

Vulnerable Groups

Female Genital Mutilation (FGM)

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Introduction

[Local Government Association \(2014\)](#) guidance for Councillors states that Female Genital Mutilation (FGM) is a serious form of child abuse and violence against women and girls. It has been illegal in this country since 1985 and councils 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](#) 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.

There are four different types of FGM, and WHO classifies these as:

- Type I: Clitoridectomy: Partial or total removal of the clitoris and/or the prepuce
- Type II: Excision: Partial or total removal of the clitoris and the labia minora, with or without removal of the labia majora
- Type III: Infibulation: Narrowing of the vaginal orifice with creation of a covering seal by cutting and repositioning the labia minora and/or the labia majora, with, or without excision of the clitoris
- Type IV: All other harmful procedures to female genitalia for non-medical purposes, for example pricking, piercing, incising, scraping and cauterisation.

(*) Type III is the most difficult to care for and manage in child birth requiring specialist obstetric and midwifery support.

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. 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.

Intercollegiate guidance published by the [Royal College of Midwives \(2013\)](#) has enabled significant progress to be made in:

- raising awareness of FGM
- training staff in recording FGM across a range of services

- agreeing recording and reporting requirements from contracted services
- agreeing pathways for the care of women antenatally and in the postpartum period
- working with partners to improve identification and take action to prosecute if necessary

What do we know?

Women who were born and brought up in countries where FGM is practiced are most at risk, as are UK born children who may be taken back to their mother's country of origin to undergo FGM.

Risk factors identified in the [Berkshire Child Protection Procedures](#) that may indicate that FGM has taken place are:

- Prolonged school absence with noticeable behaviour change on return
- Bladder and menstrual problems
- Reluctance to receive medical attention or participate in sport

Whilst the [intercollegiate guidance](#) noted that FGM was practiced mainly in North African countries, such as Somalia (for which there are now rough estimates of the numbers of children born to women of Somalian origin in Slough), advice from our local hospital indicated that women are appearing from many other countries in Europe.

The protocol for managing newly identified cases whether in primary or secondary care is now clearly understood. The gap remains in knowledge about how many children are at risk who currently attend schools in West Berkshire.

FGM's prevalence in the UK is difficult to estimate because of the hidden nature of the crime. A study conducted by [City University London \(2014\)](#) 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.
- approximately 10,000 girls aged under 15 who have migrated to England and Wales are likely to have undergone FGM.

FGM cases will not be evenly distributed across the UK and will be more prevalent in communities from practicing countries. The [City University London study](#) identified higher prevalence rates in London, Cardiff, Manchester, Sheffield, Northampton, Birmingham, Oxford, Crawley, Reading, Slough and Milton Keynes.

Since September 2014, all acute hospital providers in England are required to return monthly aggregated data about the incidence of FGM identified. This includes new cases, as well as those of women who are currently being treated for FGM-related conditions. From Sep-14 to Jan-15, 2,603 new cases of FGM were identified in England and there were 2,242 additional active cases of FGM for females previously identified. This data has also been published at an NHS Trust level for the same

period. Figure 1 shows this detail at a Trust level for those geographically located around West Berkshire.

Figure 1: Number of newly identified cases of FGM at a Trust level (Sept-14 to Jan-15)

NHS Trust	Number of newly identified cases of FGM
Royal Berkshire NHS Foundation Trust	8
Frimley Health NHS Foundation Trust	20
Heatherwood & Wexham Park Hospitals NHS Foundation Trust	Data not published
Oxford University Hospitals NHS Trust	13
Ashford and St Peter's Hospitals NHS Foundation Trust	0

Source: [Health & Social Care Information Centre \(2015\)](#)

FGM incidence data is not published at a Local Authority level, due to the small numbers reported and also the mechanisms in place to capture this data. However, our main providers now report numbers of identified FGM cases to us through our regular contract monitoring processes. This data is aggregated to a Berkshire level. Data is also routinely recorded in maternity services, sexual health services and in primary care. However, it is not possible to identify all those children who may be at risk of having the procedure as country of origin is not sufficient to identify British born children who may be at risk.

Local population estimates have been produced to show the number of people living in local authority areas who were born in other countries. Estimates for Somalian, Ghanaian and Nigerian girls and women are shown in figure 2. Estimates cannot be shown for other countries highlighted in the intercollegiate guidance, as these overall populations are too small to publish.

Figure 2: Local population estimates for females living in West Berkshire who were born in Somalia, Ghana and Nigeria

	Females born in Somalia	Females born in Ghana	Females born in Nigeria
West Berkshire	6	25	62

Source: [Office for National Statistics \(2011\)](#)

These figures suggest that there are approximately 93 females in the West Berkshire who may be at risk of, or who have already had, FGM procedures. It is important to note that these figures do not include all females born in countries where FGM is prevalent, or those born in the UK from specific ethnic groups. This estimation is also based purely on the country of birth and does not take any other indicators of risk into account.

What is the data telling us?

Despite the progress of awareness-raising, increased reporting and legal action, more needs to be done within Education to identify children at risk of travel to countries for the purpose of FGM. This is particularly difficult as country of origin

alone is not sufficient to ascertain risk. A full risk assessment, such as the one undertaken by Hackney, could be adopted locally if agreed within the Berkshire Child Protection procedures.

What are the key inequalities? The incidence of FGM is higher for:

- women born in countries in which FGM is practiced as part of particular faith beliefs
- female children of women who have undergone the practice

Other factors that might heighten a girl's risk of FGM include her family's level of integration within UK society and also being withdrawn from Personal, Social and Health Education (PSHE) as a result of her parents wishing to keep her uninformed about her body and rights ([HM Government, 2014](#))

The practice of FGM is associated with high levels of post-traumatic stress disorder and psychological distress in women and girls. ([Royal College of Midwives, 2013](#)).

What are the unmet needs/service gaps? There is clear guidance within the Berkshire Child Protection procedures in relation to FGM. However, the process of reporting FGM that has occurred overseas to social care is identified as needing to be reviewed, as well as the response pathway.

The other gap in West Berkshire is obtaining robust estimates of need within the education system in order to safeguard children at risk from travelling to countries where FGM is practiced. The central Education system (which is fed by and updated from school records) does not currently contain fields for country of birth – either for the child or the parents. Individual school systems may or may not be configurable to hold this information – and it would be a local matter for each school to decide upon. Data about a child's ethnicity, country of birth, religion and primary language could potentially be used to identify those at higher risk of FGM, based on assumptions of prevalence amongst different cultural groups.

Recommendations for consideration

Guidance sets out the expectations required of all partner organisations for identifying risk of FGM, the care and management of women with FGM and reporting or taking legal action.

Other services and partner organisations

Local best practice guidance can be found in the [Berkshire Child Protection Procedures](#).

National and local strategies

The national best practice guidance includes:

- [Local Government Association \(2014\); Female Genital Mutilation \(FGM\) – a Councillor's Guide](#)
- [HM Government \(2014\); Multi-Agency Practice Guidelines: Female Genital Mutilation](#)

- [Royal College of Midwives \(2013\); Tackling FGM in the UK – Intercollegiate recommendations for identifying, recording and reporting](#)

The Hackney Best Practice guidance for Children’s Social Care provides an assessment of risk for FGM, which includes:

- the family’s belief system in relation to the practice of FGM
- the family’s contact with community and/or faith groups that support the practice of FGM
- If the family are likely to be in contact with those who have previously or currently perform FGM
- If there are other risks including Honour Based Violence, Early Forced Marriage or Child Trafficking
- whether there are any plans for female children in the household to visit a country in which FGM is practiced
- the capacity of the child’s parents/carers to resist community and familial pressure to subject female children to FGM and to protect female children in their care from FGM
- the child(s) views, knowledge and understanding of FGM (depending on age and understanding)
- the child’s experience of family life and family / community belief systems
- whether female children in the household are able to access social / educational and health resources with an age-appropriate degree of autonomy
- whether the child has a safe adult(s) she can access if she is worried about her safety or welfare
- whether the child has already experienced or is likely to experience FGM during her minority
- whether a professional response is required to meet the child’s needs, reduce risk or provide immediate protection

Other chapters you might be interested in

Maternity

Sexual Health

If you have any questions about this chapter, please contact Public Health and Wellbeing Team on publichealthandwellbeing@westberks.gov.uk or 01635 503437