MANCHESTER JOINT STRATEGIC NEEDS ASSESSMENT 2015/16

CHILDREN AND YOUNG PEOPLE
(STARTING WELL AND DEVELOPING WELL)

CHAPTER: Safeguarding

Topic: Female Genital Mutilation

Why is this important?

Female Genital Mutilation (FGM) is a serious form of child abuse and violence against women and girls. FGM is illegal in the UK under the Female Genital Mutilation Act 2003 and Local Authorities have a statutory duty to safeguard children and protect and promote the welfare of all women and girls.

FGM is defined by the World Health Organisation (WHO) as "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". It can leave women and girls traumatised as well as in severe pain, cause difficulties in child birth, and in some rare cases it can lead to death.

The WHO classifies FGM into 4 types:

Type 1 – Clitoridectomy: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).
Type 2 – Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are the 'lips' that surround the vagina).
Type 3 – Infibulation: narrowing of the vaginal
Type 4 – Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterising the genital area.

Members of practising communities, both women and men, can be unaware of the relationship between FGM and its harmful health and welfare consequences, including the longer-term complications affecting sexual intercourse and childbirth.

The short-term consequences following a girl undergoing FGM can include:

- severe pain.
- emotional and psychological shock (exacerbated by having to reconcile being subjected to the trauma by loving parents, extended family and friends).
- haemorrhage.
- wound infections, including tetanus and blood-borne viruses (including HIV and Hepatitis B and C);
- urinary retention.
- injury to adjacent tissues.
- fracture or dislocation as a result of restraint.

The long-term health implications of FGM can include:

- chronic vaginal and pelvic infections.
- difficulties with menstruation.

- difficulties in passing urine and chronic urine infections.
- renal impairment and possible renal failure.
- damage to the reproductive system, including infertility.
- infibulation cysts, neuromas and keloid scar formation.
- obstetric fistula.
- complications in pregnancy and delay in the second stage of childbirth.
- pain during sex and lack of pleasurable sensation.
- psychological damage, including a number of mental health and psychosexual problems such as low libido, depression, anxiety and sexual dysfunction; flashbacks during pregnancy and childbirth; substance misuse and/or self-harm.
- increased risk of HIV and other sexually transmitted infections.
- death of mother and child during childbirth.

The longer-term implications for women who have had FGM Types 1 and 2 are likely to be related to the trauma of the actual procedure, while health problems caused by FGM Type 3 are more severe and long-lasting. However, all types of FGM are extremely harmful and cause severe damage to health and wellbeing. World Health Organization research has shown that women who have undergone FGM of all types, but particularly Type 3, are more likely to have complications during childbirth.

FGM is performed on women and girls at different ages, depending on the community or ethnic group that carries it out, though it is mostly carried out on girls between the ages of 5 and 8 years old. There is no cultural or religious justification for FGM. The procedure is traditionally carried out by women with no medical training. Anaesthetics and antiseptic treatments are not generally used and the practice is usually carried out using knives, scissors, scalpels, pieces of glass or razor blades.

The prevalence of FGM in the UK is difficult to estimate because of the hidden nature of the crime. However, a recent study estimated that:

- approximately 60,000 girls aged 0-14 were born in England and Wales to mothers who had undergone FGM.
- approximately 103,000 women aged 15-49 and approximately 24,000 women aged 50 and over who have migrated to England and Wales are living with the consequences of FGM. In addition, approximately 10,000 girls aged fewer than 15 who have migrated to England and Wales are likely to have undergone FGM.

It is possible that, due to population growth and immigration from practising countries since 2001, FGM is significantly more prevalent than these figures suggest. The distribution of cases of FGM around the country is likely to be uneven but will be high in Manchester where we have larger communities from the practising countries.

The Manchester Picture

According to the WHO, FGM is practised in up to 28 African countries and in some countries in Asia and the Middle East. Women and girls may also be at risk of having FGM performed on them in the UK, or being taken from the UK to have the procedure performed overseas. African countries where FGM is most commonly practised are Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, the Gambia, Guinea, Mali, Sierra Leone, Somalia and the Sudan. Prevalence of FGM is highest in countries around East and West Africa, in particular in Somalia, Guinea, Djibouti and Egypt, where more than 9 out of every 10 women are likely to have undergone FGM.

There are also a large number of women affected by FGM from communities in e.g. Kurdistan, Iraq and Pakistan. In some countries, (e.g. Egypt, Guinea, Somalia and Sierra Leone), prevalence rates are over 90 per cent and can be as high as 98 per cent. In other countries, such as Nigeria, Kenya, the Ivory Coast and Senegal, the prevalence rates vary between 20 and 50 per cent. There is also evidence that the practice is happening in Oman, Saudi Arabia and parts of Malaysia.

FGM is an inherently covert issue. The estimation of prevalence is based on Office for National Statistics (ONS) data about communities living within the UK. The statistics available are based on information about communities and making assumptions regarding current FGM practices is very difficult. A proxy measure of risk/prevalence has been the use of mother's country of birth for newborn babies. In Manchester the percentage of babies born to mothers born in Africa has grown by 38% between 2004 and 2013 (GM average is 42%). This rate of increase has been slowing down - in 2012 and 2013 Manchester experienced only a 3% increase in live births to African mothers, which is only a fifth of the average increase (15%) seen across Greater Manchester (GM) - although Manchester has greatest number of births to African mothers, accounting for 55% of all such births across GM in 2012 and 2013.

The mapping of schools census data confirms that the geographic placement of at-risk communities seems to be attuned to the geographic placement of African communities across Manchester. Girls from Somali communities remain the most at-risk due to the higher prevalence of FGM amongst those with this background.

What would we like to achieve?

A clear and consistent response for both those having experienced and those identified at being "at risk" of FGM. This includes a clear definition of "identification" (risk and/or experience) and "prevention".

Further community engagement and education, given the variety of views, experience and intended/reported behaviours from members of communities that are known to practise FGM, is key to changing attitudes regarding FGM.

We require a commissioned service to address the medical and psychological needs of girls and young women in Manchester/Greater Manchester that have experienced FGM. The Department of Health (DH) publication 'Commissioning services to support women and girls with female genital mutilation' states that "NHS England is expected to commission a patient centred healthcare response to support women and girls who have had, or are suspected to have had, FGM". Initial discussions have been held with the Deputy Director of Nursing, Patient Experience and Safeguarding (NHS England – North (Lancashire and Greater Manchester), to explore the potential service footprint and service elements.

The Sexual Assault Referral Centre (SARC) at St. Mary's Hospital (a GM service commissioned by NHS England and the Police and Crime Commissioner's Office) has provided, to date, a service for a small number of FGM cases referred there (<30 individuals) but this is not a solution to the issue.

What do we need to do to achieve this?

- The Manchester Safeguarding Children Board (MSCB) needs effective monitoring processes to enable holding agencies to account.
- We need to work with NHSE as part of a regional approach to provide a holistic service for children thought to have been subjected to FGM that would address medical (physical and psychological) needs as well as any criminal justice and safeguarding issues.
- We need to understand the true extent that FGM is (currently) practised within our communities- there is anecdotal evidence of families understanding their daughters having experienced FGM when they have not and families conforming to community norms re: FGM to avoid community exclusion.

What are we currently doing?

- An FGM subgroup of the MSCB has been established to ensure better partnership working between children's services, police, education, voluntary sector (e.g. Africans Unite Against Child Abuse - AFRUCA, BME Network, New Step for African Community - NESTAC), the NHS (hospital trusts and Clinical Commissioning Groups) and primary care GPs. The group will clarify referral pathways, provide guidance for agencies, and develop thresholds for referrals.
- Manchester City Council (MCC) Children's Services has a nominated senior management lead for FGM.
- NHS hospital trusts provide monthly data (since Sept 14) to the Department of Health (DH) regarding women/girls identified as having experienced FGM. GPs, Mental Health Trust (June 15) and all other organisations (October 15) are subject to mandatory reporting procedures.
- NHS hospital trusts are providing FGM training for staff and the Clinical Commissioning Groups (CCGs) Safeguarding Team are providing a Level 3 programme on FGM to all GP practices in 2015/16. Manchester IRIS (Identification and Referral to Improve Safety) GP domestic abuse training and service has added more detailed training about FGM for the 2015/16 programme.
- A GM multi agency working group has created a draft referral pathway with appropriate referral documentation and examination proforma.
- A literature review regarding best practice re psychological wellbeing is being undertaken.
- Social workers are receiving briefings on FGM
- A FGM screening tool is being developed for schools
- Training is available to support and assist teachers in having conversations with parents about FGM
- Voluntary sector organisations (e.g. AFRUCA, BME Network, and New Step for African Community- NESTAC) deliver community education and engagement via community groups and schools.
- Central Manchester Foundation Trust (CMFT) have been invited by the DH to be one of the early adopter sites for the FGM Risk Indication System (FGM RIS). This is a new national IT system that will allow clinicians across England to record that a woman/girl might be at potential risk of FGM

Community and Stakeholder Views

AFRUCA has issued a report entitled "Voices in the Community: Exploring Female Genital Mutilation in the African Community Across Greater Manchester". The findings of

this report, based on focus group interviews with representatives from across ten of the communities (Eritrea; Ethiopia; Kenya; Nigeria; Rwanda & Burundi; Guinea Bissau & Sierra Leone; Somalia; Sudan; Uganda; and Zimbabwe) with the greatest prevalence of FGM provide useful insight into the views of different communities towards FGM and differences between them.

Key findings included:

- Individuals from all focus groups who claimed that they were not aware of the practice still displayed a good working knowledge of its attributes, suggesting that there is still a taboo associated with FGM even in practicing communities.
- Most groups were fully aware of the kinds of FGM being practiced within their own communities.
- Fewer than half of the groups knew that FGM was illegal.
- FGM is viewed as part of a cultural heritage, but not a fixed part of it with national or ethnic variations in the underlying reasoning behind FGM
- Most groups were very open about the fact that FGM was commonly practiced among their communities with members from eight out of the ten groups said that they had undergone the procedure
- Members from only four of the ten groups openly admitted that they intended to have the practice of FGM practiced on their own children
- Individuals who perform the procedures involved in FGM - "Cutters"- were mainly found abroad, but could be found in GM

References and Links

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Safeguarding, Child Protection

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