Safeguarding Children from Abuse through Female Genital Mutilation (FGM)

Produced by Liverpool Female Genital Mutilation and Multi Cultural Women’s Health Advisory Group

And

Liverpool Safeguarding Children Board
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The Liverpool Female Genital Mutilation (FGM) and Multi-Cultural Women’s Advisory Group was established in 1996. It consists of a range of professionals such as Health Visitors, Midwives and University Lecturers, as well as local women. Our main objective has been to try to raise awareness and increase understanding of FGM and the physical and emotional damage that it causes. The group has also raised awareness of Breast Cancer screening by organising Health Awareness days. The group has worked in partnership with the NSPCC to deliver various events and conferences for professionals. Our main achievements have been to work with Liverpool Primary Care Trust (now CCG) to develop the FGM Advocacy Worker role, supporting women from FGM practising communities; and also working with Liverpool John Moores University to develop our website.

In recent years the group has increased its focus on FGM issues and held conferences in partnership with national bodies such as the Foundation for Women’s Health Research and Development (FORWARD) and the FGM National Clinical Group. The Liverpool FGM Group welcomes the opportunity to work in partnership with Liverpool Safeguarding Children Board and its member organisations, in order to strengthen safeguarding arrangements and protect children in Liverpool from abuse through FGM. We are developing this work collaboratively with SAVERA, a local BME women’s charity to ensure that local community groups are engaged. We hope that this guidance marks the beginning of a wider dialogue in our city and the development of further work in relation to this important issue.

Whilst FGM may be perceived as an issue that affects countries elsewhere in the world, the reality is that it can and does affect many girls and women in our local communities.

This document is intended to provide local practitioners with information and support. I hope that it will consolidate their understanding and professional practice in relation to FGM, within the context of Liverpool Safeguarding Children Board procedures.

At the time of writing (March 2014) the UK is poised to pursue its first prosecutions against those engaged with FGM.

In addition, the Education Secretary Michael Gove is due to write to every school in the country about female genital mutilation, reminding headteachers of their duty to protect schoolgirls. This follows a successful campaign by 17 year old student campaigner Fahma Mohamed whose fight against FGM is an inspiration to us all.

MRS DORCAS AKEJU, OBE

1. Foreword by Dorcas Akeju OBE
2. Purpose of this document
This guidance is designed for all frontline professionals and volunteers within agencies that work to safeguard children and young people from abuse. This includes, but is not limited to, NHS staff and other health professionals, police officers, children’s social care workers, and teachers and other educational professionals. The information may also be relevant to nongovernmental organisations and voluntary organisations working directly with girls and women at risk of FGM, or dealing with its consequences. These are practice guidelines and are designed to be educative and provide advice; they are not a substitute for existing statutory guidance such as *Working Together to Safeguard Children* (2013) in England or *Safeguarding Children: Working Together Under the Children Act 2004* in Wales. This document will also be ratified by the Liverpool Safeguarding Adults Board (see section 9).

**3. Definitions**

**World Health Organisation Definition 2008**

The World Health Organisation (WHO) defines ‘Female Genital Mutilation’, also referred to as ‘Female Genital Cutting' and ‘Female Circumcision’ as: all procedures that involve partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.

According to the WHO, between 100 and 140 million girls and women worldwide have undergone some sort of FGM and each year a further 2 million girls are at risk.

The International Centre for Reproductive Health estimates that in the UK 279,500 women have undergone FGM, and approx. 22,000 girls under the age of 18 are at risk each year.

FGM is practised in more than 28 countries across Africa, Asia and the Middle East

(See Appendix 1 for a profile of prevalence and legislation banning FGM in African countries).

In the UK, children from families who originate from the these countries are most likely to be affected by FGM. However, the extent of the practice and the type of FGM will vary across communities.

**Terminology** FGM may be known by a number of names, including female genital cutting or circumcision. The use of different terminology for FGM can be confusing for practising communities and even professionals. The terminology which is accepted nationally is “Female Genital Mutilation”. This can also be referred to as “Cutting” or “Circumcision”. The last two are culturally accepted amongst the practising communities The term female circumcision is unfortunate because it is anatomically incorrect and gives a misleading analogy to male circumcision. The Somali term for FGM is ‘Gudnin’. It is vital that professionals ensure that appropriate interpretation and translation arrangements are in place when discussing FGM. Broaching the subject of FGM may be difficult or sensitive for those unfamiliar with the practice. Advice can be sought from the Liverpool FGM group on this (see Contact details, appendix 4.).
4. FGM and the Law

National Legislation

In England, Wales and Northern Ireland all forms of FGM are illegal under the Female Genital Mutilation Act 2003. In Scotland it is illegal under the Prohibition of FGM (Scotland) Act 2005.

A person is guilty of an offence if he/she, excises, infibulates or otherwise mutilates the whole or any part of a girl's labia majora, labia minora or clitoris except for operations performed on specific physical and mental health grounds by registered medical or nursing practitioners. It is also an offence to assist a girl to mutilate her own genitalia.

FGM is an offence which extends to acts performed outside of the UK and to any person who advises, helps or forces a girl to inflict FGM on herself.

Any person found guilty of an offence under the Female Genital Mutilation Act 2003 will be liable to a fine or imprisonment of up to 14 years, or both.

FGM is considered to be a form of child abuse as it is illegal and is performed on a child whom is unable to resist or give informed consent.

Under the Children Act 1989 Local Authorities can apply to the Courts for various Orders to prevent a child being taken abroad for FGM.

Despite the legislation, there have been no convictions for FGM in the UK. This is something that criminal justice agencies are working hard to address at both national and local level.

International Legislation

There are two international conventions that contain articles that can be applied to FGM. They place an obligation on signatory states, including the UK to take legal action in relation to FGM:

- The United Nations Convention on the Rights of the Child
- The United Nations Convention on the Elimination of all forms of Discrimination Against Women

5 Overview of FGM

Types of FGM

FGM has been classified by the World Health Organisation into 4 types:

Type 1 - (Sonna) Cutting away the clitoral hood, with or without the removal of the clitoris

Type 2 - (Excision) Removal of the clitoris with partial or total removal of the labia minora

Type 3 - (Infibulation) Removal of the clitoris, labia minora and labia majora with stitching of the vaginal opening

Type 4 - Involves tribal cutting or burning of the vaginal orifice or the use of corrosives to narrow the vaginal passage. This may include pricking, piercing, incision and scraping.
At what age is FGM carried out?

The age at which FGM is carried out varies greatly. It can be carried out any time from shortly after birth up to adulthood. Girls between 4 and 14 years of age are most at risk. In adults FGM may be carried out immediately before marriage and immediately after child birth.

FGM is usually carried out by an older woman in a practicing community, for whom it is a way of gaining prestige. It can also be a lucrative source of income.

The procedure is normally carried out by several women unexpectedly approaching a girl and holding her down on the floor. Hazards include lack of medical expertise, lack of anaesthesia and lack of hygiene. Instruments used can include unsterilized household knives, razor blades, broken glass and stones.

Justifications used by those who practice FGM

In reality, there is no social, moral or religious justification for FGM. However, those who support FGM may use the following reasons or ‘myths’ to try to explain the practice. They may say FGM:

- Is part of being a woman;
- Is a rite of passage;
- Gives a girl social acceptance, especially for marriage;
- Upholds the family honour;
• Gives the girl and her family a sense of belonging to the community;
• Fulfils a religious requirement mistakenly believed to exist;
• Perpetuates a custom / tradition;
• Helps girls and women to be clean and hygienic;
• Is cosmetically desirable; and
• Is mistakenly believed to make childbirth safer for the infant.

Consequences of FGM

Many women are unaware of the relationship between FGM and its health and welfare consequences, particularly as some consequences in relation to sexual intercourse and childbirth can be experienced several years after the original FGM was inflicted. Consequences can vary and will depend on factors such as the type of FGM carried out, the nature and extent of force used for restraint.

Short Term Consequences

• Severe pain
• 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

Longer Term Consequences

• Chronic vaginal and pelvic infections;
• Difficulties in 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;
• Maternal or foetal death;
• Psychological damage; including a number of mental health and psychosexual problems including depression, anxiety, and sexual dysfunction;
Increased risk of HIV and other sexually transmitted infections.

6. Identification of a child who has been abused though FGM or is at risk of abuse through FGM

Three main groups affected by FGM may be identified by frontline professionals:
- A girl at risk of FGM
- A girl who has undergone FGM
- A baby girl who is born to a mother who has undergone FGM

Indications that FGM may be about to take place include:
- The family comes from a community that is known to practice FGM, so it may be more likely that they will practice FGM if a female family elder is around
- Parents state that they or a relative will take the child out of the country for a prolonged period
- A child may talk about a long holiday to her country of origin or another country where the practice is prevalent, including African countries and the Middle East
- A child may confide to a professional that she is to have a ‘special procedure’ or to attend a special occasion
- A professional hears reference to FGM in conversation, for example a child may tell other children about it
- A child may request help from a teacher or another trusted adult
- Any female child 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 female child 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.

Indications that FGM may have already taken place include:
- A girl may spend long periods of time away from the classroom during the day with bladder or menstrual problems
- There may be prolonged absences from school
- A prolonged absence from school with noticeable behaviour changes on the girl’s return could be an indication that a girl has recently undergone FGM
- Professionals also need to be vigilant to the emotional and psychological needs of children who may / are suffering the adverse consequence of the practice, e.g. withdrawal, depression etc
- A child may confide in a professional or a close friend that something has happened to them or say they have an important secret
- A child requiring to be excused from physical exercise lessons without the support of her GP
- A child may ask for help.
7. Safeguarding Children

Educational and preventative work should seek to ensure that FGM does not occur. Families must be made aware that FGM is illegal in the UK, as is removing a child from the UK for the purposes of FGM. They should be made aware of the health and legal implications.

Professionals working in communities should be alert to the possibility of coming into contact with a girl/woman who has been abused through FGM. At the first contact, professionals should consider the cultural background of the girl/woman. If the service user is a woman who has experienced FGM herself, but has no children, educational and preventative advice and support should be provided. However, consideration should be given to the welfare of any female children in the wider family and any future female children.

Any professional or agency concerned that a female infant, female child or young woman is likely to be, or has been subject of FGM, in or outside of the UK, should refer the matter to Children’s Social Care in accordance with the referrals procedure.

Agencies and individuals should strive to communicate respect for the cultural and religious beliefs and traditions of families. However, there must be no compromise in communicating the message that FGM is illegal and unacceptable in the UK.

8. Liverpool Safeguarding Children Procedure

Children’s Social Care may undertake section 47 enquiries of there is reason to believe a child is likely to be or has been subject to FGM.

As part of the initial assessment Children’s Social Care should establish if either parent or child have had access to information about the harmful aspects of FGM. If not parents and child, subject to age and understanding should be given the opportunity of considering information about FGM via educational or preventative programme’s or by discussion with someone known to the family with information about FGM. The family should be encouraged to reconsider their plans for FGM in light of all relevant information available to them.

If a member of the family has experienced FGM, therapeutic services should be offered.

The preferred outcome for the child is that the family agree to halt the process, thereby ensuring that the child is protected from significant harm.

If following consideration by the family of available information the child remains at risk of significant harm from FGM, Children’s Social Care should initiate section 47 enquiries beginning with a strategy discussion involving Children’s Social Care, the police, a community paediatrician and any other relevant agency or professional, including someone with extensive knowledge of FGM.
The strategy discussion should take the form of a meeting with access to appropriate paediatric and cultural advice, and should consider information about who within the family has been involved in the decision making regarding the plans for FGM.

If, ultimately, there is no agreement from the family that the child should not undergo FGM, legal advice should be sought with a view to ensuring the child’s protection. The objective of any legal action should be to prevent the child from undergoing FGM, whilst ensuring that the child is not removed from the family, unless this is required to protect the child. A Prohibitive Steps Order may therefore be an appropriate legal intervention.

A Child Protection conference should be convened if there is no agreement by the family that FGM should be avoided and/or the process has happened in respect of an older child within the family and there is information to indicate that other female children are at risk.
**Liverpool Safeguarding Children Board FGM Referral Pathways**

1. **Child has already undergone FGM**
   - Referral to Careline Children’s Services 0151 233 3700
   - LSCB Safeguarding Procedures
   - Strategy Meeting
     - Consideration to be given to girls within the family
     - Referral to Careline Children’s Services 0151 233 3700
   - S.47 child protection investigation commence (joint investigation with police and Children’s Services)

2. **Child at risk of FGM**
   - Referral to Careline Children’s Services 0151 233 3700
   - LSCB Safeguarding Procedures
   - Strategy Meeting
     - Consider need to initiate Section 47 enquiries
     - Consider other girls within the family
     - Consider action for immediate protection of child/children
     - Consider need for Review Strategy Meeting/ICPC.

3. **If a close family member has undergone FGM (sister/mum)**
   - Consideration to be given to girls within the family
   - Referral to Careline Children’s Services 0151 233 3700
   - LSCB Safeguarding Procedures
   - Strategy Meeting

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**For information, advice and/or referrals contact**

**Careline Children’s Services**

0151 233 3700

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**Required Actions**

- 1. Notify GP
- 2. Identify someone to visit family regarding the conflict between culture/UK Law. This will be a joint visit between police and social care as per child protection protocols
- 3. Police to seek information for possible prosecution of perpetrator.
9. Safeguarding Vulnerable Adults

This guidance is primarily focused on safeguarding the welfare on children and young people. However, FGM may also affect adult women, who may be considered vulnerable. Women who fall into this category are most likely to come to the attention of services during pregnancy related care.

In the context of FGM, a vulnerable adult is likely to be any person who is:

- Aged 18 and over and
- Who is or may be in need of community care services because of frailty, learning or physical or sensory disability or mental health issues and
- Who is or may be unable to take care of herself, or take steps to protect herself from significant harm or exploitation. This statement could apply to women who are refugees or asylum seekers.

Abuse is a violation of an individual’s human and civil rights by any other person or persons.

Abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or omission to act, it may occur where a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented or cannot consent. (No Secrets, Department of Health 2000.)

Safeguarding Adult Procedures are available on Liverpool City Council’s website www.liverpool.gov.uk

Advice can be sought and referrals can be made to Careline Adult Service 0151 233 3800

10. Information Sharing

Professionals can only work together to safeguard children if there is an exchange of relevant information between them. Any professional who has concerns about the welfare of a child should always refer these concerns to Children’s Social Care. Research and experience have shown repeatedly that keeping children safe from harm requires professionals and others to share information. Often it is only when information from a number of sources has been shared that it becomes clear that a child is at risk.

Those providing services must balance their duty to protect children from harm and their general duties to their patient or service user, but where there are concerns that a child may be at risk of significant harm, the overriding objective must be to safeguard that child. For this reason, professionals working with children, young people and families, who may receive information about child protection issues, must make it clear that they cannot give an absolute guarantee of confidentiality.

For further guidance professionals should refer to Liverpool Safeguarding Children Board Manual, Section 1.4 Information Sharing and Confidentiality:

http://liverpoolscb.proceduresonline.com/chapters/p_info_share.html

11. LSCB Responsibilities

Local Safeguarding Children Boards (LSCBs) have duties and responsibilities to promote activity amongst local agencies and in the community to:
• Identify and prevent maltreatment or impairment of health or development, and ensure children are growing up in circumstances consistent with safe and effective care;

• Safeguard and promote the welfare of groups of children who are potentially more vulnerable than the general population;

• Increase understanding of safeguarding children issues in the professional and wider community, promoting the message that safeguarding is everybody’s responsibility.

• Educate and raise awareness of FGM. Schools have a vital role to play and they now have obligations under OFSTED:
  

Liverpool Safeguarding Children Board will strive to develop appropriate initiatives in relation to FGM which fulfil these duties and responsibilities as well as working in partnership with the Liverpool FGM and Women’s Multi Cultural Health Advisory group and other agencies and stakeholders.

12. Monitoring and Reporting on FGM in Liverpool

It is vital that the key principles outlined in this document are underpinned by a commitment to develop effective arrangements for:

• Ensuring that all staff with safeguarding responsibilities receive training in relation to FGM issues
• Developing data collection around all cases where concerns have been raised in relation to FGM
• Annual review of the Liverpool Safeguarding Children Board FGM Guidance

Last up-dated: 10.06.14
## Appendix 1

### Prevalence profile and legislation banning FGM in Africa

<table>
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<tr>
<th>Country</th>
<th>Prevalence</th>
<th>Illegal / since</th>
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<tbody>
<tr>
<td>Benin</td>
<td>30%</td>
<td>Not yet</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>72%</td>
<td>1996</td>
</tr>
<tr>
<td>Cameroon</td>
<td>20%</td>
<td>None</td>
</tr>
<tr>
<td>Chad</td>
<td>60%</td>
<td>Went before parliament in 2001, not yet in place</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>43%</td>
<td>1966</td>
</tr>
<tr>
<td>Djibouti</td>
<td>98%</td>
<td>1995</td>
</tr>
<tr>
<td>Egypt</td>
<td>97%</td>
<td>1959, there are grey areas, but in 1997 court upheld govt banning of FGM</td>
</tr>
<tr>
<td>Eritrea</td>
<td>90%</td>
<td>No specific banning law for fear of driving the practice underground</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>90%</td>
<td>1994</td>
</tr>
<tr>
<td>Gambia</td>
<td>Approx. 70%</td>
<td>None</td>
</tr>
<tr>
<td>Ghana</td>
<td>15%</td>
<td>1994</td>
</tr>
<tr>
<td>Guinea</td>
<td>99%</td>
<td>Late 1980’s</td>
</tr>
<tr>
<td>Guinea Bissau</td>
<td>Approx. 50%</td>
<td>1995 govt proposal to ban was defeated</td>
</tr>
<tr>
<td>Ivory Coast</td>
<td>45%</td>
<td>1998</td>
</tr>
<tr>
<td>Liberia</td>
<td>60%</td>
<td>None</td>
</tr>
<tr>
<td>Mali</td>
<td>93%</td>
<td>None, but draft legislation and govt campaigns against</td>
</tr>
<tr>
<td>Mauritania</td>
<td>25%</td>
<td>Not illegal, but banned in hospitals</td>
</tr>
<tr>
<td>Niger</td>
<td>5%</td>
<td>Not yet, draft legislation</td>
</tr>
<tr>
<td>Nigeria</td>
<td>25%</td>
<td>In some areas since 1999</td>
</tr>
<tr>
<td>Senegal</td>
<td>20%</td>
<td>1999</td>
</tr>
<tr>
<td>Sierra Leonie</td>
<td>90%</td>
<td>None</td>
</tr>
<tr>
<td>Sudan</td>
<td>91%</td>
<td>1956, rescinded in 1983. Opposed by govt but not in law</td>
</tr>
<tr>
<td>Somalia</td>
<td>100%</td>
<td>In some areas since 1999</td>
</tr>
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Kenya 38% 2001
Tanzania 18% 1998, however not enforced
Togo 12% 1998
Uganda 5% Considering banning, children’s legislation can be used
Yemen 23% Not illegal, but banned in hospitals

The above figures are offered only to give an indication of the scale of the practice of FGM. They are figures for Africa, not for communities in the UK for which prevalence data is not available.
Appendix 2

Multi-agency Practice Guidelines: Female Genital Mutilation

Multi agency practice guidelines have been published to provide advice and support to frontline professionals who have responsibilities to safeguard children and protect them from the abuses associated with FGM. It is unlikely that any single agency will be able to meet the multiple needs of someone affected by FGM, so it is essential that agencies cooperate, share information and work together effectively:


2.1 Health Professionals

*Tackling FGM in the UK* - Inter-collegiate recommendations for identifying, recording and reporting FGM


Additional guidance for health professionals

BMA Guidance: FGM: Caring for Patients and Child Protection:


Royal College of Obstetrics and Gynaecology FGM Guidelines


Appendix 3

Glossary of Terms

1. Female Genital Mutilation is sometimes called ‘female circumcision’ or ‘female cutting’.

2. Type 1 FGM may be known to some communities as ‘Sunna’. Sunna is an Islamic word used to describe an action by the Prophet Mohammed.

3. Infibulation is derived from the name given to the Roman practice of fastening a ‘fibular’ or ‘clasp’ through the large lips of a female genitalia (usually within marriage) in order to prevent illicit sexual intercourse.

4. De-infibulation is the name for having FGM reversed and opening the entry to the vagina again.

5. Re-infibulation is the term used when women seek to be restored to their previous state usually following child birth.

6. The term “closed” refers to type 3 FGM where there is a long scar covering the vaginal opening. This term is particularly understood by the Somali and Sudanese communities.
Appendix 4

Sources of Further Information and Support

National organisations

1. Foundation for Women’s Health Research & Development (FORWARD)
   Tel 020 8960 4000
   www.forwarduk.org.uk

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

3. ChildLine: 24-hour Helpline for children
   Tel 0800 1111 (Free phone)
   www.childline.org.uk

   Tel 0808 800 5000
   help@nspcc.org.uk (Free phone)

Local organisations

1. Merseyside Police Family Crime Investigation Units
   Tel 0151 777 4582 North Liverpool
   Tel 0151 777 5308 South Liverpool
   In an emergency always call 999

2. Careline
   Tel 0151 233 3700 Social Care (Children)
   Tel 0151 233 3800 Social Care (Adults)

3. Liverpool Female Genital Mutilation Group
   Tel 07952058641
4. Savera Liverpool: Domestic Abuse Support Service for Black, Asian, Minority Ethnic and Refugee (BAMER) Communities
Tel 07716266484

5. Liverpool Women’s Hospital Multi-Cultural Antenatal Clinic
Tel 0151 708 9988

6. Women’s Health Information and Support Centre
Tel 0151 707 1826