

PART 17

FEMALE GENITAL MUTILATION

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Introduction

What is FGM

1. FGM is often referred to as 'female circumcision', which includes all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs, whether for ritual, cultural or other non-therapeutic reasons.

Types of FGM

2. Excision of the prepuce, with or without excision of part or the entire clitoris.
3. Excision of the clitoris with partial or total excision of the labia minora.
4. Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening. This is known as infibulation.
5. Unclassified, which includes: pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterisation by burning of the clitoris and surrounding tissue; scraping of the tissue surrounding orifice or cutting the vagina; introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purpose of tightening or narrowing it; and any other procedure that falls under the definition given above.

Legal Context

6. FGM is against the law and has been specifically illegal in the UK since the Prohibition of Female Circumcision Act 1985. However it was possible to evade the law by having the procedure performed out of the country.
7. The Female Genital Mutilation Act 2003 came into force March 2004. This replaced the 1985 Act and explicitly makes it illegal to take girls abroad for the procedure to be completed. The 2003 Act also increases the maximum penalty for committing or aiding the offence to 14 years imprisonment.

Children Act 1989

8. Working Together to Safeguard Children (2006) 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 be or has been the subject of FGM.”

9. FGM is a human rights issue as quoted in Article 5 of the U.N. Declaration of Human Rights 1948 and in the 1989 United Nations Convention on the Right of the Child, Part 2, Article 2.
10. 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.
11. Social services may need to consider whether the circumstances constitute likely significant harm to justify initiating care proceedings.
12. Social services may also need to consider emergency protection measures as appropriate.
13. A court may only make a Care or Supervision Order if it is satisfied that the child concerned is suffering, or likely to suffer significant harm (Children Act 1989, Section 32(2)).

Effects of FGM

14. Available medical evidence indicates that FGM is very harmful; it has parallels but is by no means equated with male circumcision. Female genital mutilation is not usually carried out in sanitary conditions by medical practitioners although there has been some evidence in London that until fairly recently, some medical practitioners were prepared to carry out this procedure.
15. FGM is usually practised by elderly women with blunt instruments in unsanitary conditions, with little or no anaesthesia. Depending on the degree of mutilation, FGM can have a number of short-term and long-term health implications:
 16. Short-term implications:
 - Severe pain
 - Shock
 - Immediate fatal haemorrhaging
 - Damage to organs around clitoris and labia
 - Urine retention
 17. Long-term implications can entail:
 - Extensive damage of the external reproductive system
 - Uterus, vaginal and pelvic infections
 - Cysts and abscesses
 - Complications in pregnancy and child birth
 - Psychological damage

- Painful sexual intercourse
- Sexual dysfunction
- Difficulties in menstruation

18. Female genital mutilation can make intercourse dangerous and painful, especially if cutting is required. The shock, anxiety and terror generated by the procedure can lead to long term psychological problems. Women who have undergone this procedure may suffer feelings of incompleteness, anxiety and depression.

Responding to FGM

19. FGM is usually performed on girls aged between 4 and 13, in some cases it is performed on new born babies or young women prior to marriage or pregnancy.

20. FGM can cause serious harm and suffering and the local authority can exercise its powers under S47 of the Children Act (1989).

21. Staff in Education settings, Obstetrics and Midwifery services will need to be aware of the potential risk to young girls and women from communities that are known to practice FGM.

22. Agencies should consider making contact with specialist groups such as:

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

Unit 4
765 - 767 Harrow Road
LONDON
NW10 5NY

Telephone: 020 8960 4000

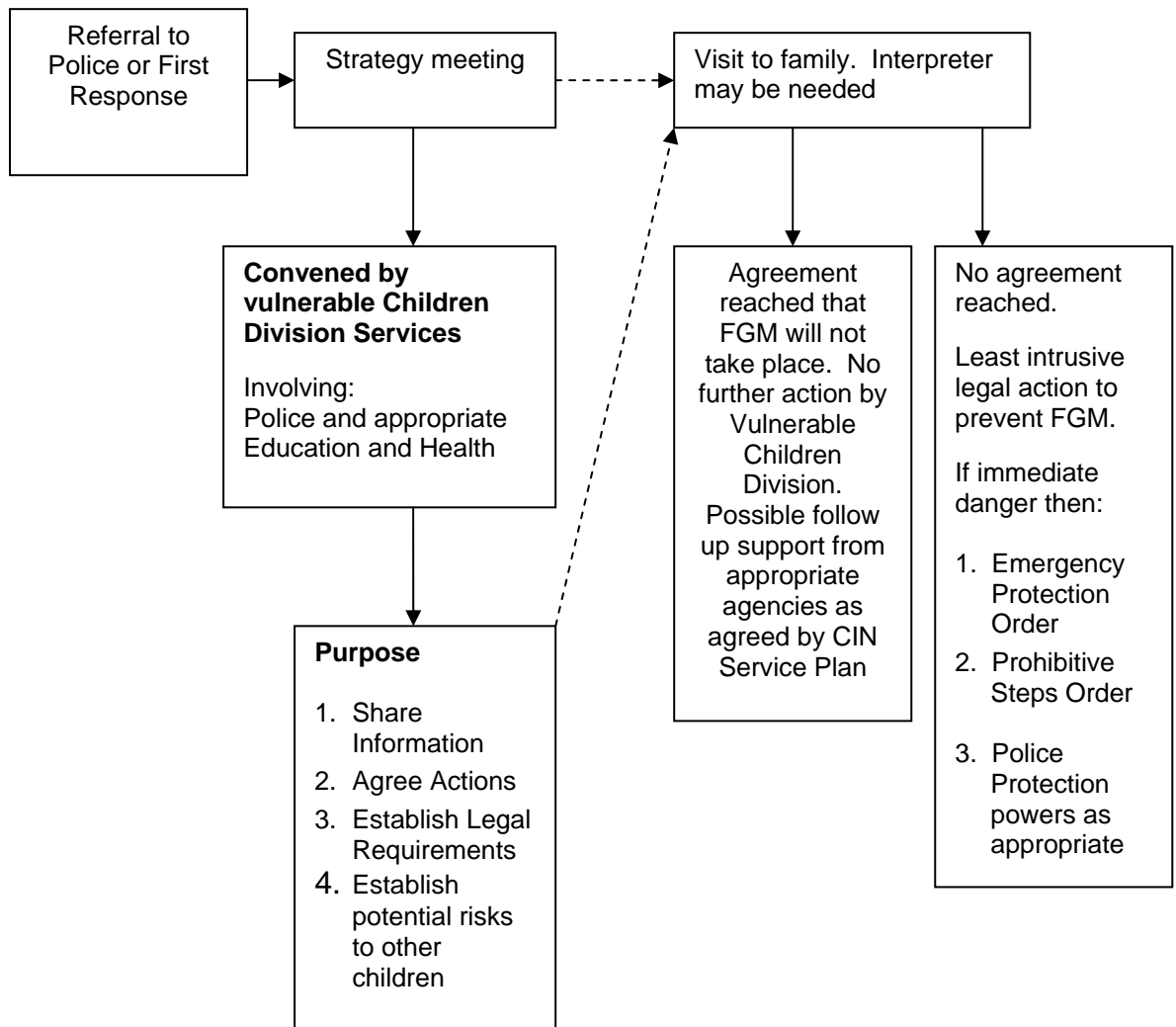
Agency for Culture and Change
Management

1 Arundel Gate
Sheffield
S1 2PN

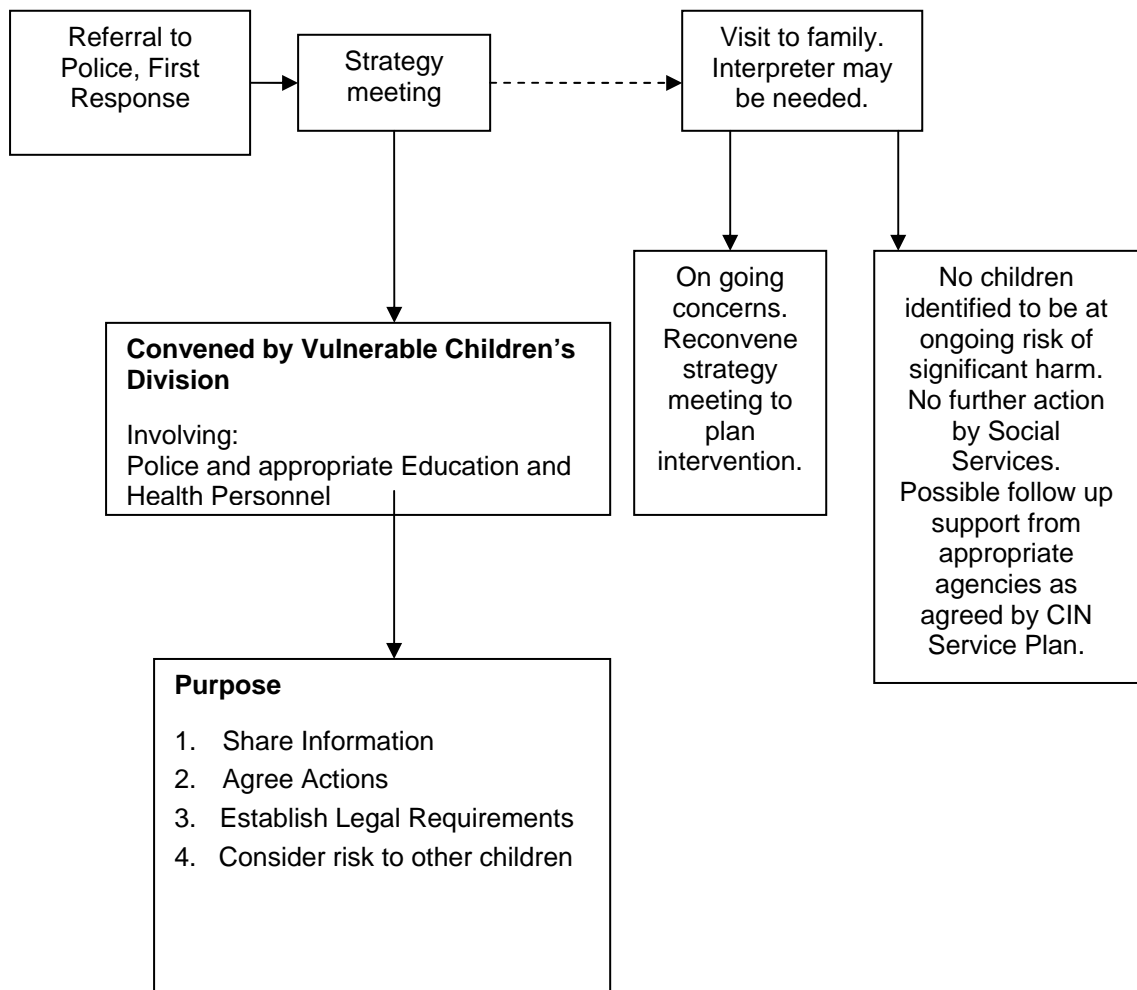
Telephone: 0114 275 0193

www.forwarduk.org.uk

A. Child at Risk of FGM



B. Child has Undergone FGM



Prevalence

23. Most of the girls and women who have undergone FGM live in 28 African countries, also in Asia and the Middle East. Some are also increasingly found in Europe, Australia, Canada and the USA.
24. The World Health Organisation (WHO) estimates that between 100 and 140 million girls and women have been subjected to FGM. Approximately two million women each year are at risk of the practice of some form of FGM. The most common type of FGM is excision of the clitoris and the labia, this makes up approximately 80% of all cases; the most extreme form is infibulation which constitutes about 15% of all procedures.

Why Is Female Genital Mutilation Performed?

25. It has not been possible to determine when or where the tradition of FGM originated. The roots of FGM are both complex and numerous. The reasons cited for its existence generally relate to tradition, power inequalities and the resultant compliance of women to the dictates of their communities.
26. 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
27. 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.

At What Age is FGM Performed?

28. 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.

Who Performs FGM?

29. The practice of female genital mutilation is often perpetrated by an older woman, who is considered to be the traditional practitioner. It is performed with crude blunt instruments and often without anaesthetic. The more affluent may have the procedure performed in a health care facility by qualified health personnel.

Community Education

30. 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.”

31. It is estimated that there are approximately 74,000 women in the UK who have undergone the procedure, and about 7000 girls under 16 yrs of age are at risk. This is based on the number of women and girls living in the UK who originate from countries such as, Yemen, Oman, Malaysia, Indonesia and the United Emirates as well as 26 countries in Africa from Gambia to Somalia. FGM is traditionally practised in these countries.
32. Cities such London, Liverpool, Birmingham, Sheffield and Cardiff have substantial populations from these countries. However it is important to note that FGM is not necessarily confined to these areas.
33. 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.
34. 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.
35. 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.

Support

36. Families involved may need to be referred to appropriate counselling services, to deal with any psychological conflicts that may arise.
37. 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.
38. A specialist trained advisor (if available) may be needed to visit families where FGM is suspected.

Raising Awareness

39. 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.
40. There will be issues for all staff involved regarding training and case management including cultural sensitivity issues.
41. 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.
42. 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.
43. 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.
44. Indicators to look for would be girls going away for a holiday which may be anything between 6-12 weeks; children who have undergone female genital mutilation; girls who present with bladder/ menstrual problems;

discussion around circumcision and pupils requesting help from teachers.

Conclusion/Summary

45. 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.
46. The practice of female genital mutilation tends to run in families therefore there will be a need to recognise the risk factors which are associated with women who present with FGM because the practice may be passed on to the next generation.
47. Any concerns regarding female genital mutilation must be acted upon within accordance of the referral procedure. The referrer however, must feel reassured that a sensitive strategy will follow, including the sensitive management of any subsequent investigation and child protection conference.

References

World Health Organization, *Female Genital Mutilation*, Fact Sheet No 241, June 2001.

Royal College of Obstetricians and Gynaecologists, *Female Genital Mutilation*, RCOG statement No. 3, may 2003.

Foundation for Women's Health, Research and Development, *Female Genital Mutilation*.

Sheffield Change Agency.

Further information in support of these guidelines can be found in *Local Authority Social Services Letter LASSL (2004)4*, which is available at www.dfes.gov.uk