North Yorkshire Safeguarding Children Board
working together to safeguard children

City of York Safeguarding Children Board
Working with children, parents and professionals to make our children's lives safer

Report to Local Safeguarding Children Boards

1.0 Date and Subject of report

1.1 Female Genital Mutilation and its prevalence in York and North Yorkshire, 9 September 2014. ***Updated for City of York Safeguarding Children Board in October 2015.***

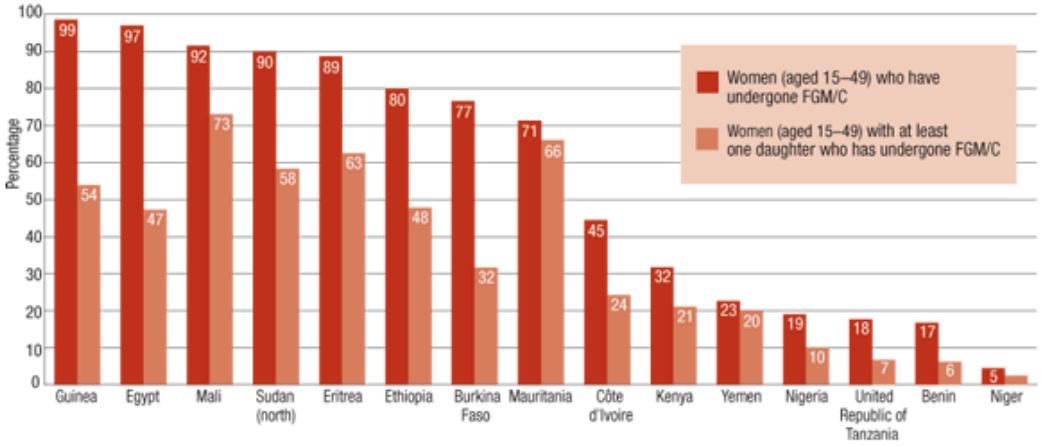
2.0 Purpose of Report

2.1 The purpose of this report is to provide the City of York and North Yorkshire Safeguarding Children Boards (CYSCB and NYSCB) with an overview of Female Genital Mutilation (FGM) and provide an estimation of its prevalence within York and North Yorkshire. The report will also make recommendations to the Boards outlining ways in w develop monitoring of FGM across agencies can be developed and awareness of FGM improved.

3.0 Background

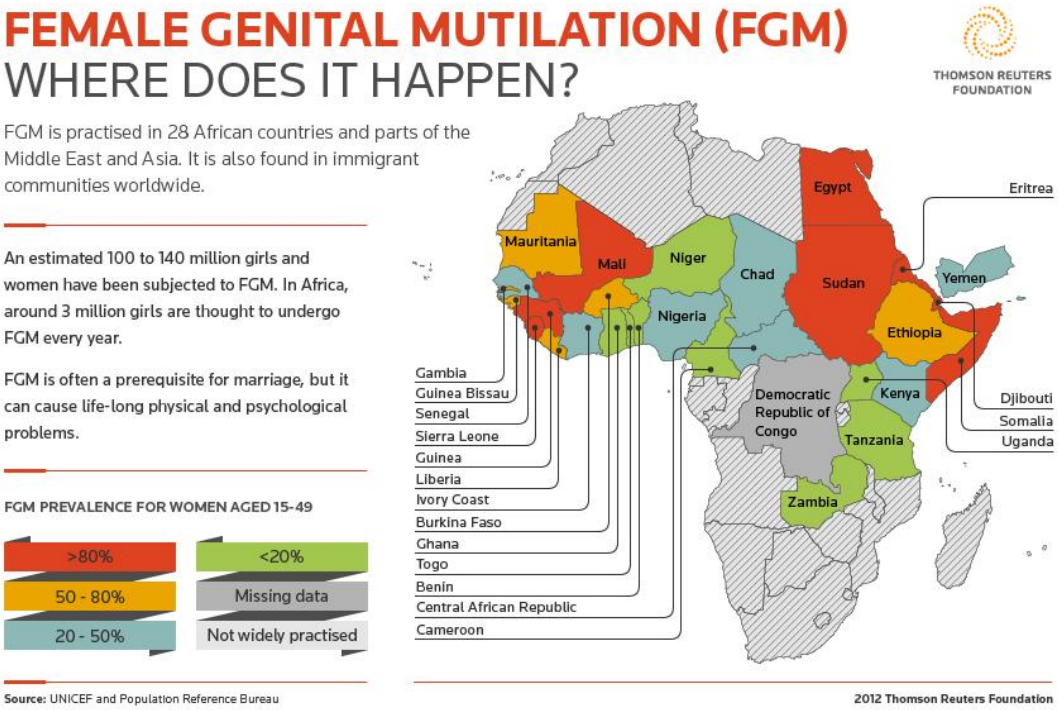
3.1 FGM involves the partial or total removal of external female genitalia or injury to external female genitals for non-therapeutic reasons. It is estimated that approximately 120 -140 million girls and women in Africa and Yemen have undergone FGM. The practice of FGM not limited to Africa and Yemen, and is also prevalent in parts of the Middle and Far East. A list of countries where FGM is more commonly practiced is included in Appendix One.

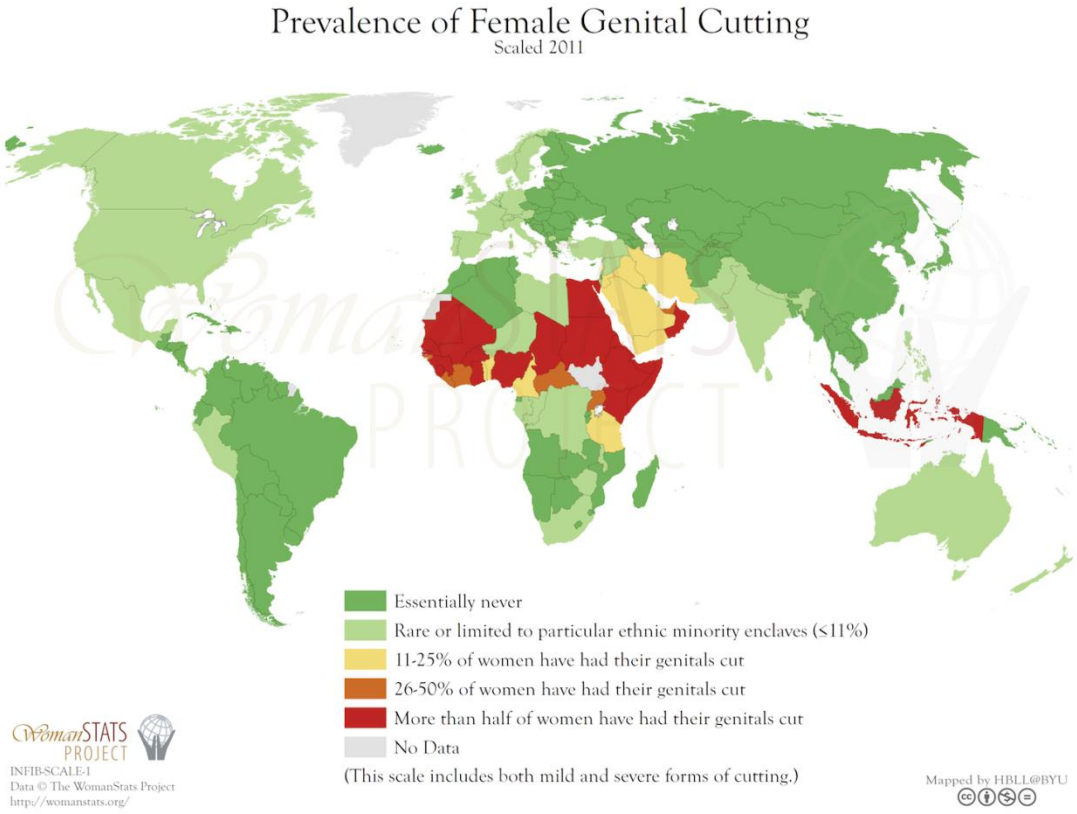
3.2 The extent to which FGM is practiced within countries varies greatly. For example, the World Health Organization (WHO) reports that 99% of women in Guinea aged 15-49 have undergone the procedure, with 54% of the female population aged 15-49 having at least one daughter who has undergone FGM, whereas in Benin the prevalence of FGM is significantly lower, with 17% of females aged 15-49 having undergone FGM and 6% having at least one daughter who has undergone the procedure.



3.3 Rather than being an issue arranged by men within communities who practice FGM, WHO report that presently 94% of women in Egypt arrange for their daughters to undergo this "medicalised" form of FGM, 76% in Yemen, 65% in Mauritania, 48% in Côte d'Ivoire, and 46% in Kenya. However, the study does not report on how much male influence has driven mothers to arrange this procedure for their children.

3.4 The maps below show the level and extent of FGM in Africa and across other countries.





3.5 The migration of people from countries which practice FGM over successive years and generations has resulted in an increase of FGM in countries where it has not historically practiced.

4.0 Female Genital Mutilation

4.1 The practice of FGM is deeply embedded in ancient cultural beliefs. It does not have any basis in religion, although there is a common misconception that it is a religious requirement. The cultural belief links to female fertility and the control of sexual and

reproductive capacity. The reasons given by communities who practice FGM differ, but common reasons include:

- The reduction of sexual desire of girls and women
- Promotion of virginity and chastity
- Maintaining fidelity in married women
- Enhancement of marriage ability
- Aesthetic reasons, and
- Pleasing husbands

4.2 In practising groups FGM is rooted in patriarchy and is considered to be central to the right of passage to adulthood, marriage, reproduction and is an integral part of society in some cultures for economic security and social status.

4.3 FGM is traditionally performed by practitioners with no formal medical training, without anaesthetics or antiseptic. Often the girl/woman is forcibly restrained and is cut using knives, scissors, scalpels, pieces of glass, or razor blades. However, in some countries FGM is practiced by health professionals, some of which have been trained in the West.

4.4 Amongst ethnic groups who commonly practice FGM, the procedure is normally performed on young girls who are below the legal age of majority. While the age at which the procedure is carried out can vary between communities, it can be carried out during infancy, on girls under ten years of age, on adolescents and occasionally on adult women including pregnant women. However, there is a growing trend in the procedure being undertaken at an earlier age.

4.5 WHO separates FGM into four distinct classifications as shown in the table below.

Type 1	Clitoridectomy, which involves partial or total removal of the clitoris and in rare cases only the prepuce
Type 2	Excision, which involves partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora
Type 3	Infibulation, which involves narrowing of the vaginal opening through the creation of a covering seal, which is formed by cutting and repositioning the inner or outer labia, with or without removal of the clitoris
Type 4	All other harmful procedures to the female genitalia for non-medical purposes, such as pricking, piercing or incision of the clitoris and/or the labia; stretching of the clitoris and/or labia; and cauterisation or burning of the clitoris and surrounding tissues

4.6 The health risks associated with FGM are wide and can be disabling. People who have undergone infibulation (Type 3) are particularly susceptible to suffering long-term complications due to stitching.

4.7 A study by WHO of six African countries which practice FGM showed that women with FGM are at a higher risk of caesarean section, post-natal haemorrhage, prolonged maternal hospitalisation, infant resuscitation and perinatal death among women. The report also identified that the risk is increased with the severity of the FGM.

4.8 Another report from the Gambia, where Type II FGM is commonly practiced, identified that women with FGM are more likely to have been infected with Herpes Simplex Virus-2 and Bacterial Vaginosis.

4.9 A controlled study undertaken in Senegal found that women subjected to FGM were significantly more likely to suffer post-traumatic stress disorder (PTSD) and other psychiatric syndromes than women who had not been subjected to FGM procedures.

4.10 FGM in the United Kingdom was originally made a criminal offence in 1985 by the Prohibition of Female Circumcision Act 1985. This Act has since been repealed and replaced on 3 March 2004 by the Female Genital Mutilation Act 2003. The Female Genital Mutilation Act 2003 makes it a criminal offence to:

- Excises, infibulates or otherwise mutilates the whole or any part of a girl's labia majora, labia minora or clitoris (subject to limited exemptions for mental or physical health)
- Aid, abet, counsel or procure a girl to excise, infibulate or otherwise mutilate the whole or any part of her own labia majora, labia minora or clitoris, or
- Aid, abet, counsel or procure a person who is not a United Kingdom national or permanent United Kingdom resident to do a relevant act of female genital mutilation outside the United Kingdom

4.11 Where a United Kingdom national or permanent United Kingdom resident has undertaken any of the above outside the United Kingdom, the legislation has extra-territorial extensions and would be treated as if the offence had occurred in the United Kingdom. A person convicted of an offence under the FGM Act 2003 is liable to imprisonment between six months and fourteen years.

4.12 Despite FGM being a criminal offence since 1985, the CPS did not receive its first referral from the police until 2010, since then a total of 14 cases have been examined:

- In the first case the decision was taken not to charge on the basis that the victim had given several different accounts of what happened. Without a clear account, the victim accepting that some of her accounts were false and the lack of any supporting evidence the CPS lawyer concluded that it was not in the public interest to proceed with the case.
- In 2012, a case referred to the CPS by the police for advice involved the allegation that a girl was suspected to have been at risk of FGM. However, the police investigation did not find sufficient evidence to support the risk of FGM and no further action was taken.
- Another case in 2013 resulted in no further action because the victim withdrew her allegation.
- In March 2014 the CPS determined that there was insufficient evidence to proceed with three of the four re-reviews and one of the new cases. One of the re-reviews included a case where the suspect was alleged to have contacted an FGM helpline to request FGM for his two daughters. On 21 March 2014, the Director of Public Prosecutions announced her intention to bring the first ever prosecutions under the Female Genital Mutilation Act 2003. The case is currently *sub judice*.

4.13 The North Yorkshire and the Vale of York CCGs report that they have been informed by a woman who has been the victim of FGM that women originating from countries who practice FGM and now reside in the UK, or women who want their children to be cut, are likely to be aware that it is an offence in the UK. They will tell professionals that they do

not agree with 'cutting/sunna' etc, or that their mother is now unhappy that she had her own daughter cut and thus:

- would not want her grandchildren cut, or
- that cutting is not something they do in their family

4.14 However, this is often used as a method to divert professionals from involvement with the children and family regarding FGM concerns.

5.0 Scope of Female Genital Mutilation in North Yorkshire

5.1 FGM is generally hidden by its nature. The prevalence of the practice in the United Kingdom is difficult to identify as the practice is both unlawful within the United Kingdom and personal to the females who have undergone or are at risk of the procedure. It is difficult to establish whether a girl or young woman is at risk of FGM due to the misleading statements reported by NY & VoY CCGs and professionals working with families must look for more evidence that a child is not at risk than a parent's word (i.e. the rule of optimism must not prevail). Females who have been subjected to FGM are also difficult to identify unless they report that the procedure has taken place, undergo an invasive medical examination or give birth.

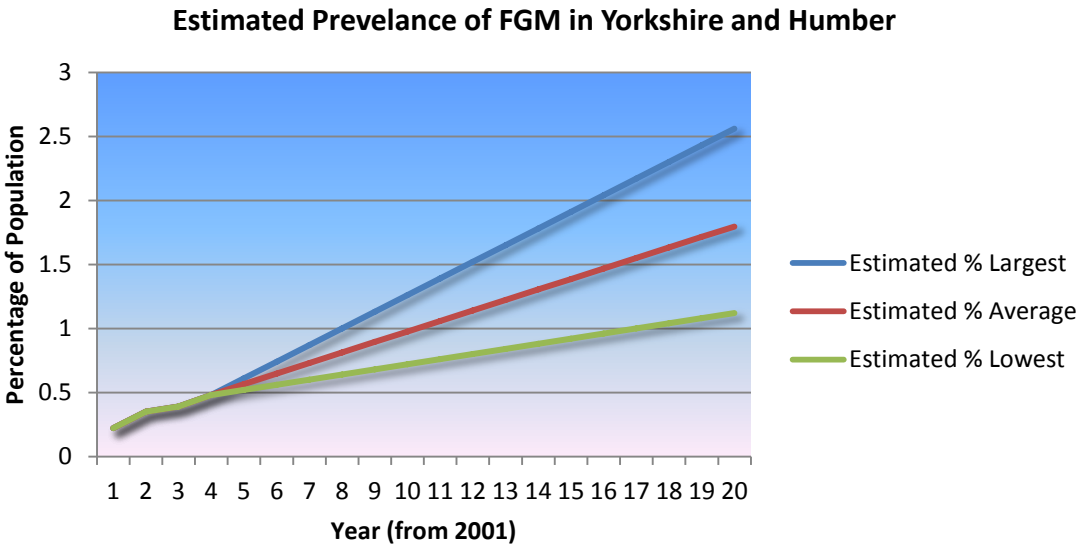
5.2 It is known that in 2013, approximately 14% of unaccompanied asylum seeking children under the age of 18 were female. However, the percentage of asylum seeking female children from countries which practice FGM is higher than this average at approximately 30.9%. In 2013, 25% (70) of unaccompanied females under 18 years of age who originated from countries which practice FGM were granted asylum in England. Unfortunately it has not been possible to identify how many, if any of these females presently reside within York or North Yorkshire.

5.3 The European Parliament Resolution of 24 March 2009 on Combatting FGM in the EU(2008/2071(INI) stated that 500,000 women living in the EU have undergone FGM and 180,000 girls are at risk of undergoing FGM every year, although it is unclear how this estimate was derived.

5.4 FORWARD UK completed a study in 2007 using census data and estimated that 66,000 women in England between 15 and 49 had undergone the procedure, either as residents of the UK or prior to migration. It further estimated that at least 24,000 female under the age of 15 were at risk of, or may have already been subjected to Type 3 FGM.

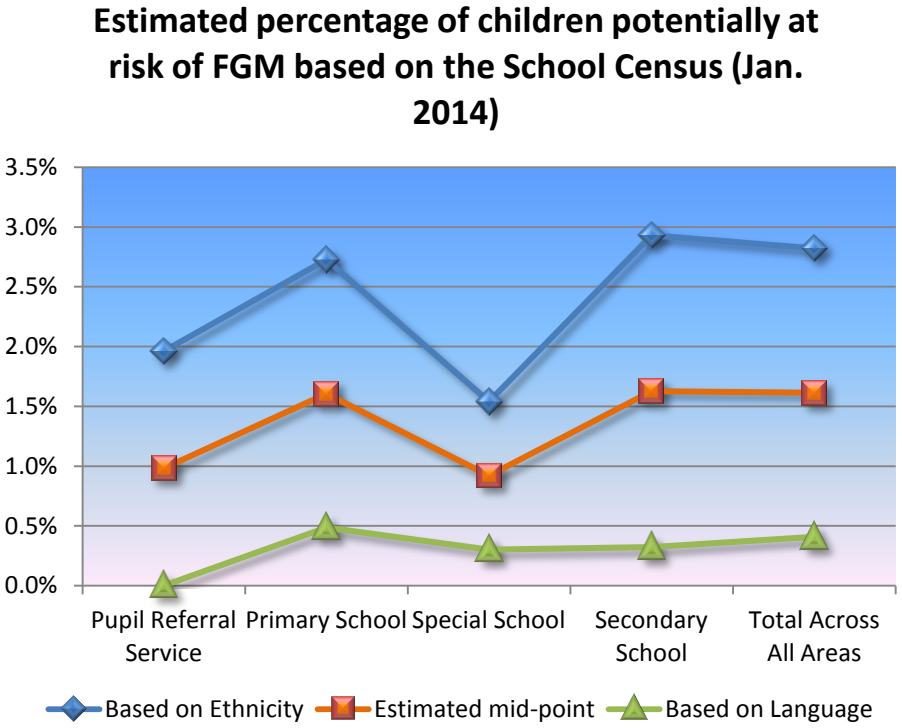
5.5 Presently there are no statistical studies which have been released that identify the extent of FGM within York or the county of North Yorkshire. One study carried out by FORWARD in 2007 identified the estimated number of all maternities to women who had undergone FGM by region and in some cases to local authority areas. As part of this study, it was estimated that FGM within the Yorkshire and Humber region had grown within this group from 0.22% in 2001 to 0.48% in 2004 across the region. However, the study also identified that Sheffield had the highest estimated percentage within the cohort at 2.14% (in 2004), while the "rest of Yorkshire and Humber" was significantly lower at 0.29%.

5.6 Based on the figures for Yorkshire and Humber, the chart below provides projected estimates for the extent of FGM to be between 1.12% and 2.56% by 2020.



5.7 It is estimated that currently between 0.88% and 1.78% of all maternities in North Yorkshire and Humber relate to females who have been subject to FGM, with a projected rise to between 1.12% and 2.56% by 2020.

5.8 The table below shows the estimated percentage of children and young people who may be at risk of FGM. These figures have been estimated based on the first language and ethnicity of children recorded in the School Census in January 2014.



5.9 Analysis of the information provided in the chart above provides a similar picture to the projection based on the FORWARD figures for the Yorkshire and Humber region. The information suggests that between 0.4% and 2.8% of children under 18 years of age are at risk of FGM within the county. However, it must be noted that there are significant caveats to the projected figures:

- Home Office ethnicity bands cover a range of people from countries which both do and do not practice FGM to any degree

- The assessment based on first language similarly provides an insight, but not an accurate measurement as children at risk of FGM may speak English as a first language and some countries which practice FGM share languages which countries which do not generally practice FGM, e.g. a number of countries practicing FGM have French as their official language.

5.10 It is important to recognise that FGM is practiced at increasingly earlier ages and in order to improve our understanding of the extent of the practice, the total population of people who originate from, or whose ethnicity or nationality relates to an FGM country must be considered. The 2011 census shows that in York approximately 0.5% of the population are recorded as having an ethnic code which links to countries that practice FGM. It is likely that this has changed with an increasingly ethnically diverse population in the city. Again this data comes with a strong caveat that it is not possible to make a distinction in ethnic categories which are shared between people whose ethnicity is associated with FGM practicing areas and those which do not practice FGM.

5.11 City of York Children's Social Care (CSC) received 4 referrals during 2014/15 in regard to possible risk of FGM. There have been none in 2015 to date. None of the 2014/15 referrals resulted in any further action although one reached the stage of a child protection strategy meeting. However, although the number of referrals is low, this does not mean that females within York are not at risk, there is an identified need to raise awareness of FGM with practitioners.

5.12 A snapshot of City of York Children's Social Care referrals between January and June 2015 shows of 1602 contacts, 10 (0.6%) were recorded as correlating with ethnic groups that *potentially* practice FGM . As previously stated, this data comes with a strong caveat that the ethnic groups include people from countries which both do and do not practice FGM to any extent and must be considered with *extreme* caution. It has not been possible to separate ethnicity any further.

5.13 NY& VoY CCGs report that there is a Somali reception centre in Hull. There is a possibility that people from there could potentially move to York or North Yorkshire. Further reports suggest that women bring their own cutting 'instruments' (i.e. sharp pieces of glass, metal etc.) to the UK.

6.0 Key Issues for the Boards

6.1 FGM is a violation of girls and women which can have serious and severe consequences. The practice does not have any medical benefits and its principle purpose is for cultural reasons. The act of carrying out FGM, aiding or abetting any person to carry it out FGM is unlawful whether it is carried out within the UK or in another territory. Despite the projected estimates within this report, the full extent of FGM remains difficult to identify due to the hidden nature of the procedure, the limited circumstances where it can be identified as having happened and recording systems which do not aid in identification of those subjected to or at risk of FGM. Although FGM is mainly applicable to a small percentage of females within the county, there are a number of concerns which the CYSCB and NYSCB need to consider.

6.2 While FGM has strong links to ethnicity, the use of the ethnic categories used by partners does not provide an accurate method of measuring the scope of FGM or moving forward, the impact made by agencies to reduce the prevalence of FGM in North Yorkshire.

6.3 FGM not only impacts on members of the community who have moved to North Yorkshire following migration from another country, but can persist beyond this into subsequent generations. There is also potential for cross-over with private fostering arrangements where girls and young women living and attending schools in York and

North Yorkshire may be returned home for treatment or have already undergone the procedure.

6.4 Awareness of FGM and the communities in which girls and young women are most likely to be at risk is also another factor. Practitioners across agencies and sectors need to be aware of issues relating to FGM, including those most likely to be at risk or who have already undergone the procedure. Health professionals, schools, voluntary and other services must understand the need to record concerns of any instances of FGM or where they suspect that a child may be at risk of having the procedure done to them as well as know what action is appropriate to take, which may also include working with families or communities, referral to Children's Social Care and/or the Police. York and North Yorkshire Children's Social Care and the Police must ensure that these factors are acted upon quickly, especially where it is a report that a child who is at risk of FGM may be taken on holiday to a country or territory which practices FGM, for example, Egypt, which is a popular holiday destination.

6.5 Evidence from the CPS has demonstrated that any prosecution of FGM must be supported by good quality evidence which supports the allegation. Achieving best evidence to support a successful prosecution is essential and practitioners need to be aware of the need to accurately record allegations or concerns of FGM and identify what evidence there is to support this.

7.0 Recommendations

7.1 In order to ensure agencies are appropriately positioned to monitor the prevalence of FGM and measure the impact of any work to reduce its prevalence it is recommended that all agencies consider recording details of the nationality and place of birth for all children and parents/carers in addition to their ethnicity. This will allow more accurate identification of children who are at risk of FGM, whether they have migrated since birth or are the children of people who have migrated from countries which practice FGM.

7.2 All agencies should consider the incorporation of an FGM flag to be included on case management systems for quickly recording and identifying cases where FGM is, or suspected to be present.

7.3 Single and multi-agency training across all sectors needs to include guidance on how to identify if FGM is a factor or concern in individual cases. Practitioners must guard against the rule of optimism and seek further assurances that where FGM is identified as an issue the risks to a child can be addressed.

7.4 The CYSCB should replace its general procedure for FGM with revised practice guidance. This practice guidance should include information to help professionals identify concerns of FGM, thresholds for referrals to CSC and the Police as well as how concerns should be progressed in a multi-agency environment.

7.5 CYSCB has carried out audits of the 4 referrals to CSC in which the risk of FGM was been identified. This has resulted in:

- The revised practitioner guidance for York.
- Awareness raising and training supported by CYSCB and NYSCB jointly and delivered by multi-agency facilitators across all agencies.
- An expansion of the FGM information and further links on both LSCB websites.

7.6 The NYSCB and CYSCB should develop a Frequently Asked Questions (FAQs) sheet to practitioners and members of the public regarding what FGM involves and who to contact for help and advice. This should be included on the both LSCB websites.

7.7 The LSCBs should provide information and leaflets which could be given to the families and communities as well being provided through both websites.

7.8 The LSCBs and their partners should work with relevant communities to raise the awareness of FGM and the law.

8.0 Author

8.1 Haydn Rees Jones, NYSCB Policy and Development Officer.

8.2 October 2015 updates by Juliet Burton, CYSCB Safeguarding Advisor (Performance)

Appendix One

List of Countries where Female Genital Mutilation is prevalent

African Region

- Benin
- Burkina Faso
- Cameroon
- Central African Republic
- Chad
- Cote d'Ivoire (Ivory Coast)
- Democratic Republic of Congo
- Djibouti
- Egypt
- Eritrea
- Ethiopia
- Gambia
- Ghana
- Guinea
- Guinea-Bissau
- Kenya
- Liberia
- Mali
- Mauritania
- Niger
- Nigeria
- Senegal
- Sierra Leone
- Somalia
- Sudan
- Tanzania
- Togo
- Uganda

Asian countries

- India
- Indonesia
- Malaysia
- Pakistan

Arabian Peninsula

- Iraq
- Oman
- United Arab Emirates
- Yemen

Other Areas

- Occupied Palestinian territories
- Certain immigrant communities in
  - Australia
  - Canada
  - Europe
  - United States of America