SAFEGUARDING CHILDREN AND YOUNG WOMEN FROM FEMALE GENITAL MUTILATION

Policy and procedure for all agencies

This policy/procedure has been agreed by the Warrington Safeguarding Children Board and replaces previous procedures and protocols

Date Agreed:

Signed………………………………………………………………………………
Chair, Policy & Practice Group
Warrington Safeguarding Children Board

Date to be reviewed: June 2009

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WARRINGTON SAFEGUARDING CHILDREN BOARD

Policy Statement – Female Genital Mutilation

Warrington Safeguarding Children Board recognises that whilst there is no intention to deliberately harm a child, the practice of Female Genital Mutilation is a violation of a child's human rights(1) and can result in both short term and long term medical complications and is, therefore, considered to be abusive. The practice of FGM is also illegal(2,3).

All children have a right to grow up safe from harm. Cultural factors neither explain nor condone acts of omission or commission which place a child at risk of significant harm. The basic requirement that children are kept safe is universal and cuts across cultural boundaries(3). Cultural heritage cannot take precedence over standards of childcare embodied in the law (4).

Professionals should be sensitive to differing family patterns and lifestyles and child rearing patterns that vary across different racial, ethnic and cultural groups. They should work with the strengths and support systems of families, ethnic groups and communities to help safeguard children and promote their welfare (4).

(1) World Health Organisation (1996)
(2) The Prohibition of Female Circumcision Act 1985
(3) The Female Genital Mutilation Act 2003
(4) Victoria Climbie Inqury
(5) Working Together to Safeguard Children (1999)

FEMALE GENITAL MUTILATION

1. DEFINITIONS

1.1 Female Genital Mutilation (FGM) comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs. It is a deliberate procedure which causes grave damage to children and women and which, in many cases, results in serious health consequences. (World Health Organisation 1996)

1.2 The various types of mutilation have been classified by the World Health Organisation as follows:

Type 1: Removal of the hood of the clitoris

Type 11: Removal of the clitoris with partial or total excision of the labia

Type 111: Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation)

Type 1V: Unclassified, 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 tissue surrounding the vagina; introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purposes of tightening or narrowing it.

2. THE LEGAL CONTEXT

2.1 FGM has been a criminal offence in the UK since The Prohibition of Female Circumcision Act 1985 was passed. The Female Genital Mutilation Act 2003, which came into effect on 3 March 2004 strengthened and amended the 1985 legislation. It makes it an offence for UK Nationals or permanent UK residents to carry out FGM abroad or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where the practice is legal. The 2003 Act

increased the maximum penalty for committing or aiding the offence from 5 to 14 years imprisonment.

2.2 A Local Authority may exercise its powers under s47 of the Children Act 1989 if it has reason to believe that a child is likely to suffer or has suffered FGM. However, parents who arrange FGM for their children do not intend this as an act of abuse, so where a family has been identified as at risk, it may not be appropriate to consider removing the child from an otherwise loving family environment and every attempt should be made to work with the parents on a voluntary basis to prevent the abuse.

3. HEALTH IMPLICATIONS OF FGM

IMMEDIATE / within first week of FGM	
• Haemorrhaging	Haemorrhage is common due to cutting of arteries and veins. Major blood loss can result in long-term anaemia. Severe bleeding, serious collapse or sudden death may occur due to haemorrhage.
• Infection	High risk of infection due to none sterile procedure by unqualified individual and/or unsuitable environment for surgery
• Acute retention of urine	Due to damage and swelling around urethra
LONG TERM	
• Irreparable damage to reproductive organs	Infertility. Recurrent uterus, vaginal and pelvic infections
• Recurrent urinary tract infections	Painful and difficult urination. May affect the bladder, ureters and kidneys
• Cysts and neurinomas	Cysts may grow to large size. Neurinoma results in whole genital area become permanently and unbearably painful

• Increased risk of fistula	Continuous leakage of urine and faeces
• Complications in pregnancy and child birth	Doubles the risk of mother's death during childbirth and increases risk of child being born dead by three to four times (WHO 1993)
• Difficulties in menstruation	Painful/ absent menstruation due to partial or total occlusion of vaginal opening.
• Sexual dysfunction	Painful intercourse, reduced sexual sensitivity
• Psychological damage	Children: Onset of behavioural disturbances; loss of trust and confidence in carers; Women: Feelings of incompleteness, anxiety, depression, chronic irritability, frigidity, marital conflicts, psychosis.

4. WHY FGM IS PRACTISED

The roots of FGM are complex and numerous, the justifications often given for FGM are:

- Custom and tradition
- Religion – in the mistaken belief that it is a religious requirement
- Preservation of virginity/chastity
- Social acceptance, especially for marriage
- Hygiene and cleanliness
- Increasing sexual pleasure for the male
- Family honour
- A sense of belonging to the group and conversely the fear of social exclusion
- Enhancing fertility

5. PREVALENCE

5.1 FGM is much more common than people realise, both worldwide and in the UK. It is reportedly practised in 28 African countries and in parts of the Middle and Far East but is increasingly found in Western Europe and other developed countries, primarily amongst immigrant and refugee communities. Estimates of girls and women who have undergone some form of FGM vary from between 135 to 150 million. Estimates suggest that there are as many as 2 million girls per year (6,000 per day) at risk of FGM. (FORWARD)

5.2 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 practised reside throughout the UK.

5.3 The age at which FGM is performed varies but is most common between the aqes of 4 and 13 years. However, in some cases FGM is performed on new born infants or on young women before marriage or pregnancy. (Working Together to Safeguard Children (2005)

6. IDENTIFYING FAMILIES AT RISK

The following are some indications that there may be an increased risk of FGM or that it may have already taken place:

Families

- Where a family comes from a community which is known to practise FGM extensively, the risk may be high, particularly if there is an elderly female relative present in the extended family.
- Midwives, nurses and doctors may treat women who have been genitally mutilated; the risk of these women arranging surgery for their own daughters is very high.
- Careful questioning in the antenatal period of women in at risk groups, in-order to identify women who may have undergone FGM in

order to plan for a safe mode of delivery and identify where children may be a risk within the family.

Child

- A child who is away from school frequently with bladder or severe menstrual problems.
- A child may make reference to 'circumcision' in conversation. Teachers may be approached for help by girls who are fearful of having surgery or visiting their country of origin.
- A child who has had a prolonged absence from school with noticeable behavioural changes on return may indicate FGM has taken place.

7. PRINCIPLES OF INTERVENTION

7.1 All children have a right to grow up safe from harm. FGM is an illegal and harmful practice and the primary objective of any professional or voluntary worker must be to ensure that a child's welfare is safeguarded. FGM is a matter of child protection, intervening to prevent FGM is not racist practice.

7.2 Despite the severe health consequences, parents and others who have FGM practised on their children do not intend it as an act of abuse and genuinely believe that it is in the child's best interests to conform with their prevailing custom. Parents and children (subject to age and understanding) should be offered the opportunity of considering information about FGM to ensure that they are fully aware that it is an illegal act which carries a potential custodial sentence and of the potential serious harm FGM causes. It is the duty of any professional to look at every possible way that parental co-operation can be achieved.

7.3 The preferred outcome for the child and family is that the family agree to halt the process, thereby ensuring that the child is protected

from significant harm. If ultimately there is no agreement from the family that the child should not undergo FGM, legal advice should be sought with a view to ensuring the child's protection. The objective of any legal action should be to prevent the child from undergoing FGM, whilst ensuring that the child is not removed from the family unless this is required to protect the child.

7.4 There is an onus of responsibility upon professionals investigating risk of FGM to attempt to understand the life experiences of families; many will be refugees who have come to the UK having had frightening and damaging experiences in their own countries. Racism in the UK may well lead them to be very wary of contact with representatives of white authority and they may have reacted against disorienting influences of white western society by attaching greater emotional commitment to their own cultural practices of which FGM may be one. (FORWARD)

7.5 Given that English is not a first language for most communities practising FGM, women accessing services should be asked whether they require an interpretor. In many instances male interpreters are not acceptable and some women may also feel reluctant to use friends or family members. The involvement of husbands should be arranged with care as they may be likely to influence a woman's decisions.

PART TWO – PROCEDURES

8. KEY STAGES IN RESPONDING TO CONCERNS

8.1 Any professional or voluntary worker who has concerns that a child or young person may be at risk of significant harm through FGM has a responsibility to ensure that they are adequately safeguarded and that they follow their agency's procedures in seeking advice from a senior manager/designated person with responsibility for child protection. (Also refer to Dept of Health publication – What to do if you're worried a child is being abused and Warrington ACPC Manual of Procedures.) The Children's Safeguarding Unit may also be contacted for advice.

8.2 Where an adult woman is identified as having undergone FGM, the worker should contact their lead professionals for Safeguarding Children for discussion regarding any possible concerns in respect of children within the family.

8.3 The British Medical Association's view is that doctors should contact Children's Social Care where they believe a child or young person to be at risk of FGM, or where a mother becomes pregnant again in a family whose existing daughters have been mutilated. (BMA 1996)

8.4 The lead professional will consider whether immediate safeguarding action needs to be taken or whether the concerns are such that a discussion with the safeguarding unit is required. The appropriateness of asking consent for referral will also be considered at this time. Where a decision is made to make a referral the Warrington Community Services Service Reception Team should be contacted. The Service Reception Team will transfer the referral to the appropriate social work team so that an initial assessment can be completed.

8.5 Concerns should be discussed with the family and, where appropriate with the child/young person who should be informed that a referral will be made to Children's Social Care. However, this should only be done where this will not place the child at increased risk.

8.6 The main emphasis of work with families in cases where there is a risk of the child undergoing FGM should be through education and persuasion wherever possible.

8.7 Children's Social Care will inform the Police of circumstances where it is suspected or known that a young person is at risk of harm through FGM. The Social Worker/Police Officer will initiate a Strategy Discussion within the same working day. This may take place at a meeting or by other means (e.g. by telephone).

8.8 The Strategy Discussion will include staff from Children's Services, the Police, the referring agency and other agencies as appropriate. Family members will not be invited to take part in discussion at this point.

8.9 Parents should usually be informed of the concerns at an early point, unless there is an indication that to do so would place the child at risk of significant harm. The decision to involve parents and what information should be shared with them will be decided at the Strategy Meeting.

8.10 The purpose of the Strategy Meeting is to:

- Share available information about the concerns, the child and family, including issues in relation to race, ethnicity or other special needs of the child, including whether the services of an interpreter or other specialist workers are necessary.

- Determine whether the child/young person is at risk of significant harm and whether Section 47 enquiries should be initiated or continued if already begun.

- Consider the needs of other children who may be affected.

- Plan how enquiries should be handled and by which agency, what further information is needed and how it should be obtained; who should be interviewed and by whom, for what purpose and when or whether medical examination or treatment is needed.

- Agree what action is needed immediately to safeguard the child amd/or provide interim services and support.

8.11 The Strategy Discussion will be recorded. Responsibility for completion of the documentation and circulation to all participants will be decided at individual Strategy Discussions (Appendix 1). Further meetings may be needed to monitor and review the outcome. Where no follow-up meeting is arranged, outcomes of actions identified, or reasons why these have not been completed, should be confirmed, within an agreed timescale, to the person designated at the Strategy Discussion.

8.12 Children's Social Care should inform those agencies working directly with the child of any decision that may have a significant impact on them.

9. IMMEDIATE PROTECTION

9.1 The first priority is to protect the child. Where there appears to be an immediate danger of FGM and parents cannot satisfactorily guarantee they will not proceed with it, an Emergency Protection Order/Police Protection Order should be sought.

Where a single agency has to act immediately to protect a child, a Strategy Discussion/Investigative Planning Meeting should take place as soon as possible to plan the next steps.

9.2 If the family are intent on sending their child out of the country and it can be shown that FGM is likely to be carried out abroad, application should be made to the Court for leave to apply for a Prohibited Steps Order under Section 8 Children Act 1989.

PART THREE – DEVELOPMENT WORK

10.1 Multi-agency training to be arranged via the Safeguarding Children Unit to enable professionals to:

- Prevent abuse and protect children by being alert to the warning signs
- Teach children about their rights to bodily integrity
- Enable workers to develop skills in dealing with the issues

10.2 Material to publicise and provide information about FGM and supportive services should be developed for use by Children's Community and Youth Services and Health

10. KEY CONTACTS & SUPPORT AGENCIES

Cheshire Police Referral Unit	Tel: 01244 614856
Warrington Borough Council:	
Community Services Service Reception Team	Tel: 01925 444239
Children's Safeguarding Unit	Tel: 01925 457013
FORWARD (Foundation for Women's Health Research And Development)	Tel 020 8960 4000 Fax:020 8960 4014
Agency for Culture & Change Management	Tel:01114 275 0193
Research, Action & Information Network For the Bodily Integrity of Women (RAINB)	Tel:020 7625 3400
Black Women's Health & Family Support	Tel: 020 890 3503

REFERENCES

Children Act 1989
www.doh.gov.uk

What to Do If You're Worried a Child is Being Abused (2003)
www.doh.gov.uk

Working Together to Safeguard Children (1999)
www.doh.gov.uk

FORWARD (1996): Child Protection and Female Genital Mutilation

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World Health Organization (1996): Female Genital Mutilation: Report of WHO Technical Working Group Geneva 17-19 July 1995

The Prohibition of Female Circumcision Act 1985
The Female Genital Mutilation Act 2003

Victoria Climbie Inquiry

British Medical Association (1996): Guidance for Doctors Approached by Victims of Female Genital Mutilation