



## **SAFEGUARDING GIRLS AND YOUNG WOMEN AT RISK OF ABUSE THROUGH FEMALE GENITAL MUTILATION**

### **November 2010**

#### **1. Introduction**

1.1 This guidance and protocol provides information to agencies and services in Buckinghamshire about female genital mutilation (FGM) and what action they should take in safeguarding girls and young women who they believe may be at risk of being, or have already been, harmed.

1.2 FGM is extremely traumatic, can be fatal, and has significant short and long term medical and psychological implications. It is illegal in the United Kingdom. Consequently, **FGM is both a criminal and child protection issue.**

1.3 This protocol should be read in conjunction with:

- Buckinghamshire Child Protection Procedures (BSCB)
- Safeguarding children and young people from forced marriage (BSCB)
- Buckinghamshire Domestic Abuse policy (BSCB)

(All of the above can be found at [www.bucks-lscb.org.uk/procedures](http://www.bucks-lscb.org.uk/procedures))

1.4 A number of UK professional bodies have published guidelines on FGM, including gynaecologists, obstetricians, paediatricians and midwives. These specific guidelines are listed in the appendices.

#### **2. BSCB Policy Statement**

2.1 Buckinghamshire Safeguarding Children Board (BSCB) recognises that whilst there is not necessarily intent to harm a girl / young woman through FGM, the practice has serious short and long term medical and psychological implications.

2.2 It is the aim of BSCB to prevent the practice of FGM in a way that is culturally sensitive; involving consultation with relevant communities where appropriate

2.3 All agencies/services should be alert to the possibility of FGM, and their approach should include a preventative strategy that focuses upon education, as well as the protection of girls / young women at risk of significant harm (refer to main Child Protection Policy to define Significant Harm).

2.4 The following principles should be adhered to:

- The safety and welfare of the girl / young woman is paramount.
- All agencies/services and staff, including volunteers, will act in the interest of the rights of the girl / young woman, as stated in the UN Convention on the Rights of the Child (1989)
- All decisions or plans for the girl / young woman should be based on thorough assessments which have a sensitive approach to the issues of age, race, culture, gender, religion. Stigmatisation of the girl / young woman or their specific community should be avoided.

- Buckinghamshire's agencies/services should work in partnership with members of affected local communities, to develop support networks and appropriate education programmes.

### 3. Female Genital Mutilation - Definition

3.1 The World Health Organisation (WHO) states that female genital mutilation (FGM) 'comprises all procedures (not operations) 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 also known as female circumcision, but this is incorrect as circumcision means 'to cut' and 'around' (Latin), and it is quite dissimilar to the male procedure. It can also be known as female genital cutting. It can cause long-term mental and physical suffering; menstrual and sexual problems; difficulty in giving birth; infertility and even death. The average age for FGM to be carried out is about 14 years old. However it can vary from soon after birth, up until adulthood. It can also be classed as honour based violence.

### 4. Prevalence

4.1 FGM is much more common than many people realise. In 2004 it was estimated that there were approximately 80,000 girls and women in the UK who had undergone genital mutilation and a further 7,000 girls under 17 were at risk (Department of Health).

4.2 A study by FORWARD estimated prevalence of FGM in England and Wales as at least 66,000 in 2001 with 24,000 girls under the age of 15 being at risk (Dorkenoo, 2007). One study (Williams et al, 1998) found that 70% of unmarried Somali girls aged 16-22 living in London had experienced FGM, and that the vast majority of those had it carried out before arriving in the UK.

4.3 Morison et al, (2004), detailing experiences and attitudes to FGM among London based Somalis aged 16-22 years; found that age on arrival to the UK had a significant impact on whether girls were circumcised. 42% of girls who arrived in the UK before the age of 6 were circumcised, compared with 91% of girls who arrived after the age of 11.

4.4 FGM is traditionally practised in sub-Saharan Africa, but also in Asia or the Middle East. Those African countries where it is most likely to be practised include Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Guinea, Mali, Sierra Leone, Somalia and Sudan. This does not mean that it is legal in these countries. There are a range of responses by individual nations: from still being legal, to being illegal but not upheld, to outright bans that are adhered to.

4.5 Girls and women from the Democratic Republic of Congo, Ghana, Niger, Tanzania, Togo, Uganda and Yemen are less likely to undergo FGM. But within these countries there are particular ethnic communities where prevalence is higher (London LSCB protocol: App 8). Girls and young women who are British citizens but whose parents were born in countries that practiced FGM may also be at risk.

### 5. Main Forms of FGM

5.1 The World Health Organisation has classified four main types of FGM:

1. **Clitoridectomy** which is the partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, rarely, the prepuce (the fold of skin surrounding the clitoris) as well.
2. **Excision** which is the partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).

3. **Infibulation** which is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, and sometimes outer, labia, with or without removal of the clitoris.
4. **Other types** which are all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area' (WHO FGM Fact Sheet, 2008).

## 6. The FGM Practice

6.1 The procedure is often carried out by an older woman in the community, who may see conducting FGM as a prestigious act as well as a source of income.

6.2 The procedure can involve the girl / young woman being held down on the floor by several women. It is often carried out without medical expertise, attention to hygiene or an anaesthetic. Instruments used have been known to include un-sterilised household knives, razor blades, broken glass and stones. The girl / young woman may undergo the procedure unexpectedly, or it may be planned in advance.

6.3 The practice is mostly carried out by traditional circumcisers, who often play other central roles in communities, such as attending childbirths. Increasingly, however, FGM is being performed by health care providers (World Health Organisation 2010).

## 7. Signs and Indicators

7.1 Some indications that a child / young women has already been subjected to FGM may include:

- A girl / young woman may spend time out of the classroom or from other activities, with bladder or menstrual problems.
- A long unexplained absence from school or holiday abroad could be an indication that a girl / young woman has recently undergone an FGM procedure, when there are noticeable behavioural changes on her return (NB. This may also be due to a forced marriage – please refer to BSCB Forced Marriage protocol)
- A girl / young woman requiring to be excused from physical exercise lessons without the support of her GP
- A girl / young woman may ask for help, either directly or indirectly
- A girl / young woman who is suffering emotional / psychological effects of undergoing FGM, for example withdrawal or depression
- Midwives and obstetricians may become aware that FGM has taken place when treating a pregnant woman / young woman.

7.2 Some indications that a child / young women may be at risk of being abused through FGM can include:

- The family comes from a community that is known to practice FGM
- A child / young women may talk about a long holiday to her country of origin or another country where the practice is prevalent
- A girl / young woman may ask for help, either directly or indirectly

## 8. Consequences of FGM

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

8.2 Short term health implications may include:

- Severe pain and shock
- Emotional and psychological shock
- Infections
- Haemorrhage
- Injury to adjacent tissues
- Fracture or dislocation as a result of restraint
- Damage to other organs.

8.3 Depending on the degree of mutilation, it can cause severe haemorrhaging and result in the death of the girl / young woman through loss of blood.

8.4 Long term health implications may include:

- Excessive damage to the reproductive system
- Uterus, vaginal and pelvic infections
- Infertility
- Cysts
- Complications in pregnancy and childbirth
- Psychological damage
- Sexual dysfunction
- Difficulties in menstruation
- Difficulties in passing urine
- Increased risk of HIV transmission.

8.5 Results from research in practicing African communities are that women who have undergone FGM have the same levels of Post Traumatic stress Disorder as adults who have been subject to early childhood abuse. Research also indicates that the majority of the women (80%) suffer from affective (mood) or anxiety disorders

*(Behrendt, A. et al, 2005 Posttraumatic Stress Disorder and Memory Problems after Female Genital Mutilation. Am J Psychiatry 162: 1000-1002, May).*

## **9. Cultural context**

9.1 The issue of FGM is very complex. Despite the obvious harm and distress it can cause, many parents from communities who practice FGM believe it important in order to protect their cultural identity.

9.2 FGM is often claimed to be practiced within a religious context. However, neither the Koran nor the Bible supports the practice of FGM. As well as religious reasons, parents may also say that undergoing FGM is in their daughter's best interests because it:

- Gives her status and respect within the community
- Keeps her virginity / chastity
- Is a rite of passage within the custom and tradition in their culture
- makes her socially acceptable to others, especially to men for the purposes of marriage
- Ensures the family are seen as honourable
- Helps girls and women to be clean and hygienic.

## 10. Legal Position

10.1 FGM has been **illegal in the UK** since the Female Circumcision Prohibition Act 1985. This made it illegal for a person to excise, infibulate (sew together the labia majora) or otherwise mutilate the whole or any part of a girl / young woman's labia majora, labia minora or clitoris. It is also an offence 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.

10.2 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, 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. The 2003 Act increases the maximum penalty for committing or aiding the offence from 5 years to 14 years in prison.

10.3 Local authorities can apply to the courts for various orders, such as an Emergency Protection Order, under the Children Act 1989, to prevent a girl / young woman being taken abroad for the purposes of genital mutilation. In emergency situations a Police Protection Order can be applied.

## 11. Roles and Responsibilities

11.1 Although the following guidance relates primarily to health, the content also aims to inform anyone working with families/communities affected by FGM.

11.2 Health professionals in GP surgeries, sexual health clinics and maternity services are the most likely to encounter a girl or woman who has been subjected to FGM. In such a situation they should be aware of the risk of FGM in relation to:

- Any younger siblings
- Daughters she has or daughters she may have in the future
- Any female members in her extended family.

11.3 All staff should be alert to the possibility that girls / young women within at risk communities may present to them with health issues. This may be due to having already undergone FGM, and they may be experiencing menstrual or sexual problems for example, or want support. Alternatively they may be very concerned that they will soon have to undergo FGM and may turn to their GP for help. However, they may find such issues extremely difficult to discuss. The GP should spend time, therefore and ask questions about presenting health issues to ascertain the exact nature of the problem.

11.4 If anyone is concerned about a girl / young woman is at risk of, or has already undergone FGM, they should follow the guidance laid out in this protocol within Section 5.0.



## **SAFEGUARDING GIRLS AND YOUNG WOMEN AT RISK OF ABUSE THROUGH FEMALE GENITAL MUTILATION**

**November 2010**

### **INITIAL ACTION**

#### **1. Action to take if practitioners believe a child is at risk of FGM**

**Any information or concern that a girl / young woman is at risk of, or has undergone FGM should result in an immediate referral to Thames Valley Police (via 08458 505 505)**

**In an emergency – do not delay – ring 999**

1.2 The risk of FGM is a risk of significant harm and will therefore also need to be investigated by Social Care under s47 of the Children Act 2004.

1.3 If a girl / young woman is thought to be at risk of FGM, workers 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.

#### **2. Requests for re-infibulation**

2.1 After childbirth, a girl / woman who has been deinfibulated (a surgical procedure to open up the scar tissue to restore the normal vaginal opening, commonly called a 'reversal') may request re-infibulation. This should be treated as a potential child protection concern, as the girl / woman's apparent reluctance to comply with UK law, may have implications for her own children if they are female. Professionals should consult with their agency's nominated safeguarding children adviser and with CYPS Social Care Services about making a referral to them.

2.2 All girls / women who have undergone FGM (and their partners or husbands) must be told that re-infibulation is against the law and will not be done under any circumstances. Each woman should be offered counselling to address how things will be different for her afterwards.

#### **3. Interpreters**

3.1 Wherever possible, a professional female interpreter should be used for women/ young girls known to have limited English. This will reduce misunderstanding; increase the likelihood of identification of FGM and any additional physical, psychological and social concerns. Use of family members is not advised as they may influence decisions and inhibit true expression of the woman's feelings.

3.2 Always brief/debrief the interpreter, explain the purpose of the meeting, ensure they understand the issue and are happy to talk about FGM. We must remain aware that the interpreter may have experienced FGM, hence may have difficulty discussing it. Alternatively, they may view FGM as a valuable practice, hindering the interpretation process.

3.3 Always check that the woman/young girl is happy to continue with the chosen interpreter, as communities affected by FGM are often small and therefore interpreters may be known socially by

the woman/young girl. The importance of confidentiality should be stressed to all parties involved.

#### **4. Strategy Meeting / Discussion**

4.1 Once a referral has been received for either a girl / young woman who is at risk or has undergone FGM, a Strategy Meeting / discussion must be convened. This must involve representatives from the police, CYPS and other relevant services. Consideration should also be given to inviting a legal advisor.

4.2 The Strategy Meeting / Discussion must first establish if the parents and / or girl / young woman have had access to information about the harmful aspects of FGM. If not, the parents / girl / young woman should be offered the opportunity of educational / preventative programmes before any further action is considered.

4.3 Every attempt should be made to work with parents on a voluntary basis to prevent abuse of FGM occurring. The investigating team should ensure that parental co-operation is achieved wherever possible, including the use of community organisations and / or community leaders to facilitate the work with parents / family. However, if it is not possible to reach an agreement, the first priority is protection of the girl / young woman.

#### **5. Child Protection Conference**

5.1 A Child Protection Conference should only be considered necessary if there are unresolved child protection issues, once the initial investigation and assessment have been completed. Please refer to *Buckinghamshire Child Protection Procedures Section 7: The Child Protection Conference System* for further information.

#### **6. Girls / young women in immediate danger**

6.1 The primary focus is to prevent the child undergoing any form of FGM, rather than removal from the family. However, if the parents cannot satisfactorily guarantee that they will not proceed with the mutilation and the Strategy Meeting / Discussion decides that as such the child / young woman is in immediate danger, then an Emergency Protection Order or Police Protection should be sought.

#### **7. If a girl / young woman has already undergone FGM**

7.1 If the girl / young woman has already undergone FGM, the Police will pursue criminal lines of enquiry

7.2 A girl / young woman who has undergone FGM should be seen as a Child in Need and offered services as appropriate. The Strategy Meeting should consider the need for medical assessment and / or therapeutic services for her.

7.3 The risk to other female children in the family and extended family must be considered at the Strategy Meeting.

## **Contacts**

**Thames Valley Police:** contact via 08458 505 505

### **Buckinghamshire County Council Social Care:-**

Referral & Assessment Team (North): 01296 387932 or 01296 387957

Referral & Assessment Team (South): 01494 475211 or 01494 475037

Emergency Duty Team (outside of office hours): 01494 675802

## **References and further information**

### **Department of Health**

The 2007 “Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales” was funded by the Department of Health (DH). FORWARD, the London School of Hygiene and Tropical Medicine and City University Midwifery Department carried out the study in order to help authorities plan services for the communities affected by FGM. (<http://www.forwarduk.org.uk/key-issues/fgm/research>)

**FORWARD (2002) Female Genital Mutilation: Information Pack:** available at [www.forwarduk.org.uk](http://www.forwarduk.org.uk)

### **List of Female Genital Mutilation Specialist Health Services in England & Wales**

<http://www.forwarduk.org.uk/download/160>

In 2007, the DoH also produced a DVD for health professionals to enable them to provide effective and sensitive care for women who have undergone FGM. Developed in conjunction with the specialist voluntary sector and health professionals as a practical resource, it provides factual and clinical information.

**British Medical Association guidance:** *FGM: Caring for Patients and Child Protection*  
[http://www.bma.org.uk/ethics/human\\_rights/FGM.jsp](http://www.bma.org.uk/ethics/human_rights/FGM.jsp)

**RCN (2006) Female Genital Mutilation:** An RCN Educational Resource for Nursing and midwifery Staff available at [www.rcn.org.uk](http://www.rcn.org.uk)

**Local Authority Social Services Letter LASSL (2004)4 Female Genital Mutilation Act 2003:**  
Department of Health  
[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4074784.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4074784.pdf)