**Female Genital Mutilation**

1. **Introduction**

Female genital mutilation (FGM), sometimes known as female circumcision, is the practice of cutting away part or all of a female’s external genitalia. FGM has no health benefits, but it can result in severe, sometimes irreversible, physical and psychological injuries and later health problems. Complications include bleeding and urinary problems, cysts, infections, infertility and complications of childbirth with an increased risk of new-born deaths. The impact of FGM on the mental wellbeing of women and girls can heavily influence their overall health and wellbeing. Individuals may suffer the symptoms of Post Traumatic Stress Disorder, particularly during vaginal exams or childbirth.

FGM is a human rights abuse as recognised by the World Health Organisation. The Female Genital Mutilation Act 2003 makes it illegal to help, support or arrange for FGM to be performed on a girl in the UK. It also forbids taking a girl outside the UK to have FGM.

From October 2015 the Serious Crime Act for England and Wales requires teachers and regulated health and social care professionals to report to the police cases of FGM in females aged less than 18 years. In addition, data collection and submission of a new FGM Enhanced Dataset became mandatory for all acute trusts from July 2015, and all Mental Health Trusts and General Practices from October 2015. This will improve the NHS response to FGM and facilitate better commissioned services to safeguard and support women and girls.

The Local Safeguarding Children Board’s recently revised its procedures for FGM reporting. Despite the requirement for social workers, teachers, doctors, nurses and midwives to report FGM, many cases are continuing to go unnoticed because FGM happened at a young age and/or abroad. The local procedures may be found at: http://lrsb.org.uk/fgm-female-genital-mutilation.

2. **The level of need in the population**

2.1 **Population Profile**

In the UK FGM is more common among communities from Kenya, Somalia, northern Nigeria, Sierra Leone, and Egypt. Over 100,000 women are living with the consequences of FGM in the UK, with 60,000 girls at risk. Although FGM is illegal in the UK, it is unlikely to be reported to the Police.

A report on FGM prevalence in England and Wales showed the highest rates in London boroughs, for example, 4.7% of women in Southwark, compared to 0.5% in England and Wales as a whole.

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1. 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, City University London, 2013
Other areas, such as Manchester, Slough, Bristol, Leicester and Birmingham had rates ranging from 1.2 to 1.6%. Experimental statistics released by the Health and Social Care Information Centre on 21 July 2016 show 30 newly identified FGM cases in Leicester City. 25 of the 30 were advised of the health implications and the illegality of FGM. This is likely to be an under-estimate of the true local picture.

2.2 Risk Factors

The most significant risk factor for whether or not a girl will be circumcised is whether or not her family has a history of FGM practice. Other risk factors include

- family indicate that there are strong levels of influence held by elders and/or elders are involved in bringing up female children;
- a woman/family believe FGM is integral to cultural or religious identity;
- a girl/family has limited level of integration within UK community;
- parents have limited access to information about FGM and do not know about the harmful effects of FGM or UK law;

As FGM is illegal in the UK, girls may be taken abroad during summer holidays for FGM to be performed.

Not all girls from FGM affected countries have undergone FGM. In Leicester and across the world, there is growing awareness that FGM is a negative practice. Many communities are therefore stopping FGM, but some communities and individuals are reluctant to say so.

2.3 Audit of Compliance with FGM Safeguarding Procedures

A recent audit on compliance with the Leicester Safeguarding Children Board FGM Procedures was conducted in 2016 and the results of this are being followed up locally. This showed that evidence that GPs are identifying and recording FGM on mother’s and child’s case notes and that women are now more commonly routinely asked appropriate questions about FGM locally. Further embedding this through local training, improving the use of interpreters and continuing to develop effective communication between agencies where referrals have been made will all help to strengthen local action to tackle FGM.

3. Current services in relation to need

Due to the uncertainty as to the true scale of burden by FGM in Leicester, it is not clear what services victims utilise and/or require. All health, social care and education professionals should ensure they are aware of and familiar with the FGM reporting guidance and processes.

The Obstetrics and Gynaecology department at UHL have a pivotal responsibility in providing accessible advice, treatment and support to women affected by FGM whilst ensuring that children are protected. Clinical guidelines are in place to ensure that healthcare professionals know how to manage FGM, as well as organise services for women with FGM. The service also provides a FGM clinic for women who wish to reverse the mutilation to some extent.
Mental health services should be improving their ability to cope with the needs of FGM. The Department of Health is running training sessions for mental health professionals to better improve their knowledge of FGM, how to ensure services are appropriate and to manage patients’ needs appropriately.

A community engagement group is currently being set up to address FGM in Leicester through community capacity building and information sharing. This work is building up on the work of a previous task and finish group at the LSCB.

Local voluntary and community groups are heavily involved in campaigning against FGM and supporting victims and communities.

### Child Sexual Exploitation

#### Child Sexual Exploitation Introduction

Child Sexual Exploitation (CSE) is defined as ‘a form of child abuse [which] involved children and young people receiving something...as a result of them performing sexual activities, or having others perform sexual activities on them’\(^4\). It can also occur without physical contact, when children are groomed to post sexual images on the internet. In all cases those exploiting the child have power over them, perhaps by virtue of their age or physical strength. These relationships are characterised by being exploitative and relying on ‘fear, deception, coercion and violence.

There are many forms of CSE. These may be within a community, intra- and inter-familial, or with people less well known to children and young people. CSE crosses boundaries of culture, disability, social class, and gender and other diverse issues. This means it is often under reported and misunderstood.

The impact on children and young people is significant. CSE effects physical, emotional and mental health both in the short and long term. Specific issues include self-harm, attempted suicide, pregnancy, injuries, sexually transmitted infection, substance misuse and impairing educational attainment.

CSE is considered a form of child abuse and, because there is no specific crime of CSE, official police statistics cannot be obtained; where perpetrators are convicted, it is for offences such as ‘grooming’ or ‘sexual activity with a child’. It is also not possible to ascertain figures through children protection proceedings as there is not recognised category of abuse for CSE. CSE data recording is often incomplete or goes unrecorded.

#### The level of need in the population

**2.1 Population profile**

For a variety of reasons it cannot be fully determined how many children and young people are survivors of CSE. The abuse can be described as ‘hidden’, with survivors not included to disclose to

\(^4\) Department for Education
what has happened to them. But some may not recognise it as abuse if the perpetrator has led them to believe they are in a relationship or if they are reliant on the protection of their abuser.

In the UK, the Office of the Children’s Commissioner’s Inquiry into Child Sexual Exploitation in Gangs and Groups (CSEGG) found that at least 16,500 children were at risk of CSE in one year. It also found that 2,409 children were confirmed victims of sexual exploitation in gangs during a 14 month period, but this is thought

In Leicester, the number of cases of children and young people at risk of CSE or subject to CSE between April and December 2016 are reported in Table 1.

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<th>April to June 2016</th>
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<td>Number of</td>
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<td>children/young</td>
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<td>medium and high</td>
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<td>risk of CSE in</td>
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<td>Leicester City</td>
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2.2 Risk Factors

The Office of the Children’s Commissioner’s Inquiry into Child Sexual Exploitation in Gangs and Groups (CSEGG) identified 11 indicators of CSE risk in children aged 10+ that can be measured using education, police or other public service datasets, to identify children at risk locally:

- Child in Need or Children Looked After
- Children persistently absent from education
- Children permanently excluded from school
- Children misusing drugs and/or alcohol
- Children engaged in offending
- Children reported missing, or Children reported to be ‘absconding’ or ‘breaching’
- Children reported as victims of rape
- Children lacking friends of similar age
- Children putting their health at risk
- Children displaying sexually inappropriate behaviour
- Children who are self-harming or showing suicidal intent.

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5 Office of the Children’s Commissioner (2012) “I thought I was the only one. The only one in the world.” Inquiry into Child Sexual Exploitation in Gangs and Groups - Interim Report, Nov 2012
2.3 Audit of Compliance with Safeguarding Procedures

A recent audit on compliance with the Leicester Safeguarding Children Board Multiagency Safeguarding Procedures was conducted in 2016 and the results of this are being followed up locally. This showed evidence that there is a lack of compliance for the multi-agency procedures across agencies, and the CSE Risk Assessment Tool is not be completed by all agencies.

Further improvement for CSE safeguarding is needed through local training, improving the use of assessment tools and continuing to develop effective communication between agencies where referrals have been made will all help to strengthen local action to tackle CSE.

3. Current services in relation to need

In September 2016, Leicester City Council established a CSE, Missing and Trafficked Children team. The team is located at a Leicestershire police station in the Multi-agency CSE hub. The team works alongside Leicestershire County Council colleagues, health and police partners to ensure a systematic approach is taken to understanding the issues for young people at risk. The coordination and sharing of key information is proving critical to creating a better understanding of the prevalence of CSE and how it is being tackled.

From 5 December 2016, the Leicester City CSE, Missing and Trafficked Children team took responsibility for undertaking return interviews (when these are required) for children and young people who go missing from education, home or care. This should help to identify any additional children and young people at risk that would otherwise not be identified.

In April 2016, a Regional Child Sexual Exploitation Framework was agreed by agencies across the East Midlands, aiming to raise standards, promote good practice and improve the quality and consistency of service delivery across the region. It has been informed by reference to key questions posed by Ofsted during their thematic inspection of CSE ‘the sexual exploitation of children: it couldn’t happen here, could it?’ (Ofsted 2014) in addition to the NWG summary of recommendations from a range of reports, inquiries, serious case reviews and research.
Gypsy and Traveller Children

1. Gypsies and Travellers Introduction

Gypsies and Travellers have the lowest life expectancy of any group in the UK, and experience high infant mortality rates. 18% of Gypsy and Traveller women have experienced the death of a child. They experience, and are being held back by, some of the worst outcomes of any group across a range of social indicators. For instance:

- In 2011 12% of Gypsy, Roma and Traveller pupils achieved for or more GCSEs over grade C, compared with 58.2% of all pupils
- There is excess prevalence of miscarriage, stillbirth and neonatal death in Gypsy and Traveller communities
- About 20% of traveller caravans are on unauthorised sites
- Gypsy and Traveller communities are subjected to hostility and discrimination and often lead separate lives to the wider community.

Gypsy, Roma and Traveller people are not homogenous. The terms may cover English and Welsh Gypsies, Irish and Scottish Travellers, and Roma from Eastern Europe. Roma people may encompass different groups too. There are other groups too, who may be seen in Leicester, such as New (Age) Travellers, bargees or boat dwellers, circus people or showmen.

2. The level of need in the population

2.1 Population profile

Leicester has a small population of Gypsy, Roma and Traveller people. Gypsy and Traveller people generally live on the 3 sites across the city. Most Roma people live in houses in the East Park Road and Narborough Road areas.

Some services have evolved, such as Babington College which specialises in education for Roma people. The Gypsy and Traveller Healthcare service is based at New Parks Health Centre. This has improved access to primary care, with higher registration rates and overcome barriers to care.

There are about 100 children and young people from Gypsy and Traveller backgrounds in Leicester. There are lower rates of take up of childhood immunisations, poor diet and dental health in young children. Rates of teenage pregnancy, domestic violence and drug taking in young males are reported to be higher than in the general population. These have an impact on the mental wellbeing of people in the community.

2.2 Health Status of Gypsy and Traveller People in the UK

Gypsies and Travellers have poorer health status than non-travellers and more self-reported symptoms than all other UK residents. However, they are less likely to access services.

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As with the general population, the health status of Gypsies and Travellers is affected by age, education and smoking. Rates of smoking are generally higher, educational attainment lower and life expectancy shorter than average for Gypsies and Travellers.

The most marked inequality is found in self-reported anxiety and respiratory problems. Trauma, mental and physical health problems endured by Gypsy, Roma and Traveller young people often result from inadequate accommodation, and experiences of eviction and discrimination. These were highlighted for instance in the Dale Farm evictions and arguments about the right to respect for private and family life, home and correspondence. The mental wellbeing of children and young people may be affected by lack of privacy, overcrowding and domestic violence.

Parry et al\textsuperscript{8} found that Travellers’ health beliefs and attitudes to health services demonstrate cultural pride in self-reliance, tolerance of chronic disease and avoidance of screening, possibly linked to fatalistic and nihilistic views on illness.

The health status of Gypsy, Roma and Traveller people is not helped by poor access to care, communication difficulties and stigma and discrimination. Barriers to health care in the past have included reluctance in general practice to register Gypsies and Travellers, expectations of service providers and Gypsies about the service to be provided.

Wilkin et al\textsuperscript{9} found that levels of educational attainment in Gypsy, Roma and Traveller pupils are lower than that for people from minority ethnic backgrounds at all key stages. This is due to a complex range of factors, including barriers that prevent them from fully accessing the curriculum, such as lack of engagement, interrupted education and negative experiences of school. The educational disadvantage of Gypsy, Roma and Traveller families is the most marked difference between this group and other socially deprived and minority ethnic populations.

2.3 Health of Gypsy, Roma and Traveller Children and Young People in Leicester

Defining the Gypsy, Roma and Traveller community is as much an issue in Leicester as it is nationally. The Roma community, which is from Eastern Europe, is generally housed, and accesses primary care, health visiting, schools and school nursing as part of the general population. There has been some interest in a specialist approach to Roma needs in some services, such as in education, where Babington College has developed expertise in looking after needs of young people from the Roma community. However, because most Roma people in Leicester are resident in houses they are most likely to access all services in the same way as the general population.

For Gypsies and Travelers though, almost by definition, housing is insecure compared to the general population. The majority will live on sites. Some Travellers have always lived in houses but have a heritage of moving from place to place and may travel for long periods during the summer months. Others are mobile all the time, some use specific sites in Leicester at Meynalls Gorse, Redhill and Greengate Lane. Show people use a site on Bath Lane in Belgrave. There may be different attitudes between those who live in houses and those who constantly travel.

\textsuperscript{9} Wilkin, A., et al., 2010, Improving the outcomes for Gypsy, Roma and Traveller pupils: final report London, DfE
Clinicians at the Gypsies and Travellers Health Service estimate there are about 100 young people aged 0 to 24 years known in Leicester. Young Gypsy and Traveller people are likely to experience high rates of trauma, accidents and lower rates of take up of immunisations and poor dental health. There are higher than average rates of drug taking in young males and teenage pregnancy. Primary school education for Gypsies and Travellers is common, but education beyond age 11 is rare and levels of literacy are low.

The local specialist approach has improved access to healthcare, with higher rates of registration with primary care. However, there may be higher than average rates of attendance at the accident and emergency department, and lower access to secondary care.

Older Gypsy and Traveller people have a traditional view of society; often this prevails in local communities. This may result in outcomes which are different to the general population; such as traditional gender roles, early marriage and teenage pregnancy. With regard to health and wellbeing, the view of older people can be influenced by their own experience or family history. Clinicians note that Gypsy and Traveller people are often stoical in their outlook on chronic disease, that males may appear less receptive to health advice than in the general population, that children may not access all vaccines which are part of the Childhood Immunisation Programme.

The local Gypsies and Travellers Health Service find that young males are less forthcoming about health need. There are also high rates of accidents among younger males and young people who have experienced bereavement.

Local clinicians agree that Gypsy, Roma and Traveller people are becoming increasingly proactive in seeking health and social care for their communities. This will need to be sustained by continued Gypsy and Traveller engagement in the design and delivery of services, confidence building through trusted practitioners and flexibility and capacity to further develop therapeutic relationships with vulnerable people.