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Stoke-on-Trent and Staffordshire Safeguarding Children Board

GUIDANCE FOR CHILDREN WHO MAY BE PARTICULARLY VULNERABLE

FEMALE GENITAL MUTILATION

Section F 09

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F09 Female Genital Mutilation

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01 What is female genital mutilation (FGM)?

Female genital mutilation (FGM) involves procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. It is illegal in the UK.

FGM is known by a number of names including ‘female genital cutting’, ‘female circumcision’ or ‘initiation’. The term female circumcision suggests that the practice is similar to male circumcision but it bears no resemblance to male circumcision, has serious health consequences and no medical benefits.

FGM is also linked to domestic abuse, particularly in relation to ‘honour based violence’. Please see page 12 for further information and links to other Staffordshire Safeguarding Children Board and Stoke-on-Trent Local Safeguarding Children Board procedures.
Types of FGM

FGM has been classified by the World Health Organisation:

**Type 1** - Clitoridectomy: partial or total removal of the clitoris (the small sensitive erectile part of the female genitalia) In rare cases the prepuce (hood of the clitoris) only is removed.

**Type 2** - Excision: partial or total removal of the clitoris and the labia minora, with or without the excision of the labia majora. (The labia are the ‘lips’ surrounding the vagina) (80% cases)

**Type 3** - Infibulation: narrowing of the vaginal opening by cutting and stitching the labia, with or without removal of the clitoris. (15% cases)

**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.

Prevalence

FGM is deeply rooted in tradition widely practiced among specific ethnic populations in Africa and parts of the Middle East and Asia. Data from Somalia, Guinea, Djibouti, Sierra Leone, Egypt, Sudan, Eritrea and Mali show a prevalence of over 80% but it is also widely practiced in other African countries. However, FGM has been found in communities in Iraq, Israel, Oman, the United Arab Emirates, the Occupied Palestinian Territories, India, Indonesia, Malaysia and Pakistan.

The World Health Organisation (WHO) estimates that between 100 and 140 million girls and women have been subjected to FGM and that around 3 million girls undergo some form of the procedure each year in Africa alone.

FGM’s prevalence in the UK is difficult to estimate due to its hidden nature but is estimated that over 20000 girls under the age of 15 years could be at risk in England and Wales and nearly 66000 women living in England and Wales are living with the consequences. The distribution of cases is likely to be uneven and will mirror the distribution of particular practicing communities.

Why Is Female Genital Mutilation Performed?

FGM is a complex issue. It is often seen as a natural and beneficial practice by a loving family who believe that it is in the girl’s best interests.

A number of factors have been identified:

- To maintain cultural identity
- Religion; in the mistaken belief that it is a religious requirement
- Social acceptance especially for marriage
• Preservation of virginity/chastity
• Increasing sexual pleasure for the male
• Men’s control of female reproductive functions
• Hygiene and cleanliness
• Family honour
• Fear of social exclusion

Many women believe that FGM is necessary to ensure acceptance in their community. They are often unaware that it is not practised in most of the world. FGM serves as a complex form of social control of women’s sexual and reproductive rights.

05 At What Age is FGM Performed?

The age at which FGM is performed varies from area to area. It can be performed on female infants who are a few days’ old, female children and adolescents and occasionally on mature women. However the majority of cases are thought to take part between the ages of 5 and 8 years.

06 Who Performs FGM?

The practice of female genital mutilation is often perpetrated by an older woman in the practicing community and can be a way of her gaining prestige and making a good income.

It is performed with crude blunt instruments such as often unsterilised household knives or razor blades but broken glass and stones are also used and often without anaesthetic. The more affluent may have the procedure performed in a health care facility by qualified health personnel.

07 Effects of FGM

FGM can cause both short term and long term complications. Some of these are as a result of the procedure being performed in unhygienic circumstances.

Short-term implications:

• Severe pain
• Shock—both emotional and psychological as well as medical
• Haemorrhage
• Wound infection including tetanus and blood borne viruses such as HIV and hepatitis B and C
• Damage to organs around clitoris and labia
• Urine retention
• Fracture of bones or dislocation of joints as a result of restraint
• Damage to other organs
• Death

Long-term implications can entail:

• Damage to the reproductive system including infertility
• Chronic vaginal and pelvic infections
• Cysts and abscesses
• Complications in pregnancy and child birth, including death
• Psychological damage
• Painful sexual intercourse
• Sexual dysfunction
• Difficulties in menstruation
• Difficulties in passing urine and chronic urine infections
• Renal impairment and possible renal failure
• Increased risk of HIV and other sexually transmitted infections

There is increasing awareness of the severe psychological consequences of FGM which can be life long. There is evidence to suggest that girls having undergone FGM suffer from post traumatic stress disorder with flash backs and many suffer from anxiety and mood disorder. The feeling of betrayal, incompleteness, anger and regret are themes reported by young women undergoing counselling.

08 Identifying girls at risk of FGM

A girl from a practicing community may be at risk of FGM but it cannot be assumed that all families from practicing communities will want their females to undergo FGM.

The risk of FGM to an individual is greater when the community is less well integrated into British society, when their own mother or sister has been the subject of FGM or when they have been withdrawn from Personal, Social and Health Education or Personal and Social Education lessons at school. The withdrawal from such lessons may be the parents’ way of keeping the girl uninformed of her rights and her own body.

A girl may be taken out of the country for a holiday for the procedure to be carried out abroad with time for recovery, but there is also evidence that FGM is carried out in the UK.

Alerts to imminent FGM may include:

• A visiting female elder being in the UK from the country of origin
• A professional hearing reference to FGM e.g. having a ‘special procedure’.
• A disclosure or request for help if the girl is aware or suspects she is at risk
• Parents taking the child out of the country for a prolonged period
• The girl talking about a long holiday to one of the countries where FGM is practiced.

FGM may already have taken place but it is important that this is recognised so that help can be offered to the girl, other family members at risk can be safeguarded and so that a criminal investigation can be carried out.

Indications that FGM has already been carried out may be suspected if;

• A girl seems to have difficulty walking, sitting or standing.
• A girl spends longer then normal in the bathroom/toilet due to difficulties urinating
• A girl spends long periods away from the classroom with bladder or menstrual problems
• A girl misses a lot of time off school or college
• A girl has a change in behaviour
• A girl being unduly reluctant to have a normal medical examination
• A girl confides in someone or may ask for help but not be explicit due to fear or embarrassment.

09 Legal Context

FGM is illegal in the UK.

The Female Genital Mutilation Act 2003 applies to England, Wales and Northern Ireland and a person, whatever their nationality or residence status, is guilty of an offence under this Act if they excise, infibulate or otherwise mutilate the whole or any part of a girl’s or woman’s labia majora, labia minora or clitoris within the UK.

Necessary operations by a registered medical practitioner or midwife for medical reasons or related to child birth are specific exclusions under the Act.

It is also an offence to assist a girl or woman in mutilating her own genitalia

Under the 2003 Act, it is an offence for a UK national to assist in FGM abroad and for a girl to be taken abroad for FGM to take place.

Anyone found guilty under the 2003 Act will be liable to a maximum penalty fine or up to 14 years imprisonment or both.

Responding to FGM

Girls and young women at risk of FGM need to be safeguarded. Anyone who has information that a child is potentially or actually at risk of significant harm is required to inform children’s social care or the police. (Children Act 1989). Children’s social care services will then assess the risk to the child.

Staff in education settings and obstetrics and midwifery services need to be aware of the potential risks to girls and women from communities known to practice FGM.

Professionals need to be aware of the sensitive and complex nature of FGM. Often the family do not see FGM as an act of abuse and in all other ways provide a loving environment. Removal of the girl from the family home may not be appropriate.

Each case needs to be responded to depending on the particular circumstances and level of danger at the time.

If an individual has undergone FGM, professionals must consider whether other girls are at risk.

When talking about FGM professionals it is good practice to:

- Ensure a female professional is available if the girl prefers
- Make no assumptions
- Be sensitive to the fact that the girl may still be loyal to her family
- Be non judgemental and stick to facts e.g. the legal position and health implications
- Gain accurate information and keep accurate records
- Use simple, non loaded and value neutral terminology
- Ask direct questions to avoid confusion

If an interpreter is required, they should have received training in relation to FGM, must not be a family member nor have any influence in the girl’s community.

Females may be frightened about contact with statutory agencies for a variety of reasons including being in breach of immigration rules. However, the female may need medical treatment of may be the victim of a crime. The situation should be handled sensitively and may need agreement between the police and UK Border Agency officials.

If a medical examination is required, this should be carried out by an appropriately trained person. For children this should be carried out under safeguarding procedures by a senior paediatrician, preferably one with experience of dealing with FGM.

Professionals may feel uncomfortable about disclosing information about FGM, but law and policy allow for disclosure when it is in the public interest or where a crime may have been committed. Professionals should follow appropriate guidance regarding confidentiality and disclosure, e.g. ‘What to do if you are worried a child is
being abused’ (2006), Nursing and Midwifery Council’s advice on confidentiality (2009), General Medical Council guidance (2009).

Professionals need to be aware that an individual may be at risk of both FGM and forced marriage. The national and local guidance on forced marriage should be consulted.

11 Legal interventions

Working Together to Safeguard Children (2010) states:

“A local authority may exercise its powers under s.47 of the Children Act 1989 if it has reason to believe that a girl is likely to suffer or has suffered FGM.”

Professionals should intervene to safeguard girls who may be at risk of FGM or has been affected by it. This is by using the relevant existing statutory procedures. There may be a joint investigation which would be handled in line with the Safeguarding Board procedures and Working Together to Safeguard Children (2010).

The police may use their protection powers under section 46 of the Children Act 1989 where there is reasonable cause to believe that a child or young person under 18 years is at risk of significant harm. Children’s social care would be informed by the police and initiate child protection enquiries.

Emergency Protection Order (EPO) can be applied for by anyone but in general is by children’s social care. An EPO authorises the applicant to remove the girl and keep her in safe accommodation. It lasts for 8 days but can be renewed for up to a further 7 days.

Care Orders and Supervision Orders- Children’s social care may need to consider whether the circumstances constitute likely significant harm to justify initiating care proceedings. The court will decide whether the threshold has been reached and which order is most appropriate depending on the circumstances and the age of the child or young person (Children Act 1989 section 31).

Under the Children Act 1989, local authorities can apply to the courts for various orders to prevent a child being taken abroad for FGM.

A Prohibitive Steps Order (Children Act 1989, Section 8) can be sought to prevent parents or carers from carrying out a particular act without the consent of the court.
A. Child at Risk of FGM

Referral to Police or First Response/Children's specialist services

Strategy meeting

Visit to family. Interpreter may be needed

Convened by vulnerable LA children's social care
Involving: police and appropriate education and health

Purpose
1. Share information
2. Agree actions
3. Establish legal requirements
4. Establish potential risks to other children

Agreement reached that FGM will not take place. No further action by LA children's social care. Possible follow up support from appropriate agencies as agreed by Child in Need Service Plan

No agreement reached.
Least intrusive legal action to prevent FGM.
If immediate danger then:
1. Emergency Protection Order
2. Prohibitive Steps Order
3. Police protection powers as appropriate
B. **Child has Undergone FGM**

- Referral to police, First Response/Children’s specialist services

**Strategy meeting**

- Visit to family. Interpreter may be needed.

- **Convened by LA children’s social care**
  - Involving: Police and appropriate education and health personnel

**Purpose**

1. Share information
2. Agree actions
3. Establish legal requirements
4. Consider risk to other children

- On going concerns. Reconvene strategy meeting to plan intervention.

- No children identified to be at ongoing risk of significant harm. No further action by LA children’s social care. Possible follow up support from appropriate agencies as agreed by Child in Need Service Plan.
12 Community Education

Working Together to Safeguard Children (2006) states:

“In local areas where there are communities who traditionally practice FGM, consideration should be given to incorporating more detailed guidance on responding to concerns about FGM into existing procedures to safeguard and promote the welfare of children. LSCB policy should focus on a preventive strategy involving community education.”

Cities such London, Liverpool, Birmingham, Sheffield and Cardiff have substantial populations from the countries where FGM is widely practiced. However it is important to note that FGM is not necessarily confined to these areas.

Practising communities where FGM is deeply embedded in the culture may resent the imposition of liberal western values on them. Professionals nonetheless must be aware that FGM can be very harmful and is not a matter that can be left to personal preference or culture.

It is important however, that any community education is sensitive to the cultural norms and pressures applied to parents and children. Professionals involved will have to be aware of language and terminology. Consideration should be given to the production of leaflets in specific languages in order to help with this process.

Any child protection policy adopted will need to be effective within the community to which it is targeted and therefore liaison with community members to work with agencies around education will need to be put in place.

13 Support

Families involved may need to be referred to appropriate counselling services, to deal with any psychological conflicts that may arise.

It is imperative for agencies to recognise that many families, who are considering perpetrating this practice, have a considerable cultural dilemma. Families should be warned that this is an illegal practice in this country and that they are liable to prosecution if they proceed. This can take away the decision from the family and therefore reduce criticism from within their own community.

A specialist trained advisor (if available) may be needed to visit families where FGM is suspected.

14 Links with domestic abuse and ‘honour based violence’

Definition of Honour-Based Violence (HBV)

The terms 'honour crime', 'izzat' or 'honour-based violence' embrace a variety of crimes of violence (mainly but not exclusively against women), including assault,
imprisonment and murder where the person is being punished by their family or community. They are being punished for actually, or allegedly, undermining the family or community believes to be the correct code of behaviour. In transgressing against this correct code of behaviour, the person shows that they have not been properly controlled to conform by their family and this is to the 'shame' or 'dishonour' of the family.

Forced marriage and honour-based violence are human rights abuses and fall within the Government’s definition of domestic violence. Forced marriage is defined as a marriage conducted without the full consent of both parties and where duress is a factor. There is a clear distinction between forced marriage and an arranged marriage. In arranged marriages, the families may take a leading role in arranging the marriage, but the choice whether or not to accept remains with the prospective spouses. In a forced marriage, one or both spouses do not consent to the marriage. The young person could be facing physical, psychological, sexual, financial or emotional abuse to pressure them into accepting the marriage. (6.20-6.21 Working Together 2010)

15 Links to Female Genital Mutilation and Forced Marriage

'Honour-based' violence can include the following issues:

- Forced marriage (FM)
- Female genital mutilation (FGM)
- Honour killings (murder)
- Domestic imprisonment
- Dowry-related abuse

As a result, FGM and FM are types of abuse that fall into the category of HBV. For further information please refer to the following Local Safeguarding Children Board Procedures for further guidance in relation Forced Marriages:

Staffordshire Safeguarding Children Board:


Stoke-on-Trent Safeguarding Children Board – Procedure D07


16 Raising Awareness

Training with regard to the recognition of female genital mutilation may be needed. Sensitivity in managing the patients, referral facilities for reversal surgery, pre-birth examination and information gathering would have to contain awareness that women may not recognise female genital mutilation as surgery and indeed may not consider it abnormal. It is important that enquiries are made as early as possible in
pregnancy in order to identify infibulated women and refer them for a medical opinion. Similarly it is important to stress that re-infibulation is illegal.

There will be issues for all staff involved regarding training and case management including cultural sensitivity issues.

There is a clear need to build up relationships with families to overcome the initial hostility which intervention generates. There is also a need to emphasise the positive aspects of the family’s culture, since for many FGM is usually practised out of a positive regard for a woman’s future status within her community.

Workers who are dealing with these issues will need specific support because it may be that if they are members of a similar community to the families they are working with, they may be seen as outsiders and treated with particular hostility.

Health Visitors and School Health Advisors will need to have an awareness of the problem, both from the point of view of offering potential counselling services and also for raising awareness in health education programmes.

17 Specialist groups which can provide advice and support for agencies:

**Foundation for Women’s Health, Research and Development (FORWARD)**

Unit 4  
765 - 767 Harrow Road  
LONDON  
NW10 5NY    Telephone: 020 8960 4000    [www.forwarduk.org.uk](http://www.forwarduk.org.uk)

**Agency for Culture and Change Management**

1 Arundel Gate  
Sheffield  
S1 2PN    Telephone: 0114 275 0193

**Equality Now**

5th Floor  
6 Buckingham Street  
London  
WC2N 6BU    Telephone: 020 7839 5456    [www.equalitynow.org](http://www.equalitynow.org)
18 Conclusion

Female genital mutilation is not a race or a religious issue; it is a safeguarding issue which will need to be managed consistently. All staff involved in the safeguarding of children must recognise this.

The practice of female genital mutilation tends to run in families and therefore if one family member is identified as being at risk of undergoing FGM or has undergone FGM, risks to other female family members must be recognised.

Any concerns regarding female genital mutilation must be acted upon in accordance with local policy and guidance. The referrer however, must feel reassured that a sensitive strategy will follow, including the sensitive management of any subsequent investigation and child protection conference.

19 References

HM Government, Multi-Agency Practice Guidelines: Female Genital Mutilation, 2011

World Health Organisation, Female Genital Mutilation, Fact Sheet No 241, 2010

20 Useful documents


Royal College of Nursing. Female genital mutilation: An RCN educational resource for nursing and midwifery staff, 2006. www.rcn.org.uk