4.21 Female Genital Mutilation

Contents

1. Background Information
2. Definitions
3. Effects
4. Common Philosophy Statements
5. The Legal Framework
6. Concerns and Referrals
7. Response of Children's Social Care - Strategy Discussion and Section 47 Enquiry
8. Prevention Strategy
9. Support Agencies

1. Background Information

Historically female genital mutilation in varying degrees has appeared in all the continents of the world, albeit in many places the practice has died out. Currently, it is known to take place in western, eastern and north-eastern parts of Africa and some parts of the Middle East and south east Asia. Female genital mutilation is said to be performed for religious, socio-cultural and aesthetic reasons. Some people believe that it is a religious requirement for Muslims but given the practice predates Islam and it is not mentioned in the Koran, this belief appears to be false. It also needs to be noted that it is practised by Christians, Muslims and non-believers alike and geographical groupings appear more significant than religious ones.

Female genital mutilation can be viewed as one of the extreme forms of oppression of females seen across cultures - it is now considered by many as an act of extreme violence against women and female children.

Ninety five per cent of female genital mutilation is performed on girls whose age ranges from a day old to 16 years of age. These children and young people usually do not have the knowledge to understand the full implications of female genital mutilation and can exercise little informed choice.

2. Definitions

Female genital mutilation is a collective term used for different degrees of mutilation of the female external genitals, which includes the partial or total removal of the extreme female genital organs or injury to the female genital organs for cultural or non-therapeutic reasons.

It is commonly referred to as "female circumcision", implying an analogy with male circumcision, however, the degree of cutting in the female is more extensive and damaging and carries far greater risk of physical damage, psychological damage and in some cases, death.

The main three forms of mutilation are:

**Sunna** - This involves the cutting of the prepuce or hood of the clitoris. This is regarded as the mildest form of female genital mutilation and seems only to be undertaken on a small proportion of females.

**Excision** - The clitoris and all or part of the labia minora are removed. It is estimated that over 80% of women and girls affected are mutilated in this way.
Infibulation - Approximately 15% of women and girls affected are thought to experience this more radical infibulation, which involves further cutting of the labia majora. After cutting, the raw areas of the labia majora are brought together to heal and form a hood over the urethra and the vagina with an artificial opening the size of a matchstick left for the passage of urine and menstrual blood.

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 - see Section 3, Effects. The procedure is typically performed on girls aged between 4 and 13 but in some cases it is performed on newborn infants or on young women before marriage or pregnancy.

Although these mutilations are commonly performed without anaesthetics the practice is not generally perceived as abusive or harmful by those arranging the operation.

3. Effects

There is substantial evidence, however, that harmful effects both in the short term and the long term can include:

Short Term
Severe pain, haemorrhages, shock, damage, infection (including tetanus and HIV) to other organs, urine retention, injury to adjacent tissue, fractures and dislocations as a result of restraint and death.

Longer Term
- Chronic infections of uterus and vagina;
- Abscesses and cysts;
- Bladder infections and damage to kidneys;
- Complications during childbirth;
- Sexual problems;
- Psychological trauma;
- Domestic violence and abuse, 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.

4. Common Philosophy Statements

All children have a right to protection, irrespective of race, colour or culture. Addressing this issue is an integral part of child protection.

It is recognised that there is no wilful intent to harm the child through genital mutilation (and in fact it is traditionally believed to positively enhance the child's social and economic status for her future). However this practice can cause long-term physical and emotional effects and create a variety of different problems throughout life.

It is further recognised that all attempts to intervene within cultures practising female genital mutilation must be attempted in a culturally sensitive and non-punitive manner with appropriate and helpful personnel who can communicate effectively with the family concerned.

It will be necessary to work closely with community representatives who can help to bridge the gaps between the communities involved and Social Services.
The ultimate aim is to prevent the practise of female genital mutilation, and to re-educate and support those communities who continue to practice this act.

It is possible to change attitudes towards female genital mutilation through supporting and re-educating families. If extreme strategies or policing of families is used, this is likely to alienate communities, and to drive the practice further underground.

5. The Legal Framework

Criminal Law

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 FGM abroad, or to aid, abet, counsel or procure the carrying out of FGM abroad.

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

The Act does not, however, make provision to prohibit children being taken out of the Country for the purpose of being entered into this procedure.

Civil Law

Section 47(6) of the Children Act 1989 imposes a duty on Local Authorities to investigate a child's circumstances who they have reasonable cause to suspect is suffering or is likely to suffer Significant Harm. The enquiries have to be sufficient to enable the authority to decide whether it should take any action to safeguard or promote the child's welfare, ie to protect the child.

Therefore, the authority having decided that female genital mutilation of whatever degree, on the face of it, constitutes Significant Harm within the meaning of the Children Act 1989, upon being made aware that a child has suffered from, or is likely to suffer from this practice, must decide what action is ought to take to protect the child. The investigation of this matter should be done jointly with the Police and considered within a multi-disciplinary context.

Powers available to the Local Authority to prevent removal of a child from the country

The Local Authority can apply to the Court for leave to apply for a Prohibited Steps Order to prevent parents from removing a child from the UK believing that mutilation can be carried out while the child is abroad.

Given the nature of the matters under consideration the most appropriate forum for such an application to be is to the High Court.

Under Court rules the local authority would usually have to give a child's parent 21 days notice of an application to the Court for a Prohibited Steps Order. However, given the obvious need for speed in such circumstances the authority can apply to Court for the Notice period to be abridged and come before the Court in a much shorter period of time for an Emergency Interim Prohibited Steps Order to be considered by the Court.

A full Prohibited Steps Order could last until the child is 16 years old or 18 in exceptional circumstances.

Emergency Protection Order
Section 44 of the Children Act 1989 enables the Local Authority to apply to the Court for an Emergency Protection Order. If circumstances are so acute as to require an Order immediately and an application for an ex-parte Emergency Protection Order is made and is successful, the authority would then consider issuing proceedings for a Prohibited Steps Order and requesting the matter, among other matters, be transferred immediately to the High Court.

As Section 8 proceedings under the Children Act are not ‘specified proceedings’ within the meaning of the 1989 Act, the Court would not ordinarily appoint a Children’s Guardian. However, in these circumstances the Court would normally appoint the Official Solicitor as the Guardian ad Litem for the child.

**Inherent Jurisdiction Of The High Court**

In exceptional circumstances the Local Authority could liaise with the Official Solicitor and seek an order to protect the child using the inherent jurisdiction of the High Court. It would be the responsibility of Legal Services to advise as to the appropriate forum for legal intervention.

**Criminal Injuries Compensation**

Claims for criminal injuries compensation should be considered in all cases of female genital mutilation. This procedure can be adopted by the Local Authority for children in their care, and assistance can be offered to those outside the care system or who have reached the age of 18, should they request it through the Social Services Department. Any application for a child in care should be made in consultation with Legal Services. In other circumstances, the child/young person should be encouraged to seek their own independent adviser.

6. Concerns and Referrals

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, for example a conversation with a child who may allude to female genital mutilation or request help to prevent it happening or express anxiety about a special procedure which may include a discussion of a holiday to their country of origin;
- Suspicion that a girl is being sent abroad for that purpose (abroad can be other countries in Europe);
- A girl's prolonged absence from school with noticeable behaviour changes on return;
- A girl spending long periods of time away from class in school during the day possibly with bladder or menstrual problems;
- One girl in a family having undergone genital mutilation, raising concerns about other, younger girls in the same family; or
- There is concern that a mother who has undergone female genital mutilation may wish to arrange the female genital mutilation of her daughters.

Any individual or agency who receives information, or has reason to believe that a child is at risk of undergoing any form of female genital mutilation, should refer the child to Children's Social Care in accordance with the Making Referrals to Children's Social Care Procedure.

7. Response of Children's Social Care - Strategy Discussion and Section 47 Enquiry

No enquiries into female genital mutilation should be undertaken by any individual without Children's Social Care first initiating a Strategy Discussion/Meeting, which will usually take the form of a face to face meeting, chaired by a manager from Children's Social Care and attended by all relevant professionals.
If, in the rare event of an emergency situation arising, and in exceptional cases, enquiries without a Strategy Discussion/Meeting may be necessary.

Convening a Strategy Discussion/Meeting is the responsibility of Children’s Social Care and invited professionals should include:

- A specialist adviser on female genital mutilation;
- The social worker and manager responsible for the Section 47 Enquiry;
- A member of the Police PPIU.

A legal representative should be available for consultation - see also Section 5, Legal Framework.

The purpose of the Strategy Discussion/Meeting is to share all relevant information and, if necessary, to plan a strategy of intervention. Allocation of same race and culture of social workers must be considered.

The Strategy Discussion/Meeting will make decisions in respect of:

- Notifying the parents that female genital mutilation 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, considering how best to provide them with information on the subject and look at ways of gaining the family’s cooperation;
- Making 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, arranging the appointment of an interpreter to assist at any interview with them. The interpreter must be female;
- Considering whether the investigation will involve the Police at this stage;
- Considering whether to apply for a Prohibited Steps Order to prevent the parents removing the child from the country;
- Considering whether there is a need for an Emergency Protection Order to protect the child;
- Convening a Child Protection Conference or Child in Need Meeting.

All interviews with children should be undertaken in a sensitive manner, and should only be carried out once. Parental consent, and the child’s agreement must be sought before interviews take place.

Where it has been identified that the child has already undergone the operation, the Strategy Discussion/Meeting will also consider the following:

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

Medical examination of the child, if necessary, must only be undertaken with the child and the parents’ consent. These examinations must only be carried out once.

If any child is found to require medical attention following female genital mutilation, this must be sought with appropriately qualified medical staff. If parents are not giving consent, consultation with Legal Services will be necessary.

Where a child has been identified as being at risk of female genital mutilation, 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. All attempts must be made to work in partnership with the parents and fully inform them of why the practice of female genital mutilation is viewed as abusive.

Evaluation of the information will be the responsibility of all agencies involved.

Following all enquiries into female genital mutilation, regardless of the outcome, consideration must be given to the therapeutic/counselling needs of the child and the family.

If a Child Protection Conference is deemed necessary and a decision is made that the child requires a Child Protection Plan, the category of abuse should be Physical Abuse.

Where a child has been identified as being at risk of female genital mutilation, 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. All attempts must be made to work in partnership with the parents and fully inform them of why the practice of female genital mutilation is viewed as abusive.

Evaluation of the information will be the responsibility of all agencies involved.

Following all enquiries into female genital mutilation, regardless of the outcome, consideration must be given to the therapeutic/counselling needs of the child and the family.

If a Child Protection Conference is deemed necessary and a decision is made that the child requires a Child Protection Plan, the category of abuse should be Physical Abuse.

Where the outcome of the Section 47 Enquiry is that there is no evidence of risk to a child, Children Social Care will:

- Consult the child’s GP about this conclusion and invite her/him to notify Children’s Social Care 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, consider whether a Child in Need Meeting is required and/or offer appropriate services to the child and family.

Where a child has been the subject of female genital mutilation but it appears that no other children are at risk, Children Social Care will take no further action other than:

- Consider any health concerns for the child who has undergone the procedure;
- 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 the operation seems to have been performed in the UK, the police will seek information for the possible prosecution of the perpetrator.

If, however, there are concerns about younger girls in the family, Children Social Care must convene a Child Protection Conference as soon as possible to discuss whether any protective action can be taken.

8. Prevention Strategy

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 the Greater Manchester Local Safeguarding Children Boards will work towards raising awareness of the issues of female genital mutilation with communities.

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

9. 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.
Forward website

AFRUCA (Africans Unite Against Child Abuse)
Unit 4S Leory House
436 Essex Road
London N1 3QP
0207 704 2261
Afruca Website