



# **Protocol for Female Genital Mutilation Of Children and Young People**

Enfield Local Safeguarding Children Board (ECSB) have worked collaboratively with Enfield Primary Care Trust and all partner agencies, particularly Linda Squelch, Head teacher, Brettenham Primary School, Jenny Jones, Head teacher, Chesterfield School, Dr Mala German, CAMHS, and Police to develop practice guidelines to aid professional work to safeguard children who may be subject to or suffering the effects of Female Genital Mutilation.

ESCB Female Genital Mutilation Sub-Group wish to thank Janette Shaw, Nurse Consultant/Designated Nurse for Child Protection, Waltham Forest Primary Care Trust, and Waltham Forest Local Safeguarding Children Board for their support and use of their Guidance and Protocol, which has supported the formulation of this document.

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# FEMALE GENITAL MUTILATION

Female Genital Mutilation (FGM) is much more common than most people realise, both worldwide, and in the UK. With migration to Western countries from areas where FGM is practiced, it is increasingly found in immigrant communities in the United States, Canada, Europe, and Australia. World Health Organisation (1997)

It is practiced in over 28 African countries, parts of the Middle and Far East. There are substantial populations from countries where FGM is endemic in London, Liverpool, Birmingham, Sheffield and Cardiff but it is likely that communities in which FGM is practiced reside throughout the UK.

In the world today there are an estimated 100 million to 140 million girls and women who have been subjected to the operation. Currently, about 3 million girls, the majority under 15 years of age, undergo the procedure every year. World Health Organisation (2007)

To respond to increasing diversity within the Borough, and in tandem with the launch of the London Safeguarding Children Board (LSCB) Female Genital Mutilation Procedure, ESCB has produced this protocol.

## 1.1 EQUALITY AND DIVERSITY STATEMENT

This protocol affects a group of young females who are particularly vulnerable. Any decisions or plans for these girls/young women need to be based on good quality assessments and be sensitive to the issues of race, culture, gender, religion and sexuality, so far as not to stigmatise the child or the practicing community.

- 2.1.1 Female Genital Mutilation is illegal and is prohibited by the **Female Genital Mutilation Act 2003**.
- 2.1.2 It is acknowledged that some families see FGM as an act of love rather than cruelty. FGM causes significant harm both in the short and long term and constitutes physical and emotional abuse to children and is unlawful in this country.
- 2.1.3 Accessible, acceptable and sensitive Health, Education, Police, Social Care and Voluntary Sector services must underpin the protocol.
- 2.1.4 All agencies should work in partnership with members of local communities, to empower individuals to develop support networks and education programmes.
- 2.1.5 The Rights of the Child as stated in the UN Convention (1989) will underpin this protocol.

### 3.1 International Standards

- 3.1.1 Legislation against FGM in the UK includes both international standards and national legislation.
- 3.1.2 There are two international conventions, which contain articles that can be applied to FGM. Signatory states, including the UK, have an obligation under these standards to take legal action against FGM. They are:
- **The UN Convention on the Rights of the Child**, ratified by the UK Government on 16th December 1991, was the first binding instrument explicitly addressing harmful traditional practices as a human rights violation. It specifically requires Governments to take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.
  - **The UN Convention on the Elimination of All Forms of Discrimination against Women**, which came into force in 1981, recognises FGM as a form of gender based violence against women. It calls on signatory Governments to take appropriate and effective measures with a view to eradicating the practice, including introducing appropriate health care and education strategies.
- 3.1.3 These conventions have been strengthened by two world conferences. **The International Conference on Population and Development** (ICPD, Cairo, September 1994) mentioned and condemned FGM specifically in several of its articles. **The World Conference on Women** (Beijing 1995) also condemned FGM and called upon Governments to actively support programmes to stop it.

### 3.2 United Kingdom Legislation

- 3.2.1 In England, Wales and Northern Ireland all forms of FGM are illegal under the Female Genital Mutilation Act (2003), and in Scotland it is illegal under the Prohibition of FGM (Scotland) Act 2005.
- The UK law states that “A person is guilty of an offence if s/he, excises, infibulates or otherwise mutilates the whole or any part of a girl's labia, labia majora, labia minora or clitoris except for operations performed on specific physical and mental health grounds by registered medical or nursing practitioners. It is also an offence to assist a girl to mutilate her own genitalia” (See FGM Type 3, in section 4).
- 3.2.2 FGM is a criminal offence, which extends to acts performed outside of the UK and to any person who advises helps or forces a girl to inflict FGM on herself. Any person found guilty of an offence under the Female Genital Mutilation Act (2003) will be liable to a fine or imprisonment up to 14 years, or both.
- 3.2.3. Under the Children Act (1989) Local Authorities can apply to the Courts for various Orders to prevent a child being taken abroad for mutilation.

### 3.3 National policy

- 3.3.1 The UK Government's Every Child Matters (2006): Change for Children Programme, which includes the Children's NSF, and is supported by the Children Act (2004), requires all agencies to take responsibility for safeguarding and promoting the welfare of every child to enable them to:
- Be healthy
  - Stay safe
  - Enjoy and achieve

- Make a positive contribution
- Achieve economic well-being

3.3.2 Working within this policy framework, professionals and volunteers from all agencies have a statutory responsibility to safeguard children from being abused through FGM.

## 4.1 Definition

4.1.1 “FGM constitutes all procedures which involve partial or total removal of the external female genitalia or injury to the female genital organs whether for cultural or other non-therapeutic reasons” (WHO, 1996)

4.1.2 The specific form that FGM takes varies from one country to another and there are difficulties associated with any classification. There is significant variation in the extent of the cutting because of the poor conditions in which it is carried out. **Girls and women may not know the type they have experienced.**

## 4.2 Types of FGM

4.2.1 Female Genital Mutilation and other terms (see glossary) has been classified by the WHO into four types:

- Type 1: Circumcision

Excision of the prepuce with or without excision of part or the entire clitoris

- Type 2: Excision (Clitoridectomy)

Excision of the clitoris with partial or total excision of the labia minora (small lips which cover and protect the opening of the vagina and the urinary opening). After the healing process has taken place, scar tissue forms to cover the upper part of the vulva region.

- Type 3: Infibulation (also called Pharaonic Circumcision)

This is the most severe form of female genital mutilation. Infibulation often (but not always) involves the complete removal of the clitoris, together with the labia minora and at least the anterior two-thirds and often the whole of the medial part of the labia majora (the outer lips of the genitals). The two sides of the vulva are then sewn together with silk, catgut sutures, or thorns leaving only a very small opening to allow for the passage of urine and menstrual flow. This opening can be preserved during healing by insertion of a foreign body.

- Type 4: Unclassified

This includes all other procedures on the female genitalia including 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 tissues; scraping of the tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purposes of tightening or narrowing it; and any other procedure that falls under the definition of female genital mutilation given above.

## 4.3 Age and procedure

4.3.1 The age at which girls are subjected to Female Genital Mutilation varies greatly, from shortly after birth to any time up to adulthood.

- 4.3.2 FGM is usually carried out by the older women in a practicing community, for whom it is a way of gaining prestige and can be a lucrative source of income in some communities.
- 4.3.3 The arrangements for the procedure usually include the child being held down on the floor by several women and the procedure carried out without medical expertise, attention to hygiene and anesthesia. The instruments used include unsterilised household knives, razor blades, broken glass and sharpened stones. In addition the child is subjected to the procedure unexpectedly.

Some health professionals are performing FGM in the belief that it offers more protection from infection and pain. However, the medicalisation of FGM is condemned by all international groups including the WHO and is illegal.

- 5.1.1 Many women appear to be unaware 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.

**5.1.2 Short-term health implications**

- a) Severe pain and shock
- b) Haemorrhage
- c) Wound infections including Tetanus and blood borne viruses (including HIV, Hepatitis B and C);
- d) Urinary retention;
- e) Injury to adjacent tissues;
- f) Fracture or dislocation as a result of restraint;
- g) Damage to other organs
- h) Death

**5.1.3 Long-term health implications**

- a) Chronic vaginal and pelvic infections;
- b) Difficulties in menstruation;
- c) Difficulties in passing urine and chronic urine infections
- d) Renal impairment and possible renal failure
- e) Damage to the reproductive system including infertility;
- f) Infibulation cysts, neuromas and keloid scar formation;
- g) Complications in pregnancy and delay in the second stage of childbirth;
- h) Maternal or foetal death
- i) Psychological damage; including a number of mental health and psychosexual problems including depression, anxiety, and sexual dysfunction
- j) Increased risk of HIV and other sexually transmitted infections.

**6.1 Professionals need to be aware of the possibility of FGM. The following are potential indicators that FGM may take place. Professionals should be vigilant at all times to the following:**

- The family comes from a community that is known to practise FGM. E.g. Somalia, Sudan and other African countries. (See introduction). It may be possible that they will practice FGM if a female family elder is present in the family network.
- Any female child born to a woman who has been subjected to FGM must be considered to be at risk, as must other female children in the extended family.
- Parents state that they or a relative will take the child out of the country for a prolonged period.
- A child may talk about a long holiday to her country of origin or another country where the practice is prevalent, including African countries and the Middle East.
- The child may confide to a professional that she is to have a 'special procedure' or to attend a special occasion.
- Reference to FGM/Circumcision is heard in conversation, for example a child may request help from a teacher or another adult.
- Individually these thresholds may not indicate risk but if there are two or more present this could signal risk to the child and you will need to implement your organisation's child protection / safeguarding procedures.

**6.2 Indications that Female Genital Mutilation may have already taken place include:**

- A child may spend long periods of time away from the classroom during the day with bladder or menstrual problems.
- There may be prolonged absences from school.
- A prolonged absence from school with noticeable behaviour changes on the girl's return could be an indication that a girl has recently undergone FGM.
- At antenatal booking the holistic assessment may identify women who have undergone FGM. Midwives and Obstetricians should then plan appropriate care for pregnancy and delivery (RCOG 2003, RCM 1998).
- Professionals also need to be vigilant to the needs of children who may/are suffering the adverse consequence of the practice.

**6.3 Reasons given for continued Practice of Female Genital Mutilation**

- Family honour;
- Custom and tradition;
- Hygiene and cleanliness;
- Preservation of virginity/chastity;
- Social acceptance especially for marriage;
- A mistaken belief that it is a religious requirement;
- A sense of group belonging.

## 7.1 General

- 7.1.1 Educational and preventative programmes should seek to ensure that the genital mutilation of female children and young women does not occur. Professionals working in a diverse community must always consider the issue of FGM in their work with service users and their families.
- 7.1.2 Staff who have responsibility for child protection / safeguarding work must be acquainted with child protection procedures and existing local preventative programmes relating to FGM.
- 7.1.3 At the first contact professionals must consider the cultural background of the girl/woman (see Introduction).
- 7.1.4 If the service user is a woman who has undergone FGM, but at the contact has no children, educational and preventative advice and support must be given.
- 7.1.5 Consideration must also be given to any existing or future female children
- 7.1.6 If FGM is suspected a referral should be completed and the questions in Annex 1 asked. Both the referral and completed answers to be forwarded to the SPOE (single point of entry).**
- 7.1.7 Any information or concern that a child is at immediate risk of, or has undergone, FGM must result in a child protection referral to Social Care. Social Care will investigate (initially under Section 47 of the Children Act (1989).
- 7.1.8 Professionals must work together to safeguard children and be aware of their own organisation's child protection/safeguarding procedures.
- 7.1.9 If a referral is received concerning one child, consideration must be given to whether siblings are at similar risk. Once concerns are raised about FGM there should also be consideration of possible risk to other children in the practicing community

## 7.2 Strategy Meeting

- 7.2.1 On receipt of a referral and following a discussion a strategy meeting must be convened within two working days, and should involve the referrer, representatives from Police, Social Care, Education, Health and Voluntary Services with specific expertise must be invited. Consideration may also be given to inviting a legal advisor (London Child Protection Procedures 2007).
- 7.2.2 The strategy meeting must first establish if either parents or child has had access to information about the harmful aspects of FGM and the law in the UK. If not - arrangements **must** be made to ensure who gives them appropriate information regarding the law and harmful consequences of FGM.
- 7.2.3 Every attempt should be made to work with parents on a voluntary basis to prevent the abuse. It is the duty of the investigating team to look at every possible way that parental co-operation can be achieved. However, the child's welfare is always paramount.
- 7.2.4 Where there is no information to suggest that significant harm is imminent the initial strategy meeting must make a decision to clarify all of the information about the family and the risk of harm, before taking any decision to continue with the formal child protection investigation. The information gathered during this initial assessment must then be considered at the review strategy meeting within 5 working days.
- 7.2.5 An interpreter/community advocate appropriately trained where possible regarding FGM should be used in all interviews with the family, and if possible, with their agreement. A female interpreter should be used and must not be a family relation.

- 7.2.6 If no agreement with the family is reached, the first priority is protection of the child and the least intrusive legal action should be taken to ensure the child's safety.
- 7.2.7 The primary focus is to prevent the child undergoing any form of FGM rather than removal from the family.

### **7.3 Children in immediate danger**

- 7.3.1 Where there is good information that the child is being taken from the UK imminently (within 2 days), legal advice should be sought in order to consider taking action to prevent the child moving before the S47 enquiries have been carried out.
- 7.3.2 If the strategy meeting decides that the child is in immediate danger of FGM and parents cannot satisfactorily guarantee that they will not proceed with it, then discussion should take place between Social Care and Police to agree whether the Police will secure Police Protection and/or Social Care will apply for an Emergency Protection Order. In which case discussion with the Assistant Director for Education, Children's Services and Leisure (ECSL) should take place regarding the appropriateness of an Emergency Protection Order being sought.
- 7.3.3 The Chair will need to complete a Need to Know.

### **7.4 If a child has already undergone FGM**

- 7.4.1 If a child has already undergone FGM and this comes to the attention of any professional, a referral should be made to Social Care. A strategy meeting must be convened within two days. The strategy meeting will consider how, where and when the procedure was performed and the implication of this.
- 7.4.2 The strategy meeting will need to consider carefully whether to continue enquiries or whether to assess the need for support services. Particular attention should be given to assessing the needs of any other girls in the family. If any legal action is being considered, legal advice must be sought.
- 7.4.3 A second strategy meeting should take place within ten working days of the referral, with the same chair. This meeting must evaluate the information collected in the enquiry and recommend whether a child protection conference is necessary. (LCPP 2007).
- 7.4.4 A girl who has already undergone FGM would not automatically be subject to a child protection conference or registered unless additional child protection / safeguarding concerns exist. However, she should be offered counselling and medical help. Consideration must be given to any other female siblings at risk and an assessment of them be completed.
- 7.4.5 A child protection conference should be considered if there are unresolved child protection / safeguarding issues once the initial investigation and assessment have been completed.

### **7.5 If a woman has already undergone Female Genital Mutilation**

- 7.5.1 If a woman has already undergone FGM and this comes to the attention of any professional, consideration needs to be given to any child protection / safeguarding implications e.g. for younger siblings, daughters or extended family members and/or she has care of female child/ren a referral should be made to Social Care.
- 7.5.2 Subsequent single assessments should identify the most appropriate way of informing parents of the legal and health implications of FGM and assessing the potential risk to female children in the family.

The London Safeguarding Children Board (2007) states 'Professionals in all agencies need to be confident and competent in sharing information appropriately, both to safeguard children from being abused through FGM and to enable children and women who have been abused through FGM to receive physical, emotional and psychological help'.

Once it is suspected that FGM may have taken place or is about to take place the matter must be discussed with the voluntary worker's Line Manager and Social Care.

**A referral should then be made to the Referral and Assessment team at Charles Babbage House, telephone: 020 8379 2507 for their investigation as per London Child Protection Procedures.**

The referrer should keep written records of:

- Discussions with child
- Discussions with parent
- Discussions with managers
- Information provided to Social Care
- Decisions taken (clearly timed, dated and signed)
- The referrer should confirm verbal and telephone referrals in writing, within 48 hours, using the Interagency Early Help Form.
- Further guidance regarding recording is available in LCPP (2007).

## 10 REFERENCES

1. Africans Unite Against Child Abuse (AFRUCA)
2. British Medical Association (2004), Female Genital Mutilation: Caring for Patients and Child Protection. Guidance from the BMA Ethics Department
3. Every Child Matters (2006)
4. Female Circumcision (Female Genital Mutilation) Royal College of Obstetricians and Gynaecologists, June (1997)
5. Female Genital Mutilation Act (2003)
6. The International Conference on Population and Development, ICPD, Cairo, September (1994)
7. London Borough of Waltham Forest FGM Protocol September (2006)
8. London Child Protection Procedures. (2007)
9. London Safeguarding Children Board
10. National Service Framework for Children, Young People and Maternity Services
11. Royal College of Midwifery
12. Royal College of Obstetricians and Gynaecologists
13. The Children Act (1989)
14. The Children Act (2004)
15. The UN Convention on the Elimination of All Forms of Discrimination against Women (1981)
16. United Nations Convention on the Rights of the Child (1989): Ratified December (1991)
17. UNICEF 2005, Innocenti Digest, Changing a Harmful Social Convention: Female Genital Mutilation/Cutting, UNICEF Innocenti Research Centre, Italy
18. Working Together to Safeguard Children – A guide to inter-agency working to safeguard and promote the Welfare of Children. HM Government (2006)
19. The World Conference on Women (Beijing 1995)
20. World Health Organisation (1997), Management of Pregnancy, Childbirth and the Postpartum Period, Report of a WHO Technical Consultation Geneva, 15-17 October (1997)
21. World Health Organisation, estimated prevalence rates of FGM updated May (2001)  
<http://www.who.int/reproductive-health/fgm/>
22. Wales FGM Protocol (2005)

1. Female Genital Mutilation is sometimes called Female Circumcision or Female Cutting
2. Closed                    The term "Closed" refers to type iii female genital mutilation where there is a long scar covering the vaginal opening. This term is particularly understood by the Somali and Sudanese communities
3. ESCB                      Enfield Local Safeguarding Children Board
4. Infibulation            The term 'infibulation' is derived from the name given to the Roman practice of fastening a 'fibular' or 'clasp' through the large lips of a female genitalia (usually within marriage) in order to prevent illicit sexual intercourse.
5. LCPP                      London Child Protection Procedures
6. LSCB                      London Safeguarding Children Board
7. Need to Know        An internal form for Social Care alerting Senior Management to serious issues.
8. Sunna                    Type i, Female Genital Mutilation may be known to some communities as Sunna which is an Islamic word used to describe an action by the Prophet Mohammed.
9. UNICEF                The United Nations Children's Fund

## 12. ORGANISATIONS THAT CAN HELP

### 1. Foundation for Women's Health Research & Development (Forward)

Unit 4, 765-767 Harrow Road, London NW10 5NY  
(0)20 8960 4000

<http://www.forwarduk.org.uk/key-issues/fgm>

### 2. British Medical Association

BMA House, Tavistock Square, London WC1H 9JP  
Switchboard: 020 7387 4499  
Fax: 020 7383 6400

<http://www.bma.org.uk/ap.nsf/Content/FGM>

### 3. AFRUCA - Africans Unite Against Child Abuse

Unit 3D/F Leroy House  
436 Essex Road  
London N1 3QP  
United Kingdom  
(0)20 7704 2261

<http://www.afruca.org>

### 4. Iranian and Kurdish Women's Rights Organisation

0207 9206460

[http://www.ikwro.org.uk/index.php?option=com\\_content&task=view&id=93&Itemid=50](http://www.ikwro.org.uk/index.php?option=com_content&task=view&id=93&Itemid=50)

**5. Woman Kind Worldwide**

Development House  
56-64 Leonard Street  
London EC2A 4LT  
Womankind.org.uk  
020 7201 9982

**6. FGM National Clinical Group**

C/o University College London Hospital NHS Trust,  
Elizabeth Garret Anderson & Obstetric Hospital,  
Huntley Street,  
London. WC1E 6DH  
<http://www.fgmnationalgroup.org/>

**7. UNICEF**

UK Helpdesk  
Tel: 0870 606 3377  
<http://www.unicef.org.uk/>

**8. World Health Organisation (WHO)**

European Observatory on Health Systems & Policies  
London School of Hygiene and Tropical Medicine  
Keppel Street  
London W1CE 7HT  
Telephone: 0207 927 2833  
[www.euro.who.int](http://www.euro.who.int)

**9. Primary Care Trust Enfield**

Telephone: 020 8270 8101

**10. SAMAFAL – Somali Women’s Group**

Telephone 020 8373 2719.

**11. Community Partnership Advisor**

Telephone 020 8379 2680.

FGM Screening Questions

1. When did the FGM take place?
2. Where did the FGM take place (i.e. which country)?
3. How old was the client when the FGM took place?
4. What type of FGM does the client have?
5. Has the client undergone a de-infubulation (reversal)?
6. What are the intentions/views of the client her partner towards the child regarding FGM?
7. Does she feel that she will be pressured into having FGM on her daughter and if so by whom i.e. community family friend partner. And if so what would she do about this?
8. Please advise the client that it is illegal to perform FGM in the UK and to take a child abroad for FGM and ensure that this is documented in the records (mother and baby if applicable) and referral.
9. Have you provided support service, information and education to client?
10. Has the health visitor been informed?