



EDUCATION

Female Genital Mutilation Policy

Document title:	Female Genital Mutilation Policy
Version number:	1.0
Policy Status	Approved
Date of Issue	April 2015
Date to be revised	April 2016

Revision Log (last 5 changes)

Date	Version No	Brief detail of change
24/04/15	1.0	Reformatted existing for Staff Portal
30/08/16	1.1	Reviewed and amended with reference to Multi-Agency Statutory Guidance on Female Genital Mutilation (2016)

This policy should be read in conjunction with the Multi-Agency Statutory Guidance on Female Genital Mutilation (2016), Working Together to Safeguard Children (2015) and Keeping Children Safe in Education (2016).

1. DEFINITION

- 1.1. The World Health Organisation (WHO) states that female genital mutilation (FGM) 'comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons' (WHO, 2008). FGM is not like male circumcision. It is frequently a very traumatic and violent experience for the victim and can cause harm in many ways. The practice can cause severe pain and there may be immediate and/or long-term health consequences, including mental health problems, difficulties in childbirth, danger for the child and mother and/or death.
- 1.2. The age at which FGM is carried out varies enormously among communities, from soon after birth until adulthood.

2. PREVALENCE

- 2.1. FGM is a deeply-rooted practice in sub-Saharan Africa, as well as in Asia and the Middle East. It serves as a complex form of social control of women's sexual and reproductive rights. It should also be remembered that girls and young women who are British citizens, but whose parents were born in countries that practise FGM, may also be at risk.
- 2.2. In the UK, the prevalence of FGM is difficult to estimate because of the hidden nature of the crime. A 2015 study noted that no local authority is likely to be free from FGM entirely.
- 2.3. FGM may be associated with other behaviours that discriminate against, limit or harm women and girls. These may include other forms of honour-based violence (e.g. forced marriage) and domestic abuse.

3. LEGAL POSITION

- 3.1. FGM has been illegal in the UK since the Female Circumcision Prohibition Act 1985. This made it illegal for a person to undertake FGM or for anyone to assist a girl / young woman to mutilate her own genitalia. The only exception is for operations for specific physical and mental health reasons, undertaken by registered medical or nursing practitioners.
- 3.2. The Female Genital Mutilation Act 2003 strengthened the 1985 Act, by making it an offence to take UK nationals and those with permanent UK residence, overseas for the purpose of circumcision, in order to aid and abet, counsel, or procure the carrying out

of FGM. It also makes it illegal for anyone to circumcise girls or women for cultural or non-medical reasons.

- 3.3. The 2003 Act was amended by the 2015 Serious Crimes Act, so that it now includes:
- An offence of failing to protect a girl from FGM;
 - A mandatory reporting duty, requiring specified professionals (including teachers) to report known cases to the police;
 - Lifelong anonymity for victims of FGM;
 - Provision of jurisdiction over FGM offences committed abroad by UK nationals and those resident in the UK.

4. CULTURAL CONTEXT

- 4.1. The issue of FGM is very complex. Despite the obvious harm and distress it can cause, many parents from communities who practise FGM believe it to be important in order to protect their cultural identity. FGM is often practised within a religious context. However, neither the Koran nor the Bible support the practice of FGM.

5. CONSEQUENCES OF FGM

- 5.1. Many people may not be aware of the relationship between FGM and its health consequences - in particular, the complications affecting sexual intercourse and childbirth which may occur many years after the mutilation has taken place.

Short-term health implications include:

- a. Severe pain and shock;
 - b. Infections;
 - c. Urine retention;
 - d. Injury to adjacent tissues;
 - e. Fracture or dislocation as a result of restraint;
 - f. Damage to other organs.
- 5.2. Depending on the degree of mutilation, it can cause severe haemorrhaging and may result in the death of the girl / young woman through loss of blood.
- 5.3. Long term health implications include:
- a. Excessive damage to the reproductive system;
 - b. Infections;
 - c. Infertility;

- d. Cysts;
- e. Complications in pregnancy and childbirth, which may cause danger or death to the child and/or mother;
- f. Mental health problems;
- g. Sexual dysfunction;
- h. Difficulties in menstruation;
- i. Difficulties in passing urine;
- j. Increased risk of HIV transmission.

6. SIGNS AND INDICATORS

6.1. Some indications that FGM may have taken place include:

- A girl / young woman may spend time out of the classroom or other activities with bladder or menstrual problems;
- A long absence from school or in the school holidays could be an indication that a girl / young woman has recently undergone an FGM procedure, particularly if there are behavioural changes on her return;
- A girl / young woman may require to be excused from PE lessons without the support of her GP;
- A girl / young woman may ask for help, either directly or indirectly;
- A girl / young woman may suffer emotional / psychological effects as a result of undergoing FGM - for example, withdrawal or depression.

6.2. Some indications that **FGM may be about to take place** include:

- A conversation with a girl / young woman during which she refers to FGM, either in relation to herself or to another female family member or friend;
- A girl / young woman requesting help to prevent it happening;
- A girl / young woman expressing anxiety about a 'special procedure' or a 'special occasion', which may include discussion of a holiday to her country of origin;
- A boy may indicate some concern about his sister or other female relative.

7. INCREASING AWARENESS WITHIN THE ACADEMY

7.1. Academies should aim to create an open environment, in which students feel comfortable and safe to discuss the problems they are facing and in which support

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

7.2. Academies can create an open and supportive environment by:

- making available information and materials about FGM;
- displaying relevant information - e.g. details of the NSPCC's Helpline and ChildLine services, Careline and appropriate black and minority ethnic women's groups;
- ensuring that the Designated Child protection Co-ordinator (DCPC) is well versed in the issues relating to FGM and that training and other awareness-raising strategies are provided to increase the awareness of all staff;
- referring students to an Academy Welfare Officer, DCPC, pastoral tutor or Academy counsellor, as appropriate;
- introducing FGM into the school curriculum within relevant classes, such as PSHE – particularly in 'Sex and the Law' at Key Stages 3, 4 and 5 - and teaching the accurate naming of body parts at Key Stage 1, which can be the first stage in ensuring that girls are aware of their bodies and rights.

8. ACTION TO TAKE IF STAFF BELIEVE A CHILD IS A RISK OF FGM

- 8.1. All efforts should be made to establish the full facts from the student at the earliest opportunity.
- 8.2. If there is an indication that the child or young person is at risk of FGM or has undergone FGM, or if she has expressed fears of reprisals or violence, the information must be shared with both the police and children's social care authority.
- 8.3. Where a teacher, in the course of his/her professional work, becomes aware of a FGM case, s/he must report it to the police. This is a mandatory duty under Section 5B of the 2003 Act.
- 8.4. Conversations with the child or young person should explain that FGM is illegal in the UK and that she will be protected by the law. Staff should recognise and respect the child's/young person's wishes where possible, but child welfare must be paramount. The approach should be victim-centred, with a clear understanding of the needs and views of those affected by FGM. Child welfare must be paramount in this process.
- 8.5. **Where there is any concern that a girl/young woman is at risk of, or has undergone, FGM, all information must be referred to the academy's Designated Safeguarding Lead (DSL) immediately, regardless of whether or not the police have already been contacted. The DSL will then make a referral to Children's Social Care.** In this process,

staff should ensure that safeguarding and protection are considered for the child/young adult and for any female family members.

- 8.6. If a girl / young woman is thought to be at risk of FGM, **staff should be aware of the need to act quickly**, before she is abused by undergoing FGM in the UK or taken abroad to undergo the procedure.
- 8.7. Staff should not:
- treat allegations merely as a domestic issue;
 - approach - whether by telephone, letter or electronic communication - the student's family, or those with influence within the community, in advance of any investigation by the police or social services. Speaking to the student's parents about the action you are taking may place the student at risk of emotional and/or physical harm. Do not approach the family, therefore, as they may deny the allegations, expedite any travel arrangements and hasten their plans to carry out the procedure.
 - remove the student from the school register without first making enquiries and/or referring the case to the police and local authority adult or children's social care.

9. Working Together to Tackle FGM

- 9.1. It is not possible for a single professional to have a full picture of an individual's needs and circumstances. It is important that women and girls affected by FGM receive the right help at the right time.
- 9.2. Wherever possible, the academy will actively seek and support ways to reduce the prevalence of FGM. The academy will work with other agencies to consider how preventative work can be embedded within its safeguarding processes. This may include committing support for girls and families at risk.
- 9.3. The lead person for FGM within the academy will be the DSL, who will ensure that cases of FGM are handled, monitored and recorded correctly. The DSL will have received appropriate training in respect of the risks associated with FGM and in how to address such issues.
- 9.4. Training will take place regularly to enable all staff to discharge effectively their safeguarding duties with regard to FGM.