital to all agencies involved, to inform decisions on what the best course of action is to protect anyone at risk of FGM. It must also be remembered that there may potentially be a need to safeguard over a number of years.
Any concerns identified through discussion with the patient and family should be recorded in the patient’s records by the healthcare professional who has obtained the information.

Information relating to potential risk of FGM should routinely be shared with other key professionals who come into contact with the girl over the course of her life. In practice this means that concerns identified should be shared with the girl’s GP and her Health Visitor (preschool children) or School Nurse (school-aged children) who are required to appropriately flag the child health record (including the PCHR) and note in other female siblings records the potential risk of FGM. A process for sharing this information with the school, either at the time of the concern or at a later time at school entry age, will need to be considered for all female children.

FGM risk must be recorded and flagged in Primary Health Care records and the fact that there is an FGM risk must be included in all referrals to Secondary Care to support the ongoing provision of care. Once Secondary Care is aware of the FGM risk, either from Primary Care or from within their own organisation, they also need to record and flag the risk in their health records. All health practitioners should check the child's NHS Summary Care Record to ensure that FGM-IS has been noted.

Schools will be expected to record and flag their records either at the time of any strategy meeting or on school entry (historical reports of FGM). This information must be transferred with the child at the time of any change of school.

Parents of children, who are considered at risk of FGM, will be made aware that the information of the potential risk will follow the child until they leave education and will be flagged on their health records to be shared confidentially with health professionals across all care settings until a girl is 18 years old.

The expectation would be that the Police and Children’s Social Care will also have a flagging system to indicate FGM risk.

The Government has published a ‘Statement Opposing Female Genital Mutilation’ leaflet, commonly referred to as the “Health Passport”. This pocket-sized document sets out the law and the potential criminal penalties that can be used against those allowing FGM to take place. It is designed to be discreetly carried in a purse, wallet or passport. It can be used by families who have immigrated to the UK and do not want their children to be subjected to FGM, but still feel compelled by cultural and social norms when visiting family abroad. You can view this using the below link:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/573623/2905975_FGM_Passport_v1_0A.PDF

Safeguarding Referral

FGM is by definition a criminal offence against children and a child protection issue.
If there is an imminent risk of FGM taking place or of a person leaving the country so that FGM can take place, then a referral must be made to the Police by ringing 999. If in doubt, advice should be sought from the Safeguarding Lead within your agency or from the Police or Children’s Social Care about what to tell the woman / family in these circumstances.

Since October 2015 registered professionals in health, social care and teaching also have a statutory duty (known as the Mandatory Reporting duty) to report cases of FGM to the police non-emergency number 101 in cases where a girl under 18 either discloses that she has had FGM or the professional observes physical signs of FGM.

It is important that the referring professional follows guidelines about working in partnership with the family by being honest where this is possible and handling any disclosure sensitively. The professional must be clear with the family about why safeguarding actions are being undertaken. Information does not have to be shared with the family if by doing so the girl may be placed in a more harmful situation or the family could ‘vanish’ with their daughter.

Health staff should be mindful that where a woman requests re-infibulation after child birth that this should be classed as a potential indicator that she/the family is not willing to comply with UK Law; this should therefore be seen as a child protection concern.

In all other cases involving children and vulnerable adults a referral must be made to either Children’s Social Care via the Initial Response Service or to the Safeguarding Adult’s Team (see flow chart for further details). In cases where only an adult with capacity is involved and the FGM has already occurred several years previously this does not require a safeguarding referral but may well require support for the woman by offering referral to community groups who can provide support, and for possible clinical intervention e.g. referral to gynaecology department. The wishes of the woman must be respected at all times.

An FGM Protection Order (FGMPO) is a civil measure which offers the means of protecting victims or potential victims from FGM under the civil law. Any professional or other person with concerns about a girl or woman at risk of FGM can apply for a FGMPO which is unique to each case. They contain conditions to protect a victim or potential victim from FGM. This could include, for example,

surrendering a passport to prevent the person at risk from being taken abroad for FGM or requirements that no one arranges for FGM to be performed on the person being protected.

A girl who has already been genitally mutilated should not normally be subject to a Child Protection Conference unless additional protection concerns exist. She should be offered counselling and medical help. Consideration must be given to any other female siblings at risk. She should be offered a referral to the Paediatric Forensic Network, Children and Young People's Clinic, The Great North Children's Hospital, Newcastle for a holistic assessment. This referral should be made by social worker on behalf of the multiagency team.

Mandatory Reporting of Children who have been subject to FGM to the Police

All practitioners in regulated professions such as doctors, nurses, social workers and teachers, must report 'known' cases of FGM in under-18s which they identify in the course of their professional work to the police via the 101 number. Healthcare professionals are not expected to investigate or make decisions upon whether a case of FGM was a crime or not, under the legislation. The police will refer the matter to the PVP Police Unit by the next working day. The case should also be reported to Children's Social Care via the Initial Response Service.
Non-regulated practitioners still have a general responsibility to report safeguarding issues relating to FGM as part of Newcastle Safeguarding Children Partnership (NSCP) safeguarding procedures. They also have a duty to share information when they become aware that FGM has been carried out on a girl under the age of 18 years.

While adult women may choose to have genital piercings, in some communities, girls are forced to have them. The World Health Organisation currently defines all female genital piercings as a form of FGM.

Strategy discussions/meeting about a child at risk of FGM must include:

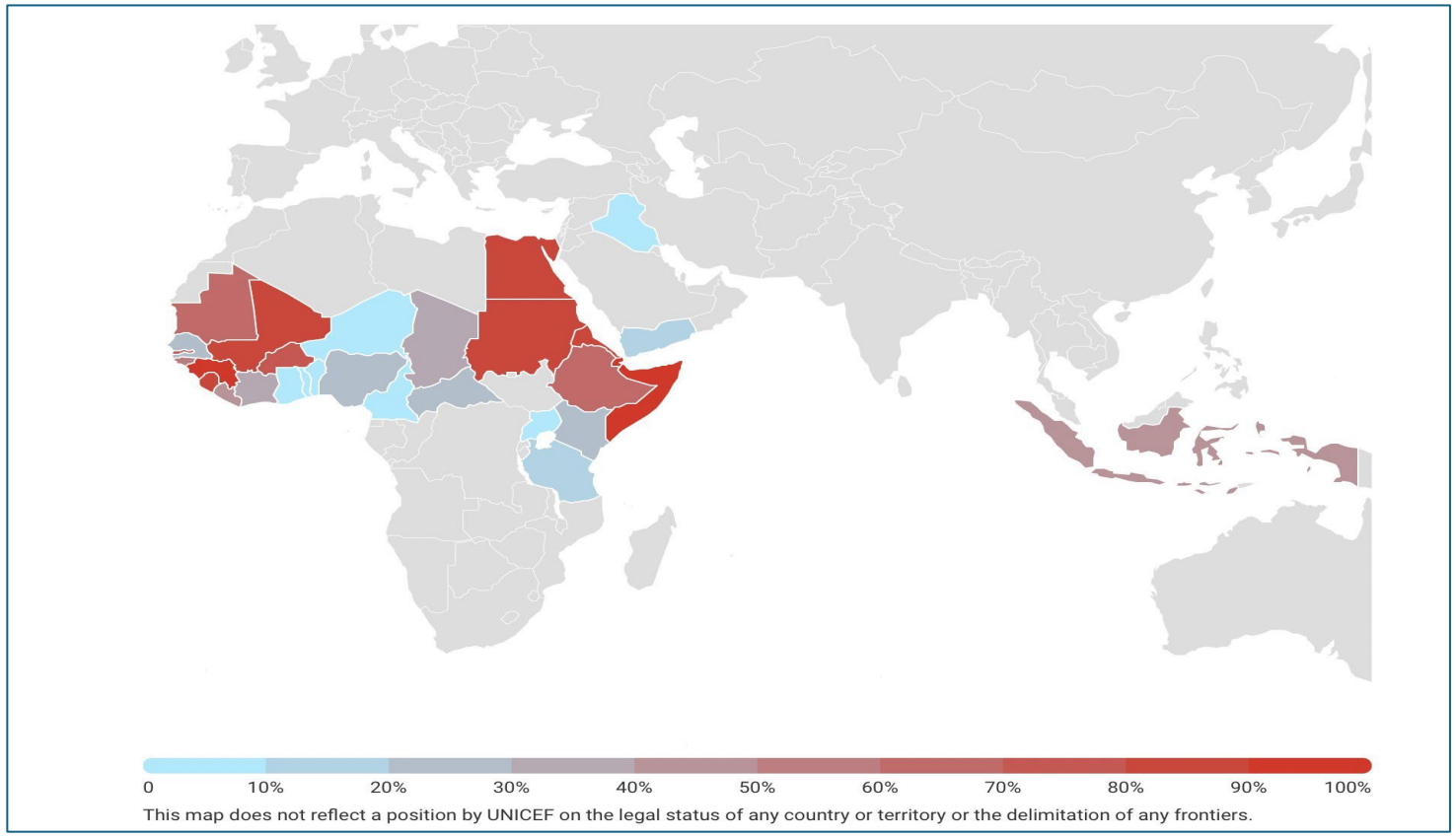
1. Decision about immediate risk and action.
2. The sharing of information about the family – who requires the information and how it will be shared.
3. A professional familiar with the culture of the potential victim/s should be present at the meeting to ensure an appropriately culturally sensitive approach.
4. Home visits should be undertaken by investigating professionals and should be undertaken by an experienced Police Officer or Social Worker. Consideration should be given to whether home visits may need to be supported by other professionals.

5. Professional interpreters must be used if either parent is not completely fluent in English and considered for all contacts. The interpreter should be an authorised accredited interpreter and should not be a family member, not be known to the individual, and not be an individual with influence in the individual's community. The gender of the interpreter is an important consideration.
6. Verbal and written information must be given to family about FGM, its illegality, notification, recording and flagging in health, school and other records. Verbal and written information regarding available support must also be given to the parent / family; information can be found at: https://www.nhs.uk/conditions/female-genital-mutilation-fgm/
7. Attempt to work with the family on a voluntary basis to prevent the abuse being undertaken and to put in place protective factors. A key element of this work relates to education and health promotion to parents / family and communities. However, the child's welfare is paramount and must remain the focus of multi-agency work.
8. If the child cannot be protected then legal advice must be sought; staff need to be vigilant to indicators of change within the family and increased risk. It must always be remembered that a Care Order alone does not prevent a child being taken out of the country and consideration needs to be given to obtaining a Female Genital Mutilation Protection Order (FGMPO) or putting the matter before the High Court in Wardship Proceedings
9. Consideration of need for Specialist Medical Assessment and possible treatment. If there is any doubt about who a girl or woman should be referred to then discuss the matter with the Hospital Safeguarding Children Team or Safeguarding Lead for Midwifery.
10. Consideration of future risk, including maintenance of flagging systems and how to ensure a continuing professional awareness of potential future risk

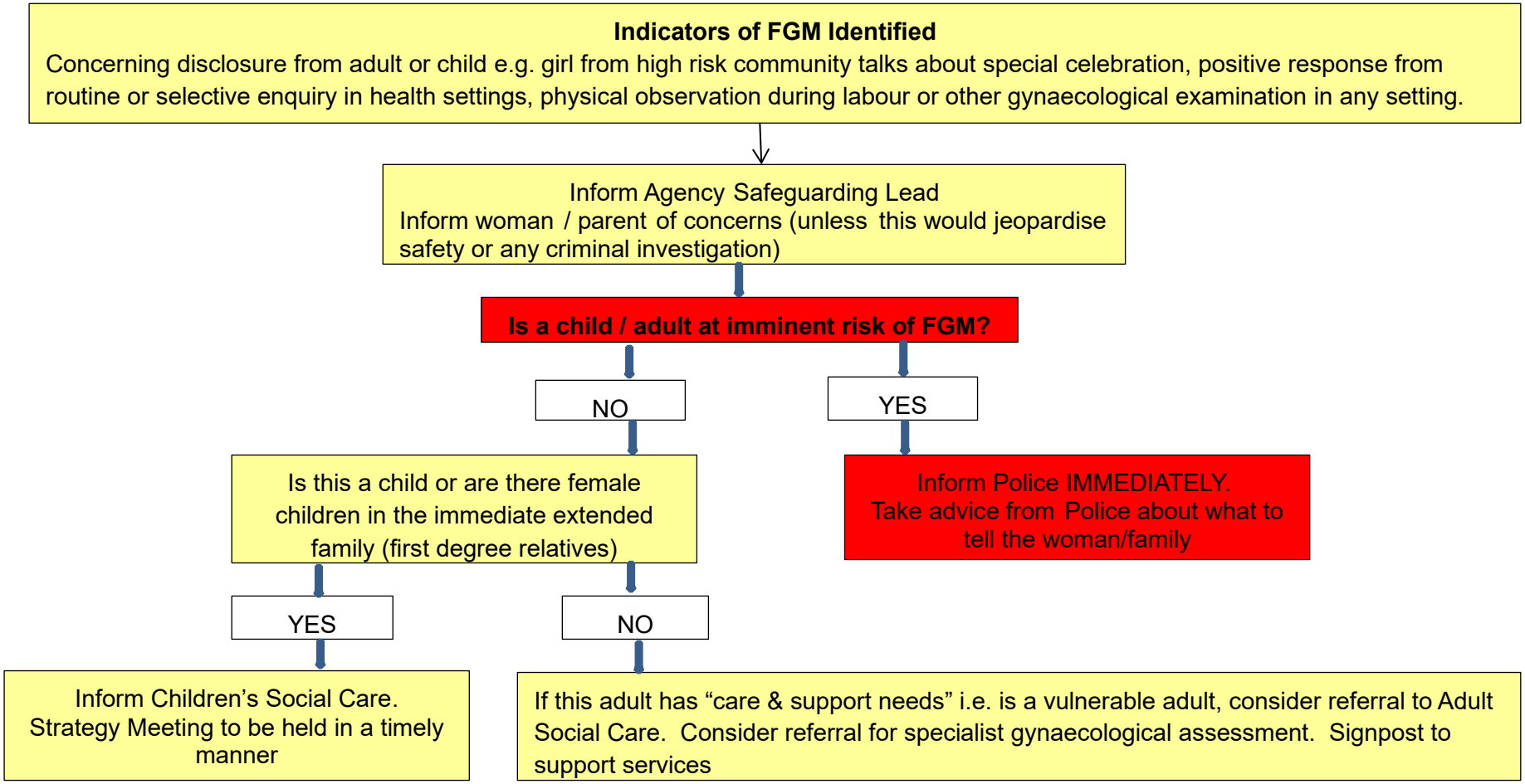
PREVALENCE OF FGM AMONG WOMEN AGED 15-49 IN AFRICA AND THE MIDDLE EAST

Source: UNICEF global databases, 2021, based on Multiple Indicator Cluster Surveys (MICS), Demographic and Health Surveys (DHS) and other national surveys, 2004 - 2020.

Available data from large-scale representative surveys show that the practice of FGM is highly concentrated in a swath of countries from the Atlantic coast to the Horn of Africa, in areas of the Middle East such as Iraq and Yemen and in some countries in Asia like Indonesia, with wide variations in prevalence. The practice is almost universal in Somalia, Guinea and Djibouti, with levels around 90 per cent, while it affects no more than 1 per cent of girls and women in Cameroon and Uganda. However, FGM is a human rights issue that affects girls and women worldwide.



FGM FLOWCHART



If a child (under the age of 18) has been subject to FGM then professionals must report this directly to the police via 101 as well as making a safeguarding children referral. This is a mandatory reporting duty which applies to all regulated professions e. g. doctors, nurses, social workers and teachers.

This duty applies when either a girl informs the professional that an act of FGM – however described – has been carried out on her, or where the person observes physical signs on a girl appearing to show that an act of FGM has been carried out

Health staff must also ensure the potential risk of FGM is noted on the national FGM-IS system for all identified female children

FGM Support Services in the North East

Organisation	Area	e-mail	Phone	Services Offered
Angelou Centre	North East	Email: admin@angelou-centre.org.uk Website: https://angelou-centre.org.uk	0191 226 0394	The Angelou Centre works with women who have experienced domestic/sexual violence often *in addition to* immigration abuse, harmful practices such as FGM, sexual exploitation, forced marriage, trafficking and HBV/A perpetrated through varying cultural and social lenses by intimate partners, family members and or community members. The communities that the Angelou Centre supports also face multiple intersecting barriers, often have the lowest socio-economic outcomes in the North East, are destitute and homeless, or living in unstable or unsafe housing without support networks. In addition, we support migrant women who also have complex immigration issues, no recourse to public funds, face racial discrimination and harassment, hate crime and economic exploitation.
HALO Project	Cleveland and Durham	Email: info@haloproject.org.uk Address**:** Vanguard Suite, 307a Broadcasting House, Middlesbrough. TS1 5JA Web site: http://www.haloproject.org.uk/	01642 683 045	The Halo Project Charity is a national project that will support victims of honour-based violence, forced marriages and FGM by providing appropriate advice and support to victims. HALO will also work with key partners to provide required interventions and advice necessary for the protection and safety of victims. HALO can offer support to the victims of FGM and are passionate about educating those in the community,

				where change ultimately has to come from to end the practice. HALO believe by working together and educating the communities while offering training and raising awareness to safeguarding agencies it is possible to start to eradicate FGM.
Rape Crisis Tyneside and Northumberland	Tyneside & Northumberland	Email: enquiries@rctn.org.uk	Admin 0191 222 0272 Helpline 0800 0352794	Rape Crisis Tyneside and Northumberland is a charitable organisation which provides information, support and counselling for women aged 16 and over who have been raped or sexually abused.
NSPCC	National	Email: fgmhelp@nspcc.org.uk Web site: https://www.nspcc.org.uk/preventing-abuse/child-abuse-andneglect/female-genitalmutilation-fgm/	0800 028 3550	The NSPCC offers support and information about FGM to girls and their families. The NSPCC also offers information, training, support and direct links to professionals and the public about FGM.
FORWARD	National	Email: support@forwarduk.org.uk Web site: http://forwarduk.org.uk/	Telephone: 020 8960 4000 Or 07834 168 141	FORWARD (Foundation for Women's Health Research and Development) is committed to gender equality and safeguarding the rights of African girls and women. FORWARD are a leading African diaspora women's campaign and support organisation. They work through partnerships in the UK, Europe and Africa to transform lives, tackling discriminatory practices that affect the dignity and wellbeing of girls and women. They focus on female genital mutilation (FGM), child marriage and obstetric fistula.
Daughters of Eve	National	Text on 07983 030488.		Daughters of Eve is a non-profit organisation that works to protect girls and young women who are at risk from female genital mutilation (FGM). By raising awareness

		Web site: http://www.dofeve.org/		about FGM and sign-posting support services Daughters of Eve aim to help people who are affected by FGM and ultimately help bring an end to this practice. The wider work of Daughters of Eve is to advance and protect the physical, mental, sexual and reproductive health rights of young people from female genital mutilation practicing communities. They recognise that FGM occurs in the context of wider harmful practices and that young people often have many different problems. They take a holistic approach, offering advice and support to help young people in as many ways as they can.
Afruca	National	Tel: 0207 704 2261 Fax: 0207 704 2266 Web site: http://www.afruca.org/	0207 704 2261	AFRUCA is embedded in and has developed out of African communities in the UK as a response to their realization of the problems African children and parents face and the gaps that exist within the child protection system for African children in the country. The main focus of their work is Prevention and Early Intervention; their stance is that culture and religion should never be a reason to abuse children.