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Development		
Lead person	To be identified	
Consultation		
List of amendments	**Made by** (name & job title)	**Date**
The FGM Act 2003 stipules that it is an offence for UK nationals to perform FGM abroad (p.6)	Kathryn Grindrod Quality Assurance Team Manager	January 2009
FGM cases differ to Child Protection cases in that parents do not intend to abuse their daughters (seen as an act of love). Furthermore in FGM there is no element of repetition. For these reasons Practitioners need guidance when undertaking strategy meetings/case conferences.	Kathryn Grindrod Quality Assurance Team Manager	January 2009

Additional information	
Related documents	LASSL(2004)4 - Female Genital Mutilation Act 2003
Notes & comments	
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MSCB
MANCHESTER SAFEGUARDING
CHILDREN BOARD

PROCEDURE FOR DEALING WITH ACTUAL OR

SUSPECTED CASES OF FEMALE GENITAL

MUTILATION

Endorsed by:
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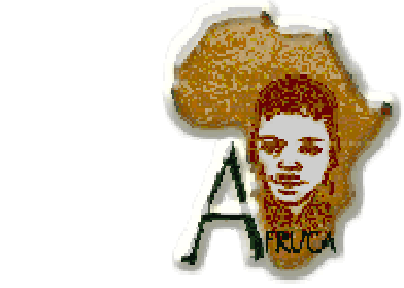

Africans Unite Against Child Abuse

FEMALE GENITAL MUTILATION

1. DEFINITION

Female genital mutilation is a collective term for procedures, which include the partial or total removal of the external female genital organs, or injury to the female genital organs, for cultural or other non-therapeutic reasons.

Female genital mutilation is an operation, which is medically unnecessary and extremely painful and has serious health consequences both at the time when the mutilation is carried out and in later life. The procedure is typically performed on girls aged between 4-13, but in some cases FGM is performed on newborn infants or on young women before marriage or pregnancy. Generally carried out on a child who is unable to resist or to consent, FGM is considered to be principally a form of physical abuse. Whilst it is also an emotionally abusive act, some level of emotional abuse is involved in all ill treatment of a child.

2. BACKGROUND

Communities on every continent have practised female genital mutilation in some form at some time. Female genital mutilation is reportedly practised in 28 African countries from the Gambia to Somalia and parts of the Middle and Far East, also in isolated communities in other parts of the world. It has been increasingly reported in immigrant and refugee populations in UK, Western Europe and other developed countries. Christians, Muslims and others practise it in a range of cultural contexts. The practice has deep cultural significance and is therefore very emotive.

Within the various cultures and countries FGM is performed in different ways.

- Type I (Also known as Sunna within some Muslim communities)
  - Cutting off of the clitoris
- Type II Excision
  - Cutting off of the clitoris and other parts of the genitalia
- Type III Infibulation
  - Sewing up the genitalia, leaving a tiny passage for urine and menstrual flow
- Type IV Unclassified
  - Inserting corrosive substances to add dryness to the vagina
  - Pulling/extension of the labia

There is a strong movement against female genital mutilation in most of the countries in which it is practised and it is legally outlawed in many of them. This law is often more of a statement of intent, acknowledging the need for education in the effects of the practice, and it may not be vigorously applied. For this reason, a family living away from their country of origin may not know of these social and legal changes.

Within the communities in which it is practised, female genital mutilation is seen as a positive experience, which is celebrated with a festival atmosphere and gifts for the child. However, children are taught from an early age that they should not discuss it within their own community, and that they should particularly not discuss it with outsiders.

The communities which practice female genital mutilation tend to be very secretive about this practice because they know it is against child protection laws (not because they are ashamed it is being done). Experience suggests that confronting a family on this issue is likely to lead to them moving away from the area and trying not to be traced, because they know it will bring them into conflict with statutory services and the law.

Justifications

- Family honour;
- Custom and tradition;
- Hygiene and cleanliness;
- Preservation of virginity / to ensure chastity;
- Social acceptance especially for marriage
- Religion. (Mistaken belief that it is a religious requirement)
- A sense of belonging to the group and conversely the fear of social exclusion
- Increasing sexual pleasure of husband
    - As a means of controlling women's sexuality. FGM is performed primarily to please the man.

3. THE LEGAL BACKGROUND

The Female Genital Mutilation Act 2003 makes it a criminal offence for a person to excise, infibulate or otherwise mutilate the whole or any part of a girl's labia majora, labia minora or clitoris, except in the case of a surgical operation which is considered necessary for the girl's physical or mental health, or for purposes connected with labour or birth, and which is carried out by a registered medical practitioner or midwife (or a person training to become a registered medical practitioner or midwife).

The Act also makes it an offence for a UK national or a permanent UK resident to carry out female genital mutilation abroad, or to aid, abet, counsel or procure the carrying out of female genital mutilation abroad.

The Act does not allow traditional and ritual requirements to be used to justify a physical or mental need for the operation.

4. POTENTIAL EFFECTS

The possible short-term effects of female genital mutilation include:

- Severe pain;
- Shock;
- Haemorrhaging, which may be fatal;
- Infection including tetanus and HIV
- Urine retention
- Injury to adjacent tissue

- Fractures and dislocations as a result of restraint
- Death

The possible long-term effects of female genital mutilation include:

- Damage to the reproductive system and infertility;
- Infections of the uterus and vagina;
- Cysts;
- Complications in pregnancy and childbirth;
- Psychological damage, flashbacks;
- Sexual dysfunction;
- Difficulties in menstruation;
- Fistulae
- Bladder infections
- Damage to the kidneys
- Sexually transmitted infections from partners going outside to have sex
- Difficulties in passing urine;
- Increased risk of transmission of HIV; and
- Domestic violence, marriage breakdown and divorce

The complications affecting sexual intercourse, childbirth etc. generally occur many years after the mutilation, and many women appear to be unaware of the relationship between female genital mutilation and its health consequences.

5. SIGNS AND INDICATORS

Some indications that female genital mutilation may be about to or has already taken place.

- The family comes from a community that is known to practice female genital mutilation and that there are elderly women (who have themselves been subject to FGM) present in the extended family.
- A conversation with a child who may allude to female genital mutilation e.g. a child may request help to prevent it happening, may express anxiety about a special procedure which may include discussion of a holiday to their country of origin.

- A prolonged absence from school with noticeable behaviour change on return may be an indication that female genital mutilation has taken place.

- A child may spend long periods of time away from the class during the day - possibly with bladder or menstrual problems.

- Midwives and Obstetricians may become aware that female genital mutilation has taken place when treating a pregnant woman. This should trigger concern for any female child of the family, and result in educational/preventative input via health professionals in liaison with Specialist agencies.

6. POLICY STATEMENT

Manchester Safeguarding Children Board recognises that the practice of FGM is a physically abusive act as it can cause serious short and long term medical complications. Suspected cases of FGM should be treated as causing significant harm to the child and should therefore be initially investigated under section 47 of the Children Act (1989)

It is the aim of Manchester Safeguarding Children Board to prevent the practice of female genital mutilation in a way that is culturally sensitive and with the fullest consultations with community representatives and professional agencies. Manchester Safeguarding Children Board will liaise with appropriate agencies to be guided in its awareness-raising work with community groups in the city.

7. REFERRAL

Concern about a child at risk of female genital mutilation may arise in a number of ways, for example:

- Information comes to the notice of a professional, which suggests that there is a plan to arrange for the genital mutilation of a girl,

- There is suspicion that a girl is being sent abroad for that purpose (abroad can be other countries in Europe)

- One girl in a family has undergone genital mutilation, raising concerns about other, younger girls in the same family, or

- There is concern that a mother who has undergone genital mutilation may wish to arrange the genital mutilation of her daughters.

Anyone who is concerned that a child may be at risk of female genital mutilation must refer the matter to Children's Services using the Inter agency referral form if they are professionals, or by calling the contact centre if they are members of the public/community group.

If a local authority has reason to suspect that a child may be subjected to female genital mutilation, and would therefore suffer significant harm, it should initiate enquiries under Section 47 of the Children Act 1989. Advice on this matter should be sought from appropriate specialist organisations.

Agencies and individual professionals should strive to communicate respect for the cultural and religious beliefs and traditions of the family concerned. There must, however, be no compromise in communicating the message that female genital mutilation is neither legal nor acceptable in the United Kingdom.

The Female Genital Mutilation Act 2003 makes it an offence for UK nationals, or permanent UK residents to carry out Female Genital Mutilation abroad, or to aid, abet, counsel or procure the carrying out of female genital mutilation abroad.

Child at risk of female genital mutilation

Where a child has been identified as being at risk, it may not be appropriate to take steps to remove the girl from an otherwise loving family environment. Experience has shown that often the parents are under pressure from older relatives to follow this cultural practice. This pressure may well continue therefore Children's Services need to be vigilant in ensuring FGM does not happen in future.

If it appears that a child is at risk of genital mutilation, the social worker will forward a section 47 enquiry.

Section 47 enquiries

In the case of FGM or likelihood of FGM, the enquiry will be initiated by the social worker convening a strategy meeting/discussion to agree appropriate actions for agencies (within 24 hours). The police must be involved in this meeting/discussion.
In convening the strategy meeting, workers should consider whether any agency could provide specialist information and advice on the subject of female genital mutilation.

The strategy meeting will make decisions in respect of:

- Notifying the parents that this is a criminal act in the UK and decide whether the child's parents are well informed about the consequences of female genital mutilation

- If the parents are not informed, consider how best to provide them with information on the subject and look at ways of gaining the family's co-operation; Make arrangements for a visit to the family (for example, with a community advocate) to assess the risk to any children and to explain the information.

- If the family's primary language is not English, an interpreter must assist at any interview with them. The interpreter must be female.

- Consider whether to apply for a Prohibited Steps Order to prevent the parents removing the child from the country; and

- Consider whether there is a need for an Emergency Protection Order to protect the child.

- Convening a case conference

If a case conference is convened and decides that the child should be made the subject of a child protection plan, female genital mutilation is normally regarded as a form of physical, rather than sexual abuse.

It is important to note that FGM differs from other forms of child abuse in two ways:

- Despite the severe consequences, parents and others who have done this to their daughters believe it is in the girl's best interest to conform to their prevailing custom – it is not intended as an act of abuse even though it is.
- There is no element of repetition – it is a one-off act of abuse, although younger siblings may be at risk too.

If the child has already undergone genital mutilation

If it is that the operation has taken place, a criminal offence may have been committed and charges may be brought.

Any strategy meeting/discussion in these circumstances must consider all the above points in respect of the child who has undergone this operation plus,

- Any available information about how, when and where the procedure was performed, and the implications for any other children in the family.

- A discussion with the family to acknowledge the conflict between their culture and the law of the UK.

- Appropriate health care to include whether any medical assessment or therapeutic services should be offered to the child and her family.

- The position of any younger girls in the family,

- The family's willingness to co-operate with the agencies concerned,

- Health education and other work with the family to reduce the risk to other members of the family,

- Community reaction to the child and family, and

- Whether the family will need support in the face of community pressure

No evidence of risk

If the section 47 enquiry concludes that there is no clear evidence of risk to a child, Children Services will:

- Consult the child's GP about this conclusion and invite her/him to notify Children Services if any further information challenges it;

- Notify appropriate professionals involved with the family of the enquiry and the stage at which it was concluded

- Inform the family and the referrer that the enquiry has been concluded

- Consider whether any child may be a child in need and, if so, offer appropriate services and

- Offer the family any appropriate support services.

If it appears that no other children are at risk:

- Children Services will take no further action other than to consider any health concerns for the child who has undergone the procedure.

- If the operation seems to have been performed in the UK, the police will seek information for the possible prosecution of the perpetrator.

- Children Services will notify the child's GP and invite her/him to notify them if any changes in the situation give rise to further concerns, e.g. the mother giving birth to further girls.

- If there are concerns about younger girls in the family, Children, Services must convene a child protection conference as soon as possible to discuss whether any protective action can be taken.

8. RESPONDING TO THE ISSUE

It is not enough to respond to this issue on the individual level. Agencies should attempt to identify the communities in which female genital mutilation is likely to be practised and give information about the law prohibiting it and about the reasons for the prohibition. It is imperative that this information is given in a sensitive and considerate way, avoiding sensationalising the issues, as change must come from within the community and cannot be imposed from outside.

It is important to deal with the community on a broad level, as individual women may feel powerless to challenge the practice. Unless a significant proportion of the community accepts that it is reasonable to challenge the need for female genital mutilation, girls and women who are not circumcised may be ostracised by the community. Therefore Manchester Safeguarding Children Board will work towards raising awareness of the issues of FGM with communities.

9. PREVENTION

Any preventive strategy must focus on community education, schools, local community groups, midwives, health visitors and GP's. All are crucial to the delivery of information about the health implications of female genital mutilation to women in the affected communities.

10. SUPPORT AGENCIES:

Specialist advice, guidance, information and support are available from:

Foundation for Women's Health, Research and Development (FORWARD), 765 Harrow Road,
London NW10 5NY
Tel: 0208 960 4000.
www.forwarduk.org.uk

AFRUCA (Africans Unite Against Child Abuse)
Unit 4S Leory House
436 Essex Road
London
N1 3 QP
0207 704 2261
Aug-06Aug-06www.afruca.org.uk