



## **The FGM Initiative**

### **Evaluation of the First Phase (2010-2013)**

**Final report by Eleanor Brown and Joanne Hemmings**

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**Disclaimer:** The views expressed in this report represent those of the authors, and not necessarily those of the various organisations that supported the work.

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The Foundation is one of the largest independent grant-makers in the UK. We make grants of £30 - £35 million annually towards a wide range of work within the arts, education and learning, the environment, and social change. We also operate a £21 million Finance Fund which invests in organisations that aim to deliver both a financial return and a social benefit. [www.esmeefairbairn.org.uk](http://www.esmeefairbairn.org.uk)

**Trust for London** is the largest independent charitable foundation tackling poverty and inequality in the capital. It supports work providing greater insights into the root causes of London's social problems and how they can be overcome; activities that help people improve their lives; and work empowering Londoners to influence and change policy, practice and public attitudes.

Annually it provides around £7 million in grants, and at any one point it is supporting some 400 voluntary and community organisations. Established in 1891, it was formerly known as City Parochial Foundation. [www.trustforlondon.org.uk](http://www.trustforlondon.org.uk)

**Rosa, the UK Fund for women and girls** is the first UK-wide fund for projects working with women and girls. Rosa's vision is of equality and social justice for women and girls and a society in which they:

- are safe and free from fear and violence;
- achieve economic justice;
- enjoy good health and wellbeing;
- have an equal voice.

Rosa will achieve this by championing women and girls, raising and distributing new funds and influencing change. [www.rosauk.org](http://www.rosauk.org)

### [About the evaluators](#)

**Options UK** is the UK programme of Options Consultancy Services Ltd, a leading international provider of technical assistance, consultancy, and management services in the health and social sectors. Options UK was launched in early 2006 to provide technical expertise to service providers, policy makers, and commissioners in the UK. Working with the NHS, local authorities and Third Sector organisations, the multidisciplinary Options UK team provides fresh, innovative, and practical advice, support, and solutions to providers and commissioners of health and social care services.

To learn more about Options UK, visit [www.options.co.uk/uk](http://www.options.co.uk/uk). The PEER approach is a specialism of Options, developed in collaboration with academics at the University of Swansea. For more information about PEER contact [peer@options.co.uk](mailto:peer@options.co.uk) or see [www.options.co.uk/peer](http://www.options.co.uk/peer).

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## Acronyms

AAF	Africa Advocacy Foundation
BAWSO	Black Association of Women Step Out
BME	Black and Minority Ethnic
BSC	British Somali Community
BSCA	Bolton Solidarity Community Association
BSWAID	Birmingham and Solihull Women's Aid
BWHAFS	Black Women's Health and Family Support
CBO	Community-based Organisation
CCG	Clinical Commissioning Group
DH	Department of Health
FGM	Female Genital Mutilation
FORWARD	Foundation for Women's Health, Research and Development
GSWG	Granby Somali Women's Group
HIV	Human Immunodeficiency Virus
IDVA	Independent Domestic Violence Advisor
M&E	Monitoring and Evaluation
NSPCC	National Society for the Prevention of Cruelty to Children
OFSTED	Office for Standards in Education, Children's Services and Skills
OSCA	Ocean Somali Community Association
PCT	Primary Care Trust
PEER	Participatory Ethnographic Evaluation and Research
PSHE	Personal, Social, Health and Economic Education
SCA	Southall Community Alliance
SDS	Somali Development Services
VAWG	Violence against Women and Girls

## Foreword

When the idea of investing in community-based work to tackle Female Genital Mutilation (FGM) was first discussed in early 2010 there was little attention given to the subject by Government or the media. As a group of independent funders, many of us were already funding small but dedicated groups who had been campaigning on the issue for many years. They were telling us that since the updated legislation in 2003, FGM was sliding down the political agenda, and they were concerned that there were still many young girls at risk in the UK.

The FGM Initiative was launched in the House of Lords, hosted by Baroness Ruth Rendell, a long-time campaigner on the issue, and 15 groups were funded to develop community-based projects in various locations across England and Wales. Alongside the £1million investment, an external evaluation was commissioned, so that the groups could be supported to capture evidence of the difference they were making, and also to share the learning with others.

This report provides significant evidence of the progress which community-based prevention work has made over three years, but also highlights the remaining challenges and makes a number of recommendations for improvements.

The key message of the evaluation is that investing in community-based work within affected communities is powerful and effective, not least because the advocates are trusted which means the messages they convey about FGM are more likely to be listened to. But the responsibility does not solely lie with them; statutory bodies need to become more proactive in their response to protecting girls and young women at risk, and an integrated approach which means that responsible agencies working alongside community groups is the most effective way of addressing the issue.

The report also provides useful information about what works, with a number of case studies illustrating the practical work that has been undertaken, which others can learn from. As the Initiative moves forward to the next phase, Comic Relief's investment of £350,000 for a small grants programme to extend the reach of this important work both geographically and with a broader range of communities, is very much welcomed. This will help to build an even stronger network of dedicated campaigners, many of whom take personal risks to highlight the issues, and build the momentum to end Female Genital Mutilation in the UK once and for all.

***Maggie Baxter OBE***

**Chair of the FGM Initiative Advisory Group**

## Executive Summary

### Introduction

The aim of the Female Genital Mutilation (FGM) Initiative is to safeguard children from FGM, through community-based preventive work. This UK-wide initiative was established by three independent charitable organisations: Trust for London, the Esmée Fairbairn Foundation and Rosa, the UK Fund for Women and Girls. The first phase of the Initiative invested approximately £1 million in community-based organisations across the UK over a three-year period (2010-2012). The second phase started in 2013 and will last for another three years. This is the summary of an independent evaluation, conducted by Options UK.

### Key Findings

1. Where community-based preventive work is taking place, rejection of FGM has increased.
2. Funded projects have increased understanding of what works in tackling FGM in the UK (learning is summarised on page 3).
3. Working with younger women to empower them to speak out and make decisions has been more effective than trying to change the often deeply entrenched opinions of older people.
4. The arguments used by funded groups against FGM are maturing and becoming more sophisticated. This has resulted from funded projects sparking necessary discussions and debate about FGM, in a culturally sensitive and grounded way. Projects recognise the risk of legal messages sounding punitive and threatening, and have worked to develop understanding of FGM as a form of child abuse.
5. Awareness of FGM is rising, and discussions about FGM are taking place more frequently, both at community level in project areas, and in national policy circles. The Initiative has made a valuable contribution to increasing the number of safe public and private spaces in which to discuss FGM in an informed and balanced way.
6. Projects have brought together male and female religious leaders and scholars of different faiths to confront misconceptions about links between religion and FGM. There are now clear examples of religious leaders dismissing the perceived religious basis for certain forms of FGM.
7. There is mounting support within affected communities for a more interventionist stance to be taken by the UK authorities against FGM.
8. FGM prevention requires multiple stakeholders – including community groups – working together at local level, mainstreaming FGM under violence against women and girls or safeguarding strategies.
9. Community groups have a valuable role in comprehensive responses to FGM. They have supported women's access to specialist care, acted as intermediaries with social care professionals in cases of girls at risk, disseminated information in schools, and provided training to health and other professionals.
10. The Initiative has helped to build a stronger network of community organisations tackling FGM with increased confidence and skill. The Pan-London FGM Forum has lobbied on national policy issues, and the funders and Advisory Group members have contributed key strategic actions to support the work of projects.

## Challenges

1. There is no effective national policy on the role of local authorities in tackling FGM. Without this, funded groups find it difficult to advocate for a comprehensive response to FGM, if the issue is not already on their local authority's agenda.
2. Some people within affected communities continue to support FGM, which they link to their cultural heritage and/or control of female sexuality. Support for less severe forms of FGM is still also reported.
3. 'Speaking out' within communities still carries risks, and requires sensitivity, safeguards and a long-term approach.
4. Although there are examples of promising practice (e.g. Bristol), local statutory responses to FGM prevention are largely patchy and inadequate, and do not reflect local levels of need. Although most project areas had policies in place, they were not always translated into concrete actions, e.g. training social care/health professionals in issues relating to FGM.
5. Government cut-backs, decentralisation and re-organisation have all impacted on projects' strategic relationships. Although the new commissioning landscape may provide opportunities for projects, there is likely to be increased competition for scarce resources in future, which may make relationship-building harder still.
6. Although there have been some successes, most projects faced resistance when trying to work in schools. Many schools said that they did not want to address the issue for fear of stigmatising certain groups.
7. In less diverse settings, there was a perceived risk that discussing FGM could contribute to stigmatisation of particular ethnic groups. This created challenges for groups conducting prevention work.
8. Some frontline staff, including teaching, social work and health professionals, lack the confidence and/or skills to respond adequately, or to act proactively, in relation to FGM. Some are afraid to raise the issue for fear of appearing discriminatory.

## What Works: Tackling FGM at the Grassroots, Community Level

During the first phase of the Initiative, the following promising approaches to tackling FGM at the community level were developed:

- **Incorporating FGM into other messages**, including a wider range of health issues (e.g. sexual health, mental health), and the law. Exclusive focus on FGM can feel threatening for people who are unaccustomed to talking about FGM or can lead to people feeling fed up of discussing the issue. Inviting health professionals to contribute to these sessions has proved helpful for many projects.
- **Providing safe spaces** to discuss FGM and related issues, where all opinions are heard in confidence (within an appropriate safeguarding framework: any information regarding a child who may be at risk of FGM must be reported to the appropriate authorities).
- **Working with religious leaders**, addressing religious justifications for FGM.
- **Working with young people** (often young women) using a **rights-based approach**.
- Recruiting, training and supporting **Community Champions or Advocates** to mobilise community rejection of FGM and increase the reach of prevention activities.



- Avoiding associating FGM with a **single ethnic/religious group** in public settings.
- Working with **mixed groups** (different ages, ethnicities, or genders) helps to counter views of FGM as an immutable practice.
- Use of **performance and visual/multi-media**. Developing dramas and films has successfully engaged young people in their production, and the final audience in exploring issues relating to FGM.
- Reaching out to **diverse communities** (rather than working with the existing client base of a CBO).
- **Partnering with frontline health workers** to support women affected by FGM in clinical settings.

## Recommendations

### *National leadership*

1. A clear national policy on FGM should be a priority for government, addressing:
  - Standards for how local authorities should engage with community groups to respond to local needs.
  - Mandatory training in FGM for appropriate professionals.
  - How the performance of local areas in response to national guidance will be managed and monitored.
2. Although there is rising awareness of FGM in national policy circles, this needs to be translated into concrete actions. This must include funding prevention strategies, and addressing the demand to bring about a prosecution under FGM legislation.
3. A number of promising national initiatives have been launched (including the Multi-agency Guidelines on FGM and Health Passport). However, attention and resources need to be committed to implementation and follow up to ensure they have an impact. Building stronger relationships with community groups, to roll out such initiatives, is recommended.

### *A co-ordinated, integrated, and resourced local response*

1. FGM prevention at a local level needs to be co-ordinated and integrated. Violence against women and girls and safeguarding frameworks are both useful for this. Multiple stakeholders, including statutory agencies and community groups, should work together to identify local needs and implement appropriate prevention strategies (e.g. through the local Joint Strategic Needs Assessment (JSNA)). A focal person to coordinate and champion the cause – e.g. from within midwifery services or primary care – is important.
2. Community groups can play a central role in helping statutory agencies to deliver their safeguarding obligations in terms of protecting children from FGM. However, they need to be:
  - Significantly better resourced.
  - Supported to ensure they have the relevant skills.
  - Connected with local agencies for coordination and sustainability.
  - Invited to participate meaningfully in planning and commissioning cycles. Existing models in health (e.g. HIV prevention) show how this can be done.

3. There should be proactive attempts to reach new arrivals to the UK with FGM prevention efforts. Community groups can also contribute to this, for instance, by developing information about FGM to include in packages of support to new arrivals.
4. Professionals should seek out support and advice from appropriate community groups to help them build their confidence to work on issues related to FGM.
5. Schools should be encouraged to address the issue of FGM, and should seek out appropriate community groups that can help them raise the issue sensitively.
6. Current resourcing for FGM prevention does not always match need. In the absence of reliable prevalence data, local areas can work with community groups and analyse existing data to see whether there are affected populations in their area, and decide how best to reach them.

#### *Strengthening community groups and their prevention efforts*

1. Accreditation for community groups, demonstrating an appropriate level of training and quality in their FGM-related work, would be useful in terms of helping local authorities to identify groups to partner with on FGM prevention. Quality standards for third-sector groups working on harmful practices are currently being piloted by Imkaan and could be adopted.
2. Working with volunteers requires careful resourcing, in terms of training, monitoring and supporting them, particularly to ensure that they are meeting their safeguarding obligations.
3. Periodic re-engagement with religious leaders will be required to ensure the important messages that they have communicated remain relevant and fresh.
4. Groups in less diverse settings should be supported to network more widely, for increased confidence and skills, or to join forces with other groups in their area for a stronger voice.
5. All project workers and volunteers should be provided with appropriate training so that they can effectively support safeguarding agencies in the context of FGM-related work.

## 1. Introduction

*“One grandmother stated, ‘My God, I have never been asked tougher questions and had to justify why this is my culture. I understand the problems it brings and I know that my granddaughter will not be part of this tradition, but it is sad to see what I grew up believing in leave me, what will we do now?’ The influence produced at this event was a different type of influence, not one argued articulately by outsiders who had never had FGM performed on them, but argued by those within the community affected most by this type of practice and its continuation”<sup>1</sup>*

The aim of the *Female Genital Mutilation Initiative* is to safeguard children from female genital mutilation (FGM, see Box 1) through community-based, preventive work. This UK-wide initiative was established by three independent charitable organisations: Trust for London, the Esmée Fairbairn Foundation and Rosa (the UK Fund for Women and Girls). The first phase of the Initiative invested approximately £1 million in fourteen organisations across the UK over a three-year period (2010-2012).

The *project-level* outcomes of these participating organisations were:

1. To **raise awareness** among affected communities about UK law and the health and psychological risks of FGM
2. To **increase the confidence** of women, men and young people within affected communities to reject this procedure as part of their identity
3. To **increase the skills and capacity** within affected communities to influence individuals, groups, and statutory agencies
4. To **strengthen the voice** of women and communities speaking out against FGM
5. To **improve co-ordination** of activities amongst voluntary and community groups and statutory agencies working on this issue

The FGM Initiative also had the following *programme-level* objectives:

1. To **increase awareness** of FGM amongst policy-makers, statutory agencies, affected communities and the general public in the UK
2. To **strengthen the network** of community organisations tackling this issue with increased confidence and skill
3. To **increase understanding of what works** in tackling this issue within affected communities in the UK
4. To **improve policy and practice** as a result of learning from this initiative

Options UK supported the Monitoring and Evaluation (M&E) of this initiative. The aim of this evaluation is to assess the extent to which both programme and project-level objectives have been met, whilst highlighting examples of effective practice and lessons learned.

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<sup>1</sup> A project worker reflects at the end of a discussion session in Liverpool.

## 1.1 Overview of FGM Initiative

The FGM Initiative consisted of the following interlinked components:

- Fourteen projects (twelve by the end of phase one) carrying out community-based preventive work in Liverpool, Leicester, Cardiff, Middlesbrough, Manchester, Birmingham, Bristol, Bolton, and six projects in London (see page 13)
- Activities to build capacity and strengthen the network between these projects, including learning events and exchange visits between projects
- The formation of an Advisory Group to advise on coordination, communication and sharing of learning, and the strategic direction of the FGM Initiative
- National level activities coordinated by the funders, including support for communications, and advocacy and discussion events
- Research and M&E

### **Box 1. The four main types of female genital mutilation<sup>2</sup>**

The World Health Organisation classifies female genital mutilation into four major types:

- Type 1: Clitoridectomy: partial or total removal of the clitoris
- Type 2: Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora
- Type 3: Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.
- Type 4: Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterising the genital area.

## 1.2 Methodology

Several methods were used to gather information for the evaluation:

- Review of the funded projects' self-reported M&E data
- Interviews with key stakeholders (those with a strategic, operational or clinical role related to FGM)
- Qualitative Participatory Ethnographic Evaluation and Research (PEER) endline data
- Rapid policy mapping

Interim evaluation reports (from 2011 and 2012) and the full PEER base and endline reports are available on the funders' websites<sup>3</sup>.

### **Stakeholder Interviews**

Stakeholders were identified by FGM Initiative project leads, in collaboration with the evaluation lead. In addition, stakeholders with a strategic/operational role related to FGM in local health and social care agencies in areas with funded projects were contacted directly by evaluators. However, few people at local level (4 out of 7 people contacted) were willing

<sup>2</sup> Source: World Health Organisation, Fact Sheet no 241: FGM

[www.who.int/mediacentre/factsheets/fs241/en](http://www.who.int/mediacentre/factsheets/fs241/en)

<sup>3</sup> <http://www.trustforlondon.org.uk/special-initiatives/female-genital-mutilation-fgm/>

<http://esmeefairbairn.org.uk/what-we-fund/major-grants/female-genital-mutilation-special-initiative>

to be interviewed. Where stakeholders (such as Safeguarding leads) were unresponsive or declined to be interviewed, further interviews with project leads in these areas were conducted to understand barriers to working with local stakeholders. A total of 15 people were interviewed (see Table 1), with questions focusing on the extent to which *programme-level* objectives of the FGM Initiative had been met.

**Table 1. Summary of Stakeholders Interviewed**

Organisation/level	Number of interviews
<b>Government Departments</b>	2
London NHS	2
Police	1
London, local authority level	4
Non-London, local authority level	3
FGM Advocates	2
Domestic Abuse Charity (non-London)	1
<b>TOTAL</b>	<b>15</b>

#### **Project M&E Data**

Each project collected its own M&E data using a framework tailored to their activities. The following approaches to data collection were typically employed:

- Keeping records on the number of activities carried out, and who participated
- Evaluations/short questionnaires for participants, requesting feedback on activities and information on their attitudes towards FGM
- Project worker reflections/descriptions of activities and their effects, and how people in the community and other stakeholders have responded to the project

#### **PEER Data**

PEER is an ethnographic evaluation method which uses qualitative research to explore project impact<sup>4</sup>. PEER provides rich insights into attitudes and how they change over time, but does not provide data on the prevalence of behaviours or attitudes. Options UK conducted training for project workers on how to conduct PEER. Project workers then recruited volunteer community members to interview their friends about the impact of the project and their views on FGM. This provided an opportunity to assess attitudinal change since the baseline PEER exercises (in 2010). Findings from the PEER endline are provided in a separate report<sup>3</sup>, and have been integrated into this evaluation report.

#### **Rapid Policy Mapping**

Local-level policies were reviewed in project areas, to assess policies in place for FGM and child safeguarding, and integration of FGM into local Violence against Women and Girls (VAWG) strategies. In a few cases, project leads identified local policy-maker leads for

<sup>4</sup> "Price, N and K Hawkins. Researching sexual and reproductive behaviour: a peer ethnographic approach. *Social Science & Medicine* 55 (2002) 1325–1336". See [www.options.co.uk/peer](http://www.options.co.uk/peer) for more information.

further in-depth interviews to assess the impact of funded groups' advocacy on local policy-making.

### 1.3 Structure of the Report

The evaluation report is presented as follows:

- Contextual/background factors affecting the FGM Initiative
- Key informants' views on the most effective approach to FGM prevention (against which the FGM Initiative's past and future direction can be assessed)
- The extent to which the FGM Initiative's *programme-level* objectives have been achieved
- The extent to which the FGM Initiative's *project-level* outcomes have been achieved
- Conclusions, implications and recommendations
- Summary of individual project activities, progress made, and challenges faced (Annex 1)

#### **Funded Organisations<sup>5</sup>:**

Africa Advocacy Foundation, London [www.a-af.org](http://www.a-af.org)

Birmingham and Solihull Women's Aid [www.bswaid.org](http://www.bswaid.org)

Bawso, Wales [www.bawso.org.uk](http://www.bawso.org.uk)

Black Women's Health and Family Support, London [www.bwhafs.com](http://www.bwhafs.com)

Bolton Solidarity Community Association [www.boltonbsca.com](http://www.boltonbsca.com)

British Somali Community, London [www.britishtosomali.org](http://www.britishtosomali.org)

FORWARD [www.forwarduk.org.uk](http://www.forwarduk.org.uk)

Granby Somali Women's Group, Liverpool [www.granbysomaliwomensgroup.org](http://www.granbysomaliwomensgroup.org)

Manor Gardens Centre, London [www.manorgardenscentre.org](http://www.manorgardenscentre.org)

Ocean Somali Community Association, London [www.oceansomali.org.uk](http://www.oceansomali.org.uk)

Somali Development Services, Leicester [www.sds-ltd.org](http://www.sds-ltd.org)

Southall Community Alliance, London <http://southallcommunityalliance.org/>

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<sup>5</sup> Sudanese Women's Association (Camden) and Women's Health and Cultural Organisation (Middlesbrough) were also funded for a limited period. The outcomes of their work are included in the First Interim Report (October 2011) [www.trustforlondon.org.uk/FGM%20Interim%20Report.pdf](http://www.trustforlondon.org.uk/FGM%20Interim%20Report.pdf)

## 2. Results

### 2.1 Contextual/Background Factors Affecting the Initiative

Several factors had cross-cutting influence on the impact and strategic direction of the FGM Initiative. These should be considered in any analysis of the sustainability of FGM prevention. They include:

- a) **Austerity** – this has affected funding for entities responsible for mainstreaming FGM prevention, including local Safeguarding boards.
- b) **Funding/commissioning** – in general, there has been a strong move away from local authorities funding single ethnic group third sector organisations, towards more ‘general’ Black and Minority Ethnic (BME) and health organisations, in order to address health inequalities.
- c) **Re-organisation within the local NHS** - which in some areas has resulted in greater availability of funding for FGM prevention (for instance, through the Clinical Commissioning Groups (CCGs)), but in most areas has resulted in lack of engagement and responsiveness from local policy-makers and commissioners whose remit is to assess local health and social care needs.
- d) **Capital/regional divides** – there appear to be strong divides (echoed in the PEER data) between the resources and dynamics of FGM prevention in London and other areas of the UK with populations of affected communities.

### 2.2 Stakeholder Views on Approaches to Tackling FGM in the UK

This section reports stakeholder views on approaches to FGM prevention, detection and care in the UK. A consensus among FGM experts on the most effective approach emerged from interviews, which provides a framework against which the past and future direction of the FGM Initiative can be discussed. An integrated approach to tackling FGM – incorporating the efforts of multiple partners including communities, safeguarding children specialists, and clinical services - is increasingly being promoted.

Stakeholders described three main approaches which currently exist at local level in the UK to respond to the health, social protection and legal issues raised by FGM:

- Integration into **child protection/safeguarding** (see Box 1, the ‘Bristol Model’)
- Integration into **VAWG** strategies (Box 2)
- Providing **clinical** (specialist gynaecological/obstetrics) services

**Box 1. The 'Bristol Model'**

Bristol's Primary Care Trust (PCT) has led the city's focus on FGM. A multi-stakeholder group, including representatives from the health, police and third sectors, has focused on mainstreaming FGM prevention as a child protection issue. The PCT has funded three main community groups (from different ethnic communities, so that messages against FGM are not overly associated with a single ethnic group, which can be stigmatising) to carry out FGM prevention work, which has included raising awareness of the legal and health implications of FGM. The incorporation of FGM prevention into child protection has bolstered support from frontline agencies, and visible community support has increased. The local CCGs continue to be interested in funding future FGM prevention efforts.

Experienced FGM campaigners – both in stakeholder interviews and during discussion forums that have taken place under this Initiative<sup>6</sup> – argue that the Bristol Model represents the most comprehensive and integrated model, and should be applied in areas with populations affected by FGM. It entails a high level of coordination between agencies responsible for preventing, detecting, referring and caring for women and girls affected by FGM. This level of response is resource-intensive. However, it has been effective due to its stewardship by the (former) PCT and clinical champions within the health system.

**Box 2. The VAWG Model**

This model can be illustrated by recent activities in the London Borough of Lambeth. The local authority lead for VAWG selected eight strands to focus on in their VAWG strategy. An initiative-funded project lobbied for its inclusion in the strategy. FGM is now discussed in multi-stakeholder meetings, which include representatives from health, the local authority, social care and police. The local authority has funded a 'one stop shop' service for women affected by violence. Front-line staff screen all women attending services for FGM. They have also funded empowerment training for a small group of women from affected communities, who are taking anti-FGM messages back to their communities.

Mainstreaming FGM under VAWG efforts has also started to take place in many of the FGM Initiative areas, such as Birmingham and Islington. Projects which frame their work within a VAWG approach come into frequent contact with local health and social care agencies, and have developed strategic links with safeguarding boards. This model differs from the Bristol Model in terms of which agency leads, but there are many similarities:

- A multi-sectoral response, bringing together leads from different sectors and frontline professionals to discuss FGM prevention
- A named liaison person to coordinate efforts
- Strong leadership and coordination
- Working with – and resourcing - local community groups as partners in prevention

Stakeholders acknowledge the importance of specialist obstetrics services. Prevention and care of women who have experienced FGM are related, as women may view FGM-related complications as '*normal women's problems*'<sup>7</sup> until they access clinical care. Specialist maternity services provide an opportunity to engage with women who may be mothers to

<sup>6</sup> See [www.trustforlondon.org.uk/FGM.pdf](http://www.trustforlondon.org.uk/FGM.pdf)

<sup>7</sup> Quotation from endline PEER research



girls at risk of FGM. However, there is growing consensus among FGM campaigners that although the clinically-focused approach is the most common across the UK, it is too narrow to prevent FGM effectively. In addition, the involvement of local community groups in prevention is much less pronounced (e.g. community groups are not necessarily included in needs assessments and the commissioning cycle).

Some stakeholders argued that integrated models, as described above, are needed for a truly preventive approach, and that this guidance should come from the national level. As one local authority lead stated, integrating FGM under a child protection or VAWG approach unlocks the resources needed at a local level for mainstreaming prevention.

### 2.3 Progress Against Programme-level Objectives

This section discusses the *programme-level* outcomes of the FGM Initiative, in terms of changes in policy, practice and awareness about FGM. The majority of this section is based on information from Stakeholder Interviews. In many cases, interviewees discussed FGM prevention in general, rather than the FGM Initiative specifically. Objectives One and Four are reported together, as there is a clear link between increased awareness among policy makers and statutory agencies, and its translation into improved policy and practice.

#### 2.3.1 Objective 1: Increased awareness of FGM amongst policy-makers, statutory agencies, affected communities and the general public in the UK and Objective 4: Improved policy and practice as a result of learning from this initiative

##### **What Changes Have Occurred?**

There was consensus among stakeholders that the visibility of FGM as an issue, and actions taken to address it, have increased at national level, especially in the last 18 months. Positive steps at national and policy levels include:

- Roundtables and an action plan by the office of the Director of Public Prosecutions on bringing about a prosecution for FGM
- Activities by the All Parliamentary Group on FGM (from December 2011)
- In January 2013, the Office for Standards in Education, Children's Services and Skills (OFSTED) announced that FGM prevention efforts would be included in their inspection of schools
- The recent Survey of teachers' attitudes and awareness of FGM (conducted by the National Society for the Prevention of Cruelty to Children (NSPCC)<sup>8</sup>)
- Initiatives led by the Mayor's Office to chair a multiple stakeholder group to focus on FGM prevention (London only)
- Focus by the Department of Health (DH) to support better recording of, and access to, routine health service data to obtain a more robust estimate of FGM prevalence
- Progress in developing an action plan for improving FGM prosecutions by the Crown Prosecution Service<sup>9</sup>

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<sup>8</sup>See [www.nspcc.org.uk/news-and-views/media-centre/press-releases/2013/female-genital-mutilation/NSPCC-warning-teachers-on-FGM\\_wdn94822.html](http://www.nspcc.org.uk/news-and-views/media-centre/press-releases/2013/female-genital-mutilation/NSPCC-warning-teachers-on-FGM_wdn94822.html)

A few stakeholders also asserted that there was a greater awareness of the need for identification and referral of, and care for, girls and women affected by FGM, especially within the health sector and among frontline staff. Resources such as HM Government's 'Multi-Agency Practice Guidelines' on FGM<sup>10</sup> have, in some areas, garnered commitment from local policy-makers and agencies. Those working directly with women affected by FGM (e.g. in clinical services) reported a strong shift in attitudes towards and awareness of FGM. For example, they reported that women accessing services are less likely to view discussing FGM as inherently wrong, and that front-line health workers' confidence in leading conversations on FGM has increased, resulting in better access to care for affected women.

There is also visibly more interest from local BME/African community organisations in working on FGM, and in several areas, these groups have taken on FGM as a priority issue with very little funding.

The policy mapping highlighted that in some areas, especially where there is high ethnic diversity and local authorities take an inclusive approach (such as in London), FGM has gained policy momentum, and is included within key policies and guidance in all areas where the FGM Initiative has funded projects (e.g. Personal, Social, Health and Economic Education (PSHE) frameworks, Safeguarding training, VAWG strategies). In about half of the areas where projects work, FGM policies were already in existence before the beginning of the FGM Initiative. Only one area (Liverpool) neither had a specific VAWG or FGM policy in place. In areas where FGM prevention is more comprehensive, FGM professional forums now focus on how to operationalise these policies.

#### **Programme-level activities and achievements**

The funders undertook strategic, one-off events and actions to underpin the work of the projects, and provide them with a strategic advantage, including:

- Acting as a contact point for queries from the police, media etc.
- The Youth Conference, which was the launch pad for Daughters of Eve, a campaigning organisation (which showed that by providing a small amount of resources, and helping to raise confidence, doors can be opened for young advocates)
- The Open Space event<sup>11</sup>, which brought new actors to the table and raised interest and awareness, sparking a number of subsequent actions
- Working with a communications agency to develop key messaging for the projects to work with, and providing media training to some of the funded groups

<sup>9</sup> [www.cps.gov.uk/news/latest\\_news/female\\_genital\\_mutilation\\_action\\_plan\\_launched/index.html](http://www.cps.gov.uk/news/latest_news/female_genital_mutilation_action_plan_launched/index.html)

<sup>10</sup> See [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/97857/FGM.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/97857/FGM.pdf)

<sup>11</sup> This discussion and consensus building event took place in July 2012  
<http://esmeefairbairn.org.uk/news-and-learning/publications/what-will-it-take-to-end-fgm-in-the-uk-and-how-can-we-work-together-to-achi>

### **What Lies Behind These Changes?**

Stakeholders viewed this progress as largely driven by a few leading advocacy organisations (those frequently mentioned were Equality Now, Integrate Bristol, the Foundation for Women's Health, Research and Development (FORWARD) and Daughters of Eve) and by a greater focus within the media. There was limited mention of Initiative-funded projects (other than FORWARD) as a source of influence at national level. However, there is some evidence of the FGM Initiative contributing to raised awareness and facilitating advocacy, policy and research developments:

- A number of examples of 'best practice' community engagement and empowerment work conducted by Initiative-funded projects were recognised by stakeholders. These included work with women's groups in Cardiff and Birmingham by the Black Association of Women Step Out (BAWSO) and Birmingham and Solihull Women's Aid (BSWAID) respectively, and the production of useful resources for reaching wider audiences, such as the play and resulting DVD produced by the Ocean Somali Community Association (OSCA) (see Box 3)
- Public forums, such as the Open Space event, were highlighted by some stakeholders as being important in bringing together partners across the media, and third and statutory sectors, to raise the issue of FGM prevention, and reach a clear consensus on safeguarding girls at risk of FGM.
- Some projects have influenced FGM prevention procedures in the statutory sector (see Box 2, above; another example is BASWO's contributions to the Welsh Government's Subgroup on FGM, Forced Marriage and Home Based Violence).
- Others have thus far successfully exerted pressure for the retention of specialist clinical services and FGM safeguarding forums (e.g. BSWAID).
- The FGM Forum in London (coordinated by Manor Gardens) has successfully influenced policy and practice. For example, Project Azure<sup>12</sup>, a regular member of the forum, consulted forum members on the design of their summer FGM campaign in 2012. The forum has also produced a number of campaigning letters (e.g. on an action plan to ensure the implementation of the multi-agency guidelines, on ring-fencing funds on FGM in the VAWG agenda and on regulating female genital cosmetic surgery).
- Many frontline workers in the health and social sectors highly valued partnerships with Initiative-funded projects to work with people from affected communities. Projects worked alongside clinical FGM leads to support women affected by FGM and their partners in clinics, and some project workers partnered with social workers/Independent Domestic Violence Advisors (IDVAs) to work with parents who may support FGM. These professionals felt that project leads were much better placed than them to challenge FGM as a practice. The results from the PEER data strongly support this conclusion.

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<sup>12</sup> The Metropolitan Police Child Abuse Investigation Command's response to the practice of female genital mutilation.

### Box 3. 'Muted Cry'

A group of women volunteers involved with OSCA's work developed a play about FGM with a Somali playwright, translators, and directors. All the characters and stories are based on true stories that the women had heard about or personally experienced. The resulting play, *Muted Cry* has been widely shown within the community, and is used to prompt discussion about FGM. OSCA also succeeded in getting strong contributions from two religious leaders / scholars who contributed to the DVD recording of the play. Responses have been generally positive:

- *'The play was very thought provoking. The discussion helped widen my knowledge in terms of the cultural aspects of FGM.'*
- *'The play was a realistic illustration of the risk of FGM and dynamics in Somali communities.'*

### Remaining Challenges

Some stakeholders questioned the extent to which enhanced awareness among policy makers is being translated into a strategic response and tangible action at national and local levels. Local authority leads asserted that the inclusion of FGM within policies or procedures can be tokenistic if resources are not allocated to it, or staff are not named to champion the issue and translate it into practice across local government agencies (as per the Bristol model).

Some key stakeholders wanted the Initiative to consider the issue of sustainability more carefully. If, ultimately, the aim is for FGM prevention to be mainstreamed into VAWG or Safeguarding policies – and thus be funded by local authorities – this transition will involve closer working and coordination with local authorities, which may require greater support from the FGM Initiative if the local policy environment is unfavourable. In some cases, stakeholders who have funded community-based prevention would have liked to have known more about Initiative-funded projects, to better integrate them into their own strategic plans. However, simply placing FGM under a Safeguarding or VAWG strategy does not constitute a comprehensive response. Although local authorities are increasingly willing to incorporate FGM within Safeguarding, this has been interpreted by some FGM advocates as a move away from the need to engage with communities affected by FGM<sup>13</sup>.

Most projects funded by the Initiative *have* attempted to engage with local health and social policy-makers, but while there is increased awareness of and dialogue around FGM at the national level, there has been a reduction in opportunities at local levels for organisations to exert influence on FGM policy and practice. In several areas local safeguarding boards had sub-groups focusing on FGM, which have now been disbanded in recent government cuts and re-organisations (Liverpool, Leicester). The new organisations that will be assessing needs and commissioning services have only just come into existence, and at the time of this evaluation had not yet established alternative mechanisms.

In some areas, where Initiative-funded projects have identified a high level of need, relatively little has resulted from engagement with local policy-makers, despite resource-

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<sup>13</sup>See 'Imkaan, Equality Now and City University (2011) The Missing Link: a joined up approach to addressing harmful practices in London Executive Summary. London: Greater London Authority' [www.dropbox.com/sh/4zq0jgk4xyez91i/9xvCKa5r0H/The%20Missing%20Link%20Exec%20Summary%20September%202011.pdf](http://www.dropbox.com/sh/4zq0jgk4xyez91i/9xvCKa5r0H/The%20Missing%20Link%20Exec%20Summary%20September%202011.pdf)

intensive efforts (mostly outside London, but also, for example, in East London). A few stakeholders felt that not all Initiative-funded projects have the requisite skills to engage in this sort of policy advocacy. As one stakeholder commented, *“If they are just doing a bit of education, then do we force them to become policy advocates? The Initiative needs to think whether they can support a central group to put pressure on local authorities.”* In a few areas, despite the presence of communities affected by FGM, local policy-makers have been largely unresponsive, but this may be due to local strategies already being in place. In one area in London where there has been a lack of response to Initiative-funded projects, for instance, FGM is already included in local safeguarding policies and training strategies, but another organisation acts as a local advocate. Organisations outside London have to work harder to make links with strategic agencies. In one area, project workers asserted that with no named person to liaise with in the local council, advancing a mainstreaming agenda had become very time consuming: *“Do we deal with the stuff to do here or do we spend time hunting down the right organisations?”*

A recurring theme was the lack of clarity about respective roles of, and lines of communication between, national and local levels. A few stakeholders, including within statutory agencies, wanted to see stronger links between national and local levels in relation to FGM policies and practice. They provided examples of where national agencies should provide greater leadership (e.g. holding local authorities to account for comprehensive and well-resourced FGM prevention, and publishing national directives to guide local responses).

The ‘Health Passport’<sup>14</sup> was quoted by several stakeholders as an example of national level agencies launching an intervention with little follow up to ensure that local agencies fully understood what was expected of them. Some stakeholders wanted to see better direction from the Mayor’s Office (London) to coordinate and monitor the implementation of current policy, and provide direction for local authorities to ensure commitment to tackling FGM. Likewise, if information from the local level (e.g. about barriers to conducting FGM prevention work) were communicated effectively to the national level, this could facilitate a better response from the national level to address these barriers. For instance, Initiative-funded projects frequently faced barriers to working in schools; OFSTED’s announcement that they will inspect FGM prevention activities in schools could now make them more open to working with community groups.

Some stakeholders were critical of generally slow progress at local level in responding to FGM. It was felt, for instance, that efforts were too focused on specific areas, such as improving the availability of specialist health services, or bringing about a prosecution, resulting in a siloed response.

Outside London (with some notable exceptions, such as Bristol and Wales), gaps in FGM prevention also emerged. Several stakeholders felt that statutory and other funding sources

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<sup>14</sup> A government statement that can be carried in a passport explaining that British residents can face jail if they are involved in arranging FGM while abroad, see [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/118121/FGM-declaration.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/118121/FGM-declaration.pdf)

were more readily available in London; that there is greater policy focus on FGM in London; and that there is a more diverse range of views on FGM (including strong anti-FGM voices) in the Capital. This contrasts with relatively isolated, more newly established migrant/refugee communities outside London, who may adhere more strongly to their traditional values. It may also be that outside London, professionals are less aware of FGM and more reluctant to intervene. Furthermore, in areas outside London where ethnic groups are more socially isolated, it may be harder for affected women to demonstrate opposition to FGM against the prevailing views of their communities, for fear of stigmatising their community.

Challenges within the social care response were identified by a range of stakeholders, including local authority and clinical leads, many of whom did not feel confident that they could refer girls at risk of FGM. Barriers included high referral thresholds for social care agencies, and failure to take into account the particular nature of FGM as a form of violence. In some cases, social workers are reported to focus on current abuse cases, rather a historic case of FGM: *“If they have a child with bruises they would rather focus on that than on a child with FGM done five years ago.”*

Stakeholders are also concerned about the overall low numbers of specialist services, especially outside London. Reports of women being de-infibulated too late, or during labour, are still too common.

Some stakeholders argued that FGM is highly prevalent among some ethnic groups that have been overlooked to date. This corroborates data from the PEER research which found that some ethnic groups (in particular, some Somali groups) have reached a stage of more vocal opposition, whereas others have not.

Many stakeholders commented that the funding that the FGM Initiative has provided has been a lifeline for FGM prevention: *“It is really helping to find a voice for these groups at a grassroots level”* (local authority lead, London). However, both statutory and third sector stakeholders criticised very low levels of government funding for FGM prevention. Central government departments may expect local authorities to assess local needs and fund FGM prevention accordingly, but stakeholders are largely sceptical that this will actually meet the current need for FGM prevention nationally.

There was very little consensus or clarity among stakeholders on the potential role of CBOs in FGM prevention, especially from stakeholders at national/regional levels (as opposed to local levels). This is partly because commissioning for prevention activities is seen as the responsibility of local statutory agencies, and partly because there are relatively few opportunities for engagement of CBOs in higher level strategic forums.

### **2.3.2 Objective 2: A stronger network of community organisations tackling this issue with increased confidence and skill**

Three networks have operated through the FGM Initiative: **the advisory group**, which comprises of policy leads, FGM advocates and FGM specialists within the statutory sector;

**third sector organisations** funded by the Initiative to lead on community-level FGM prevention; and the **London FGM forum** (coordinated by Manor Gardens, which was the largest non-statutory sector forum on FGM in London).

### What Changes Have Occurred?

Firstly, several stakeholders who had participated in the **advisory group** found this to be a useful part of the Initiative, in terms of sharing and disseminating information on FGM prevention activities: *“It’s a very good way of finding out what’s happening, pulling together different experts and look at the issues from all angles”* (Government Department).

In terms of **building a network of organisations** conducting community-based preventive work, a number of examples of Initiative-funded projects’ contributions were discussed by stakeholders:

- Manor Gardens’ role in coordinating London-wide FGM work,
- Linkages with statutory agencies in Birmingham (BSWAID) and Cardiff (BAWSO).

The network approach and peer support offered through the Initiative were cited by several project workers as building their own confidence in tackling support for FGM: *“It has meant that I was able to speak to other groups and meet them one to one, which has formed a working relationship and a deeper understanding of all the work that has been done nationally. This has had an impact on the project in terms of giving me ideas and sharing my good work with others, as well as skills and techniques I need in overcoming the challenges and struggles of educating the community about this deep-rooted culture.”* (Bolton Solidarity Community Association (BSCA))

Being part of a network was particularly useful for project workers when it came to the issue of links between religion and FGM. They found it useful to hear about work with religious leaders undertaken by other organisations in the Initiative. Several project workers reported that this helped them feel more confident about approaching religious leaders to talk about FGM, and projects shared materials used to tackle misconceptions about the links between FGM and religion.

Project workers also credited the network with strengthening the impact of their work: *“The fact that many different projects were operating in London made it easier to put pressure on statutory professionals to include FGM in their safeguarding agendas”* (Manor Gardens).

Learning events have provided an opportunity for project workers and volunteers to share knowledge and lessons learned, either in person on the day, or with follow-up visits/communications. They have also helped them build their skills in key areas of their work. For many of the projects, the statutory regulations that they routinely encounter through their work on FGM have been complex (e.g. Child Protection procedures), and the learning and capacity-building approach adopted by the Initiative was highly valued: *“The most useful aspect of the learning events was getting in experts in the field, such as Efua Dorkenoo and Dr. Creighton, who shared their knowledge and inspired us to continue our work”* (Manor Gardens). In another example, BSWAID found that attention from the media

presented a big challenge to public perceptions of their work in 2012 after an alternative doctor and a dentist were reported to have expressed willingness to perform FGM or arrange for the operation. BSWAID received a lot of sensationalist attention from the media, and found that the training from Champollion, a communications agency (which was provided by the Initiative), was extremely helpful in dealing with press attention.

Formats that encouraged project workers to share experiences or approaches face to face have been more valued than online formats. The knowledge gateway has been used as a library rather than as a forum for online debate, and it may be that formats such as email newsletters would be more appropriate for engaging projects in virtual debate and learning.

### **Remaining Challenges**

In some local forums, national-level FGM organisations are present and are even named as 'FGM leads', bypassing local CBOs. This led to some resentment among local projects, which could hamper the effectiveness of the network. This is compounded by the fact that the same few organisations representing affected communities tend to be invited to national-level strategic forums. The role played by these national-level organisations reflects the limited spaces in policy-making forums and lack of clarity about the role of CBOs in FGM prevention, rather than the desire of particular organisations to dominate. Where comprehensive models of FGM prevention are being rolled out (such as in Bristol), a network approach across stakeholder groups is encouraged, and there is room for multiple community voices to contribute.

Different projects within the Initiative have different levels of capacity and experience. It is not always straightforward, therefore, to pitch training at the appropriate level. However, the initiative has provided the opportunity to link less experienced groups with people who can advise them, in a supportive atmosphere, and in general, the more experienced groups have been very enthusiastic about sharing their knowledge with a wider network.

A few stakeholders expressed the need to support CBOs further in the following areas:

- basic project management and fundraising skills
- skills to engage with local health and social care policy-makers, particularly to promote mainstreaming FGM prevention

### **2.3.3 Objective 3: Increased understanding of what works in tackling this issue within affected communities in the UK**

This section considers 'what works', and whether this knowledge has been effectively communicated to a wider audience, in terms of approaches at two main levels:

- Preventive work at the grassroots, community level
- Mainstreaming FGM (working with statutory agencies)



Robust data on whether particular approaches have had a positive impact on attitudes and behaviour is very difficult to obtain. For the purposes of this evaluation, the following proxy measures are used to identify whether particular approaches 'work':

- **Community level:** project activities are met with positive response by community, are well attended, are valued by the community (positive feedback), stimulate discussion and interest, are credited with catalyzing change in M&E and PEER data, generate a high level of consensus among stakeholders about effectiveness of approach
- **Mainstreaming:** resources are committed to FGM, sustainability of efforts is high

#### **What Works: Preventive Work at Grassroots, Community Level**

Projects have found that the following approaches to be effective at community level:

- Incorporating the issue of FGM into other messages, including a wider range of health issues (e.g. sexual health, mental health), and the law. Exclusive focus on FGM can lead to people feeling fed up of discussing the issue, or can appear overly threatening for people who are unaccustomed to talking about FGM. Inviting health professionals to contribute to these sessions has proved helpful for many projects.
- Providing safe spaces to discuss FGM and related issues, where all opinions are heard in confidence (within an appropriate safeguarding framework: any information regarding a child who may be at risk of FGM *must* be reported to the appropriate authorities).
- Working with religious leaders, and/or addressing religious justifications for FGM (Box 4), particularly when rights-based messages are integrated.
- Working with young people (often young women) using a rights-based approach. A few stakeholders felt that there should be a firmer embrace of this approach, which argues for 'zero tolerance' of all forms of FGM, and that work with others in the community – such as older people supportive of FGM – was unlikely to be effective.
- Recruiting, training and supporting Community Champions or Advocates to mobilise community rejection of FGM (see Box 5) and scale up the reach of prevention activities
- Avoiding associating FGM with single ethnic/religious groups in public settings
- Working with mixed groups (mixed ages, ethnicities, genders) which helps to counter views of FGM as an immutable practice
- Use of performance and visual/multi-media to explore issues relating to FGM. For instance, developing dramas and videos has been a successful way to both engage young people in the production of these materials, and for the final audience to explore issues relating to FGM (e.g. BAWSO's partnership with the National Theatre Wales and young Sudanese people to raise awareness of harmful traditional practices like FGM through drama)
- Reaching out to diverse communities (rather than working with the existing client base of a CBO), see Box 6
- Partnering with clinical leads to support women affected by FGM

#### **Box 4. Case Study: Working with Religious Leaders**

FGM is commonly believed by some religious leaders and communities to be sanctioned in religious texts and teachings. This mistaken belief legitimises the practice for many people, and can be a barrier to changing communities' attitudes about FGM, even when the health risks are widely understood.

In response to this challenge, the Manor Gardens project in London has worked directly with religious leaders to confront misconceptions about FGM and religion. In 2011, the project team organised a multi-faith conference '*Faith against FGM*' at which religious leaders (including a Professor of the Muslim College, a Somali Imam, a member of the Muslim Council of Britain, and Christian Pastors) spoke about teachings on FGM in their faiths. They identified a shared message across their religions: that 'your body is a temple of God'. The conference was attended by 70 people, and recordings of the event have been subsequently viewed on YouTube over 600 times. Encouragingly, 91% of attendants reported that their views on the links between religion and FGM had changed to some degree as a result of attending the event.

Gaining the trust of religious leaders to participate in the conference was a challenge. Project workers started by identifying leaders with the strongest voices within the communities they worked in, before establishing whether they would be willing to participate. The team carefully researched what Islam, Christianity and Judaism say about FGM, and invested time forming relationships with individual leaders, meeting them each in person before the event to discuss aspects of their faith. Project workers quickly realised that the main risk was that speakers would not condemn all types of FGM at the event. The concern was around a disputed Hadith that has in the past been used to support the practice of Type 1 FGM. Project workers screened participants in advance, and one of the programme's advocates, who is himself an Imam, prepared a list of questions about Islam and FGM to check whether potential Muslim participants would condemn all types of FGM. With Christian leaders, the concern was lack of knowledge around the subject and fear of speaking publicly about a taboo issue. In order to help leaders overcome their concerns, project workers researched religious documents and scholarly texts and helped them prepare their speeches. When leaders felt that they could not speak out against FGM in a public forum because of cultural taboos, Manor Gardens encouraged them to hold events within their communities.

Despite many challenges organising the event, Project Manager Hekate Papadaki feels that the conference was crucial: '*The majority of believers have not studied religious documents and most of what forms their faith is passed on orally, by example and alongside other cultural practices,*' she says. '*Therefore, the only people who can challenge the belief that FGM is a religious obligation are religious scholars and leaders themselves.*'

#### **Box 5. Case Study: BSWAID Community Champions**

In early 2012, BSWAID started an initiative to develop a cadre of FGM Community Champions. Their role was to raise community awareness about harmful practices such as FGM and encourage people to eradicate these practices. BSWAID started the initiative as a natural progression from their PEER research study into FGM in Birmingham; through the research they had already recruited several female community members who wanted to play a larger role in raising awareness of FGM. They were keen to ensure that the community was empowered to lead work on FGM prevention in Birmingham, and also hoped to increase the impact of their work: '*The main challenge I faced in my role was a lack of time,*' says Project Worker Khadija. '*By getting community members to take a role in FGM work, I hoped to increase the reach of the project and the amount of time dedicated to FGM*

prevention.’

Over several months, BSWAID recruited women from regular FGM community groups who showed leadership qualities and people skills, alongside the women who were already involved from the PEER research. Several men who were keen to eradicate FGM were also recruited along the way. Khadija and colleagues at BSWAID provided training on FGM and health, religion, and human rights; domestic violence; and facilitation techniques. Khadija also provided on-going mentoring support to develop the Champions’ skills and confidence. *‘The Champions informed me when their communities were gathering,’* says Khadija, *‘And I encouraged them to practise their skills at the event by talking about the harmfulness of FGM, what Islam says about type 3 FGM or what Christianity says about harming other humans.’* In addition to this on-going work at community and religious meetings, the champions each used funds from Birmingham City council to organise and facilitate an event. Khadija assisted them with this and the Champions received a certificate and a small payment to reward and acknowledge this work.

Khadija feels that the Community Champions have added significant value to BSWAID’s work. By recruiting Champions from different backgrounds, ethnicities, and religions, she feels that the project has been able to reach a far greater and more diverse range of people than Khadija alone would have been able to through her own predominantly East African networks. Engaging the time and energy of a group has also amplified the reach of the project. For Khadija, the key to the initiative’s success has been carefully selecting confident, skilled volunteers, and investing sufficient time to support and nourish their ideas and enthusiasm.

#### **Box 6. Reaching Diverse Communities**

BAWSO is an All Wales organisation which has been particularly successful in reaching a diverse range of people from different ethnicities, nationalities, religions and language groups in Cardiff. The organisation points to a number of factors which has allowed it to connect with people from countries including Sudan, Gambia, Somalia, Sierra Leone, Nigeria, Indonesia and Yemen:

- BAWSO has an on-going and long established programme of work to engage with community groups on issues of interest to their members, and help build their capacity. This has established an important level of trust which has enabled project workers to engage with communities on more sensitive issues such as FGM.
- A close partnership with the Welsh Refugee Council has also been central to the project’s success. Staff at the Refugee Council have agreed to alert BAWSO when refugees arrive from areas with high FGM practice rates. Project workers then attend sessions organised by the Refugee Council where they introduce the FGM project and identify if BAWSO’s wider programme of work may be of interest.
- The use of interpreters has been important in effective communication with people from a wide range of language groups. Although most clients speak some English, BAWSO has found that using interpreters allows a level of discussion and debate that cannot be achieved in a second language. Carefully selecting interpreters (sometimes from outside the community to protect anonymity), and speaking with interpreters about their beliefs about FGM before they start work has been essential.
- BAWSO has found that employing people to work within their own communities can have both advantages (more immediate sense of trust, better grasp of the cultural norms) and disadvantages (lack of objectivity, fear of judgment by community). The key has been to ensure that project workers remain self-aware, conscious of how their own ethnicity, religion

and race may affect their effectiveness.

- Finally, BAWSO has found that it is crucial that project workers engage with communities on their own terms, understanding their interests and priorities, without reducing people to their experiences of FGM. For example, BAWSO has found that while the local Somali community are most interested in engaging with the issue of FGM in the context of health and family planning, the Sudanese community in Cardiff is more interested in the relationship between religion and FGM, and individuals from Gambia and Sierra Leone are just keen to learn more about FGM in general.

### **Remaining Challenges**

- A few stakeholders felt that working with religious leaders was not an approach that could be further developed, or that funders should prioritise, as both national-level leadership and the extensive resources required to engage with faith leaders were lacking (see section 2.4.2).
- Several stakeholders pointed out that some Initiative-funded projects are yet to fully embrace a rights-based approach. Some projects lack the skills/desire to do so, or report that some communities are hostile to/uninterested in the concept.
- In some cases, Initiative-funded projects have focused on working with groups where support for FGM is strongest (often older people), rather than empowering those who are more likely to protect and prevent (arguably, younger people/parents of younger children).

### **What Works: Mainstreaming FGM**

The following approaches – which have been discussed in greater detail earlier in the report – characterise the strategies of projects which have been successful in integrating FGM into statutory responses (thus leveraging resources and improving the sustainability of efforts):

- Positioning FGM within a VAWG or Safeguarding agenda
- Working with frontline statutory staff to address FGM-related issues in a culturally sensitive way
- Coordinating the Initiative’s work with local authorities in areas where FGM is being addressed (and resourced)

### **Remaining Challenges**

The policy mapping highlighted that Initiative-funded organisations were often working in parallel to, rather than in conjunction with, local authority leads.

Initial phases of the FGM Initiative have focused on piloting and developing approaches, and so far, have not focused on documenting and sharing what they have found to be effective. Many stakeholders wanted to see better visibility of projects’ work at national level, including evidence on successful approaches to tackling FGM.

## **2.4 Progress Against Project-level Outcomes**

This section examines the extent to which projects funded by the Initiative have made progress under five outcome areas (see section 1.1). Two separate streams of data are

referenced: PEER endline data and project M&E data. Quotations in boxes are either from PEER data, or are project workers' reflections from their M&E reports.

#### 2.4.1 Outcome One: To develop projects within community organisations to raise awareness among affected communities about UK law and the health and psychological risks of FGM

##### **Project Activities**

All projects included raising awareness of the law on FGM and of the psychological/health effects of FGM as part of their key messages in community-based activities, including outreach in clinical settings. Many projects have integrated FGM into other health-based messages, e.g. sexual health. Health-based messages have been communicated in several ways – through outreach and workshop-based activities, and through individualised support to women affected by FGM at drop-in sessions or on-site support in specialist clinical services. Project workers in all projects have provided consistent messages about the law on FGM, as well as implications for Safeguarding (that a girl child affected by FGM may be removed from her parents).

##### **Legal Awareness**

Awareness of the law was low but variable at baseline, varying by migration route into the UK. In communities who had transited through the Netherlands, for instance, awareness of FGM as both illegal and harmful was already high. The PEER endline study provided evidence of a substantial shift in attitudes towards FGM, with awareness of the law and penalties for performing FGM having increased substantially since baseline.

However, the extent to which the law deters the practice of FGM is variable. Individual instances of mothers choosing not to conduct FGM on their daughters because of fear of implications were cited by a few, but in project areas where support for FGM was more pronounced, project workers noted that some people were not deterred by fear of the law, as the lack of prosecutions for FGM in the UK is widely known.

I want more support for the women, like what Women's Aid are doing, not what government are doing. If you don't know the law... you get punished. First educate, and she knows it's wrong: if you go to an event and Women's Aid tell her that if you do it you will lose your kids and go to jail, and she does it, then she knows. But if she doesn't know the language, or know the law, and she has done it by mistake and she takes punishment... if she is not educated it is unfair. I like to educate the community. **BSWAID**

PEER researchers asked specifically about views on the UK government's interventions and legal stance towards FGM. Views depended on respondents' own attitudes towards FGM, but those who had discussed the issue and viewed themselves as anti-FGM wanted to see more legal awareness/education on ethical grounds, so that people were aware of how to not break the law.

Legal awareness appears lower in some ethnic/nationality groups than in others: Sudanese and Eritrean groups reported lower legal awareness than Somali groups, who have been targeted by long-standing interventions. Some respondents wanted to see more legal

information and education targeted at new arrivals, which respondents and project workers consistently identify as having higher levels of support of FGM.

I know that it is against the law and that it is illegal in the UK but I am not aware of the penalty. I am not sure if this fact is widely known amongst the Sudanese community in the UK. I suggest a talk to raise awareness about UK government views and laws on FGM. **BAWSO PEER data**

Generally this community has got the awareness and is willing to stop and protect their children and friends from abuse. It's important that communities are made aware that FGM is illegal in UK when they arrive in the UK. **BSWAID**

The main question they ask is: "Can my citizenship be revoked?" They are surprised by the sentence attached to it, as they generally do not see it as a serious issue – they are conditioned to think that it is normal. **BWAFHS – Project worker notes**

Younger women still maintain that the lack of convictions relating to FGM practice was due to the police 'not caring about the issue'. **BWAFHS – Project worker notes**

In many instances, project workers noted that legal awareness results in shallow shifts in attitudes towards FGM, and that deeper shifts result from understanding of FGM as a form of abuse, rather than as a means of protecting girl children. Project workers are often well placed to deliver complicated messages around safeguarding children, because they are recognised and trusted within their communities.

There is some indication that where support for FGM is still strongly tied to cultural identity, people tend to view the law as punitive: *"Some communities believe the practice is who they are, and that their tradition/culture is being taken away from them."* (Southall Community Alliance (SCA)).

One indicator of rising legal awareness is that there is a clear and emergent demand, particularly among young women, for more interventions from prosecuting authorities.

Lastly, awareness that less severe forms of FGM are illegal was low at baseline. Many projects have developed comprehensive responses addressing these perceptions. Communications with the police (Project Azure) at the beginning of the project ensured that all projects were clear in stating that all forms of FGM are illegal.

Issues concerning legality and detection were also discussed, and how it would be very hard to stop or find out if someone was going to carry out FGM on their child unless the community endorse a 'no tolerance' policy, and how this should be the direction the workshops take in the next phase of the project. **Granby Somali Women's Group (GSWG)**

However, both interim evaluation reports (2011 and 2012) and the PEER endline study identified that there was still support for lesser forms. Project workers have been developing 'zero tolerance' arguments to FGM (i.e. not tolerating FGM in any form, including 'lesser' forms).

### **Health Awareness**

Discussing the health impacts of FGM has been the most accessible entry point for project workers looking to mobilise women to participate, and to shift attitudes towards recognising the harm that FGM causes. The second interim report from the Initiative commented that

while raising health awareness on FGM has been successful in countering support for FGM, support for less severe forms of FGM has been harder to counter using health-based arguments. Most of the elderly Somali women reached by OSCA have expressed a certain degree of scepticism about the health dangers associated with FGM having not experienced any the dangers directly themselves, and several other projects estimate that there remains considerable support in their communities for less severe forms of FGM.

Greater awareness of the harms that FGM causes has also supported discussions on why FGM is illegal in the UK, explaining why a practice viewed by some as intrinsically part of cultural expression is viewed as a form of child abuse by many.

Most women attending groups held by AAF were found to be against type 3 FGM, but there was support for type 1 FGM from women who had undergone the procedure themselves. For these women, FGM was felt to be central to their cultural identity and was perceived as harmless.

**AAF M&E data**

A few projects have also worked alongside specialist FGM clinical services, or as health advocates for women accessing services. PEER data show that in project areas, there has been a substantial increase in women's knowledge of who they can contact to access specialist services, or one to one support.

Project and PEER data show that women often prefer to access social support from an FGM advocate before accessing care. FGM clinical leads have reported increases in women accessing care, and where specialist FGM staff work with project workers on-site, they highly valued their presence, which helped them to have conversations with patients about attitudes to FGM. Project workers' reports show that women accessing care may not recognise the severity of their symptoms, or that health problems they have experienced are due to FGM, until this is confirmed by clinical staff and/or project workers.

**2.4.2 Outcome Two: To increase the confidence of women, men and young people within affected communities to reject this procedure as part of their identity; and Outcome Four: To strengthen the voice of women and communities speaking out against FGM**

Outcomes Two and Four are presented together as there is considerable overlap in the evidence used to assess each outcome.

**Project Activities**

'Increasing confidence to reject FGM' at a community level requires several stages of work, including (but not limited to): identifying those willing to be involved; developing community understanding and skills; and designing and implementing a range of activities where confidence can be developed, and people have the opportunity to reflect on and talk about FGM and related issues.

Project activities in the early stages of the Initiative focused on tackling perceptions of FGM as a religious practice; working with a range of women and girls through workshops; youth-

led approaches (building up the confidence and skills of young people to campaign against FGM); and conducting outreach to help people develop confidence to talk openly about FGM (e.g. chatting with people in community centres or places where they meet to socialise).

The Gambian lady owns a shop and salon, lots of people go there. She lost her first child to FGM... Her mother in law is a cutter. Now she is very committed (against FGM) and she has a lot of influence in the African community because of the shop and salon. **BAWSO**

In later stages, many projects have moved onto working with men, religious leaders, and multiple ethnic or inter-generational format workshops. Projects have also diversified the ways in which they reach people.

For example, having previously struggled to reach Eritrean women at sessions in the community, the Manor Gardens project successfully engaged this group by organising workshops at regular prayer meetings held at the home of local women. Eritrean men were successfully engaged through workshops in a grill restaurant that they regularly frequented. BAWSO has worked with a Gambian woman (see quote above) who has become an advocate against FGM, talking to women about the issue in her shop/salon, and organising an event to discuss the negative effects of FGM attended by 26 Gambian people.

The way in which projects have approached the aim of getting people to *'reject FGM as part of their identity'* has varied according to context. The extent to which FGM is an important part of people's identity is highly variable, and often relates to patterns of migration into the UK, the position of BME communities within their wider social and political context, education of women and girls, and levels of understanding of FGM. In some areas, such as Leicester, project workers and PEER baseline data showed that there was pre-existing rejection of FGM, probably reflecting this community's migration through other European countries where there had been interventions to prevent FGM. In other areas, the baseline report found that support for FGM was often mixed but was largely difficult to discuss openly. Parents' decisions to perform FGM or not largely appeared to take place in secret.

*'Strengthening the voice'* can likewise take many forms. Projects have used performance art, conferences, and intergenerational dialogue to provide opportunities for people to speak out about FGM both within and outside their immediate communities. Strengthened voices are also important at the household level (young women resisting FGM, or men assuming a greater role in prevention of FGM). Some projects have hosted inter-generational or mixed-ethnicity events to reach a wider audience and provoke community debate. BWFHS, for instance, hosted a "Zero Tolerance to FGM" day, as well as a "Mothers and Daughters Day" (in collaboration with OSCA). OSCA in 2012 hosted a play (developed with participation from women affected by FGM, see Box 3), and this attracted a mixed audience where participants could speak out against FGM.

Initially, projects focused on 'voice' in a quite literal sense (i.e. women speaking out at public events), but subsequently projects have used a variety of other ways to capture voice. BSWAID, for instance, conducted a PEER study, the results of which were used to stimulate



discussion about FGM among affected communities in Birmingham more widely. They also published a 'Voices of Women Leaflet' to raise the profile of women's groups in Birmingham rejecting FGM (see Box 7 below). Somali Development Services (SDS) have also collected stories from women affected by FGM, to highlight and share their experiences.

**Box 7. Voice of Women Leaflet, BSWAID**

BSWAID have developed a leaflet called 'Voices of Women' targeted at professionals working with women affected by FGM. The leaflet includes the following pieces of advice:

- Listen to our views on FGM before passing judgement
- To us, the UK offers us rights which we came to the UK for, and which we value greatly
- Our fears are that we'll be seen as child abusers instead of as a community trying to overcome the horrible practice of FGM
- FGM is a private matter to us and we'd rather discuss it with someone we feel comfortable with when the need arises

Almost all projects have worked to address misconceptions that FGM has religious justifications. Projects have organised open public forums to discuss FGM and religion, including a multi-faith forum for religious leaders, who openly stated their opposition to FGM (jointly organised by OSCA and Manor Gardens, see Box 4). Projects such as SDS (Leicester) and the Africa Advocacy Foundation (AAF) (London) have worked through religiously-linked informal women's networks to raise the issue of FGM. In some areas, such as Ealing, project workers (from SCA), were unable to find religious leaders willing to work with them, but the Initiative's network approach allowed for the development and sharing of materials to counter religious justifications for FGM, without having to rely on religious leaders themselves to speak out against the practice.

Many projects also engaged with community leaders to advocate for the need to break the silence around FGM. They have also sought to develop 'Community champions' (often project workers themselves, not all of whom are from affected communities, but many of whom are, see Box 5). Many of the projects have also worked with community-based volunteers, who have disseminated information, helped to organise events, or had a wider role as community mobilisers working with an empowerment approach (this involves building the skills and confidence of volunteers through training, coaching, and mentoring, such that they gradually take on more responsibilities and achieve greater independence in their work).

Work targeting men has been undertaken through outreach, workshops, and on-site support to men accompanying their partners to access clinical services. The Interim Report (2012) reported that many groups have found it challenging to engage with men on FGM, but by the end of Phase One, many were using more effective methods, such as outreach to places where men congregate, and male outreach workers to reach men. It is expected that this area of work will be developed in the next phase of the Initiative.

## **Project Impact**

At baseline, the PEER data indicated that there was some awareness that FGM was not a religiously condoned practice, but that there was a lack of clarity on this issue. OSCA's project worker reported, "They are starting to realise it is not their religious duty ... yet they don't quite know how it works and why and how it is not religiously allowed. Another problem is that those who are not doing FGM because of religious reasons are committed to doing the 'symbolic FGM' and some think that this is a religious duty."

The conference provided to the participants a clear understanding of the Islamic perspective on FGM as well as the opportunity to question prominent Islamic leaders on the issue. Most participants said they benefited a lot from the conference, and it was an unprecedented opportunity to meet such religious experts who provided clarification of a longstanding misperception. **British Somali Community (BSC)**

The participants discussed whether FGM was a religious obligation or not. Most women stated that as they were growing up, they were led to believe that FGM was a religious obligation and this is the main reason why they did not question it and even promoted it and practiced it. **OSCA**

The reason why I have decided to leave my daughter alone is because I asked a woman from the mosque who teaches me Qur'an. She said that it was not written in the Book and this practice was attached to my culture and traditions, not the religion. **GSWG**

Many of the projects identified *religious identity* as a focus area. Several project workers reported that clarification on this issue through their work with religious leaders has directly led to greater confidence amongst some to reject FGM. One of the learning events focused on critical analysis of the links between religion and rights-based arguments, and project workers have grown visibly more confident in discussing this issue.

The PEER endline data show that there have been attitudinal shifts in perceptions of FGM as a religiously-sanctioned practice. Some projects have worked with religious communities (Christian and Muslim) to argue that FGM is tied to culture, and not religion. Multi-ethnic groups, or multi-religious forums, have worked well to address these perceptions.

However, some project workers found it hard to locate religious leaders who would openly state that FGM is not a religious practice. In some areas, there were reports that religious leaders were still supportive of less severe forms of FGM, referred to as 'Sunnah'<sup>15</sup>, and this resulted in unclear messages on FGM. There are also doubts among FGM advocates and funders about whether this approach can be developed at a national level and over time. Engagement with religious leaders has lacked a focal point at a national level. Many project workers have noted that work with faith leaders is labour intensive, requiring long-term engagement. Religious counter-arguments have also not worked in tackling those whose support for FGM is linked to cultural expression or heritage, or is justified as a means of protecting girls in a sexually permissive society: "Despite [the success of messages on religion in countering FGM], many in the community remain in favour of FGM and claim it is part of their culture." (OSCA)

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<sup>15</sup> 'Sunnah' is typically used to describe Type 1 or Type 4 FGM, but the term can include more severe forms.

One entry point which shows promise is through faith communities' safeguarding efforts. A few projects have been approached by mosques (including AAF in London) to speak to faith leaders about the links between FGM, faith and safeguarding. It may be that integration of FGM into local authority safeguarding policies has given credibility to mainstreaming it into faith-based safeguarding efforts<sup>16</sup>.

In a poll of 63 people who attended workshops organised by Manor Gardens, encouragingly, 85% of participants did not believe that FGM was a religious obligation after the workshop. However, almost a fifth (17%) of participants continued to believe that female cutting is 'good for the health of mothers and their babies', and perhaps surprisingly, women in one group (24%) were more likely than males (6%) to hold this belief. These women were also far more likely than participants in the men's group (40% vs. 12%) to believe that cutting prevents promiscuity. **Manor Gardens M&E data**

Project workers frequently reported that their own levels of confidence in addressing support for FGM had risen. This is an important outcome, as the PEER data showed that resistance to discussing FGM is a significant challenge for project workers, who in turn have to offer support to women speaking out against FGM.

In some instances, project workers have acted as valued intermediaries between communities and health agencies, developing women's confidence to access specialist care. Overall referrals and one-to-one sessions with families with daughters at risk of FGM have been low, but in some cases project workers have been approached for advice, and have had an opportunity to dissuade parents: *"There are cases where individuals come to the project regarding whether or not they should perform FGM on their children and what the implications are if they do."* (BSCA) Several projects have worked to address negative reactions towards health or social workers who ask questions about parents' attitudes towards FGM.

The PEER data confirm that many respondents prefer to have these kinds of messages delivered by FGM project workers, who can deliver them in culturally sensitive ways.

BSC has received two referrals from Social Services. One relating to a child protection order and the second relating to a child who was thought to be experiencing FGM related trauma. BSC provided practical advice to the families in both cases. **BSC M&E data**

This underlines the importance of project workers as culturally grounded and trusted advocates, working alongside statutory responses to prevent FGM.

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<sup>16</sup> See for instance "Newham Child Protection Policy for Mosques and Madrassahs" (Newham Children and Young People's Service): *'There has been a wide misconception that FGM is an Islamic Mandate. However, Islamic scholars have not authenticated any Hadiths that have been used to justify its existence. If any member of staff become aware of a child who may be at risk of this procedure, they must contact CYPS as soon as possible. It is good practice for issues such as FGM, forced marriages, domestic violence and its adverse impact on the entire family to be discussed during Friday sermons.'* (p.18)

Key stakeholder interviews echo these findings. Whereas national-level stakeholders tended to have a narrow view of the role of community groups in prevention, in some local areas, partnerships between local authorities and CBOs have been highly valued – often when project workers have carried out these intermediary roles, working alongside frontline staff. These stakeholders recognise the need to engage communities in communicating complex messages around FGM, without stigmatising and alienating people.

The impact of work through community volunteers has been harder to evaluate, as projects have typically not included monitoring of volunteers in their M&E strategy (a recommendation for future stages of the Initiative). FORWARD, BSC and BSWAID have all applied an empowerment approach to their work with volunteers, who then go on to host their own events where people have an opportunity to openly reject FGM.

### **Women Rejecting FGM**

Over the last three years the topic has been more widely spread and has been a focus in the media (TV, news) so it has become a talking point and is now something up for general discussion without much preparation. Now both men and women (young people) can talk about it more openly.

#### **FORWARD**

There has been a significant increase in anti-FGM views across age groups and ethnicities (in the last six months). I met many women and the majority were adamant that the practice should not be allowed to continue. They blame the continuation of the practice on communities not accepting it as an issue. **Black Women's Health and Family Support (BWHAFS) – Project Worker Notes**

According to them, FGM is not something that could be discussed openly within the family or the community, it's perceived as a forbidden and incredibly sensitive subject. However, over the course of the project there has been a massive change in attitude, it has increased women's and young's girls' confidence to speak out. They are now more willing to share their experiences and stories. **BSCA**

Hearing other people's experiences is eye-opening- there are so many similarities... we help each other. **BWFHS**

It is much easier for people to discuss FGM

In the first phase of the Initiative, projects predominantly focused on work with women. Both PEER and project monitoring data show a perceptible rise in women rejecting FGM, and in their confidence to speak out about it, for instance at public events.

There is good evidence that FGM is now discussed more openly in some circles, and that this has crystallised the position that people take on the issue, *"the very fact that FGM is being talked about is progress in itself. It is a taboo topic that is being discussed in the Somali community, in different genders, between Imams and the rest of the community."* (OSCA, Project Worker Notes)

The importance of creating 'safe spaces' where FGM can be discussed by women who support, oppose or are directly affected by FGM has been highlighted by many projects. Project workers explain that women may not have discussed the impact of FGM on their lives, and that FGM is a deeply personal and intimate issue, which women may be reluctant to discuss. However, these 'safe spaces' have enabled women to 'break the silence' around FGM, though sensitivities

without shying away and avoiding as it is such a sensitive topic. In the beginning of the project it was an avoided topic and seen as rude to talk about circumcision however over the course of the project there has been a massive shift. However there are still those that will walk out of a room where they hear FGM being discussed.  
**BSCA**

remain (for instance, people are unwilling to share information about where and how FGM may be taking place).

Arguments against FGM, developed by projects over the course of the Initiative, have matured and become more confident over time.

These include using a rights-based approach, tackling the links between FGM and concepts of sexual purity, and the development of 'zero tolerance' arguments (which condemn all types of FGM, including the least severe forms). In some cases, young women are also questioning the historical cultural links made between FGM, sexual purity and marriageability, arguing that FGM reduces their future marriage prospects in the UK. For example, at workshop and outreach sessions run by BWHAFS, some community members felt able to speak out against FGM and discuss the practice in relation to young women's sexuality: *"Why is it so bad for women to be sexually alert? Even inside marriage it is scorned. FGM is done to take away women's feelings indefinitely!"* (Female group discussion, BWHAFS).

There is also now a broad understanding of which groups of women are likely to support FGM or not. Open and strongest support for FGM was reported among older women, and this is also where the fewest shifts in support for FGM are found. For example, BSC have found that older women have the most strongly held opinions about FGM, and place a high value on the importance of cultural and traditional practices.

Some women attending SCA workshops have spoken out against FGM during the forum

- *FGM is one of the most degrading human rights abuses. I believe we all have to stand against this practice*
- *It has no clear benefits and it's an example of cultural burden implemented on these women*
- *FGM in its simplest form is a torturous and oppressive practice that damages the female identity*

**(Female participants in FGM workshop held by SCA)**

Most of my family laugh and are appalled [that I won't circumcise my daughters], but I will not circumcise my daughters – I made a mistake with my eldest. **BWHAFS**

Young people are absolutely against FGM. My niece went to Somaliland with her aunt and her relatives started to make plans to circumcise the niece but she refused and her mother who was not with her but in the UK, called the family and asked them to leave her alone if she did not want to be circumcised. She came back unharmed but

Women who have been affected by FGM themselves have also in some cases become strong advocates, though this is not always the case. Women directly affected by FGM face barriers in speaking openly about FGM, and women who have experienced FGM and who are supportive of Type 1 or 4 FGM have often presented the strongest difficulties for community advocates, *"older women tend to steer the sessions and the subject matter in the direction they like and this at times can*

old people are still holding on the practice. **OSCA PEER data**

*be off putting to people who are new to the sessions or even new to the centre.”*

Younger women who are UK born were often described as knowing little about FGM (reflecting the taboo status of FGM), but are often most widely engaged and mobilised by projects to reject FGM openly once they find out about it: *“People were amazed with the presentation of a young girl (17, from Sudan) who talked about her experiences of FGM without feeling shame. It is brave, as it can be hostile”* (BAWSO Project Worker’s Notes).

There were many examples in the PEER data of older women intending to carry out FGM, but being dissuaded by younger women’s opposition. This finding should be at the forefront of the next phase of the Initiative: in some cases, projects focused on changing attitudes among people who strongly support FGM, arguing they hold sway in decision-making, whereas focusing on young people may be more effective.

Young people attending BSC run workshops consistently reject FGM. They engage in lively debate about the root causes of the practice and are keen to pose questions about the reasons for the practice to adults, especially their parents and relatives. Confronted by the questions of young people, the adults sometime seem unable to defend the practice; resorting to the explanation of culture. **BSC Project Worker notes**

“The older woman interjected, “So, you would like your elders arrested, put in a foreign jail?”, the girl continued, “I just want them to know it is not OK to physically damage girls – it is not right, and it’s worse that they know the effects but do it anyway – Allah teaches us to respect the rights of everyone: youngers and elders.” **GSWG Project Worker’s Notes**

I saw a young girl who couldn't urinate, because of the FGM. She was saying that she hates her mother and I am afraid that my daughters will hate me if I circumcise them. **SDS PEER Data**

PEER data suggest that decision-making processes can shift if young women’s ability to articulate their views is strengthened, and if they have the confidence to refute arguments supporting FGM. A more realistic aim in terms of changing the attitudes of older women would be to recognise that the decision to carry out FGM is not within their direct sphere of influence, *“Although I must say there are group of people who are not really against the practice but they understand it is a criminal offence, and this is a big protection for girls as long they know their rights and they can say no”* (FORWARD PEER Data).

### Working with Men

Men and women used to see FGM differently but now in the UK, they have come to see the issue as one. I think there is a divide between old and young, as there will be a number of old people who see FGM as normal and part of the process of growing up but young people like my son, who was born in the UK, laughs when you mention FGM to him and he will say that, “You people are

The baseline report provided only limited evidence of men’s opposition to FGM. This is now clearer, with information about young men’s perception of FGM as an outdated practice that is alien to their own worldview of what makes a ‘good’ woman. In some cases, reflecting young women’s anxiety,

crazy and need to go back home and do your crazy practice there.” **GSWG PEER Data**

having a wife who had suffered FGM was explicitly described in negative terms.

The endline PEER data also provide examples of older men who have changed their views and, in some cases, have even apologised to their daughters for the suffering caused by their support for, or passive acceptance of, FGM. At BSWAID, the project worker has found that men are increasingly beginning to understand the health impact of FGM because in the UK, unlike in their home counties, they are more involved with the process of childbirth. *‘I met many men at the clinic who had accompanied their pregnant wives; they were shocked to hear how FGM affects the delivery of the baby and [to learn about] the continued health effects of FGM’* (BSWAID project worker).

Some of the projects have focused on events during which mixed audiences can openly discuss FGM. OSCA’s play, for instance, elicited support from many younger men in the audience, and men accessing clinical services are also reported to be predominantly against the practice: *“Their husbands believed it was an out-dated procedure, which they thought had stopped with their mothers and would not be willing to have their own daughters go through such pain”* (OSCA). Some projects have successfully recruited men to work as volunteers/advocates for the projects, including BSCA, which has seven men helping the project. The project has also hosted workshops for men, to answer their questions about FGM.

### **Remaining Challenges**

I have had FGM performed on me and I have had no problems or nothing that I cannot live with. If I had a daughter I would have carried out FGM on her and I don’t think my husband or family would object but I have sons, which is good as they are less trouble. I know a lot of women in the community who have had FGM carried out on their daughters. **GSWG – PEER Data**

There is wide variation in support for FGM in the different settings where projects work. Strongest support for FGM was often found in areas with a high proportion of newly arrived migrants (such as East London, or dispersal areas outside London), or in areas where communities affected by FGM were relatively isolated from wider society, such as Liverpool.

These findings echo views of key stakeholders, who argued that it may be harder to change attitudes in smaller and more marginalised communities, where there is less diversity of opinion, and possibly more pressure to maintain cultural traditions. Raising the issue of FGM may be harder if there is a perception that the community’s image is already under threat, as there is the risk of counter-productive stigmatisation.

One group still remains intransigent and is even upset that discussion about FGM is taking place and consider FGM as part of Somali culture. The other group recognises that FGM does not need to be practised anymore and are happy that this

Although overall, it has become easier to discuss FGM, in some cases there has been a concomitant rise in opposition to speaking out against FGM. This may be the result of actual support for FGM by those who view it

work is happening to increase people's awareness of this practice. **OSCA Project worker notes**

as an essential part of their cultural identity, or of fear that their community will be stigmatised.

The risks to women of speaking out also have to be recognised. One woman supported by BAWSO spoke out against FGM but had to be moved and placed under police protection. In this context, although projects have successfully supported the strengthening of voices, long-term support to enable women in particular to speak out is needed.

### 2.4.3 Outcome Three: To increase the skills and capacity within affected communities to influence individuals, groups, and statutory agencies

#### **Project Activities**

Initiative-funded projects have exerted their influence in several ways (some of which have been discussed previously):

- Encouraging, training and supporting community leaders and volunteers/champions to speak out against FGM (as discussed in section 2.3.3)
- Advocating for an improved response to FGM by statutory agencies (as discussed in section 2.3.1)
- Training health and social care professionals
- Promoting the mainstreaming of FGM into local policy and practice

In some instances, local FGM polices have resulted in projects working to train professionals through Safeguarding boards, and to work with frontline professionals to build their confidence to identify FGM and respond to it. Many of the groups have worked alongside health and social care professionals: at specialist FGM clinics, with social workers or IDVAs, with sexual health leads, and, latterly, and in some areas only, with schools during PSHE sessions. This has also enabled project workers to get a good sense of where to focus FGM prevention efforts, as the profile of service users reflects levels of need within the community. Some projects have also acted as an information/support resource for local authorities, for examples, the Manor Gardens Advocacy Project is the main contact listed in Islington Council's 'Local Provision on FGM'.

Several projects have worked with midwives, in some cases on-site in FGM clinical services, to provide counseling and support and to reinforce legal and child protection awareness. BSWAID has started to provide training on FGM to trainee midwives (in Birmingham) to build professionals' confidence in providing a sensitive service to women affected by FGM. GSWG has also facilitated awareness-raising sessions for primary health care staff to understand the

A short evaluation was carried out with 15 Health Visitors who received training from Manor Gardens about FGM. After the training, 70-85% of participants reported that they had good understanding of the FGM, a good understanding of the health implications of FGM, and a good ability to identify girls at risk. This compares to just 6% of participants who reported good knowledge in these areas prior to the training.

#### **Manor Gardens M&E Report**

In partnership with the London Borough of Ealing



sensitivities of women affected by FGM accessing cervical screens, and SCA has helped to develop a new training course for statutory sector professionals in Ealing.

and Ealing Community and Voluntary Service, SCA have helped to develop a new course, 'Safeguarding Children in Faith and Diverse Communities', which is now offered to all professionals from the statutory sector, voluntary and community centres, and faith groups in Ealing. It covers safeguarding issues related to FGM, child trafficking, forced marriages and honour based crime. **SCA M&E Report**

### **Project Impact**

The mixed success that groups have had in terms of promoting a better response to FGM among statutory agencies, and mainstreaming FGM into local policy, has been discussed in section 2.3.1.

There is evidence of the initiative-funded groups promoting better referral pathways, for instance, in linking women affected by FGM with community-based support services and specialist clinical services. Project workers report that it has been important to include health professionals in the delivery of health sessions which integrate messages on FGM, as this mobilises higher rates of participation, particularly among people who may initially be pro-FGM.

She started by telling the health professionals about the issues and the need for sensitivity, she hoped that another person in the same predicament would not feel isolated, ashamed and judged by another. By telling such a personal story, the volunteer influenced the attitude of these health professionals and felt very confident on her returning, telling everyone at the centre what she had done and how it had been a triumph for her. **GSWG Monitoring Data**

Frontline staff, such as IDVAs, social workers, or FGM clinical specialists, highly valued having project workers available to work with women and families affected by FGM, as they could often work in culturally sensitive ways to tackle support for FGM. These kinds of referrals, though highly valued, have generally remained quite low since baseline.

In some areas outside London, safeguarding leads were reportedly reluctant to carry out routine enquiries in health settings with women affected by FGM with girl children, for fear of being viewed as 'discriminatory'. In these situations, projects face real challenges in encouraging health and other professionals to actively seek out and identify girls at risk.

There has been some progress in working along with schools, with FORWARD conducting awareness-raising sessions in schools in Greenwich attended by a total of 560 young people since December 2012 (see also Box 9 for a summary of their educational work in Bristol).

### **Box 9. The 'FGM Game' in Schools**

In Bristol, six young women members of the Bristol FGM Youth Group developed an FGM game to raise awareness of FGM in local schools. To accompany the game, the group wrote three lesson plans and developed associated resources. Seventeen copies of the game have been distributed to schools

in Bristol, and to date 148 young people have directly benefited from it. A total of 65 professionals including school staff, health professionals and those working in sexual and domestic violence have also been introduced to the resource. Feedback from the game has been positive:

- *'one of our teachers tried it with a group of year 8 students, boys and girls, and it was a huge success!... It's fantastic that resources are getting into schools; having one or two organisations working with a group of young people isn't enough, the work needs to be mainstreamed if FGM is to stop.'* **Teacher from a school in Bristol where the FGM game was trialled**
- *'I'm impressed with the sheer professionalism of the resource, it is such a switched on game and that is what gets people talking'* **Bristol PCT employee**

Reflecting upon their areas of successes, FORWARD's London group commented that placing FGM in the wider context of GBV has been beneficial particularly when working in schools where there are a wide range of young people present. *'[This strategy] allows the topic of FGM to seem less like a practice done by 'other' communities, and makes it more relatable'*. However, there have been challenges in accessing schools: *'Many schools are still hesitant about engaging with the issue of FGM as they feel it is too difficult or sensitive... However, we have had some success in entering schools through subjects such as health and social schools, and through other avenues such as International Women's Day and through young women's groups.'*

Teachers are worried about their reaction within the school. Domestic violence is now discussed in assemblies, but FGM is not included. Teachers are difficult – we know who practices these things, but we don't want kids to feel bad about it. **OSCA**

Getting into schools was a challenge, and it was found that when there is buy-in from local authorities getting into schools is less of a challenge. **FORWARD**

However, some projects have found schools to be generally unresponsive, and this has partly been attributed to fear that focus on FGM may lead to stigmatising certain communities.

Recent changes on OFSTED's inspection regime may encourage schools to mainstream FGM, but while this has been successful in some areas (for instance in Bristol), to date there has been little reported change in the areas where the projects work.

#### **2.4.4 Outcome Five: To improve co-ordination of activities amongst voluntary and community groups and statutory agencies working on this issue**

##### **Project Activities**

Initiative-funded projects met regularly through 'learning events' and cooperated in sub-groups to focus on specific aspects of FGM prevention. An online means of sharing information, through a knowledge gateway, was also set up. Information on activities of the Advisory Group has also been shared with the funded groups, while findings from baseline and interim reports on the groups' activities (including challenges and barriers faced along

the way) have been shared with the advisory group. The Advisory Group has provided a forum for sharing information between various stakeholders (most of whom operating at the national level, or in London and Bristol).

### **Project Impact**

There is good evidence that funded projects within the Initiative have worked together to widen their impact. This has included joint working on a Faith Leaders Against FGM forum (led by Manor Gardens and OSCA), a pan-London co-ordination forum (led by Manor Gardens), and a range of smaller joint working activities (for instance, a 'Mothers and Daughters' event jointly led by OSCA and BWHAFS). More recently, groups outside London have undertaken visits to one another, to understand how each project tackles strong support for FGM as a cultural practice (particularly among older generations).

The pan-London FGM Forum has been regularly attended by local safeguarding professionals, and organisations such as the NSPCC and the Foundation for Women's Health, Research and Development. In addition to sharing learning and resources, the Forum has engaged with national issues by preparing two collective responses to government consultations on FGM, and by sending out lobbying letters. Project workers report that being part of a national initiative has helped their projects to carry more weight, for instance, in advocating for the inclusion of FGM on local safeguarding agendas.

Probably the biggest impact would be the opening up of discussions and bringing FGM on to the agenda...This creates a stronger voice for the campaign when we have many different groups in the entire UK. Also links with other organisations like the police. It is a very interesting platform, and strengthens the work itself and consolidates the projects. **OSCA M&E Data**

AAF reports that their involvement in the FGM Initiative has '*made it easier to present the project to stakeholders and helped [increase] recognition of the topic of FGM*'. In London in particular, this has also been facilitated by the pan-London Children's Safeguarding procedures, which have put added pressure on local boards to include FGM.

In some cases, good strategic alliances have been built between the Advisory Group and projects. An example of this is engagement with the Metropolitan police 'Project Azure' team, who met project workers at a learning event. Since then, members of the Project Azure team have been invited to attend some community events, and have attended every meeting of the pan-London FGM Forum. The police fully recognise the need for community engagement and for culturally sensitive messaging about FGM, and joint working with the projects is an area that could be further developed in the next phase of the Initiative. Individual projects (such as BAWSO) have also conducted joint projects with leading advocates who sit on the Advisory Group (including Equality NOW and FORWARD), which they have credited with better responsiveness of participants to messages around FGM.

As mentioned in section 2.4, the extent to which evidence and learning from funded projects has been communicated to the advisory group and wider circles (including policy makers and other community groups) has thus far been limited. Stakeholders requested greater

attention be paid to this area. There is a need to better coordinate local evidence from funded projects (e.g. identifying barriers to FGM prevention) such that a national level response can be developed, if required. An example of this is FGM prevention in schools. Many projects attempted to work with schools, but faced a lack of response from schools authorities. The recent inclusion of FGM prevention in OFSTED's schools inspection regime could potentially encourage schools to mainstream FGM prevention in education.

Where there have been differences in approaches between the groups, learning events have been the main conduit for debating and analysing these differences, but future phases of the Initiative could include closer joint working. Events such as the Open Space event on FGM prevention were perceived as being valuable by both key stakeholders and the Initiative-funded groups, as starting the dialogue for a more strategic response to FGM prevention.

## 3 Conclusions

### 3.1 Summary of Findings

Where community based preventive work is taking place, attitudes towards FGM are changing: there is growing opposition to FGM, and growing support for a more interventionist stance to be taken by the UK government in safeguarding all women and girls from FGM. These changes are taking place against a backdrop of heightened media and policy attention on FGM.

Over the course of the Initiative, funded groups have gained clarity on where they can mobilise opposition to FGM, and how to build confidence to voice this opposition. Important elements of community-based work have been identified as:

- Providing safe spaces to talk about FGM (in groups or individually)
- Empowering community champions/advocates to speak out about FGM, and to act as trusted intermediaries between people from affected communities and frontline services
- Incorporating messages about FGM into wider health issues, and using a rights-based approach to argue for 'zero tolerance' of all forms of FGM
- Confronting misconceptions about links between religion and FGM
- Working with mixed groups (ethnicities, ages, genders)
- Targeting efforts at younger people

Participants have credited Initiative-funded projects with sparking necessary discussions and debate about FGM, in a culturally sensitive and grounded way. Projects recognise the risk of legal messages sounding punitive and threatening, and have worked to develop wider understanding of FGM as a form of child abuse. Arguments against FGM are maturing and becoming more sophisticated: funded groups, particularly those who have worked with affected communities over many years, are addressing the perceived links between FGM and control of women's sexuality, and developing 'zero tolerance' arguments.

Project workers working alongside the statutory sector have been highly valued in the geographic areas where statutory agencies recognise that there is a need to work preventatively with community-based groups.

A network approach including group-based learning has worked well to build the confidence and skills within funded projects, and they report that this has brought many strategic advantages. They would like to widen the remit of the network further, through more opportunities to engage with strategic leaders, and more concerted group learning.

In order to develop their community-based work further, and to ensure future sustainability of prevention efforts, an enabling local policy-making environment is essential. Ultimately, the aim should be for CBOs working on FGM to be involved in needs assessments and the commissioning cycle (as directed by national guidance for HIV prevention), and to be engaged with local Health and Wellbeing Boards. There is limited evidence that funded

groups have been effective at pushing local health and social care agencies towards a wider FGM prevention programme when the issue is not already on the local authorities' agenda. Groups outside London may need either extra resourcing or more strategic support from the Initiative to do so. The Initiative should monitor the strength of local responses to FGM and help projects to hold local authorities to account if they fail to address FGM in either policy making or operationalising policies (e.g. allocating resources).

There is now consensus that the most effective approach to FGM prevention requires multiple stakeholders at a local level, mainstreaming FGM under VAWG and/or Safeguarding strategies, and community groups playing a role in prevention. The strategic direction of the Initiative, and the type of support offered to its projects, should be influenced by this model.

Challenges remain for the projects conducting community-based work. Some people continue to support FGM, which they associate with concepts of cultural heritage and control of women and girls' sexuality. Support for less severe forms of FGM (often referred to 'Sunnah') is still also widely reported. 'Speaking out' within communities still carries risks, and requires sensitivity and a long-term approach. Over the course of the Initiative, government cut-backs, decentralization and re-organisation have all impacted on the strategic relationships that the projects have been able to make. Although the new commissioning landscape of the NHS and local authorities may provide opportunities for projects, further public sector cuts are likely to lead to increased competition for scarce resources.

### 3.2 Implications and Recommendations

A number of discussion points emerge for the strategic direction of the Initiative. These have relevance both for the second phase of the Initiative, and for a wider audience with interest in FGM prevention.

#### *National leadership*

- A range of local and national agencies are charged with responding to FGM, with the risk of 'passing the buck'. A clear national policy on FGM – stating roles and responsibilities - should be a priority for government, addressing:
  - The role of local authority leads in responding to FGM, including standards for how local authorities should engage with community groups to respond to local needs.
  - Mandatory training in FGM for appropriate professionals.
  - How the performance of local areas in response to national guidance will be managed and monitored.
- Although there is rising awareness of FGM in national policy circles, this needs to be translated into concrete actions. This must include funding prevention strategies, and addressing the demand to bring about a prosecution under FGM legislation.
- A number of promising national initiatives have been launched (including the Multi-agency Guidelines on FGM and Health Passport). However, attention and resources need to be committed to implementation and follow up to ensure they have an

impact. Building stronger relationships with community groups, to roll out such initiatives, is recommended.

#### *A co-ordinated, integrated, and resourced local response*

- FGM prevention at a local level needs to be co-ordinated and integrated. Violence against women and girls and safeguarding frameworks are both useful for this. Multiple stakeholders, including statutory agencies and community groups, should work together to identify local needs and implement appropriate prevention strategies (e.g. through the local Joint Strategic Needs Assessment (JSNA)). A focal person to coordinate and champion the cause – e.g. from within midwifery services or primary care – is important.
- Community groups can play a central role in helping statutory agencies to deliver their safeguarding obligations in terms of protecting children from FGM. However, they need to be:
  - Significantly better resourced.
  - Supported to ensure they have the relevant skills.
  - Connected with local agencies for coordination and sustainability.
  - Invited to participate meaningfully in planning and commissioning cycles.Existing models in health (e.g. HIV prevention) show how this can be done.
- There should be proactive attempts to reach new arrivals to the UK with FGM prevention efforts. Community groups can also contribute to this, for instance, by developing information about FGM to include in packages of support to new arrivals.
- Professionals should seek support and advice from appropriate community groups to help them build their confidence to work on issues related to FGM.
- Schools should be encouraged to address the issue of FGM, and should seek out appropriate community groups that can help them raise the issue sensitively.
- Current resourcing for FGM prevention does not always match need. In the absence of reliable prevalence data, local areas can work with community groups and analyse existing data to see whether there are affected populations in their area, and decide how best to reach them.
- More could be done to develop the potential role of CBOs in directly preventing FGM (i.e. identifying girls at risk, working with their families), working alongside the statutory sector. The nature of FGM is that, unlike other forms of child abuse, there are often few signs of a child being at risk, and people may feel more comfortable approaching a trusted project worker with concerns than the police or other representatives of statutory agencies.

#### *Strengthening community groups and their prevention efforts*

- Accreditation for community groups, demonstrating an appropriate level of training and quality in their FGM-related work, would be useful in terms of helping local authorities to identify groups to partner with on FGM prevention. Quality standards for third-sector groups working on harmful practices are currently being piloted by Imkaan and could be adopted.

- Working with volunteers requires careful resourcing, in terms of training, monitoring and supporting them, particularly to ensure that they are meeting their safeguarding obligations.
- Periodic re-engagement with religious leaders will be required to ensure the important messages that they have communicated remain relevant and fresh. It is recommended that projects working with religious leaders focus on using female social networks/scholars within religious institutions, and make better use of existing resources developed through the Initiative that counter beliefs that FGM is a religiously condoned practice.
- All project workers and volunteers should be provided with appropriate training so that they can effectively support safeguarding agencies in the context of FGM-related work.
- Building on the success of working alongside health and social care professionals to support women and families affected by FGM, projects should consider how they can widen this sphere of influence (e.g. working with GPs with an interest in sexual and reproductive health).
- While the FGM Initiative has provided valuable funding, key stakeholders viewed current levels of funding for prevention as too low. The Initiative could consider supporting projects to advocate for more resourcing (e.g. from the Home Office, CCGs, Health and Wellbeing Boards), particularly outside London.
- Accountability mechanisms outside London: in London, the pan-London Safeguarding board can act as an accountability mechanism in terms of persuading Local Authorities to respond to FGM. Groups in less diverse settings should be supported to network more widely, for increased confidence and skills, or to join forces with other groups in their area for a stronger voice.
- Broadening the national advocacy scene: project workers do not currently have high-level national visibility as advocates, and a small number of organisations dominate the (London-centric) national advocacy scene. There is an appetite among other groups to be included in discussions at national level (which in turn will strengthen their motivation and develop their advocacy skills, which they can take back to their home towns), and there is a need for the national debate to hear more voices from around the UK.
- The Initiative and its funded projects need to clear about when they should be advocating for a national response (e.g. for national-level guidelines) and when they should be lobbying at a local level. With the current localism agenda, national agencies may be increasingly likely to refer issues back to the local level (e.g. Health and Wellbeing boards, or CCGs). Some projects will need extra support to lobby at a local level, as they do not all have skills in policy advocacy, nor the time and resources to conduct extensive lobbying.
- Consideration needs to be given to Exit Strategies/sustainability: Although another two to three years' worth of funding has been assigned, the need for long-term approaches for FGM prevention is clear.



## 4 Annexes

### Annex 1. Project Summaries

This section summarises projects activities and progress over the whole Initiative, with current challenges, based on their reports to Options UK.

#### 1. Africa Advocacy Foundation (AAF), London

##### Activities:

- Community champions (ten women) supporting outreach and workshop activities.
- Workshops to raise awareness about health, confidence building and leadership skills.
- Weekly counselling and support sessions for women affected by FGM, and provision of support around referrals to NHS.
- Annual young people's trip with a focus on intergenerational relations.
- Monthly 'sisters' circles' meetings with women in Mosques.
- On-going work with Muslim leaders from Sierra Leone, Ivory Coast, Somalia and Nigerian communities.
- On-going dissemination of information materials.
- Partnership working with Lambeth Council with a focus on VAWG.
- On-going interagency work (e.g. with African-led community organisations, Victim support (Lambeth/Southwark)).

##### Progress:

- Increased awareness amongst women that FGM is not a religious but a cultural practice.
- Women are more willing to share their stories which builds a sense of shared experience.
- Religious leaders are more willing to discuss FGM and reject the practice openly.
- Young people are very confident in rejecting FGM.
- Putting FGM on the 'Violence Against Women' and Girls' agenda in Lambeth.
- Working with 'sisters' circles' in local mosques.
- Training of FGM community champions to work more widely in local communities.

##### Challenges:

- Engaging men, and keeping men actively involved in FGM work beyond workshops.
- On-going belief that type one (Sunnah) is acceptable and less harmful.
- Struggling to build working relationships with local statutory organisations in Southwark and Lewisham.
- Engaging Christian faith communities.

## 2. Birmingham and Solihull Women's Aid (BSWAID), Birmingham

### Activities:

- Supporting work at African Well Women's clinic and one-to-one referrals with 192 women.
- Working with six community champions from Guinea, Somalia and Uganda, to train them on violence against women, and reaching out to wider communities using community events.
- Production of 'voices of women' leaflet.
- On-going partnership working through multi-agency working group (Birmingham against FGM – BAFGM).
- Organisation of events (three) with BAFGM, which have reached out to a wide range of frontline professionals across the statutory and voluntary sectors, attracting around 70 people to each event.
- Training of professionals (five groups), including multi-agency group representatives (two sessions, including midwives, GPs, housing workers and social workers) and Midwives (three sessions).
- Monthly group-based awareness raising with five women's and young person's groups.
- Men's awareness raising event, created by working with a male community champion.
- Sourcing additional funding for further project activities to raise awareness of the law, health effects and consequences of FGM, to empower women to reject FGM.

### Progress:

- For the first time, men are beginning to identify the health impact of FGM on their wives, due to greater involvement in childbirth.
- Recruitment of community champions to undertake awareness raising work in communities.
- Increasing numbers of women willing to reject FGM.
- 'Voices of women' leaflet providing written case studies of women rejecting FGM will be disseminated next year (2014).
- Framing FGM within the domestic violence, child protection and human rights discourse.
- Accessed extra funding from other organisations to support on-going FGM work.
- Advocacy with inter-agency groups, including implementation of FGM Action plan, and development of FGM strand of the Violence Against Women Strategy.
- Developing new links with new community groups in the local area.
- Delivered workshop at the national Women's AID Federation conference in July 2012.

### Challenges:

- Persistent belief that type one (Sunnah) is prescribed by religious teaching.
- Pressure to disband the African Well Women's clinic.

### 3. BAWSO, Wales

#### Activities:

- On-going distribution of information materials and advocacy pack for health professionals.
- Speaking at conferences to raise awareness of the project (e.g. Cardiff Women's Aid conference, Welsh Refugee Safe Guarding Conference).
- Training trainee midwives studying in their third year at Cardiff University.
- On-going production of another advocacy booklet aimed at different local authority service providers.
- On-going training and support to ten community advocates who were trained by BAWSO to undertake outreach work.
- Convene FGM Stakeholders' Forum to continue partnership working, and widen partners involved.
- Community workshops with women, men and young people from practicing communities (e.g. from Somalia, Yemen, Eritrea, and Sudan).
- One-to-one support to families with at-risk daughters, alongside social services.
- On-going work with religious leaders.
- On-going work with other third sector partners (e.g. Cardiff Metropolitan University, Wales National Theatre, Children in Wales, Public health University of Wales, MEWN Cymru).

#### Progress:

- Training of third year midwives in FGM issues.
- Widening the membership of the FGM stakeholders' forum in Wales.
- Partnership working (e.g. with Cardiff Metropolitan University, Wales National Theatre) to broaden reach and impact of FGM project.
- Working through women in the community as advocates to broaden social networks and engage new women in awareness raising activities.
- Creation of a Sudanese youth-written play called 'The Haircut', performed at the big 'cut it out' event.
- Work with families identified by social services as having girls at risk from FGM.
- In the process of building relationships with three youth groups.
- Broadened the range of ethnicity groups involved in the work.

#### Challenges

- Gaining access to schools.
- Engaging Somali and Yemeni men in FGM work.
- Need a clinic in Wales that can deal with FGM related health problems.
- Hard to engage with Imams who state that FGM does not exist in their communities.
- Lack of resources to provide childcare for women attending events.

#### 4. Black Women's Health and Family Support (BWHAFS), London

##### Activities:

- Community awareness-raising workshops with community members.
- Workshops with professionals (e.g. trainee midwives, school nurses, young person's advice centre).
- Trained young community advocates to support on-going outreach work.
- On-going partnership working with African Family Services (Tower Hamlets), NHS Hackney maternity services, and safeguarding boards (Tower Hamlets, Hackney).
- Organised Mother's and Daughter's event with OSCA, with a focus on intergenerational dialogue.
- Work with parents through Parents Associations in schools with high numbers of pupils from affected communities.
- Organised 'Let's abandon FGM' event during Black History Month.
- On-going production and distribution of information leaflets.
- On-going provision of support to women affected by FGM (e.g. referrals to NHS, face to face meetings).
- On-going work with religious leaders and scholars (e.g. Madrassa teachers).
- Use of 'Gossip board' at events.

##### Progress:

- Significant increase in anti-FGM views across age and ethnic groups.
- Repeated instances of women speaking out against FGM in communities.
- Working with community advocates to identify and work with new community groups and organisations in Newham.
- Organised the 'Let's abandon FGM' and 'mothers and daughters' events, both of which enabled reflective cross-generational dialogue.
- Increasing knowledge amongst professionals routinely working with FGM affected communities (Children's centres, GPs, social workers).
- Increasing community awareness of illegality of FGM in the UK.

##### Challenges

- Lack of convictions and prosecutions softens the impact of legislation.
- Hard to engage schools and teachers in FGM work.
- Certain groups of community members who are very resistant to FGM awareness work, including regular groups of new arrivals into Newham.

#### 5. Bolton Solidarity Community Association (BSCA), Bolton

##### Activities:

- On-going work with Somali religious leaders in workshop settings.
- Community workshops with men, women and younger women.

- Collaborative work with 'Bolton at home' and its women only 'safe house', carrying out two sessions per month with ethnic minority women.
- Provision of 'drop in' centre facilities two days per week for women affected by FGM, as well as other ethnic minority refugee groups.
- Awareness raising workshops with health professionals (midwives, school nurses, GPs).
- On-going distribution of information leaflets and printing of posters.
- On-going distribution of information packs to partner organisations.
- On-going attendance at steering group meetings in the Greater Manchester region.

**Progress:**

- Increasing interaction with men in workshops, and more men seem willing to talk to other men about FGM.
- Young women and girls are more and more willing to speak out and reject FGM which they perceive as abusive.
- Increasing working relationships with NHS Bolton, Bolton council, the Greater Manchester FGM forum, and third sector organisations.
- Enhanced awareness that FGM is illegal.

**Challenges**

- Persuading older men to change their beliefs on why FGM is important (i.e. women's purity).
- On-going perceptions that type one (Sunnah) is a religious obligation.
- Conservative views amongst community members who view discussion about FGM as signifying that someone is becoming 'Westernised'.

## 6. British Somali Community (BSC), London

**Activities:**

- Awareness raising workshops for young people, mixed audiences (young and old women), and with different ethnic groups (e.g. Sudanese, Somali, Ethiopian) and work with religious leaders.
- On-going distribution of leaflets and posters throughout the community.
- Attending local statutory forum meetings (e.g. Safeguarding Board, Royal Free Hospital Equality Access Board).
- Local networking with religious organisations (e.g. London Central Mosque and Islamic Centre, Muslim Council of Britain, Whitechapel Mosque).
- Local networking with third sector organisations (e.g. Kings Gate Community Centre, West Hampstead Women's Centre, Sudan Women's Association).
- Awareness raising workshops and development of FGM prevention with young people, including young men.
- Steering Group meetings
- FGM seminar to designated safeguarding staff in schools

- Girls Conference to discuss empowering women and girls
- Trained ten volunteers (five young people and five women) to raise peers' confidence, influence, and speak out against FGM, as well as assist the project worker.
- Participating actively in the endline PEER research.
- FGM seminar to Camden professionals working with children

**Progress:**

- Younger people more willing to reject FGM and take part in lively debates during workshops.
- More middle-aged women declaring that they would not circumcise their own daughters.
- Held a Religious conference where religious leaders and scholars provided clarification of longstanding religious misconceptions.
- Partnership working with a wide range of local community-based organisations, local authority services, NHS and safeguarding boards.
- Reducing significantly stigma attached to non-FGM practicing people in the community, and reduced the extent to which FGM is seen as a taboo subject
- Increased confidence to reject FGM by girls and most women

**Challenges:**

- Working with older people and trying to lessen the effect of religious and cultural values which support FGM.
- Working with men to overcome apathy and a perception that FGM is a woman's issue.
- No funding for project to continue after March 2013

## **7. FORWARD, London, Manchester, Bristol, Middlesbrough**

**Activities:**

- Prevention of FGM using an empowerment approach with young women in four locations: London, Manchester, Bristol and Middlesbrough.
- Transition of young women in youth group to becoming youth advocates, helping to facilitate community workshops and other youth programmes.
- Development of youth friendly advocacy materials (including: '16 Ways to help end FGM', 'FAQ booklet' and 'Information services and support guide' (ready to be printed in Summer 2013).
- Delivery of 'Empowered' – a peer mentoring/education programme delivered over six sessions focussing on FGM, assertiveness, self-defence, mental and sexual health – in Brent and Haringey.
- Delivery of 'Creative' – a youth-led programme on creative campaigning with sessions focused on leadership, FGM and identity.
- Youth groups in Greater Manchester, Bristol and London.

- Awareness raising workshops with young people at school (three London schools) and in universities (e.g. Leeds, Oxford and Warwick)
- Community awareness events (e.g. launch of FGM game in Bristol; photography, poetry and dance events in London).
- Social media campaigning, through Facebook and Twitter.
- FGM online forum to inform, campaign and share information in Rochdale.
- Annual youth forum which brings youth advocates from all the cities together for training and sharing learning.

**Progress:**

- Production and use of the FGM game as a discussion tool with young people in Bristol.
- Enhanced youth leadership in youth-led peer mentoring/education programmes called 'Empowered and Creative'.
- Publication of two youth-friendly FGM resources.
- Burgeoning follower-base at Facebook and twitter accounts.
- Positioning FGM within broader 'gender-based violence' issues allows the topic of FGM to seem less of a practice done by 'other' communities, and more relatable to daily life.
- Recruitment of young men to Rochdale's youth group.

**Challenges:**

- Engaging and working with young men in FGM work.
- Retaining youth advocates who can lead quite transient lifestyles, taking them away from the organisation.
- Gaining access to work in schools; particularly primary schools

## **8. Granby Somali Women's Group (GSWG), Liverpool**

**Activities:**

- Monthly awareness raising workshops with older women (aged 30-60) and young women (aged 14-17 years).
- Awareness raising workshops with men.
- Annual event – a Q&A session led by young women, focusing on inter-generational communication.
- Monthly one-to-one drop in sessions to support women affected by FGM.
- On-going partnership working with NHS FGM health worker, NHS social exclusion team, police community liaison officer.
- Member of patient participation boards of two local health centres, to raise awareness of sensitive health care for women affected by FGM.

**Progress:**

- Increasing occurrence of women saying that they will not practice FGM on their daughters.
- Women more willing to discuss their personal experiences of FGM.
- Younger women more able to ask questions about why FGM is still practiced.
- Discussion of FGM amongst other health issues enables a difficult topic to be broached more sensitively.
- Production of literature by younger women.

**Challenges:**

- Gaining access to statutory organisations in Liverpool.
- Difficulty in engaging with Islamic leaders from different ethnic groups.
- Difficulty engaging men in FGM work.
- Local hospitals are not able to deal with FGM related health problems.
- Conservative cultural views that FGM is still a positive way to control women in society.
- Difficulty in controlling older women in groups who voice pro-FGM opinions quite dominantly.

**9. Manor Gardens Centre, London**

**Activities:**

- Work with community advocates from the Somali, Kurdish, Arabic and Eritrean communities, to broaden and enhance access to hard to reach groups.
- Working in partnership with Whittington Hospital African Well Woman Clinic to facilitate access to specialist services
- Integration of FGM prevention and health messages.
- Innovative outreach activities to reach people in community meeting places.
- Community awareness raising workshops with men and women.
- Workshops with health professionals including health visitors, social workers and family key workers and a children's centre.
- Campaigning to mainstream FGM as a child protection issue at local and national level
- Member of Harmful Traditional Practices Group, Islington Council
- One-to-one advocacy and support sessions with women affected by FGM.
- Coordination of the 'FGM Forum' for London-based groups who are working on FGM, to improve coordination.
- Setting up the Religious Leaders working group and organising the conference 'Faith against FGM', including production and dissemination of associated materials.
- Hosting launch of the Multi-agency Government Guidelines on FGM
- Working in schools as part of Domestic Violence training to train pupils on FGM

**Progress:**

- Tackling ideas of religious justification for FGM in public forums.
- Working with community advocates to deliver integrated messages addressing FGM, including the health impacts of the practice.



- New engagement with hard to reach communities (e.g. Eritrean women and men) using innovative approaches, working in spaces which are familiar to particular communities.
- Training frontline professionals on FGM and safeguarding, including teachers, health visitors, and children's centre workers.
- Training health visitors to broaden outreach to women not engaging in community groups.

**Challenges:**

- Lack of funding to recruit and train new community advocates, or spend time working with religious leaders.
- Hard to access local schools.

**10. Ocean Somali Community Association (OSCA), London**

**Activities:**

- Participatory development of a film – 'Muted Cry' - on FGM and its effects, shown through community events to mixed audiences (men and women), based on the voices of women affected by FGM.
- On-going work with 15 community advocates.
- Community events at Somali Week (e.g. intergenerational discussion around the play).
- Awareness raising workshops with older women and women of mixed ages.
- Child protection training sessions with Social Services and the African Family Unit in Tower Hamlets.
- Somali film nights to attract young people and others who do not normally engage in events which are FGM-related.
- Work with Islamic leaders through the religious leaders' forum to raise awareness of anti-FGM religious stance.

**Progress:**

- Enhanced awareness of the negative health effects of FGM.
- Wider rejection of FGM through public forums, including during screenings of the FGM film 'Muted Cry'.
- Increased awareness that FGM is not a religious practice, based largely on clear, concise messages presented by religious leaders in the play, 'Muted Cry'.
- Child protection training sessions with Tower Hamlets' social services and Africa family units.
- More open discussion about FGM across genders, and between religious leaders and community members.
- Increasingly common for women to declare that they will not circumcise their daughters.

**Challenges:**

- Persistent belief among older generations that type one (Sunnah) is not harmful.
- Engaging older women in work that is anti-FGM.
- Gaining access to schools.
- Families have more pressing problems than FGM, such as need to generate incomes and overcome household poverty.
- Lack of financial resources inhibits the amount of time that can be spent on FGM work.

**11. Somali Development Services (SDS), Leicester****Activities:**

- Working with community advocates who are involved in outreach work to raise awareness of the harms and effects of FGM, and of the law and services for women affected by FGM.
- Awareness raising workshops with women, young people and men.
- On-going distribution of brochures and leaflets.
- On-going work with religious leaders and scholars at five local Somali mosques to raise awareness that FGM is not a religiously condoned practice.
- Involvement in local Safeguarding Forum.
- On-going partnership working with Leicestershire NHS trust, NSPCC Balk Rasha project, Leicestershire Children and Young People's forum, Domestic Violence forum, Highfields Children and Young People Trust and Leicestershire AIDS Support Services.
- Informal weekly one-to-one conversations with women attending SDS centre.
- Trainings for professionals working with the affected community.
- Giving presentations about FGM to Multi-agency Forums.
- Giving safeguarding trainings to Somali parents.
- Developing information materials for schools.
- Participating regularly in meetings of different forums and organisations.
- Dissemination event about the project attended by more than 150 women.
- Conducting a small survey (participated in by more than 30 persons) regarding how the Somali community in Leicester sees FGM and if it is practised in Leicester.

**Progress:**

- Providing referrals and support for women affected by FGM to access care.
- Increased awareness of health effects of FGM, and the illegality of FGM in the UK.
- Increased occurrences of women campaigning against and rejecting FGM.
- Working collaboratively with health professionals in community workshops with women.
- Sharing information and expertise with other organisations.
- Increased the number of women who are aware of that FGM is not a religious practice.

- In the process of building relationship with different schools.

**Challenges:**

- Intergenerational dialogue between younger and older generations in the local area.
- Difficulty engaging schools and colleges in FGM work.

## 12. Southall Community Alliance (SCA), London

**Activities:**

- Media events including involvement in an ‘Action Women’s Radio show’, and a TV show on Universal TV (Somali channel)
- Creation of a social networking site and media platform (Facebook).
- On-going work with voluntary sector organisations (e.g. Southall Black Sisters, Anti-tribalism movement, Somali Women’s network).
- Working with teachers and parents through school fairs and coffee mornings.
- On-going involvement in local Safeguarding board, and in training frontline staff on awareness of FGM.
- On-going dissemination of promotional materials.
- Trained young people as community outreach volunteers to assist work.

**Progress:**

- Working with Ealing Council (through membership of Ealing Safeguarding Board and its subgroup on faith and diversity) and persuading them to prioritise work that promotes anti-FGM messages.
- Working with other third sector organisations. Increased awareness of the health risks and illegality of FGM in local communities.
- Younger women, and mothers aged 30-50, are increasingly willing to speak out and reject FGM.

**Challenges:**

- Difficulty engaging older males in FGM work.
- Hard to work with Islamic leaders locally.

## Annex 2. Beliefs to Reinforce, Beliefs to Change

This table summarises findings from the PEER data collected by most of the projects, in terms of beliefs that can be supported to strengthen FGM opposition ('beliefs to reinforce' in project activities and messaging', and beliefs that underpin support for FGM (beliefs that projects should aim to change).

Issue	Belief to reinforce	Belief to change	Implications for focus of interventions (key target group)
Health	There are no health benefits from FGM	FGM does not result in health problems	<p>Messaging is required on:</p> <ul style="list-style-type: none"> <li>Increased emphasis on perceived links between FGM and cultural identity (all)</li> <li>Affirmative messages that FGM does not destroy cultural identity (all)</li> <li>Continuation of messages opposing FGM by religious leaders (all)</li> <li>'Zero benefits' from FGM (all)</li> <li>The health benefits of no FGM (all)</li> <li>Girls can become 'good women' without FGM (focus on parents and grandparents)</li> <li>Men do not desire a future wife to have had FGM (focus on parents and grandparents)</li> <li>Negative impact of FGM on relationships (young men and women)</li> <li>FGM will lead to prosecution (all)</li> <li>FGM is a human rights issue (all)</li> <li>Affirmative gender-based messages (young women and parents)</li> </ul> <p>Communication avenues:</p> <ul style="list-style-type: none"> <li>Community organisations and workers</li> <li>Religious and community leaders</li> <li>Peer to peer</li> <li>Male role models</li> <li>Grandparent role models</li> </ul>
	FGM results in life-long challenges to physical and emotional well-being	Less severe forms of FGM do not cause health problems	
	It is good to seek help for FGM-related problems	Women must suffer in silence	
	Specialist services exist and can help	FGM-related problems are a 'normal' part of women's life	
Gender	FGM is a form of control over women	FGM is an appropriate ways of controlling women's sexual behaviour	
	Girls can become 'good' women without FGM	A woman will not be 'marriageable' if she is not circumcised	
	Young men do not want circumcised women as wives	Men will not want to marry an uncircumcised woman	
	Men of all ages are opposed to FGM	Men view FGM as a 'women's issue' and are disinterested in FGM	
	Young married women and men have a right to enjoy their married sexual lives	Men have no part to play in opposing FGM	
	Cultural identity is not dependent on FGM		

Issue	Belief to reinforce	Belief to change	Implications for focus of interventions (key target group)
Cultural identity	It is acceptable to challenge tradition	Stopping FGM is an attempt to destroy individuals' cultural identity	<ul style="list-style-type: none"> <li>• Service providers (GPs, Hospitals, Social Services, Well-woman clinics etc.)</li> <li>• Need to work with less well-supported (in terms of community organisations) ethnic groups e.g. Ethiopian and Gambian communities</li> </ul> <p>Messages should be provided in a range of formats: verbal, written leaflets, plays, group meetings, mass media etc.</p> <p>Service issues:</p> <ul style="list-style-type: none"> <li>• Need for further education of service providers</li> <li>• Dissemination on information about referral services and FGM specialist health workers</li> <li>• Need to increase male health practitioners awareness of women's embarrassment</li> <li>• Need for more specialist practitioners e.g. FGM repair and specialist midwives</li> </ul>
	A woman can be a good x (ethnicity) woman without FGM		
Religion	FGM goes against religious teachings	The 'Sunnah' form of FGM is acceptable	
	Religious leaders oppose FGM	Women's religious identity is conditional on the 'Sunnah' form of FGM.	
Human rights	FGM is an abuse of human rights	Stopping FGM protects women, girls and children	
	Women have the right to make decisions about their own bodies		
	FGM is victimisation of women, girls and children		
	Parents have the right to protect their children		
UK legislation	Legislation exists and penalties are severe	It is not possible for the Government to know if someone has carried out FGM on a UK resident in the UK or overseas	
		The Government will not prosecute individuals	