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FGM

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Bri-d Hehir suggests a change in the way women are supported and cared for

Female genital mutilation (FGM) has been a controversial, high profile issue in Britain for some years now, as many women and girls from traditional FGM practising communities live here. There is a widespread, if erroneous, belief that this illegal, harmful practice continues to be performed here. Politicians of all hues, government departments, media campaigners, victims, survivors, charities and professionals have all contributed to this illusion.

The Home Office established an FGM Unit in December 2014 and Â£3m was contributed to the national FGM Prevention Programme partnered by NHS England, *'with a package of measures to support NHS staff in preventing FGM, protecting girls at risk and caring for survivors'*. That they may be helping to protect even one child from abuse and preventing a breach of their human rights is thought to justify making it everybody's business.

FGM definition

WHO defines four types of FGM, but they are only a rough guide because it's hard to categorise FGM with any degree of accuracy when it has been carried out with crude instruments. Types 1 (clitoridectomy) and 2 (Type 1 with excision of the inner labia) are the most frequently seen, but in the public mind the most severe form, Type 3 (infibulation), is assumed commonest. Type 3 is mostly limited to girls and women from the Horn of Africa. Type 4 (pricking, piercing, cutting) is the mildest form, and the most commonly diagnosed in the new, national, specialist centre for under 18s at University College London Hospital. However, even experts find it hard to confidently distinguish Type 4 FGM from natural variation. In countries where FGM is still practised it is increasingly being medicalised and carried out by health professionals, which results in cleaner, if differently damaging, cuts.

Data

The NHS estimates that 137,000 women across the UK are affected by FGM, and the NSPCC estimates that 23,000 girls under 15 could be 'at risk' in England and Wales. Individual-level data has only been collected in England by the NHS since April 2015 (different arrangements exist for Wales and Scotland). Analysed reports for the 12 months from April 2015 show that almost all of the 4979 women and girls seen were cut outside of Britain, with only 22 reported as born here. This small number is a far cry from the belief that FGM is a hidden and persisting problem here. However, I am certainly not seeking to

minimise its seriousness by asking whether such a small number should form the basis for ongoing awareness raising.

Why does FGM command such interest?

This has become a perfect issue for politicians, the media and campaigners to unite around. Who could possibly condone FGM? Who wouldn't like to see an end to a practice that appals and horrifies in equal measure? Who wouldn't want to support the survivors who have been trying to highlight it for years? In the awareness-raising frenzy that's ensued over what is a largely non-existing practice here, does it matter that information has been presented simplistically; that facts don't matter much and the challenges in addressing the very real problem it represents to girls and women where it is practised, mostly in the developing world, are glazed over? I think it does.

What are the consequences?

Unsurprisingly, the many official measures adopted and implemented are hugely problematic for people from supposedly still practising communities as they are based on the assumption that FGM is being undertaken here, irrespective of the evidence.

Because of the deeply-held belief that FGM is an intensely private matter, communities are reluctant to engage in public discussion and are ashamed and angry at the fingers pointing at them in regard to it. They also feel taken advantage of due to their silence. So, exaggerated claims about the prevalence of FGM go unchallenged.

Unsurprisingly, therefore, little acknowledgement or credit is given to immigrants and their descendants in Britain and Europe who have ended the practice. Years of high-profile surveillance and scrutiny by the police and border forces, health, social care and education services, have identified just 11 women and girls who underwent FGM here, of which eight were genital piercings only, one had Type 2 FGM and two the type is unknown. In all those cases information was given voluntarily to health service staff. Even suspected Type 4 referrals are made more out of professional fear than conviction. To date there has not been a successful prosecution.

Nevertheless, organisations are encouraged to be alert, to proactively identify girls 'at risk'. Communities consequently feel surveilled, stigmatised and scrutinised. Under-18s, pregnant women, mothers and older relatives are paid particular attention.

With the advent of mandatory reporting in October 2015, registered professionals must report to the police when they see, or have confirmed, that an under-18-year-old has undergone FGM. The police will then investigate and may instigate a multiagency response. This requirement not only removes professionals' independent ability to judge and act on a situation; it also effectively turns them into arms of the criminal justice system. This undermines patients' hard-won trust, leaving some fearful of seeking health care, knowing the possible consequences for themselves and their families. Interestingly, when the data was last reported, the police had received only 20 appropriate referrals, none of whom had

undergone FGM here.

Pregnant women are coming under intense scrutiny. Immigrants have traditionally been wary of officials but have trusted NHS staff. Now, antenatal checks are being used as a way of surreptitiously introducing social workers to women who have been cut, with the intention of identifying their cutting intent for their daughters and ensuring they know that the practice has been illegal here since 1985.

However, denying intent once is not enough. It has become common for women to be asked the question repeatedly, often in inappropriate circumstances: for example, a woman in advanced labour who was questioned by a paramedic, and a pregnant woman with a sick child who was questioned by a paediatrician. If the woman who has said 'No' has close contact celebrate the 'reverse socialisation' process that occurs when children raise the issue with their parents. However, this is not welcomed by all parents and has led to friction.

What should be done?

FGM has serious consequences for women and girls and should end. How this happens needs more discussion. Problems associated with current initiatives, awareness campaigns, their methods and strategies should be acknowledged because they themselves are causing harm.

It would make a huge difference to women themselves if the issue was depoliticised, kept in perspective and the campaigns scaled back.

Our priority should be to identify and support those who need help, freeing them from the constraints of asking. Some women may suffer short or long-term consequences, some may not. High-quality NHS care, mental health support and reconstructive surgery should all be accessible and sensitively provided to those who need and want them. The money allocated to the FGM Prevention Programme could be usefully diverted to this purpose.

We need to accept that different strategies are required to address the issue here and overseas, and those strategies should be decided with people in those countries.

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