

Practice Guidance

Protecting Children from Female Genital Mutilation

- 1.1 Female Genital Mutilation (sometimes known as female circumcision) is a child protection issue. It is a term used to refer to any practice which includes the removal or alteration of the female genitalia. There are three main types of female genital mutilation that are practised: sunna; excision or infibulation. These three operations differ in intensity.

2. Introduction

- 2.1 Leicester City, Leicestershire and Rutland LSCB recognise that whilst there is no intent to harm a child through female genital mutilation, the practice can directly cause short and long term medical problems. Consequently, the practice of female genital mutilation is seen as a physically abusive act.
- 2.2 The aim is to end the practice of female genital mutilation (FGM), but to do so by educating and supporting those communities who continue to practice this form of abuse.
- 2.3 It is possible to change perceptions towards female genital mutilation through supporting and educating families. It requires a sensitive approach, as strategies which focus on the policing of families are likely to alienate communities and to drive the practice further underground.
- 2.4 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.
- 2.5 Ninety five percent of female genital mutilation is carried out on girls usually aged from 7 days old to 16 years of age although this may vary depending on other factors. 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.

3. Criminal Law

- 3.1 Female genital mutilation has been illegal since 1985. The Female Circumcision Act 1985 has been replaced by the Female Genital Mutilation Act 2003. This Act makes it an offence for UK nationals or permanent UK residents to carry out female genital mutilation in this country or abroad and to abet, counsel or procure the carrying out of female genital mutilation abroad, even in countries where the practice is legal.

4.Types of Female Genital Mutilation

4.1 The main three forms of mutilation are:

4.2 **Type 1 - Sunna**

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

4.3 **Type 2 - Excision**

The clitoris and labia minora are removed.

4.4 **Type 3 - Infibulation**

This is 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.

4.5 Although these mutilations are commonly performed without anesthetics, the practice is not generally perceived as abusive or harmful by the family, the community, or those arranging the operation.

5. Geographical Distribution

5.1 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.

5.2 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 reported in immigrant African populations in Europe, Australia, New Zealand, Canada and U.S.A.

5.3 Some people believe that it is a religious requirement for Muslims, but given the practice pre-dates Islam and it is not mentioned in the Koran, this belief is 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 is said by some to be performed for religious, socio-cultural and aesthetic reasons.

6. Justification

6.1 Typical arguments supporting female genital mutilation are that it will reduce promiscuity, increase cleanliness, and enhance femininity. In cultures where female genital mutilation is common, marriage prospects are higher for women who have undergone the procedure. All of these

reasons are cultural and traditional and are not rooted in any religious texts.

7. Signals

- 7.1 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, especially if there are elderly women present in the extended family
 - a conversation with a child may refer 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 child may spend long periods of time away from class during the day - possibly with bladder or menstrual problems
 - Midwives and Obstetricians may become aware that FGM has taken place when treating pregnant women. This should trigger concern for any female child of the family, and result in educational/preventative input via health professionals in liaison with support groups e.g. Agency for Culture and Change Management

8. Effects of Female Genital Mutilation

Physical Effects

- 8.1 Genital mutilation can lead to death. At the time the mutilation is carried out, pain, shock, haemorrhage and damage to the organs surrounding the clitoris and labia can occur. Afterwards urine may be retained and serious infection may develop. Use of the same instrument increases the spread of infections, HIV, AIDS and hepatitis.
- 8.2 More commonly, the chronic infections, intermittent bleeding, abscesses and small benign tumours of the nerve which can result from clitoridectomy and excision cause discomfort and extreme pain.
- 8.3 Infibulation can have even more serious long-term effects: chronic urinary tract infections, stones in the bladder and urethra, kidney damage, reproductive tract infections resulting from obstructed menstrual flow, pelvic infections infertility, excessive scar tissue, keloids (raised, irregularly shaped, progressively enlarging scars) and dermoid cysts.
- 8.4 First sexual intercourse can only take place after gradual and painful dilation of the opening left after mutilation. In some cases, cutting is necessary before intercourse can take place. Some new wives are seriously damaged by unskillful cutting carried out by their husbands. A possible additional problem resulting from all types of female genital mutilation is that lasting damage to the genital area can increase the risk of HIV transmission during intercourse.

- 8.5 During childbirth, existing scar tissue on excised women may tear. Infibulated women, whose genitals have been tightly closed, have to be cut to allow the baby to emerge. If no attendant is present to do this, perineal tears or obstructed labour can occur. After giving birth, women are often reinfibulated to make them 'tight' for their husbands. The constant cutting and restitching of a woman's genitals with each birth can result in tough scar tissue in the genital area.
- 8.6 The secrecy surrounding female genital mutilation and the protection of those who carry it out make collecting data about complications resulting from mutilation difficult. When problems do occur these are rarely attributed to the person who performed the mutilation. They are more likely to be blamed on the girl's alleged "promiscuity" or the fact that sacrifices or rituals were not carried out properly by the parents. Most information is collected retrospectively, often a long time after the event. This means that one has to rely on the accuracy of the woman's memory, her own assessment of the severity of any resulting complications, and her perception of whether any health problems were associated with mutilation.
- 8.7 Some data on the short and long-term medical effects of female genital mutilation, including those associated with pregnancy, have been collected in hospital or clinic based studies, and this has been useful in acquiring knowledge of the range of health problems that can result. However, the incidence of these problems and of deaths as a result of mutilation, cannot be reliably estimated. Supporters of the practice claim that major complications and problems are rare, while opponents of the practice claim that they are frequent.

Effects on Sexuality

- 8.8 Genital mutilation can make first intercourse an ordeal for women. It can be extremely painful, and even dangerous, if the woman has to be cut open; for some women, intercourse remains painful. Even where this is not the case, the importance of the clitoris in experiencing sexual pleasure and orgasm suggests that mutilation involving partial or complete clitoridectomy would adversely affect sexual fulfilment. Clinical considerations and the majority of studies on women's enjoyment of sex suggest that genital mutilation does impair a woman's enjoyment.

Psychological Effects

- 8.9 The psychological effects of female genital mutilation are more difficult to investigate scientifically than the physical ones. A small number of clinical cases of psychological illness related to genital mutilation have been reported. Despite the lack of scientific evidence, personal accounts of mutilation reveal feelings of anxiety, terror, humiliation and betrayal, all of which would be likely to have long-term negative effects. Some experts

suggest that the shock and trauma of the operation may contribute to the behaviour described as 'calmer' and 'docile', considered positive in societies that practice female genital mutilation.

- 8.10 Festivities, presents and special attention at the time of mutilation may mitigate some of the trauma experienced. However, the most important psychological effect on a woman who has survived is the feeling that she is acceptable to her society, having upheld the traditions of her culture and made herself eligible for marriage, often the only role available to her. It is possible that a woman who did not undergo genital mutilation could suffer psychological problems as a result of rejection by the society. Where the female genital mutilation practising community is in a minority, women are thought to be particularly vulnerable to psychological problems, caught as they are between the social norms of their own community and those of the majority culture.

9. Intervention

- 9.1 Primary Health Care staff are best placed to identify those families about whom there may be some concern, while nursery and school staff may learn about instances directly from the children involved.
- 9.2 If information is given to any agency or professional staff that a female has been subject to female genital mutilation or that she is likely to be subject to that practice they should contact the local children's social care or police child abuse investigation unit immediately. Female genital mutilation places a child at risk of significant harm and will therefore be investigated under Section 47 of the Children Act, by children's social care and the police CAIU.
- 9.3 Where a referral indicates that a child is at immediate risk of female genital mutilation and parents/carers cannot guarantee satisfactorily that they will not proceed with it, an Emergency Protection Order must be sought. If a child's parents are intent on sending the daughter abroad and it can be proven that mutilation is likely if she goes, a Prohibition Order should be sought.
- 9.4 In other circumstances on receipt of a referral a strategy meeting must be convened by a social worker in collaboration with the police Child Abuse Investigation Unit (CAIU). Consideration must also be given to the involvement of appropriate linguistic, paediatric, equality and legal representation.
- 9.5 If a child has already undergone female genital mutilation and this comes to the attention of any professional, a referral should be made to children's social care or the police CAIU and a strategy meeting convened to consider the implications of how, when and where it was performed. It

- should consider a medical assessment and therapeutic services that are offered to the child and the risk to other female children should be considered at the strategy meeting. A child who has undergone female genital mutilation must be seen as a child in need and offered appropriate services.
- 9.6 If a woman or an older sibling has already undergone female genital mutilation and this comes to the attention of any professional, child protection implications need to be considered e.g. for younger female children/siblings and a referral made to children's social care or police CAIU. A strategy meeting should be convened to determine the risk to the child and the most appropriate way of informing the parents of the legal and health implications of female genital mutilation.
- 9.7 Where it appears that a person is willingly and illegally offering his/her services to perform female genital mutilation then the police should be notified who would then undertake a criminal investigation.
- 9.8 A child protection conference should only be convened if there are unresolved child protection issues once the initial investigation and assessment has been completed.

(Please refer to Government Guidance)

10. Web Addresses and Useful Contacts

www.amnesty.org - Human Rights information pack
www.humanrightsreference.com
www.fco.gov.uk
www.ippfo.org - Bibliography
www.accm.sheffield.org.uk
www.womankind.org.uk
www.stopfgm.org.uk
www.forward.dircon.co.uk
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