

## SECTION 17

### FEMALE GENITAL MUTILATION

This section sets out –

- The definition of female genital mutilation
- The possible short- and long-term effects;
- The law which prohibits it; and
- Matters which should be considered in any strategy discussion and section 47 enquiries in which female genital mutilation may be an issue;

#### 1. GUIDANCE

Working Together to Safeguard Children [2010] Chapter 6, Paragraphs 6.14 – 6.19

#### 2. DEFINITION

- 2.1 Female genital mutilation is a collective term for procedures which include the partial or total removal of the external female genital organs, or injury to the female genital organs, for cultural or other non-therapeutic reasons.
- 2.2 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. The procedure is typically performed on girls aged between 4 and 13 but in some cases on new born infants or on young women before marriage or pregnancy. It is considered to be a form of physical abuse and should not be regarded as child sexual abuse.
- 2.3 Background information about female genital mutilation, its effects and the law prohibiting it will be found in the Appendix to this Section.

#### 3. PREVENTION

- 3.1 Any preventive strategy must focus on community education - change must come from within the community and cannot be imposed from outside. Midwives, health visitors and GP's are crucial to the delivery of information about the health implications of female genital mutilation to women in the affected communities:
- 3.2 Agencies should attempt to identify the communities in which female genital mutilation is likely to be practised and practitioners should 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, respectful of the cultural and religious beliefs and traditions of the family concerned. There must, however, be no compromise in communicating the message that female genital mutilation is neither legal nor acceptable in the United Kingdom.

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3.3 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 it, girls and women who have not been subjected to genital mutilation may be ostracised by the community.

3.4 Advice, guidance, information and support are available from the Foundation for Women's Health, Research and Development (FORWARD), 765 Harrow Road, London NW10 5NY, Tel: 0208 960 4000.  
[www.forwarduk.org.uk/key-issues/fgm](http://www.forwarduk.org.uk/key-issues/fgm)

## 4. REFERRAL

4.1 Concern about a child at risk of female genital mutilation may arise in a number of ways, for example:

- Knowing that a family belongs to a community in which female genital mutilation is practised, and are preparing to take the child on holiday, and the child may talk about a “special procedure” taking place;
- One girl in a family has undergone genital mutilation, raising concerns about other, younger girls in the same family; or
- Concern that a mother who has undergone genital mutilation may wish to arrange the genital mutilation of her daughters.

4.2 Anyone who is concerned that a child may be at risk of female genital mutilation should refer the matter to children's social care, who will commence an initial assessment and convene a FGM strategy meeting. Where possible this will be chaired by a Principal Officer/Child Protection and Review. Advice and guidance on the issues can be obtained from the central safeguarding unit at the Silvermere Centre (Tel: 303 8454). Advice, information, guidance and support are also available from FORWARD (see contact details in paragraph 2.11 above).

4.3 If children's social care has reason to suspect that a child may be subjected to female genital mutilation, and would therefore suffer significant harm, it should initiate enquiries under section 47 of the Children Act 1989.

4.4 If a child has undergone, or is felt to be at risk of, female genital mutilation, and another female member of the family is a vulnerable adult, then she is also likely to have undergone female genital mutilation. This may have significant implications for her physical and mental health. The lead social worker should ensure that the relevant adult services are aware of these.

**5. SECTION 47 ENQUIRIES**

**Strategy meeting**

5.1 In convening the strategy meeting, practitioners should consider whether they need to seek specialist information and advice from any agency.

5.2 The strategy meeting will:

- Decide whether the child's parents are well informed about the consequences of female genital mutilation;
- If the parents are not well informed, consider how best to provide them with information on the subject;
- Look at ways of gaining the family's co-operation; and
- Make arrangements for a visit to the family to assess the risk to any children and to explain the information.  
If possible, this visit should be made by someone who is not from one of the statutory agencies.

5.3 If the family's primary language is not English, an interpreter must assist at any interview with them.

**No evidence of risk**

5.4 If the strategy meeting concludes that there is no clear evidence of risk to a child, children's 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, offer appropriate services; and
- Offer the family any appropriate support services.

**Child at risk of genital mutilation**

5.5 If it appears that a child is at risk of genital mutilation, the social worker will:

- Notify the parents that this is a criminal act in the UK;
- Arrange a child protection conference to discuss the issues;

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- Consider whether to apply for a Prohibited Steps Order to prevent the parents removing the child from the country; and
  - Consider whether there is a need for an Emergency Protection Order to protect the child before the conference.
- 5.6 Where a child has been identified as being at risk, 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.
- 5.7 If a conference concludes that the child needs to be the subject of a child protection plan, female genital mutilation is normally regarded as a form of physical, rather than sexual, abuse.
- If the child has already undergone genital mutilation**
- 5.8 It is not always appropriate to carry out section 47 enquiries in respect of a girl who has undergone genital mutilation. When the operation has taken place, a criminal offence may have been committed and charges may be brought, but it is likely that there will be no further child protection concerns in respect of the individual child concerned. In this situation any action taken should focus on:
- 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.
- 5.9 The strategy meeting should consider any available information about how, when and where the procedure was performed, and the implications for any other children in the family. It should also consider whether any medical assessment or therapeutic services should be offered to the family.
- 5.10 A visit should be made to the family to acknowledge the conflict between their culture and the law of the UK. If possible, this visit should be made by someone who is not from one of the statutory agencies.
- 5.11 If it appears that no other children are at risk:
- Children's social care will take no further action other than to consider any health concerns for the child who has undergone the procedure.

- If the operation seems to have been performed in the UK, the police will seek information for the possible prosecution of the perpetrator;
  - Children's social care will 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.
- 5.12 If there are concerns about younger girls in the family children's social care must convene a child protection conference as soon as possible to discuss whether any protective action can be taken.
- 5.13 If a child protection conference decides that any child should be the subject of a child protection plan, female genital mutilation is normally regarded as a form of physical, rather than sexual, abuse.

**BACKGROUND INFORMATION ABOUT FEMALE GENITAL MUTILATION**

- 1 Female genital mutilation has been practised in some form by communities on every continent at some time. Currently it is carried out in the United Kingdom, in the United States, in Europe and in parts of Africa, the Middle East and South East Asia. Christians, Muslims and others practise it in a range of cultural contexts. The practice has deep cultural significance and is therefore very emotive.
2. There is a strong movement against female genital mutilation in most of the countries in which it is practised and it is legally outlawed in many of them. This law is often more of a statement of intent, acknowledging the need for education in the effects of the practice, and it may not be vigorously applied. However, a family living away from their country of origin may not know of these social and legal changes.
3. Within the communities in which it is practised, female genital mutilation may be seen as a positive experience, which may be celebrated with a festival atmosphere and gifts for the child. However, children are taught from an early age that they should not discuss it within their own community, and that they should particularly not discuss it with outsiders.
4. The communities which practice female genital mutilation tend to be very secretive about their cultural practices in general and about female genital mutilation in particular. Experience suggests that confronting a family on this issue is likely to lead to them moving away from the area and trying not to be traced.

**Effects**

- 5 The possible short-term effects of female genital mutilation include:
  - Severe pain;
  - Shock;
  - Haemorrhaging, which may be fatal;
  - Infection;
  - Urine retention; and
  - Fractures and dislocations as a result of restraint.
6. The possible long-term effects of female genital mutilation include:
  - Damage to the reproductive system and infertility;
  - Infections of the uterus and vagina;

- Cysts;
  - Complications in pregnancy and childbirth;
  - Psychological damage;
  - Sexual dysfunction;
  - Difficulties in menstruation;
  - Difficulties in passing urine; and
  - Increased risk of transmission of HIV.
7. 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.
- Law**
8. The Female Genital Mutilation Act 2003 makes female genital mutilation an offence in the UK. It also makes it a criminal offence for UK nationals or permanent UK residents to carry out female genital mutilation abroad, or to aid, abet, counsel or procure the carrying out of female genital mutilation abroad, even in countries where the practice is legal.