Female Genital Mutilation
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Summary

Female Genital Mutilation introduction

- Female genital mutilation (FGM) refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genitalia for non-medical reasons.
- It has no medical benefits and serious potential harms including both short-term and long-term physical and psychological problems.
- Over 125 million women and girls are thought to have undergone FGM worldwide. It has been documented in 28 African countries and is also thought to occur in other countries in Africa, the Middle East and Asia.
- It is usually carried out on girls aged between 0 and 15 and is linked to cultural beliefs. Reasons given for the practice include social acceptance, beliefs about preserving virginity, cleanliness and hygiene, and religious beliefs.
- It is illegal to carry out FGM in the UK, or overseas on a permanent or habitual UK resident.
- There is no comprehensive information on how many women and girls in the UK are affected by FGM. Recent estimates suggest that there are over 127,000 women aged 15 and over in England and Wales who are likely to have undergone FGM, and almost 10,000 girls aged 0-14 at risk of FGM.
- Recording of FGM is now mandatory within many NHS services in England and Wales. Almost 4,000 newly identified cases were reported between September 2014 and March 2015.

Female Genital Mutilation key points

- Maternity services serving the Suffolk population identified fewer than 10 women with FGM between September 2014 and March 2015.
- Estimates based on school census data suggest there may be at least 115 girls aged 5-16 in Suffolk schools who are from FGM-practising countries.
- Estimates based on census data suggest there may be at least 470 women and girls of all ages of African or Kurdish origin in Suffolk who have undergone, or may be at risk of,
This needs assessment was prepared in July 2015 by the Public Health Action Support Team on behalf of Suffolk County Council.

Female Genital Mutilation recommendations

1. The FGM multiagency group should continue its work in Suffolk with a particular focus on training, workforce development and the dissemination of good practice, take into account risk, safeguarding, and legal requirements. It should continue to encompass health, social care, education and early years services, and engage communities.

2. The FGM group should consider ways to engage partners and the wider community in raising awareness, agreeing priorities and supporting joint work on FGM. It should use information from interviews and focus groups which have already taken place to
develop a picture of the views of groups affected in Suffolk.

3. Training should cover awareness-raising and cultural competence and also support frontline staff to develop skills and competence in raising and discussing questions around FGM and responding to safeguarding concerns.

4. FGM should continue to be part of mandatory safeguarding training. Training should take into account the views and knowledge of communities in Suffolk who are affected by FGM.

5. Consistent guidance should be promoted across Suffolk. This should include agreed risk assessment frameworks, how to record and report FGM as well as information about local arrangements.

6. All frontline staff working with children and families in any setting should know how to recognise and respond to safeguarding concerns in relation to FGM and this should be part of mandatory safeguarding training and covered in local guidelines.

7. NHS England and Suffolk CCGs should clarify responsibilities for commissioning and provision of services for women and girls with physical and psychological health needs as a consequence of FGM.

What is Female Genital Mutilation and why is it important for Suffolk?

Background

Female Genital Mutilation (FGM) (sometimes called Female Genital Cutting (FGC)) refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genitalia for non-medical reasons. WHO has classified FGM into four types, as shown in Table 1 (WHO, 2008). These are shown diagrammatically in the Appendix.
Table 1: WHO classification of Types of FGM

<table>
<thead>
<tr>
<th>Type 1</th>
<th>Partial or total removal of the clitoris and/or the prepuce (clitoridectomy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 2</td>
<td>Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision)</td>
</tr>
<tr>
<td>Type 3</td>
<td>Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation)</td>
</tr>
<tr>
<td>Type 4</td>
<td>All Harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization</td>
</tr>
</tbody>
</table>

Source: WHO

FGM has no medical benefits and is a violation of the human rights of girls who are subjected to it. Short-term harms include severe pain and psychological trauma, and risk of infection, urinary retention and haemorrhage which can lead to death. In the longer term women may suffer chronic pain, urinary problems, infection and infertility, and have an increased risk of obstetric complications including obstructed labour, lacerations and haemorrhage. They are also at risk of long term psychological problems and sexual dysfunction which are not reduced by FGM being a culturally accepted practice within the community (FORWARD, 2014; UNICEF, 2013). Research in practising African communities has found that the majority of women have affective or anxiety disorders, and levels of post-traumatic stress disorder are similar to those of adults who have been subjected to early childhood abuse (Behrendt, 2005).

It has been estimated by UNICEF that at least 125 million women and girls worldwide have undergone FGM and it has been documented in 28 countries in Africa as well as Kurdish communities mainly in Iraq and Iran. It is also thought to occur in a number of other countries in the Middle East and Asia but there are no data about its extent in those areas. Figure 1 shows estimated prevalence of FGM among women aged 15-49 in Africa (UNICEF, 2013). The countries where the practice is known are mainly those in West, Central and East Africa, and national prevalence’s vary from over 90% (eg. Somalia, Egypt) to under 10% (eg. Ghana, Niger). There are also wide variations within some countries, for example in
different areas of Senegal FGM prevalence varies from 1-92%, and in Iraq the practice of FGM is concentrated in the north-east and unknown in the rest of the country.

FGM is usually carried out on girls aged between 0 and 15, but in half the countries in the UNICEF study it was carried out on girls aged under 5. It is often carried out by traditional practitioners using various instruments such as blades or glass, although there is evidence of increasing involvement of health professionals in some countries such as Egypt. It is linked to cultural beliefs and reasons given for why FGM is carried out include social acceptance, cleanliness/hygiene, better marriage prospects, to preserve virginity, and in some places it is considered to be a religious requirement. While prevalence is highest among Muslim communities in many countries it is also found among other religious groups. The most commonly reported reason found by UNICEF for carrying out FGM was a sense of social obligation; social and peer pressure within a community appeared to be a strong factor, and in some cases it was reported that decisions about FGM were taken by a group (UNICEF, 2013).

The UNICEF report also found increasing awareness of the potential harms of FGM, and that it could have serious consequences. There was evidence that attitudes are changing and that support for FGM has fallen among both men and women over the last 20 years, but that practice is lagging behind changes in attitudes. Surveys have found that the proportion of both men and women who supported continuation of FGM appeared to be lower than the proportion of women who had actually had the procedure. A significant proportion of women who thought it should stop had daughters who had had FGM. UNICEF concluded that not only changes in individual attitudes, but changing social expectations about the practice of FGM across entire communities are important in changing practice.
This needs assessment was prepared in July 2015 by the Public Health Action Support Team on behalf of Suffolk County Council.

Figure 1: Percentage of women and girls aged 15-49 who have undergone FGM/C, by country (UNICEF, 2013)

Why is FGM important in the UK and Suffolk?
Women who have had FGM are increasingly found in the UK due to migration from countries where it is practised, but it is known that the practice may also continue in girls of families who have migrated to the UK, including those who have been born in this country.
It has been illegal to carry out FGM in the UK since the Prohibition of Female Circumcision Act 1985. This was replaced by the Female Genital Mutilation Act 2003, which was extended by the Serious Crime Act 2015, to cover procedures carried out overseas (Home Office, 2015a). It is now a criminal offence for anyone to carry out, or assist anyone else to carry out FGM in the UK on anyone, whether or not they are a UK resident or national. It is also illegal for anyone to carry out or assist FGM being carried out overseas on a UK national or permanent or habitual UK resident. The extra-territorial offences are intended to cover taking a girl abroad to be subjected to FGM. The 2015 Act also introduces a new offence of failing to protect a girl from risk of FGM, and introduces a duty on healthcare professionals, teachers and social care workers to notify the police of known cases of FGM carried out on a girl aged under 18.

However there have to date been no successful prosecutions for FGM under this law, although a number of cases have been examined by the Crown Prosecution Service in the last few years (House of Commons, 2014). The House of Commons Home Affairs Committee commented in March 2015: ‘There seems to be a chasm between the amount of reported cases and the lack of prosecutions. Someone, somewhere is not doing their job effectively’ (House of Commons, 2015).

There are three groups of women and girls in the UK with whom intervention may be needed to reduce the risk of, and harms arising from FGM:

**Girls who may be at risk of FGM:** despite the fact that it is illegal, girls may be at risk of FGM being carried out within the UK or overseas. To prevent this happening it is essential to work with communities to change attitudes to FGM, along with effective safeguarding arrangements to protect girls at risk.

**Girls who have had FGM:** FGM is dealt with as child abuse, and as well as a legal response, action is needed to try and mitigate the physical and psychological effects suffered by the child, to protect the child from any further harm, and to protect any others who might be at risk.
Women who have had FGM: the long-term health and psychological problems caused by FGM may be amenable to intervention; for example, surgical deinfibulation can reverse some of the potentially harmful physical effects and reduce the risk of problems arising during childbirth. Psychological interventions may be helpful for women who are suffering from psychological problems such as post-traumatic stress disorder, anxiety or sexual dysfunction as a result of FGM.

What is the national and local picture?
There is currently no comprehensive information on how many women in the UK are affected by FGM, or how many girls have been subjected to the procedure either in the UK or overseas.

NHS reporting of FGM – national data
A FGM Prevalence Dataset was published by HSCIC (the Health and Social Care Information Centre) on 1 April 2014 and from September 2014 it became mandatory for acute NHS Trusts in England to provide monthly returns on patients identified with FGM (HSCIC, 2014). In April 2015 this was replaced with the FGM Enhanced Dataset, which contains more data items, including patient demographic data, specific FGM information, and referral and treatment information (HSCIC, 2015). Collection of the enhanced dataset is mandatory for all acute NHS Trusts from 1 June 2015, and all GPs and mental health NHS Trusts from 1 October 2015. Clinicians are required to record in the clinical notes every time a patient with FGM is identified (whether on clinical examination or self-reported), and the type of FGM. The report on the first quarter of the enhanced dataset will be published in September 2015.

The FGM dataset reports two sets of data:

**Newly identified cases:** Patients who are first identified during the reporting period as having undergone FGM.

**Active caseload:** Patients identified as having a history of any FGM type prior to the reporting period and still being actively seen/treated for FGM-related conditions or any other non-related condition at the end of the month. This does not include patients newly identified within the reporting period.
Numbers between 1 and 5 for individual Trusts are suppressed for confidentiality reasons.

Figure 2 shows the number of newly identified cases by month in the England Regions between September 2014 and March 2015. A total of 3,963 women with FGM were identified, of whom 2,040 (50%) were in London, 849 (21%) in the Midlands and East of England, 707 (18%) in the North and 367 (9%) in the South. Between 520-610 new cases were reported per month. Of all those newly identified 3,882 were aged 18 and over, 60 (1.5%) were aged under 18, and for 21 (0.5%) age was not recorded. Figure 4 shows the breakdown by Type of FGM; the majority (63%) were recorded as Type 4 or not known, and around 14% as Type 1, 12% as Type 2 and 11% as Type 3.

Figure 2: Newly identified cases of FGM reported by NHS Acute Trusts, England Regions, Sept 2014-Mar 2015

![Graph showing the number of newly identified cases of FGM by month and region between September 2014 and March 2015.](source: HSCIC)
This needs assessment was prepared in July 2015 by the Public Health Action Support Team on behalf of Suffolk County Council.

Table 2: Newly identified cases by type of FGM* reported by NHS Acute Trusts, England Regions, Sept 2014-Mar 2015

<table>
<thead>
<tr>
<th>Region</th>
<th>Type 1</th>
<th>Type 2</th>
<th>Type 3</th>
<th>Type 4 and Not Known</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>London</td>
<td>255</td>
<td>183</td>
<td>191</td>
<td>1,411</td>
<td>2,040</td>
</tr>
<tr>
<td>Midlands and East of England</td>
<td>181</td>
<td>171</td>
<td>163</td>
<td>334</td>
<td>849</td>
</tr>
<tr>
<td>North of England</td>
<td>93</td>
<td>77</td>
<td>52</td>
<td>485</td>
<td>707</td>
</tr>
<tr>
<td>South of England</td>
<td>42</td>
<td>47</td>
<td>20</td>
<td>258</td>
<td>367</td>
</tr>
<tr>
<td>England</td>
<td>571 (14%)</td>
<td>478 (12%)</td>
<td>426 (11%)</td>
<td>2,488 (63%)</td>
<td>3,963</td>
</tr>
</tbody>
</table>

*for Type descriptions see Table 1 and Appendix

Source: HSCIC

Figure 3 shows the active caseload of women with a history of any type of FGM, who were still being actively seen/treated for any condition. This has gradually increased in all areas, but most markedly in London. At the end of March 2015 the total active caseload in England was 3,164, of whom 1,783 (56%) were in London, 686 (21%) in Midlands and East of England, 448 (14%) in the North and 247 (8%) in the South. Over the 7-month period there were 290 women nationally who underwent deinfibulation and 10 who underwent repeat deinfibulation.
The total number of care contacts (for any type of care) with acute Trusts for patients with any type of FGM were also reported. In England over the 7 months September 2014 to March 2015 there were a total of 17,875 contacts, of which 47% occurred in obstetrics, 30% in midwifery, 6% in gynaecology, 3% diagnostic imaging and 2% in genitourinary medicine (GUM). The remainder were across a wide range of other specialties. This indicator includes multiple counts for single individuals if they have more than one care contact during that time.

Source: HSCIC
NHS reporting of FGM – Suffolk data
Table 3 shows the reported figures for newly identified cases, active caseload and total care contacts for the three main hospital providers to the Suffolk population. At both Ipswich and James Paget hospitals there have been less than six newly identified cases in total between September 2014 and March 2015. The active caseload at Ipswich hospital at the end of February was less than six, and there have been a total of 11 care contacts for any woman known to have had FGM. At James Paget hospital no care contacts have been recorded, and at West Suffolk hospital no cases of FGM have been identified. The figures include the totals reported from each hospital (not only women resident in Suffolk).

Table 3: Newly identified cases, active caseload and total care contacts for FGM reported by main hospital providers for Suffolk, Sept 2014-Mar 2015

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ipswich Hospital NHS Trust</td>
<td>*</td>
<td>*</td>
<td>11</td>
</tr>
<tr>
<td>James Paget University Hospitals NHS FT</td>
<td>*</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>West Suffolk NHS FT</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

NB: Ipswich active caseload is for Feb 2015; March data not reported.

*number suppressed for confidentiality reasons; 5 or less

Source: HSCIC

Estimated prevalence of FGM, England and Wales
The most recent estimates for England and Wales are from research undertaken by City University, London, published in 2014, which used 2011 Census data and the most recent known prevalence of FGM in the countries involved. They estimated the number of women permanently resident in England and Wales who were born in countries where the prevalence of FGM is known and who are likely to have undergone FGM (Macfarlane et al,
They were only able to make these estimates for women born in African countries where the estimated prevalence of FGM is known; they were not able to make estimates for women from other countries in the Middle East and Asia who may have undergone FGM because there are no data about its extent in those areas.

Table 4 shows the estimates by age group for countries represented in Suffolk data (see below). Data are not available for the Kurdish ethnic group because the estimates are based on country of birth. There are estimated to be over 100,000 women aged 15-49 and almost 24,000 aged 50 and over in England and Wales who have undergone FGM, as well as almost 10,000 girls aged under 15 who have undergone or will undergo FGM. In addition, the authors used birth registration data to estimate that since 1993 over 76,000 girls were born in England and Wales to women with FGM.
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Table 4: Estimated number of women and girls permanently resident in England and Wales who are likely to have undergone FGM (aged 15 and over) or to undergo FGM (aged 0-14), numbers by country of birth (2011 Census)

<table>
<thead>
<tr>
<th>Age group</th>
<th>0-14</th>
<th>15-49</th>
<th>50+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iraq</td>
<td>86</td>
<td>1,256</td>
<td>459</td>
</tr>
<tr>
<td>Eritrea</td>
<td>456</td>
<td>6,286</td>
<td>1,028</td>
</tr>
<tr>
<td>Somalia</td>
<td>5,316</td>
<td>41,842</td>
<td>7,489</td>
</tr>
<tr>
<td>Sudan</td>
<td>436</td>
<td>4,421</td>
<td>846</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>332</td>
<td>5,101</td>
<td>604</td>
</tr>
<tr>
<td>Kenya</td>
<td>181</td>
<td>3,270</td>
<td>969</td>
</tr>
<tr>
<td>Tanzania</td>
<td>15</td>
<td>505</td>
<td>110</td>
</tr>
<tr>
<td>Nigeria</td>
<td>1,277</td>
<td>19,451</td>
<td>5,965</td>
</tr>
<tr>
<td>Ghana</td>
<td>28</td>
<td>1,527</td>
<td>821</td>
</tr>
<tr>
<td>All other countries</td>
<td>1,637</td>
<td>19,462</td>
<td>5,628</td>
</tr>
<tr>
<td>Total</td>
<td>9,763</td>
<td>103,177</td>
<td>23,918</td>
</tr>
</tbody>
</table>

Source: City University London
Table 5 shows FGM-practising country groups as defined in the City University, London report. The African countries where there are known estimates of FGM prevalence and Iraqi Kurdistan are put in four groups, based on the prevalence and the types of FGM practised.

**Table 5: FGM-practising country groups**

<table>
<thead>
<tr>
<th>Group</th>
<th>Definition</th>
<th>Countries and prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Almost universal FGM, over 30% FGM Type 3</td>
<td>Somalia, Eritrea, Djibouti, Sudan (north). Reported prevalence range 87%-98%</td>
</tr>
<tr>
<td>1.2</td>
<td>High national prevalence of FGM, Type 1 and 2</td>
<td>Egypt, Ethiopia, Mali, Burkina Faso, Gambia, Guinea, Sierra Leone. Reported prevalence range 74%-95%</td>
</tr>
<tr>
<td>2</td>
<td>Moderate national prevalence of FGM, Type 1 and 2</td>
<td>Central African Republic, Chad, Cote d'Ivoire, Guinea Bissau, Iraq (Kurdistan), Kenya, Liberia, Mauritania, Nigeria, Senegal. Reported prevalence range 24%-70%</td>
</tr>
<tr>
<td>3</td>
<td>Low national prevalence of FGM, Type 1 and 2</td>
<td>Benin, Cameroon, Ghana, Niger, Democratic Republic of Congo, United Republic of Tanzania, Togo, Uganda, Yemen. Reported prevalence range 0%-15%</td>
</tr>
</tbody>
</table>

Source: City University, London; for FGM types see Figure 1 and Appendix

**Women and girls potentially at risk of FGM in Suffolk**

**School census**

Data based on findings from the January 2014 Suffolk school census are shown Table 6. The census recorded both first language and ethnicity. Recorded categories were not consistent; for example in some cases only language or ethnicity is recorded, and in some cases both.

The table shows ‘best guesses’ of FGM country group based on recorded ethnicity, language or both, for girls whose first language was not English. These data suggest that about 115 girls aged 5-16 who were in school in Suffolk in January 2014 were from countries or ethnic groups recognised to be at increased risk of FGM. Eighty-five were of primary
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school age and 30 of secondary school age. Twenty-seven were from areas where there is a high or almost universal prevalence of FGM (country groups 1.1 and 1.2), 46 from moderate prevalence areas (country group 2), and 42 from low prevalence areas (country group 3). (See Table 5, FGM-practising country groups).

Table 6: Estimated numbers of girls in Suffolk schools in January 2014 whose recorded first language and/or ethnic group suggests they are at increased risk of FGM

<table>
<thead>
<tr>
<th>FGM country group (Fig 8)</th>
<th>Ethnicity recorded in school census</th>
<th>Mother tongue recorded in school census</th>
<th>Primary school</th>
<th>Secondary school</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Sudan</td>
<td>Arabic, Other</td>
<td>0</td>
<td>*</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>1.2 Ethiopia</td>
<td>Amharic</td>
<td>7</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2 Egypt</td>
<td>Arabic, Other</td>
<td>12</td>
<td>*</td>
<td>&lt;17</td>
<td></td>
</tr>
<tr>
<td>1.2 Sierra Leone</td>
<td>Other</td>
<td>0</td>
<td>*</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>2 Iraqi/Kurdish</td>
<td>Kurdish, Other</td>
<td>35</td>
<td>11</td>
<td>46</td>
<td></td>
</tr>
<tr>
<td>3 Ghana</td>
<td>Akan (Twi/Asante), Akan/Twi-Fante, Ewe, Ga, Hausa, Other</td>
<td>22</td>
<td>0</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>3 Nigeria</td>
<td>Yoruba, Edo, Igbo, Other</td>
<td>9</td>
<td>11</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>85</strong></td>
<td><strong>30</strong></td>
<td><strong>115</strong></td>
<td></td>
</tr>
</tbody>
</table>

*number suppressed for confidentiality reasons; less than 5

Source: Suffolk school census January 2014

Census data
Table 7 shows census data on detailed ethnic group for Suffolk and Districts, for selected countries where there is known to be an increased risk of FGM. These data are only available for a limited number of countries and all the relevant ones for which the data are available are shown here; all of these are in Africa. Estimates have been made of the approximate number of females of all ages who might be affected by FGM in the Suffolk population, as follows:
1. Estimates for the number of females have been derived simply by halving the census figures, as the data were not available for women only and the gender balance within these communities in Suffolk is not known;

2. The figures for each country were adjusted by the same factor used in the City University research to allow for approximate numbers of women who might be at lower risk due to their religion or other factors;

3. The most recent reported prevalence’s of FGM in each of these countries were used to estimate approximate numbers of women affected in Suffolk (UNICEF, 2013; Macfarlane et al, 2014).

Because these estimates have been based on a number of assumptions they are intended as a rough guide only to the possible impact of FGM in Suffolk. Bearing in mind these caveats, these data suggest that an estimated 205 women and girls from African countries who are resident in Suffolk may be at risk of having had, or of undergoing FGM. The majority are from Central and West African countries, with a smaller number from East African countries.

Other research has used language rather than country of origin as an indicator of risk (London Borough of Islington, 2012), and this was explored for Suffolk using the main language recorded in the census (Table 8). However this appears to be a less useful way of identifying FGM risk because few people in Suffolk specified a language, apart from Kurdish-speaking people. Seven hundred and twenty-eight people identified their main language as Kurdish, of whom 682 lived in Ipswich. The country of origin of all the Kurdish community is not known, but is known that there are significant numbers of people who are of Iraqi origin. Based on the prevalence of FGM in Iraqi Kurdish communities (estimated to be 72.7%) (WADI, 2010), this group may include about 265 women and girls who have undergone or are at risk of FGM. Estimates were not made for other languages because numbers recorded appear too small to be useful.
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Table 7: Detailed ethnic group as recorded in 2011 Census, Suffolk and Districts, indicating those where risk of FGM may be higher, and estimated prevalence of FGM (note: not all countries are recorded separately in the Census)

<table>
<thead>
<tr>
<th>Central and Western Africa</th>
<th>South and Eastern Africa</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ghana</td>
</tr>
<tr>
<td>FGM country group (see Fig 8)</td>
<td></td>
</tr>
<tr>
<td>**</td>
<td>3</td>
</tr>
<tr>
<td>Average FGM prevalence</td>
<td>0-91.1%</td>
</tr>
<tr>
<td>Babergh</td>
<td>87,740</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>59,748</td>
</tr>
<tr>
<td>Ipswich</td>
<td>133,384</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>96,731</td>
</tr>
<tr>
<td>St Edmundsbury</td>
<td>111,008</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>124,298</td>
</tr>
<tr>
<td>Waveney</td>
<td>115,254</td>
</tr>
<tr>
<td>Suffolk (% of total population)</td>
<td>728,163</td>
</tr>
<tr>
<td>Estimated no. females all ages affected by FGM</td>
<td>(est) 10</td>
</tr>
</tbody>
</table>

**Most low/ no reported prevalence of FGM apart from Egypt (91.1%).
$ countries not known, but other Central/ West African countries with largest numbers in England & Wales are Gambia, Sierra Leone, Ivory Coast, Cameroon and DRC; reported prevalences range 0-76%; midpoint used.
# Most low/ no reported prevalence of FGM apart from Ethiopia (74.3%) and Tanzania (14.6%)
Source: 2011 Census; City University, London
Table 8: Main language as recorded in 2011 Census, people aged 3 and over, Suffolk and Districts, indicating those where risk of FGM may be higher (note: not all languages are recorded separately in the Census)

<table>
<thead>
<tr>
<th>Language recorded</th>
<th>Kurdish</th>
<th>Amharic</th>
<th>Tigrinya</th>
<th>Somali</th>
<th>Swahili/Kiswahili</th>
<th>Lingala</th>
<th>Akan</th>
<th>Yoruba</th>
<th>Igbo</th>
<th>Any other Nigerian</th>
<th>Other W African</th>
<th>Other African</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likely country</td>
<td>Iraq/Turkey</td>
<td>Ethiopia</td>
<td>Eritrea</td>
<td>Somalia</td>
<td>Tanzania/Kenya</td>
<td>CAR</td>
<td>Ghana</td>
<td>Nigeria</td>
<td>Nigeria</td>
<td>Nigeria</td>
<td>W Africa</td>
<td>Most S Africa/Zimb'we</td>
</tr>
<tr>
<td>FGM country group (Fig 8)</td>
<td>2</td>
<td>1.2</td>
<td>1.1</td>
<td>1.1</td>
<td>2/3</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1.2/2/3</td>
<td>-</td>
</tr>
<tr>
<td>Average FGM prevalence</td>
<td>72.7%</td>
<td>74.3%</td>
<td>88.7%</td>
<td>97.9%</td>
<td>14.6 – 27.1%</td>
<td>24.2%</td>
<td>3.8%</td>
<td>56.9%</td>
<td>40.8%</td>
<td>27%</td>
<td>4-89%</td>
<td></td>
</tr>
</tbody>
</table>

| Babergh            | 10     | 2      | 1      | 0      | 2      | 0     | 0    | 2      | 0    | 0      | 0          | 38             |
| Forest Heath       | 0      | 2      | 0      | 0      | 1      | 0     | 3    | 2      | 1    | 1      | 6          | 45             |
| Ipswich            | 682    | 2      | 1      | 4      | 11     | 0     | 15   | 13     | 5    | 5      | 12         | 123            |
| Mid Suffolk        | 8      | 1      | 0      | 0      | 1      | 1     | 0    | 0      | 0    | 2      | 2          | 41             |
| St Edmundsbury     | 16     | 0      | 0      | 3      | 3      | 2     | 3    | 2      | 10   | 3      | 1          | 44             |
| Suffolk Coastal    | 5      | 0      | 0      | 0      | 4      | 0     | 2    | 1      | 0    | 3      | 3          | 74             |
| Waveney            | 7      | 1      | 1      | 1      | 1      | 0     | 2    | 0      | 7    | 1      | 9          | 20             |
| Suffolk            | 728    | 8      | 3      | 8      | 23     | 2     | 24   | 21     | 24   | 10     | 33         | 385            |

| Estimated no. females all ages affected by FGM | 265     |                      |                  |        |        |        |        |        |        |        |            |                |

Source: 2011 Census; London Borough of Islington; City University, London

This needs assessment was prepared in July 2015 by the Public Health Action Support Team on behalf of Suffolk County Council.
This needs assessment was prepared in July 2015 by the Public Health Action Support Team on behalf of Suffolk County Council.

Table 9 shows data from a census question which allowed people to write in their ethnic group: in Suffolk 669 Kurdish people did so, of whom 626 were in Ipswich. A detailed breakdown by age group was available for the Ipswich residents only (no gender breakdown was available). Table 10 shows that this population is predominantly young adults and children. These data suggest there may be around 49 girls aged 5-16 of Kurdish origin in Ipswich; these numbers are comparable with the school census data identifying 46 girls with Kurdish language and/or ethnicity. The language and write-in ethnic group data give very similar numbers suggesting this is a reasonably accurate estimate of the Kurdish community in Suffolk.

Table 9: Ethnic group: write-in responses, number stating ‘Kurdish’ by District in Suffolk (2011 Census)

<table>
<thead>
<tr>
<th>District</th>
<th>Kurdish</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suffolk</td>
<td>669</td>
</tr>
<tr>
<td>Babergh</td>
<td>15</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>0</td>
</tr>
<tr>
<td>Ipswich</td>
<td>626</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>7</td>
</tr>
<tr>
<td>St Edmundsburry</td>
<td>9</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>1</td>
</tr>
<tr>
<td>Waveney</td>
<td>11</td>
</tr>
</tbody>
</table>

Source: 2011 Census (supplied by Suffolk CC)

Table 10: Ethnicity, write-in responses where the response was 'Kurdish', by age group, Ipswich (2011 Census)

<table>
<thead>
<tr>
<th>Age group</th>
<th>0-9</th>
<th>10-19</th>
<th>20-29</th>
<th>30-39</th>
<th>40+</th>
<th>All ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. respondents 'Kurdish' (Ipswich)</td>
<td>106</td>
<td>65</td>
<td>234</td>
<td>181</td>
<td>40</td>
<td>626</td>
</tr>
</tbody>
</table>

Source: 2011 Census (supplied by Suffolk CC)
Census data records the resident population in 2011 but in addition, Suffolk is a ‘dispersal’ area for Home Office-housed asylum seekers. There are known to be a number of asylum-seeking and refugee women and girls in Suffolk who come from countries with an increased risk of FGM, this is not a fixed population and exact figures are not available.

**Maternity data**

Data on deliveries to women who were Suffolk residents over the three years 2011/12–2013/14 are shown in Table 11. Detailed country of birth or ethnicity data are not recorded, so the ‘African: Black or Black British’ group is shown, among whom there were an average of 33 deliveries per year, almost two-thirds of whom delivered at Ipswich hospital.

However as shown in Table 7, only around a third of the Suffolk population of African origin are from countries where FGM is known to a practise, and among those the prevalence of FGM ranges from 4% to 98%. Therefore if a third of the African women delivering in Suffolk were from these countries, less than 10 women of African origin who had undergone FGM might be expected to deliver per year. In addition there will be a number of deliveries to Kurdish women and women from other countries who have undergone FGM for whom these data are not available, as well as possibly a small number of deliveries to women who are refugees or asylum seekers. A reasonable estimate might be that less than 15-20 women in Suffolk might deliver each year who have undergone FGM.
Table 11: Suffolk resident mothers delivering 2011/12-2013/14; no. and % of Total and African (Black or Black British) ethnic group delivering at each provider.

<table>
<thead>
<tr>
<th></th>
<th>Total deliveries (% of Suffolk total by provider)</th>
<th>African (Black or Black British) (% of Suffolk total by provider)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colchester Hospital University NHS Foundation Trust</td>
<td>211 1.1%</td>
<td>0 0.0%</td>
</tr>
<tr>
<td>James Paget University Hospitals NHS Foundation Trust</td>
<td>3,049 15.5%</td>
<td>14 14.3%</td>
</tr>
<tr>
<td>Ipswich Hospital NHS Trust</td>
<td>9,160 46.5%</td>
<td>61 62.2%</td>
</tr>
<tr>
<td>West Suffolk NHS Foundation Trust</td>
<td>5,257 26.7%</td>
<td>10 10.2%</td>
</tr>
<tr>
<td>Cambridge University Hospitals NHS Foundation Trust</td>
<td>1,372 7.0%</td>
<td>7 7.1%</td>
</tr>
<tr>
<td>Norfolk and Norwich University Hospitals NHS Foundation Trust</td>
<td>531 2.7%</td>
<td>&lt;5 &lt;5%</td>
</tr>
<tr>
<td>Other</td>
<td>103 0.5%</td>
<td>&lt;5 &lt;5%</td>
</tr>
<tr>
<td>Total over 3 years (% of total deliveries)</td>
<td>19,683</td>
<td>98 (0.5%)</td>
</tr>
</tbody>
</table>

Source: HES (Suffolk CC Public Health)

**Information from women in Suffolk**

A number of women in Suffolk are known to have disclosed to various staff that they have undergone FGM – figures of between 10 and 20 over the last year were reported. Suffolk Refugee Support are currently carrying out a project on FGM and the following section reports findings from interviews carried out as part of the initial phase of this work.

Over a period of seven weeks from mid-April to the end of May 2015 the FGM Project Assistant based at Suffolk Refugee Support\(^1\) interviewed 18 women and 4 men from countries where there is known to be a risk of FGM. In total, over 24.5 hours were spent on interviews. Countries the interviewees came from are shown in Figure 15 (listed under the ‘FGM-practising country groups’, see Figure 8).

\(^1\) with thanks to Rohma Ullah, Suffolk Refugee Support
Eight of the interviewees disclosed experience of FGM, almost all thought to be Type 2. A number also disclosed that members of their families were living with the consequences of FGM.

Table 12: Countries of origin of interviewees, listed under ‘FGM-practising country groups’

<table>
<thead>
<tr>
<th>Group 1.1 &amp; 1.2</th>
<th>Group 2</th>
<th>Group 3</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somalia</td>
<td>Nigeria</td>
<td>Ghana</td>
<td>Malawi</td>
</tr>
<tr>
<td>Eritrea</td>
<td>Iraqi Kurdistan</td>
<td></td>
<td>Pakistan</td>
</tr>
<tr>
<td>Sudan</td>
<td></td>
<td></td>
<td>Sri Lanka</td>
</tr>
<tr>
<td>Egypt</td>
<td></td>
<td></td>
<td>Sao Tome &amp; Principe</td>
</tr>
</tbody>
</table>

See Figure 8 for FGM-practising country groups

**Reasons for carrying out FGM:** Of the 22 people interviewed, 17 noted that the reasoning behind FGM in their countries was around controlling women’s sexuality and sexual desires. All of those interviewed said it is believed a woman is unclean and would be tempted into promiscuity if they are not cut. 3 women interviewed noted that in Iraqi Kurdistan in particular, it is ‘haram’ or forbidden to eat the food of an uncut woman. All 22 interviewees said that the practice has been justified on cultural grounds and has no place in religion.

**Attitudes towards FGM:** Of the women who disclosed having undergone FGM, all 8 were against the practice and did not want it to continue due to its harmful consequences. All 8 also noted that it is a discriminatory practice which infringes on women’s rights and seeks to assert control over them. One woman said: “**The old woman [who cuts the girls] uses the same blade for many people she cuts at the same time. She doesn’t clean her hands. We [Africa] are number 1 in the world for HIV. There are loads of people that are dying as a result of FGM. I am a mum. I don’t want this to happen to my baby at all.”**

Many of those interviewed also considered that attitudes are beginning to change as new generations come in who are more educated.
Health Needs: None of the eight women who disclosed reported needing any physical health or medical attention as a result of the FGM. All said they experienced the FGM as children and said they have subsequently adjusted to living with it.

Conclusions: women and girls at risk in Suffolk
Estimates based on census data suggest that there may be at least 470 women and girls of all ages resident in Suffolk who have undergone, or are at risk of FGM; approximately 205 who were born in African countries where the prevalence of FGM is known, and approximately 265 of Kurdish origin. There may also be additional women and girls at risk who are not included in these figures. These could include women and girls from other countries in Africa, the Middle East and Asia where FGM is thought to be practised but the prevalence is not known; girls born in the UK to women from communities where FGM is practised among whom the risk of FGM is not known; and asylum-seeking and refugee women and girls who come from countries with an increased risk of FGM. A very rough estimate of the number of women from Suffolk who have undergone FGM who deliver is less than 15-20 per year.

These figures should be regarded as rough guide only for a number of reasons:

- The prevalences are based on countries of origin and it is not known how these relate to prevalence in this country;
- Migrant communities may not be typical of their countries of origin;
- Some of the original prevalence data in the UNICEF and other reports is from surveys several years old;
- It was not possible to adjust the local data for age distribution, level of education, socioeconomic group, etc, as individual records are not available; the adjustment factor applied by the City University researchers was used as an approximation;
- Language data alone did not appear to be useful except for the Kurdish group;
- All estimates based on census data may under-enumerate women from migrant communities;
- There are no maternity data on detailed ethnic group of women delivering in Suffolk.

Apart from the Kurdish community in the Ipswich area, there do not appear to be large communities from other countries which practise FGM in any particular area of Suffolk. Over 1,500 people of African origin were recorded in the Ipswich area in the 2011 census, as well as over 1,000 in each of St Edmundsbury and Suffolk coastal. However these groups come from a range of different countries only some of which practise FGM.
Only a small number of women who have undergone FGM have been identified through NHS services to date but it is known that a number of women have disclosed in other settings that they had undergone FGM. In interviews carried out by Suffolk Refugee Support with women and men who were from FGM-practising countries, eight women disclosed that they had undergone FGM and others reported that they knew of other women affected. The views on and experience of FGM reported by this group were similar to those found in larger research studies. None of those who had undergone FGM expressed support for the continuation of the practice.

**What is the evidence base for interventions? What is best practice?**

Interventions to reduce the risk of and mitigate harms resulting from FGM fall into three main areas:

- Girls who are at risk of FGM
- Women and girls who have undergone FGM
- Reducing the prevalence of FGM.

Guidance has been published on many aspects of the response to FGM and key documents which are drawn on in the following section are shown in Figure 4.
Figure 4: Key guidance on FGM

<table>
<thead>
<tr>
<th>Risk assessment frameworks included in the March 2015 Department of Health (DH) guidance could usefully be incorporated into local guidance and used by professionals to help assessment in different circumstances (DH, March 2015a):</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Child/ young adult under 18 – to consider risk of FGM</td>
</tr>
<tr>
<td>• Child/ young adult under 18 – to consider whether a child has had FGM</td>
</tr>
<tr>
<td>• Pregnant women: to decide whether an unborn child, or female children in the family are at risk, or the woman herself is at risk of further harm;</td>
</tr>
<tr>
<td>• Non-pregnant adult women over 18: to decide whether female children are at risk or the woman herself is at further risk</td>
</tr>
</tbody>
</table>
Girls at risk of FGM

Identifying girls at risk of FGM

All professionals working with children and families need to be aware of factors that indicate an increased risk of a girl undergoing FGM, which include (FORWARD, 2014; Home Office 2014; DH, 2015a):

- girls from communities which are less integrated into British society;
- families which have migrated from countries here there is a high acceptance of FGM;
- any girl born to a woman who has been subjected to FGM;
- any girl who has another family member who has already undergone FGM, particularly a sister;
- there is a female family elder who is very influential and involved in the care of the girl;
- a girl is withdrawn from Personal, Social and Health Education (PSHE) in school.

In addition, indications that FGM may be about to take place include:

- the presence of a female family elder, particularly if visiting from a country of origin;
- plans to take a girl out of the country particularly for a long period;
- the girl has attended a travel clinic or similar for vaccinations/ anti-malarials;
- a girl may talk with other children about it;
- a girl may confide that she is to have a ‘special procedure’ or to attend a special occasion to ‘become a woman’;
- a girl may request help from a teacher or another adult if she suspects she is at immediate risk.

There are many terms used for FGM in different languages and sensitivities associated with discussing it (DH, 2015a). Staff across a wide range of settings including; early years, schools and colleges, health, social care and voluntary settings, need to be sensitive to possible indicators of risk. They also need to feel confident and competent to raise the issue with children and their families. There may be only one opportunity to do this with an individual child.
Safeguarding girls at risk

DH guidance sets out different levels of response which might be appropriate depending on the level of risk identified, which should be decided on a case by case basis with expert input from all agencies involved (DH, 2015a). In outline, these are:

1. Discussions with the family and information sharing between agencies with no specific protection plan in place;
2. An ongoing safeguarding approach led by social services;
3. Urgent action if there is felt to be an immediate risk.

Where a girl is identified at risk there is a duty to safeguard her, with a legal obligation for anyone who has concerns about a child under 18 who is at risk of undergoing FGM to inform police or social services (this can be through the Multiagency Safeguarding Hub (MASH)). This can present particular challenges for professionals as the families may give no other cause for concern. Once a referral is made a strategy meeting should be called involving police, social care, health professionals and other agencies and aiming to involve the family. The least intrusive legal action should be taken but if there is no other option for keeping the child safe an Emergency Protection Order should be sought and the child removed to a place of safety. The safety of siblings and other girls in the community also needs to be considered.

Schools and colleges have a statutory requirement to safeguard girls at risk of FGM, which will be assessed in Ofsted inspections (Home Office and DfE, 2015). This includes staff training and awareness of safeguarding procedures and local arrangements, and what action has been taken in respect of particular children.

Women and girls who have undergone FGM

There are four main elements to the response for women and girls who have undergone FGM:

- a legal response if FGM has been carried out on a girl aged under 18;
- assessing and meeting needs for safeguarding for the woman or girl, and other children within the family unit and more widely;
- meeting the physical health needs of a woman or girl with FGM;
- meeting the mental health needs of a woman or girl with FGM.
Intervening if a girl has undergone FGM

Under the Serious Crime Act 2015 there is a mandatory duty on those working in regulated professions (for example, teachers, social workers and healthcare workers) to report the discovery of FGM appearing to have been carried out on a girl under 18. This applies regardless of whether FGM is thought to have been carried out in the UK or overseas. If an examination including a physical or psychological assessment is needed, this should follow safeguarding children procedures and be carried out by professionals with specialist expertise in these areas. Girls should also have access to further physical and psychological support as described below.

Indications that a girl might have undergone FGM include that she (Home Office, 2014):
- has difficulty walking, sitting or standing or looks uncomfortable;
- has frequent urinary, menstrual or stomach problems;
- has increased emotional needs or significant change in behaviour;
- avoids physical exercise;
- spends a long time in the bathroom or toilet.

Guidance makes clear that disclosure may need to go beyond the usual boundaries of patient confidentiality if it is in the public interest or a criminal act may have been perpetrated.

Safeguarding when a woman or girls has undergone FGM

If a girl has undergone FGM, the possibility of any potential further risk to the child must be considered, as well as risk to siblings or other girls in the community, and safeguarding arrangements put in place if needed. For adult women there is no requirement for referral to social services or the police, but there should be an assessment of whether the woman is at any further risk. In addition, if they are pregnant or have daughters who might be at risk, the need for safeguarding should be considered (DH, 2015a).

Services for women and girls who have undergone FGM

Guidance on commissioning services for women and girls who have undergone FGM has been issued by the Department of Health, and identifies responsibilities for both NHSE and CCGs to ensure high quality services are in place (DH, 2015b). Women and girls where FGM is found or suspected need evaluation by health professionals experienced in FGM who are able to determine the need for further treatment and perform a risk assessment for
potential safeguarding issues. Health professionals, particularly nurses and midwives, need to be aware of the specialist care required by women and girls who have undergone FGM, particularly during labour and childbirth.

If the patient has undergone FGM, referral to a specialist FGM clinic should always be considered, and self-referral should also be available. Women who have undergone Type 3 FGM (infibulation) should be informed that deinfibulation (reversal) is an option available to them. Girls and women who have undergone FGM should also be offered psychological support to address any psychological or emotional problems they may have as a result of FGM. It is recognised that local arrangements will vary depending on the prevalence of FGM but there should be clear referral pathways wherever the services are located. Interpreters should be available if required and there should be advocacy support and links to FGM support groups.

Collection of data on FGM has been mandatory for all Acute Trusts since September 2014, and will be mandatory for all GPs and mental health NHS Trusts from 1 October 2015 (see Figures 3-6). Guidance recommends that all Trusts should have a named lead for FGM.

Reducing the prevalence

Partnerships

The need for partnership working to address the risk and impact of FGM underpins much of the recent guidance. The Government’s Multiagency Practice Guidelines on FGM are aimed principally at health and social care professionals, police, schools, colleges and universities. They advise that organisations should work together within existing arrangements, including Community Safety Partnerships, Local Safeguarding Children Boards (LSCBs), Children’s Trusts and partnerships, Adult Protection Committees, Health and Wellbeing Boards and local Criminal Justice Boards. They also suggest that LSCBs consider developing and supporting a centralised virtual team of experts (including community groups and specialist women’s groups) to advise professionals on the prevention of FGM in the community and the appropriate professional response to individual cases.

Some areas have set up dedicated FGM forums or Partnership groups, for example Greater Manchester FGM Forum (which covers both adults and children) has been in place since 2011 with the following aims (Greater Manchester FGM Forum, 2014):

- To monitor the prevalence of FGM through midwifery and children’s social care data.
• To influence the provision of FGM training and protocols/policies
• To work with CPS/police on best practice approaches to protection and prosecution
• To publicise the prevention of FGM as a safeguarding and human rights issue.
• To consult with local women affected by this issue.
• To promote a holistic approach to adult women who have been mutilated, considering referral pathways to support and knowledge of options including deinfibulation surgery.
• To report on progress annually to representatives’ Local Safeguarding Children’s Board or Local Safeguarding Adults’ Board.

Training and workforce development

All frontline professionals need the competence, knowledge and awareness to discuss issues relating to FGM, identify those at risk, and ensure protection of girls at risk and an appropriate response for girls and women who have undergone FGM (RCM, 2013). The Multiagency Practice Guidelines make clear that LSCBs are primarily responsible for ensuring that single agency and inter-agency training on safeguarding and promoting welfare is provided to meet local needs (Home Office, 2014). FGM should be a part of all staff training on safeguarding and included within training on domestic violence, forced marriage and other relevant areas.

E-learning has been developed both by Health Education England (HEE) and the Home Office. The HEE package comprises five 20-30 minute sessions aimed primarily at health professionals, endorsed by professional bodies covering General Practice, community nursing, midwifery, obstetrics and child health. It covers background about FGM, communication skills, legal and safeguarding issues, and issues in children, women and in pregnancy (HEE, 2015). The Home Office programme is intended for teachers, police, doctors, social workers and Border Force staff to help them identify and assist girls who are at risk of FGM (Home Office, 2015b).

In the past training has often focused on awareness-raising but it is clear that professionals also need the skills and knowledge to be able to raise the issue of FGM and discuss it in a culturally sensitive way (Home Office, 2014). This requires direct and simple language, recognising concerns about illegality and health risks while avoiding judgements about communities or individuals. It also requires an awareness of the variety of terms which may be used to refer to FGM and its meanings in different languages (DH, 2015a). Training
should be supported by the dissemination of guidance but guidance alone is unlikely to equip staff with all the skills and knowledge they need to be confident in addressing these sensitive questions.

As well as the professionals referred to above, training should also be offered to people working in third sector organisations who come into contact with FGM-practising communities.

**Working with communities**

Local authorities, LSCBs and all professionals are encouraged to consider how they can engage FGM-practising communities in work on FGM. An evaluation of community-based preventive work in different areas of the UK found that rejection of FGM increased in areas where this had taken place (Trust for London, 2013).

AFRUCA (Africans Unite Against Child Abuse) carried out focus groups with African communities in Greater Manchester to explore attitudes to and experience of FGM (AFRUCA, 2014). They found that some did not perceive there to be any risks around FGM. They also identified a ‘culture of silence’ whereby some participants did not want to admit to having any previous knowledge or personal experience of FGM or its occurrence in their communities, and did not admit to knowing anyone who would perform FGM, while saying everyone knew where to go if they needed a ‘cutter’. A few also said they knew that children are being taken back to their countries of origin to have FGM procedures done. However it was also said that most people would not inform others if they were going to perform the procedure on their children, as FGM is viewed as a private practice that stays within families.

Some common themes identified by AFRUCA and others working with FGM-practising communities include the need to:

- involve communities in finding their own solutions;
- develop community education programmes to help raise awareness of the law on FGM and the consequences of offending, recognising the need to address FGM in a way that does not attack people’s culture but works with and engages them as stakeholders;
- provide separate FGM awareness for men;
- work with young people, to empower and support affected girls and young women and engage boys and young men in questions around FGM;
encourage community members to report any suspected cases of FGM, including highlighting anonymous means for doing this such as Childline and the NSPCC (Home Office, 2014);

work with religious leaders to help challenge misperceptions about religious requirements for FGM.

What is the pattern of services in Suffolk at present?

Suffolk Refugee Support are currently undertaking a project on a number of aspects of FGM including reviewing information available, developing multi-agency approaches to reporting, risk assessment and safeguarding, training and awareness raising with professionals, and working with victims of FGM and communities from FGM-practising countries.

Girls at risk of or who have undergone FGM

Girls who are thought to be at risk are referred through the Multiagency Safeguarding Hub (MASH). Parental consent is not required although there should be an open discussion with the family unless it is thought that this might place the girls at risk. If a strategy meeting is called in relation to FGM, it will be chaired by the Suffolk Council safeguarding team and advice would be sought from the Police lead for honour based violence, forced marriage and FGM. The aim is for agencies to work together, and if there is thought to be no immediate risk but longer term involvement with the family may be needed, a decision will be made on which professional will lead on this. If a girl needs to be examined this will be carried out by specialist staff at the Ferns Sexual Assault Referral Centre (SARC) in Ipswich.

The LSCB for Ipswich and East Suffolk and West Suffolk, has adopted the national Multiagency Practice Guidelines and also produced local guidance for health professionals in February 2015, based on the national guidelines. It was distributed to all GP practices and to Trusts for dissemination to their staff. The stakeholder group plans to review the protocols and procedures of local organisations to ensure they are comprehensive and consistent in relation to requirements for FGM.

Women and girls who have undergone FGM

Ipswich maternity unit reported that a decision about whether a postnatal safeguarding referral of a woman who had a baby girl was needed would follow discussion with the woman and family, and would depend on the level of risk identified. There is a lead midwife for safeguarding who can provide advice to other midwifery staff. It was felt that because
they are used to asking sensitive questions, midwives find it easier to raise questions about FGM than some other staff. However the discussion about intentions for the baby was still considered difficult. Midwifery staff recognised that women do not always know what procedure has been done, and because there are no routine vaginal examinations during pregnancy they may only find out during labour.

Women and girls who have had FGM can be referred to specialist clinics, most of which are in London, as well as in Birmingham, Bristol, Liverpool and Nottingham (Department of Health, 2014). However while this provides access to specialist care the need to travel was considered by some in Suffolk to be potentially prohibitive, particularly if this needs to happen on several occasions. Provision for deinfibulation has now been established in hospitals in Norfolk. There is reported to be no specialist counselling currently available for FGM in Suffolk and this is one area being looked at by Suffolk Refugee Support. It is currently not clear where lead commissioning responsibilities for FGM services in Suffolk lie, between the CCGs and NHSE.

**Partnerships**

A Suffolk FGM stakeholder group held its first meeting in April 2015 and has agreed to start joint work on procedures and protocols, training and education and sharing resources. FGM also comes within the remit of local Children and Adults Safeguarding arrangements.

**Training and workforce development**

The Police lead for honour based violence, forced marriage and FGM has for several years been providing training for partner agencies including health professionals, teachers and police officers. This is sometimes carried out jointly with others such as midwives or other health professionals and is highly regarded locally because of her experience and depth of knowledge. To date the training is reported to have been mainly around awareness raising and understanding legal requirements. Training is also carried out by the Safeguarding Children Team, for GPs, hospital staff and others. Training packages have been developed by Suffolk Refugee Support and work carried out in Norfolk has included training resources as well as a pocket guide on FGM for health professionals.
Working with communities

Suffolk Refugee Support report that they saw about 500 different people from 40 countries over a year within their drop-in service, and run various services and events including women’s & men’s groups. They are actively engaging both men and women in discussions about FGM. The Police FGM lead has also delivered sessions with several community groups to discuss FGM, including men's groups.

What additional information is needed?

There is still little robust information about views on and attitudes to FGM in the communities in Suffolk who come from FGM-practising countries. This could be addressed by further interviews, focus groups and community work. The Kurdish community in Ipswich and the surrounding area is by far the largest identifiable group, but local knowledge may indicate groups from African countries in other areas who could also be approached.

A record of more detailed information about ethnicity or country of origin in healthcare services would give a clearer indication of the numbers of women who might be at risk and could prompt further enquiry, as it is not clear whether all those affected are being identified currently.

What can be concluded about health needs?

The numbers of women and girls who have undergone FGM, and girls who are at risk of FGM, are lower in Suffolk than in many areas of the country, but there are probably still several hundred girls and women in Suffolk affected or at risk. While some may be part of well-defined communities, such as the Kurdish community around Ipswich, others may be part of smaller groups or relatively isolated.

Health needs relate to:

- Prevention: raising awareness in the wider community and among professionals, recognising when a girl might be at risk, and taking the opportunity to intervene in a proportionate way to protect them if needed;
- Identifying the physical and psychological health needs of women and girls who have had FGM, including needs which may not have been identified by the women themselves because they assume it is something they have to live with;
- Providing effective and accessible support to meet physical and psychological needs.
The relatively low prevalence of FGM and FGM risk in Suffolk presents particular challenges, as many professionals will rarely see women and girls affected so it will be more difficult for them to be familiar with the risk factors and to feel confident and competent in raising questions around FGM. Much of the work on FGM in Suffolk is still in the early stages and it appears likely that there are still unrecognised and unmet needs in all the areas above. However risk groups can be identified and many approaches can be targeted.

References


Appendix A Diagrammatic representations of Types of FGM

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<tr>
<th>Unaffected female anatomy</th>
<th>Type 1 FGM</th>
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<td></td>
<td>Removal of all or part of the clitoris and/or the prepuce</td>
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Type 2 FGM
Removal of part or all of the clitoris and the labia minora, with or without excision of the labia majora

Type 3 FGM
Cutting and bringing together the labia minora and/or labia majora to create a narrow orifice, with or without removal of the clitoris.

Type 4 FGM
Removal of clitoris, part or all of labia minora, with a bringing together of the labia majora to cover the urethra and most of the vaginal opening.
Different practices of varying severity, including pricking, piercing or incising of the clitoris and/or labia, stretching/pulling of the clitoris and/or labia, cauterisation of the clitoris and surrounding tissue, scraping or introduction of corrosive substances or herbs into the vagina, and scraping of tissue surrounding the vaginal orifice.