West Lothian

Female Genital Mutilation Protocol

May 2011

1. Introduction

FGM is a collective term for all procedures which include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. Unlike male circumcision, FGM is a very harmful practice. It causes amongst other things long-term mental and physical suffering, difficulty in giving birth, infertility and even death.

Female Genital Mutilation (FGM) is recognised internationally as a violation of human rights and a form of violence against women and girls.

FGM is practised in over 28 African countries, parts of the Middle and Far East. The following countries have the highest incidence of FGM: Djibouti (98%), Egypt (97%), Eritrea (95%), Guinea (99%), Mali (94%), Sierra Leone (90%), and Somalia (98-100%). There is very little data documenting prevalence in the UK and Scotland because of the lack of reporting and knowledge/ training on the issue. In 2004, it was estimated that 74,000 women in the UK have undergone FGM and a further 7000 under the age of 17 are at risk. (The Department of Health, CMO Update 37, 2004)

In response to recent migration trends and growing BME communities within West Lothian, West Lothian Child Protection Committee in partnership with the Violence against Women Strategic Group has produced this protocol to support professional decision making in order to safeguard and promote the welfare of women and children.

2. Legislative Framework

<u>International Standards</u>

There are two international conventions, which contain articles, which apply to FGM. Signatory states, including the UK, have an obligation under these standards to take legal action against FGM.

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.

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.

Legislation in Scotland

The **Prohibition of Female Genital Mutilation (Scotland) Act 2005** makes it an offence to aid, abet, counsel, procure or incite female genital mutilation (including self-mutilation), even if the mutilation is carried out overseas. The Act makes it illegal for anyone to circumcise children or women for cultural or non-medical reasons. The Act increases the maximum penalty for committing or aiding the offence to 14 years in prison.

It also allows a convicting court to refer the victim and any child living in the same household as the victim, or person convicted of the offence, to the reporter to the children's panel. The reporter has grounds to refer such children to a children's hearing, under section 52(2) of the Children (Scotland) Act 1995. These provisions also give the reporter grounds to refer to a children's hearing any other children who are, or become, or are likely to become members of the same household as either the victim or the offender.

3. Definition and Main Forms of FGM

Female Genital Mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons (World Health Organisation, WHO, 2010).

Female genital mutilation is classified into five major types (UNICEF 2005):

a) Type i
Refers to excision of the prepuce with partial or total excision of the clitoris (clitoridectomy).

b) Type ii
Refers to partial or total excision of the labia minora (small lips which cover and protect the opening of the vagina and the urinary opening), including the stitching or sealing of it, with or without the excision of part or all of the clitoris.

c) Type iii (Infibulation)
Indicates excision of part or most of the external genitalia and stitching/narrowing or sealing of the labia majora- often referred to as “infibulation”. The two sides of the vulva are 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 is often preserved during healing by insertion of a foreign body.

d) Type iv
Makes specific reference to a range of miscellaneous or unclassified practices, including 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), and the introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purposes of tightening or narrowing it; any other procedure that falls under the definition of FGM given above and the symbolic practices that involve the nicking or pricking of the clitoris to release a few drops of blood.

4. Consequences of FGM

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

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 fetal death
i) Psychological damage; including a number of mental health and psychosexual problems including depression, anxiety, and sexual dysfunction. In Western cultures, the young person may also be disturbed by Western opinions of a practice which they perceive as an intrinsic part of being female.
j) Increased risk of HIV and other sexually transmitted infections.

5. Signs and Indicators

Professionals need to be aware of the possibility of FGM. The following are potential signs that FGM may take place. None of the following indicators automatically signify risk in isolation, however professionals should be vigilant at all times.

- Any female child born to a woman who has been subjected to FGM must be considered to be at risk, as must female siblings and children in the extended family.
- 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.

- 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.

Indications that FGM 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.

6. Justifications for continued practice of FGM:

The procedure is usually carried out on children aged between four and ten years old. It is a deeply rooted cultural practice in certain African, Asian and Middle Eastern communities. Justifications for female genital mutilation may include:

- 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;
- Increased male sexual pleasure.

7. Procedures and practice guidelines.

1) Any information or concern that a child or a woman is at risk of, or has undergone FGM should result in an immediate child protection referral either to the Police Public Protection Unit or the Paediatrician for Child Protection or Social Work Children and Families Duty Manager (or SCET out of hours office).

2) FGM places a child at risk of significant harm and will be investigated under Child Protection procedures.

8. Inter-Agency Referral Discussion (IRD)

On receipt of a referral an IRD must take place.

Children in immediate danger:

The IRD must first establish if the child is in immediate danger. Where the child does appear to be in immediate danger of mutilation and parents cannot satisfactorily guarantee that they will not proceed with it, then a Child Protection Order should be sought.

Where the child does not appear to be in immediate danger, a child protection investigation should be undertaken in the usual way and a decision taken on whether to proceed to an initial CP case conference. Every attempt should be made to work with the parents on a voluntary basis to prevent the abuse.

If a child has already undergone FGM

If a child has already undergone FGM and this comes to the attention of any professional, a referral should be made to one of the core agencies. An IRD will consider, how, where and when the procedure was performed and its implications for other female children in the family.

A child who has undergone FGM will be seen as a child in need and offered services as appropriate. Medical assessment and both short-term and long-term therapeutic services are to be considered by the IRD. Advice and support should be sought by specialist organisations e.g. DARF. The risk to other female children in the family must be assessed.

If a woman has already undergone FGM

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 implications e.g. her own children, extended family members and a referral made to one of the core agencies if appropriate.

If the woman is the mother of a female child or has the care of female children, professionals need to assess the potential risk to female children in the family and need to identify the most appropriate way of informing parents of the legal and health implications of FGM.

Circumstances where a child protection conference should be considered

A child protection conference should be considered necessary if there are unresolved child protection issues once the initial investigation and assessments have been completed.

Specialist advice and support:

Shakti Women's Aid
57 Albion Road
Edinburgh, Midlothian EH7 5QY
Telephone: 0131 475 2399
Email address: info@shaktiedinburgh.co.uk

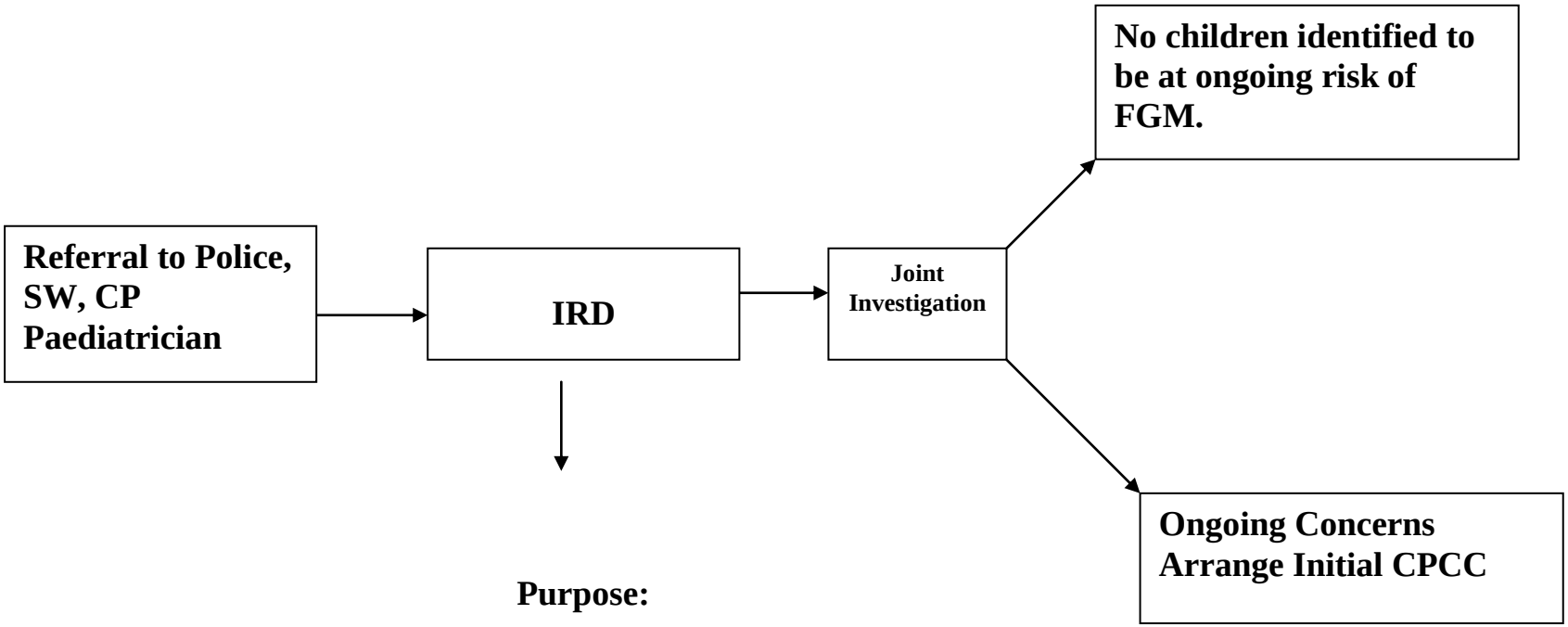
Dignity Alert Research Forum (DARF)
Telephone: 0131 453 4249
Email address: dignityalert@hotmail.co.uk

Amina (Muslim Women Resource Centre)
Network House, 311 Calder Street,
Glasgow, G42 7NQ
Telephone: 0141 585 8026
Email address: info@mwrc.org.uk

ACCM (UK)
King's House, 245 Ampthill Road
Bedford, MK42 9AZ
Telephone: 01234 356910
Mobile: 0771248 2568
Email: info@accmuk.com

Forward UK
Suite 2.1 Chandelier Building, 2nd Floor, 8 Scrubs Lane,
London, NW10 6RB
Telephone: 020 8960 4000

CHILD HAS UNDERGONE FEMALE GENITAL MUTILATION.



Purpose:

To consider how, where and when procedure was performed and its implications for this and other children / families

CHILD AT RISK OF FEMALE GENITAL MUTILATION