Leeds City Region Conference

Female Genital Mutilation

16 September 2014

Summary Report prepared for BHI Leeds by
Dr Jean Garrod and Anj Handa
People Help People

© People Help People

Acknowledgements

Many people have helped in research for this report, which is contributed by the People Help People Foundation.

People Help People Foundation

Our charitable objectives are to develop the capacity and skills of the members of socially and economically disadvantaged communities of England in such a way that they are better able to identify, and help meet, their needs and to participate more fully in society.

The Foundation will support initiatives relating to:

- Gender-based Violence, Female Genital Mutilation and Forced Marriage
- Older and vulnerable people living in isolation
- Young people not in education, employment or training
- Participation in sport for people with disabilities.

We have contributed this report in support of the BHI Leeds City Region Conference, which has been funded by Rosa's FGM Small Grants Programme. The views expressed are not necessarily those of Rosa.

www.peoplehelppeople.co.uk
Follow us on Facebook and Twitter: @peoplehelppeeps

The conference and report are presented by a Multi-Agency Team set up by BHI and neither could have happened without the following key partners:
- Heather Nelson JP, CEO Black Health Initiative (BHI)
- Nicolette Clark, Specialist Midwife for BME Women, Leeds Teaching Hospital Trust – St James' University Hospital
- Roy Sanyang, Executive Director, The Gambia Volunteers
- Elaine Eruenah, The Gambia Volunteers
- Catherine Sobolowski, Specialist Community Public Health Nurse

Thank you also to Richard Haslett, Information & Intelligence Officer at Leeds City Council who in true partnership provided the raw statistics from the 2011 Census for Leeds, and to Sharon White, Professional Office, School & Public Health Nurses Association (SAPHNA), who provided useful feedback on the draft report.

Please be aware that there are images and words herein that some may find distressing.

Foreword

The commitment to eradicate Female Genital Mutilation has already been demonstrated by a range of partners, including:

- Leeds City Council (and All Party Councillors)
- Leeds Teaching Hospitals Trust
- Leeds Community Hospital Trust
- Third Sector Organisations
- West Yorkshire Police
- Diverse Communities and Individuals

Amongst educators, clinicians and politicians (and others), this abuse needs to be recognised and addressed. This conference is the start of dialogue and the identification of partners to join together for a city-wide response.

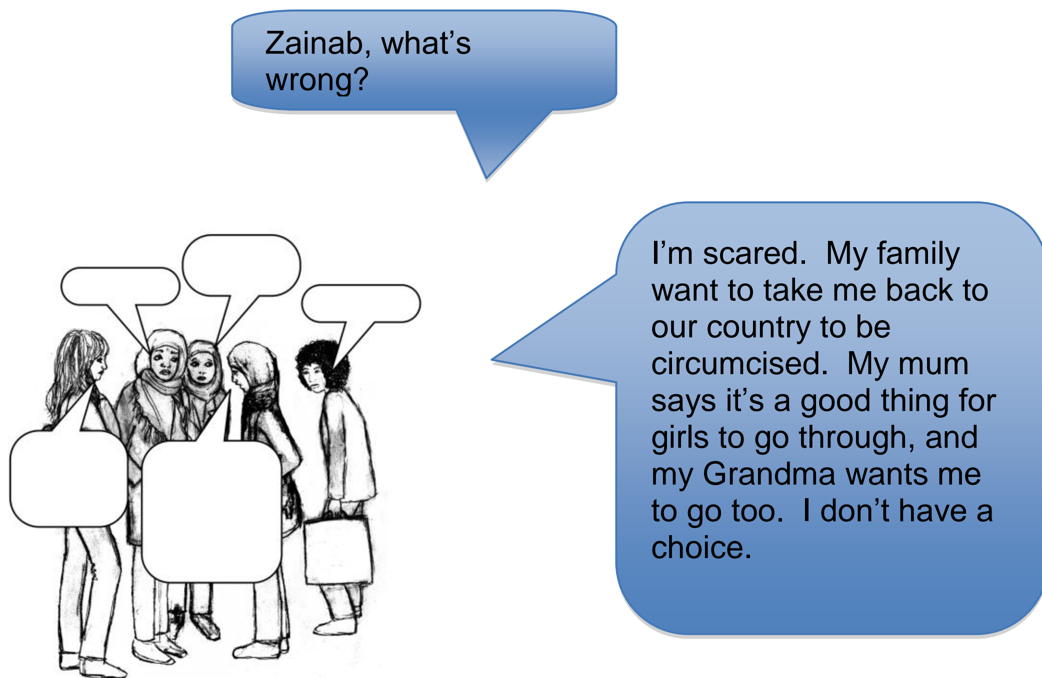
I would like this conference to conclude with commitments to the following outputs:

- Clear City of Leeds statement on FGM
- Clear Safeguarding referral pathways for all agencies to use once FGM is disclosed
- Sustainable funding for continued good practice/services
- Make stakeholders aware of national Safeguarding guidelines for FGM for implementation within their own organisations
- Sharing specific Safeguarding guidelines (e.g. school) with partner organisations (e.g. school nursing)

Please note that that the above list is not exhaustive and should be viewed as a starting point for collaborative working.

Heather Nelson JP, CEO, Black Health Initiative (BHI)

Zainab's Scenario[1]



Would YOU know what to say and do?

If you are worried that a child may be at risk of FGM you can call the Police on 999, make an anonymous call to the NSPCC free 24-hour FGM helpline on **0800 028 3550** or email fgmhelp@nspcc.org.uk.

What will happen when you report FGM to professionals?

- If you tell a member of school staff that someone is at risk from FGM then this will be treated confidentially and will be seen as a child protection issue.
- The Children's Service will treat this as a serious concern and parents will be part of the meeting to discuss this concern.
- The girl will not automatically be taken away from home. This would only happen in rare cases if the parents won't guarantee that they will not have their daughter cut.

Information taken from FORWARD, Foundation for Women's Health Research and Development

[1] Taken from KS3 FGM Lesson: "*SRE Covered: all you need to teach about sex and relationships in secondary schools"* Published by Healthy Schools

Key Facts

1. It is estimated that 170,000 women and girls are living with Female Genital Mutilation (FGM) in the UK.
2. It is estimated that 65,000 girls aged 13 and under are at risk of FGM in the UK.
3. Over 200 FGM-related cases were investigated by the police nationally in the last five years.
4. It has taken 29 years since the criminalisation of FGM for the first prosecutions to be brought.

These are the Key Facts that the Home Affairs Select Committee published in their recent report[2]. They found these facts shocking. What is even more shocking is that these are still 'estimated,' despite FGM having been illegal since 1985. Indeed, no country in the world has accurate figures. Figures quoted in this and other reports are based on estimates, and these are likely to be under-estimates for a variety of reasons, some of which are highlighted in this report.

It has taken the courage of FGM survivors in speaking out and the campaigning of a small number of people to ensure that FGM is now recognised as the major child abuse offence in the UK. It is sometimes called 'cutting' or 'female circumcision,' but it is felt by many that these terms do not do justice to what the UN describes as 'torture'.

We estimate that between **1,761 - 2,667 women and girls have undergone, or are at risk of, FGM in Leeds,** not including those from communities where prevalence is unknown. The lower figure seems to correspond more with other studies on prevalence, but practitioners claim such figures are serious underestimates. In common with other areas of the country, it is impossible to provide more accurate information.

In the UK, the over-reliance on a health-focused approach with an ineffective legal measures has demonstrated that a better approach is needed. Such an approach needs to use a blend of all the available strategies and interventions. This will require investment as well as leadership at national, local and grassroots levels.

[2] *Taken from House of Commons Home Affairs Committee (2014) Female Genital Multilation: the case for a national action plan. Published by The Stationery Office Limited.*

Introduction

Female Genital Mutilation (FGM) is a 'hidden' issue; not usually discussed, even in practising communities, until recently. It is global in scope, with prevalence dependent on a number of factors.

The practice is found in at least 28 African countries, where it ranges from a prevalence of 5% in Zaire to 98% in Somalia.

However, FGM is not just an African practice. FGM has been reported in the Middle East and South Asia: countries such as Indonesia, Malaysia, Pakistan, Iraq and the Philippines. Figures are not available in most of these countries.

FGM has sometimes linked to religion, but it pre-dates most religions, including Christianity and Islam, and has been practised by communities holding a range of different religious beliefs.

It carries with it immense social meaning and serves as proof of maturity, virginity, and membership in the community. In addition, it complies with traditional beliefs about the roles and characteristics of women in the community. This practice is often kept secret and hidden in communities, which makes it difficult to study and even more challenging to change. Such secrecy is not correlated with rarity, but rather with cultural significance. FGM can be found anywhere, and is illegal in many countries. Despite that, it remains difficult to eradicate.

The NSPCC factsheet on FGM[3] comments:

> *"In the UK, FGM tends to occur in areas with large populations of FGM practising communities. These areas include London, Cardiff, Manchester, Sheffield, Northampton, Birmingham, Oxford, Crawley, Reading, Slough and Milton Keynes. However, FGM can happen anywhere in the UK."*
> (NHS Choices, 2013)

Leeds is not specifically mentioned and some have taken this to mean that FGM does not happen in Leeds. This reports presents the evidence, based on Leeds data, to show that this assumption is mistaken.

Since the Prohibition of Female Circumcision Act 1985, it has been illegal to carry out FGM in the UK, or to assist a girl to carry out FGM on herself. In the Female Genital Mutilation Act (2003), the Act was extended to criminalise FGM being carried out on UK citizens overseas. Despite this, no prosecution was undertaken until this year (2014).

[3] http://www.nspcc.org.uk/Inform/resourcesforprofessionals/minorityethnic/female-genital-mutilation_wda96841.html

Purposes of this report

The purposes of this report are to:

- Define FGM and describe some of the surrounding issues.
- Estimate of the incidence of FGM in Leeds.
- Promote confidence in frontline practitioners to tackle this abuse and examine work that has been undertaken towards prevention.
- Inspire and support communities in eliminating this harmful practice to safeguard and support their women and girls.

Regional Backdrop

Leeds, Bradford and Sheffield are major dispersal centre for asylum seekers, many of whom are fleeing FGM and other violence against women and girls.

Despite the demographics in terms of practicing communities, the region appears to be less advanced in terms of awareness and partnership working than some other parts of the UK.

There has been a general perception by agencies that “Female Genital Mutilation doesn’t happen here”. The lack of national leadership, the lack of knowledge of the procedure and the lasting harm it inflicts, the secrecy surrounding FGM, concerns about ‘interfering’ in community traditions and fear of being seen as racist have all contributed to a lack of confidence among frontline professionals.

For those practitioners that did take action, many were frustrated to find that referral pathways did not exist. Those at-risk girls and women who sought help, remained at risk. When care pathways did become available, many practitioners did not know how to use them appropriately.

Equally, practising communities have been reluctant to disclose the existence of FGM within an environment where they feel it is misunderstood. Some families know that it is illegal and are fearful of the consequences of disclosure. Even when families realise the harm it does, and that it is a criminal offence, there are social pressures to conform that make it very hard for them to refuse to go along with the practice.

Using the criminal law to prosecute perpetrators means that victims find it hard to testify against family members, so prospective prosecutions may fail.

Despite the many difficulties, a number of groups, such as the Leeds Teaching Hospitals Trust and the Black Health Initiative (BHI), have developed good practice and valuable experience that give a grassroots perspective of FGM in Leeds. To date, this has not been widely shared and this Conference and Report seek to remedy that.

FGM **does** exist in Leeds and in many other places in the UK. It is real, it is happening today and it is blighting the lives of many women, girls and their families.

So let's begin by looking at exactly what Female Genital Mutilation is.

Female Genital Mutilation

Definition

The World Health Organisation (WHO) defines Female Genital Mutilation as:

> *All procedures, which involve, partial or total removal of the female external genitalia, or any other injury to the female genital organs, for non-therapeutic reasons.*

It is also sometimes called 'cutting' or 'circumcision' or 'female circumcision'. There are four types of FGM as described by the World Health Organization (WHO).

Type One - Clitoridectomy
Clitoridectomy is the process of removing the clitoris.

Type Two - Excision
Excision occurs when the clitoris and the labia minora are scooped out. Sometimes the clitoris is left, as the Cutter knows that if the girl dies due to excessive bleeding it will be a bad advertisement for her services.

Type Three - Infibulation
Infibulation involves cutting away the labia and stitching together the flesh. This can leave behind scar tissue so that the opening can be as small as half a centimetre. This means that urine and menstrual blood can be trapped within the body causing further complications.

With this type of FGM, women in developing countries often die in labour as the uterus will keep contracting but there is nowhere for the baby to emerge. There is usually little or no access to medical help. The uterus can rupture and this is fatal for both mother and child.

In the UK, a deinfubulation procedure can open up the closure, but can be extremely traumatic. In effect, it is the reverse procedure of what they had to undergo, usually as a little girl. It can bring flashbacks and extreme psychological distress at an already traumatic time, as well as causing further physical damage with lasting impact.

This type of FGM is frequently performed in the horn of Africa. Here 98-99% of the Somali community will have undergone FGM, usually between the ages of three and eight.

Women with Type 3 may actively avoid smear tests due to the ridged scar tissue and reduced vaginal opening. Avoidance of smears is common with women with all types of FGM, but this is usually related to lack of knowledge of what and why a smear is needed and cultural sensitivities around intimate examinations.

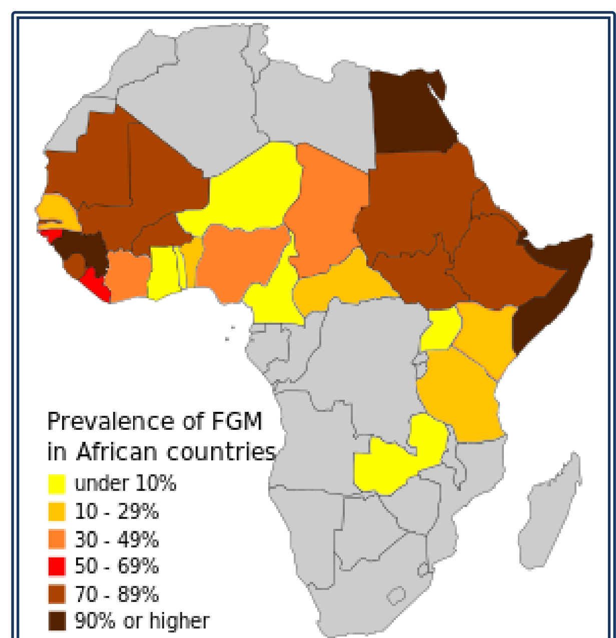
Type Four - Unclassified

Pricking, piercing, stretching, cauterising the clitoris/labia, scraping of tissue surrounding the vagina (*gishiri cuts*) introduction of corrosive substances to cause bleeding/tighten the vagina and any other procedure that falls under the definition above.

At first glance, this classification seems clear cut. In reality, however, the practice is not. There are no guidelines on how circumcise a girl. Cutting methods are passed down by word of mouth through non-medically trained, elderly women and are generally performed on an un-anaesthetised, struggling girl. The resulting cutting and degree of tissue damage therefore varies dramatically and an individual woman's FGM may not fall precisely into any one of the specified types.

Occurrence and prevalence

Africa has the greatest concentration of FGM-practicing communities in the world with prevalence varying from under 10% to almost 100% in countries like Somalia. The map shows the concentration of the practice and how the prevalence varies[4].



With the migration of many Africans to other countries, the practice has spread through the diaspora and can be found now in most, if not all, countries in the world.

[4] *Diagram courtesy of the World Health Organization*

High rates of FGM have also been reported in Yemen and the Kurdish region of Iraq. Additionally, FGM is also found in parts of Asia, such as Malaysia, Indonesia and the Philippines. Among other West Asian countries, FGM has been locally reported, but overall FGM prevalence rate is unknown.

There are real difficulties encountered in discovering prevalence. In the early days of research into this area, some surveys relied on women self-reporting. This proved unreliable. Despite clinical evidence of FGM, a study in Nigeria[5] found that many women wrongly thought they had not been cut.

Within the EU, there are two studies referred to in the FGM Research Methodological Workshop held in London in March 2012[6]. These results carry some implications for the UK's campaign to eradicate FGM in a generation[7].

- Firstly, the use of community terminology for FGM is important to help get accurate information about its existence. In this case 'sunna' was perceived as different from FGM, and this may apply to other communities as well. A list of words used by different communities is given in Appendix 1.

- Secondly, religious and prominent community leaders can add weight to the campaign by speaking out against FGM. The recent publication from the Muslim Council of Britain[8] is a welcome contribution to this.

- Thirdly, the evidence that not all men want their wives to have FGM seems to be an emerging theme now that FGM is being more openly talked about. It is vital that young men understand what FGM involves, since they can play a big part in advocating against it. Part of the challenge is to get men and women discussing the issue together.

- The final point is a telling one. Because many campaigns are based around the health risks of FGM, there has been a growing drive in some countries to medicalise the procedure: carried out by doctors in a hospital facility with appropriate sterile equipment and pain relief. Where community leaders or cutters feel their culture is under attack, this can be viewed as a good compromise.

---

[5] *Mandara, M.U. (2003) Female genital mutilation in Nigeria. International Journal of Gynecology and Obstetrics 84 (2004) 291–298*

[6] FGM: Report of a Research Methodological Workshop on Estimating the Prevalence of FGM in England and Wales*: March 22-23 2012 Published by Equality Now*

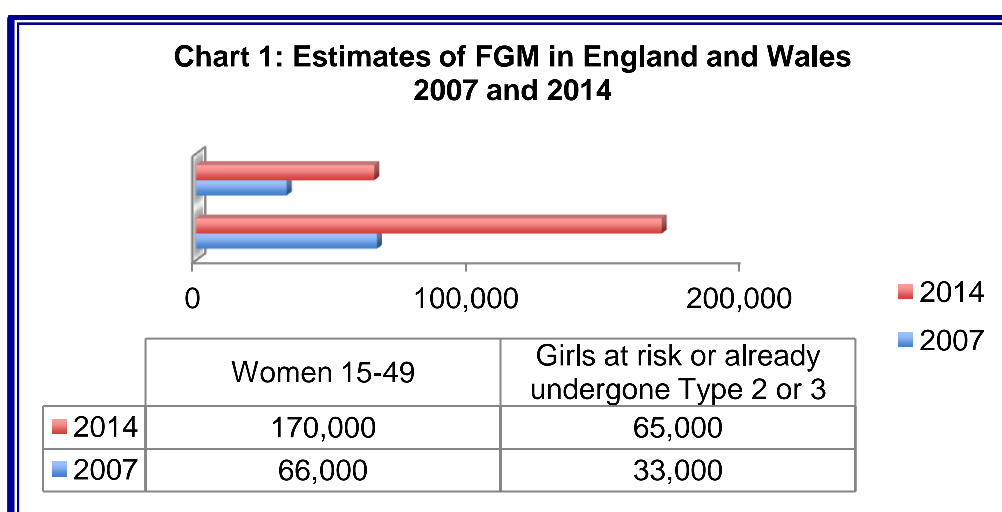
[7] *Researching Female Genital Mutilation (FGM) Intervention Programmes Linked to African Communities in the EU (REPLACE). Paper presented by Dr David Beecham, Faculty of Business, Environment and Society, Coventry University and Hussein Hussein, Researcher.*

[8] *http://www.mcb.org.uk/muslim-council-of-britain-speaks-out-against-female-genital-mutilation/*

Anyone who is speaking out against FGM needs to be aware that this point will be raised, along with the perceived double standards of male circumcision and labiaplasty. Some professionals have been taken aback by such challenges.

A second study[9], undertaken in Hamburg, Germany contrasts the deterrent effect of the law when compared with the UK. It was not until 2014 that two medical practitioners were arrested and charged with FGM offences. Since then, there have been more cases, including those taking children abroad to have the procedure and a 'cutter' being arrested. It remains to be seen whether this will have any major impact on perceptions.

In 2007, FORWARD UK published a study using 2001 census data along with the numbers of women in practicing communities in the UK, multiplied by the estimated prevalence of FGM in that community to estimate prevalence of FGM in the UK.



	Women 15-49	Girls at risk or already undergone Type 2 or 3
2014	170,000	65,000
2007	66,000	33,000

This resulted in an estimate of 66,000 women between the ages of 15 and 49 in England and Wales having undergone FGM, including women who were cut before entering the country, and women who have been cut since becoming residents. The study also estimated that at least 24,000 girls under the age of 15 in the UK were at high risk or may have already undergone FGM Type 3.

Since then, because of increased migration from practicing countries, particularly Somalia and the rest of the Horn of Africa, as well as population growth over the last decade, the prevalence of FGM and the number of girls at risk is thought to have increased significantly[10].

---

[9] *Listening to African Voices, Female Genital Mutilation/Cutting among Immigrants in Hamburg: Knowledge, Attitudes and Practice. Paper presented by Dr Anja Stuckert, Project Coordinator of Plan Germany.*

[10] *FGM 0029 para 14, and FGM 0049 (Alison Macfarlane and Efua Dorkenoo), para 1.3 Evidence to Home Affairs Select Committee, published in Female Genital Mutilation: the case for a national action plan. Published 3 July 2014. London: The Stationery Office Limited). Access found at: www.parliament.uk/business/committees/committees-a-z/commons-select/home-affairs-committee/inquiries/parliament-2010/female-genital-mutilation/*

A more recent study using 2011 census data estimated that around 170,000 women and girls were living with FGM in the UK, and that 65,000 girls aged 13 and under were at risk of being cut[11].

Options UK carried out three research studies[12] that reinforce some of the previous findings: the lack of legal deterrent in the UK; the attitudes of some men; the lack of communication between men and women on the issue and the challenges emerging from over-reliance on a health-based approach.

Other emerging issues are the strong support for FGM in some communities; the lack of parental control over girls being subject to FGM and the rising age of vulnerability to FGM. All these need to be understood and taken into account when devising strategies and interventions if FGM is to be ended within a generation.

We have no accurate information globally, nationally or locally of the size of the population that is affected by, or at risk of, FGM practices. That knowledge gap means that adequate attention and resources are not focussed on the issue.

In this report we used the FORWARD methodology to estimate incidence of FGM in Leeds, with some subsequent learning to help refine the estimates. The same methodological problems that are acknowledged in other estimates also apply here.

To arrive at the estimate, we worked in four stages.

1. Identifying the countries where FGM is reported to be a traditional practice.
2. Identifying numbers in each community with a presence in Leeds, based on the 2011 Census data.
3. Calculating the numbers subject to or at risk of FGM, based on prevalence in country of origin.
4. Calculating the numbers subject to or at risk of FGM, based on prevalence by language.

[11] *Julie Bindel for the New Culture Forum, An Unpunished Crime: The lack of prosecutions for female genital mutilation in the UK, 2014*

[12] *Kate Norman, Joanne Hemmings, Eiman Hussein, Naana Otoo-Oyortey (July 2009) FGM is always with us, Experiences, Perceptions and Beliefs of Women Affected by Female Genital Mutilation in London Results from a PEER Study, http://www.forwarduk.org.uk/news/news/563;*

Alexis Palfreyman, Eleanor Brown, Sara Nam (April 2011) Understanding Female Genital Mutilation in Birmingham, Findings from a PEER Study http://www.bswaid.org/wp-content/uploads/2012/01/Final-report.-PEER-FGM-in-Birmingham.-06.05.2011.pdf;

Joanne Hemmings (October 2011) The FGM Initiative Interim Report http://www.trustforlondon.org.uk/FGM%20Interim%20Report.pdf;

Previous studies used Census data according to gender (female only), age (15-49) and either country of origin, ethnicity or language spoken. The figures we were able to obtain did not give male and female figures separately, nor the ages of residents.

However, the more we thought about it, the less relevant the ages seemed. Anecdotal evidence is emerging of children cut at very young ages, either as ‘tradition’ or to prevent them giving evidence against perpetrators. At the other end of the age range, elder females may be grandmothers exerting pressure for FGM or, indeed, be cutters themselves. That means that ALL women (and, indeed, men) need to be included in interventions and strategies if they are to be successful.

Ethnicity was used in this Census and made available to us, but in some cases ethnicities were grouped into a geographical region, rather than given as separate ethnicities. We estimated that 50% of these populations were female, and from that number calculated the numbers at risk of, or having undergone FGM, based on correlating reported ethnicity with prevalence in country of origin using the most reliable figures available.

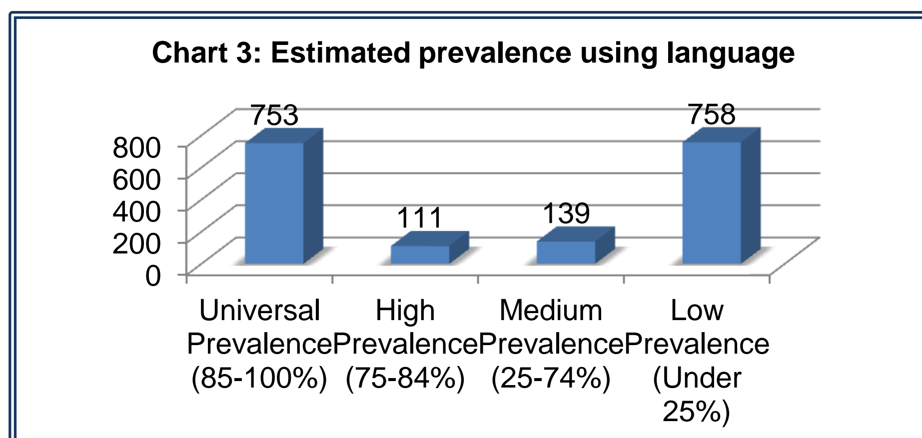
Using this approach, the estimated number of females in Leeds who have undergone or are at risk of FGM is **2,667**. This seems very high in comparison with some other studies, but is more consistent with what community activists are reporting. It must also be remembered that undocumented persons, such as asylum seekers, will not be recorded in Census numbers, but a large number will fall into at-risk groups.

Given so many missing data fields, we further refined the figures. Within the data provided, the language spoken was recorded and had proved helpful in other studies to refine estimates.

We also felt that the approach used by two recent studies[13] that categorized prevalence into Universal, High, Medium and Low groups would be helpful to policy makers and practitioners.

One Census category was “West African language”. This was too generalized to make any meaningful attribution. Attracting 155 responses, this could potentially result in an underestimate of the number affected or at risk, but the probability of error in skewing the results was too high to attribute it to any one category. These results are given in Chart 3 on the next page.

[13] *Osibona, Funmi. (March 2014)* The WONDER Fpoundation Female Genital Mutilation Report: Estimating FGM Risk in Westminster. *Published by The WONDER Foundation: and Macfarlane, Alison: Dorkenoo, Efua: (21 July 2014)* Female Genital Mutilation in England and Wales: Updated statistical estimates of the numbers of affected women living in England and Wales and girls at risk: Interim report on provisional estimates*. Published by City University, London and Equality Now*



Using this more refined estimate, the number of females in these groups is 1,761. **The best estimate therefore is that the minimum number of women and girls affected by, or at risk of, FGM lies somewhere between 1,761 and 2,667**.

Undocumented people such as asylum seekers are excluded from official figures and are not included in these estimates. Bearing in mind that one third of all asylum seekers in the UK are women, and that a proportion will have fled from the fear of FGM being undertaken on themselves or their daughters, the figure for Leeds is likely to be higher than the suggested numbers above. Leeds also has residents from other countries, outside the African ones, that practice FGM, but their prevalence is unknown. Such residents are also excluded from these estimates. All these estimates are based on 2011 Census data, but what does the issue look like to frontline practitioners?

FGM Clinic Data
In 2013, 154 pregnant women delivered in Leeds and were reviewed in the FGM clinic. If we consider 50% those children born were female, that represents 77 girls potentially at risk of FGM. The level of risk to each of these children must be assessed thoroughly and continue to be monitored throughout childhood.

The women seen in the Leeds FGM Clinic are generally from Ethiopia, Eritrea, Somalia, Sudan, Gambia, Guinea, Nigeria, South Africa and Kenya. Not surprisingly, **81%** of these women live in the most disadvantaged areas of Leeds within the LS7, LS8, LS9 postcodes.

What's interesting to know is that **80%** of the women that report to the Leeds FGM Clinic come from three countries: Eritrea, Somalia and Sudan. This is a significant finding when we consider the prevalence and types of FGM performed in these countries.

Essentially, **95%** of Eritrean women will be circumcised with Type I, 2, or 3; **89%** of Sudanese women and **98-100%** of Somali women will be circumcised with Type 3. **So we know that our local population consists of those women and girls at-risk of the most severe physical, psychosexual and obstetric complications.**

Reasons why FGM undertaken

The practice of female genital mutilation/circumcision dates back to ancient times. It was first recorded by Herodotus in Egypt, where he recorded that a Pharaoh's wife had the procedure performed on herself to prove her chastity while her husband was away.

Given that the practice is so harmful, many people find it hard to understand why FGM persists. Female genital mutilation persists, despite many efforts to eliminate it, because of a mix of cultural, religious, political, social and economic factors within families and communities. Successful efforts to eliminate it will need to discover and address the complex array of such factors, which interplay in different ways for each community.

Those who are working in practicing communities across the world comment that the only way in which one achieved respect as a member of a society and the entire community was through circumcision. As well as 'tradition', researchers have identified a range of reasons given by practicing communities. These are in Table 4 below.

Table 4: Recorded reasons for the community practicing FGM[14]

Reason	Comments
Social convention	Uncut women and those who protect them from cutting are regarded as cursed, so they are excluded from social interaction.
Preparation for marriage	Motivated by beliefs about what is considered proper sexual behaviour, premarital virginity and marital fidelity. In many communities, it is believed to reduce a woman's libido and help her resist "illicit" sexual acts. When a vaginal opening is covered or narrowed (type 3), the fear of the pain of opening it, and the fear that this will be found out, is expected to further discourage "illicit" sexual intercourse among women with this type of FGM.
Making girls 'clean and pure'	Cultural ideals of femininity and modesty, which include the notion that girls are "clean" and "beautiful" after removal of body parts that are considered "male" or "unclean".
Belief it is required by religious scripts	No religious script requires FGM, but the belief persists. Some religious leaders promote FGM, some consider it irrelevant to religion, and others contribute to its elimination.
Power and authority	Local structures of power and authority, such as community leaders, religious leaders, circumcisers, and even some medical personnel can contribute to upholding the practice. In some of these cases, there is a strong economic dimension at work as well.

[14] *Taken from: Garcia-Moreno, Claudia; Guedes, Alessandro; Kerr, Wendy (2012) Understanding and addressing violence against women: Female genital mutilation. Published by the World Health Organization*

Consequences of FGM

FGM is such a traumatic and invasive procedure that the consequences are many. Some are short-term, others long-term: some are physical, but there are also clear psychological consequences as well. The following table sets out the consequences, based on current and most reliable evidence from the World Health Organization (WHO)[15].

Table 5: Consequences of FGM

Immediate health risks	**Longer term health risks**
Severe pain	Need for surgery
Shock	Urinary and menstrual problems
Haemorrhage (excessive bleeding)	Painful sexual intercourse and poor quality of sexual life
Sepsis	Infertility
Difficulty in passing urine	Chronic pain
Infections	Infections (e.g. cysts, abscesses and genital ulcers, chronic pelvic infections, urinary tract infections)
Death	Keloids (excessive scar tissue)
Psychological consequences	Reproductive tract infections
Unintended labia fusion	Psychological consequences, such as fear of sexual intercourse, post-traumatic stress disorder, anxiety, depression)
	Possible increased risk of cervical cancer (although more research is needed to confirm this)
Known obstetric complications/risks	**Conditions often considered to be associated with FGM but for which evidence is equivocal or shows no link**
Caesarean section	HIV (in the short term)
Postpartum haemorrhage	Obstetric fistula
Extended maternal hospital stay	Incontinence
Infant resuscitation	
Stillbirth or early neonatal death	

Survivors and health professionals have also identified the following consequences: fracture or dislocation (through being tied to a chair or having a knee in the back), lower back pain, vaginismus (when the muscles around the vagina tighten involuntarily whenever there is an attempt to penetrate it.)

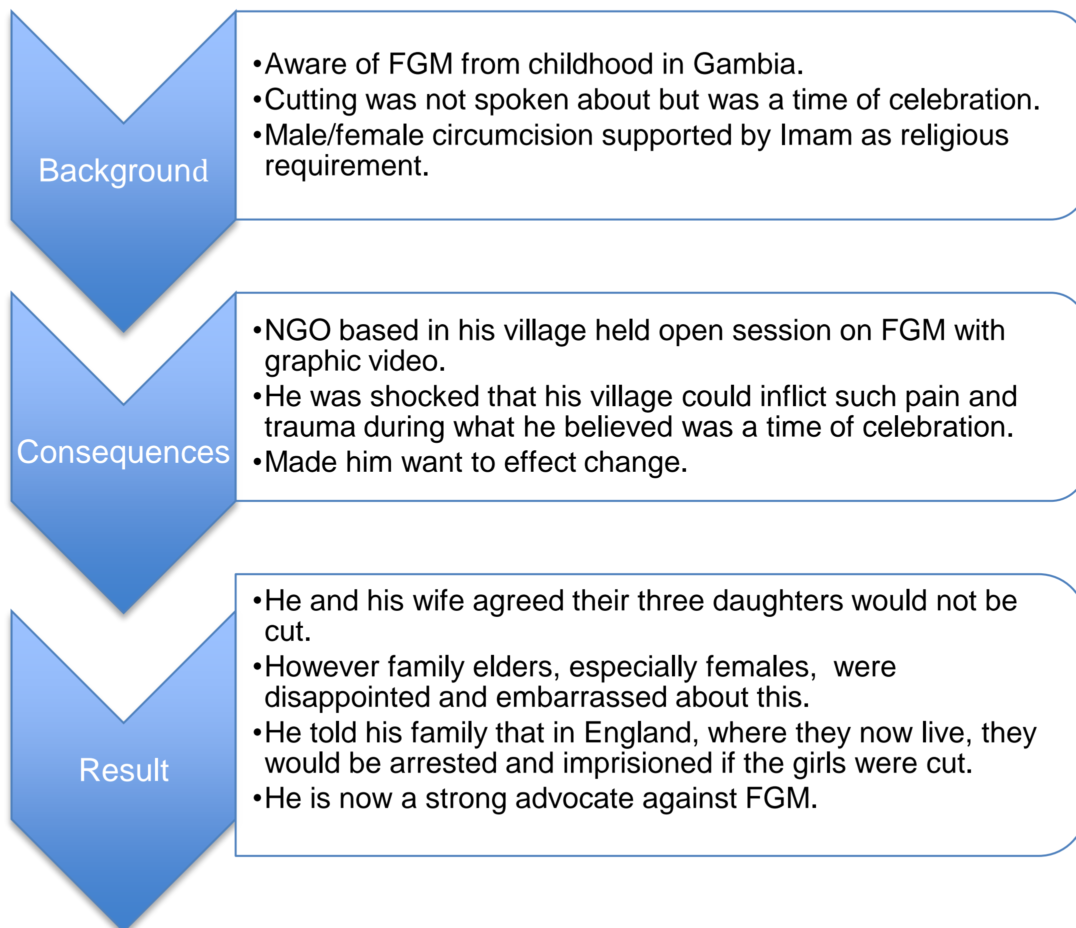
Social change is rarely a smooth, simple process – it is often contentious and proceeds in fits and starts. But as more light is being shed on the harm it causes, more people, many of them men, are not afraid to make their preferences known, like a 36-year-old man who was approached for a television interview in the marketplace:

[15] *Garcia-Moreno, Claudia; Guedes, Alessandro; Kerr, Wendy (2012) Understanding and addressing violence against women: Female genital mutilation. Published by the World Health Organization*

> *"I don't support it. In Saudi Arabia, they don't do it. The Koran does not say it is a must. I'll not take my girls to be cut. And if I have to choose between a girl who is cut and one who is not, I'll take the one who is not."*

Getting the support of men within the community is essential if FGM is to be eradicated. If families believe that there are husbands out there who will marry their uncut daughters, then they are more likely to consider abandoning the practice. Below is a Case Study from a local Leeds man, who is keen to lend his voice in support of eradicating the practice.

Ebrima Janneh. Came from Gambia to study in London in 1999. Since 2003, he has lived in Leeds. Lends his voice and time to Gambian Volunteers to help eradicate FGM.



Since so many people value the practice for a range of reasons, the whole community must be involved in changing it. Interventions need to be strategically targeted, based on the specific meanings associated with it in different communities.

Christine Ochieng, the National Coordinator of the programme for UNPFA, the UN Population Fund, confirms that *"One form of intervention will not work everywhere. It depends on why they do it."*

Conclusion

In the UK, the over-reliance on a health-based approach with ineffective legal measures has demonstrated that a better, more nuanced approach is needed to achieve the Government's stated aim of eradicating FGM within a generation.

This will require investment and leadership: leadership at national, local and grassroots levels so that it works flexibly with the local communities, who must be involved in developing solutions. According to the evidence, the current piecemeal strategy of giving small grants to grassroots organizations is not working.

Such a strategy needs to involve a whole range of community groups if it is to be effective; it will need strong leadership to be managed efficiently; and it will need to have a practical underlying investment plan in order to be economical and sustainable. This will have significant social value, which also needs to be captured.

Postscript

Precious Simba, who spoke during the #Sheroes slot at the Girl Summit in July 2014, says that we shouldn't pity girls who've been cut, nor should we feel horrified by the act itself. We should understand that cut girls just want to be treated as normal girls.

Within Leeds, we need to generate a buzz and conversation that will, inevitably, reach everywhere – including communities that practice FGM. If the conversations held are open and inclusive, it is so much more likely that communities will listen and get involved, rather than feel attacked.

The question – and challenge - for Conference delegates and others is:

"So, what will you now do differently as a result of what you know?"

References

Further reading

Search the NSPCC Library Online for publications about female genital mutilation.

Related resources

For Schools

KS3 FGM Lesson SRE Covered: all you need to teach about sex and relationships in secondary schools, a new and comprehensive resource pack with activities and resources to address the breadth of sex and relationship education topics. For further information, or to order a copy, please contact helen.cameron@islington.gov.uk

For Midwives (Students and Teachers)

www.who.int/gender/other_health/**teachersguide**.pdf
www.who.int/reproductivehealth/publications/**fgm**/en/

Further Support

There are very few support organisations within Leeds that are known to provide a service within Female Genital Mutilation. A number are listed below, but this is not exhaustive. There are also a number of other support organisations for women and girls, many based in London or cities other than Leeds, but may be able to assist in referral to more local support agencies.

Organisation	Services
Black Health Initiative (BHI) Leeds 231 – 235 Chapeltown Road Leeds LS7 3DX Tel: 0113 3070300 Web: www.blackhealthinitiative.org	• School liaison and support with partners e.g. social workers • Emotional support • Expertise in post-traumatic stress counselling • Family counselling and support • Awareness raising both within and amongst communities and service providers • Support group
The Gambia Volunteers 124 Roundhay Road Leeds LS8 5NA Tel: 0113249 88 97 Email: enquiries@gambiavolunteers.org Website: www.gambiavolunteers.org	• Support for anyone struggling with issues of FGM • Workshops and training on FGM for Gambians and for diaspora women affected by FGM

The School Nursing Service Children and Family Services NHS Leeds Community Healthcare School Nursing Team 2nd Floor Reginald Centre, 263 Chapeltown Road Leeds LS7 3EX Tel: 0113 8434396 Fax: 0113 8434492	• Provision of support, advice and signposting for school staff
Midwife-Led FGM Clinic Haamla Office Level 4 Gledhow Wing St James's University Hospital Tel: 0113 2066392 Email: leedsth-tr.fgmleeds@nhs.net	• Care, support and counselling to all pregnant women with FGM in Leeds • Time and space for women to discuss FGM and their health needs in a culturally sensitive, non-judgmental environment. • Provision of the necessary treatment, education, signposting • Referral appropriate services (Examinations are offered to assess the type of FGM and a plan of care is made together with women for their pregnancy and labour. A deinfibulaiton service (the surgical opening of Type III FGM) is offered antenatally or in labour).

Appendix

FGM-related terms and definitions

Angurya cuts:
A form of FGM type 4 that involves the scraping of tissue around the vaginal opening.

Sunna:
The traditional name for a form of FGM that involves the removal of the prepuce of the clitoris only. The word '**sunna**' refers to the 'ways or customs' of the prophet Muhammad considered (wrongly in the case of FGM) to be religious obligations.

Studies show that the term '**sunna**' is often used in FGM practicing communities to refer to all forms of FGM, not just FGM that involves only the removal of the hood of the clitoris.

FORWARD (2006)

Copyright © People Help People