Open Agenda

Education & Children's Services Scrutiny Sub-Committee

Wednesday 21 October 2015
7.00 pm
Ground Floor Meeting Room G02B - 160 Tooley Street, London SE1 2QH

Supplemental Agenda

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Contact

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Date: 19 October 2015

Education & Children's Services Scrutiny Sub-Committee

MINUTES of the OPEN section of the Education & Children's Services Scrutiny Sub-Committee held on Tuesday 15 September 2015 at 7.00 pm at Ground Floor Meeting Room G01B - 160 Tooley Street, London SE1 2QH

PRESENT: Councillor Jasmine Ali (Chair)
Councillor Lisa Rajan
Councillor Sunny Lambe
Councillor Charlie Smith
Councillor Kath Whittam
Lynette Murphy-O'Dwyer

OFFICER SUPPORT: Assistant Director, Simon Mitchell
Julie Timbrell, Scrutiny Project Manager

1. APOLOGIES

1.1 There were apologies for absence from Councillor James Okosun, Councillor Sandra Rhule, Martin Brecknell and Kay Beckwith.

2. NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT

2.1 There were no urgent items of business.

3. DISCLOSURE OF INTERESTS AND DISPENSATIONS

3.1 There were no disclosures of interests or dispensations.

4. MINUTES

RESOLVED:

That the minutes of the meeting held on 30 June were agreed as a correct record.

5. DRAFT AUTISM STRATEGY

The chair opened the session by explaining that Peta Smith, lead officer for the strategy, and Jay Stickland, Director, were not able to attend this evening and sent their apologies. The chair said she was grateful that the Assistant Director, Simon Mitchell, had stepped in that but as it was important to hear from the lead officers Jay & Peta would be invited back in December to feedback on the results of the consultation. She then invited the Assistant Director to briefly present the paper circulated, and then invited the committee to ask questions.

The following queries, comments and answers were received:

Members asked about the consultation day and who was booked on, and if an additional Saturday would be considered, or north or south of borough. The Assistant Director said that if more days were needed, they would be added, however the service needed to be mindful of resources, hence only one location in the centre of the borough had been booked as other places in the north and south had been prohibitively expensive.

The committee raised the pivotal time of transition from childhood to adulthood, the move to different services, and the importance of liaising with Further Education.

Members asked if there had been liaison with school SENCO leads as a correct and timely diagnosis is very important , and the Assistant Director agreed that it is important to diagnose early to prevent latter problems and avoid a misdiagnosis for a behaviour problem .

A member commented that the strategy is a little thin on schools and also that she could not see a document that meets the needs of professionals. She asked the Assistant Director if officers will be sending out a questionnaire to professionals. He responded that he did not know if there was a survey for professionals, but there is a dedicated session for professionals to feed into the strategy.

The chair suggested using the services of the Headteachers' Executive to promote the consultation to schools. A member reported that Redriff autism unit had not heard about the consultation, which was a concern.

Members stressed the importance of 'Independent Living', and people with autism being able to access adequate support to live in the community, e.g. services like Keyring and employment support.

A member raised concerns that the strategy focused almost exclusively on data and training frontline staff and much of this training was online.

There was a comment that the document is fairly dry and the consultation also lacked an open question.

A member asked if there will be section on monitoring the implementation of the strategy , and a section on how it will be kept updated. The Assistant Director referred to Statement of Intent, and the member followed up by emphasising the important of measurable

targets & outcomes and a continual cycle of refreshment of the strategy aims and content.

There was a comment that that autism is not a mental illness, not a disability, just different. People are not going to get better or worse - but are at risk of becoming isolated, and the strategy would benefit from taking that stance.

Members queried if there was sufficient engagement with parents.

Concern was raised at national figures that show that only 15% of people with an autism diagnosis are in employment, and the importance of achieving a much higher rate in Southwark.

RESOLVED

Cllr Kath Whittam will take the lead in preparing a summery on behalf of the scrutiny committee on the points raised and submitting this to officers.

Officers will be invited back to present on the results of the consultation and next stage in the strategies development.

LIVE-STREAM / VIDEO LINK TO DRAFT AUTISM STRATEGY

http://bambuser.com/v/5791934

6. WORKPLAN

RESOLVED

The workplan was agreed.

LIVE-STREAM / VIDEO LINK TO WORKPLAN

http://bambuser.com/v/5792022

Female Genital Mutilation

Dr Comfort Momoh MBE

FGM/Public Health Specialist/Consultant

FGM: International Level

- **FGM is abuse, a health and Human Right issue for girls and women.**
- **UN General Assembly resolution on the elimination of FGM in December 2012 is an important step in effecting global efforts to tackle FGM.**
- **UN Commission on the status of women March 2013.**

Female Genital Mutilation

- In its many and complex cultural meanings, FGM is a long-standing tradition that has become inseparable from ethnic and social identity among many groups

- **Convention and Charter**
- Convention against Torture and other cruel, Inhuman or Degrading Treatment or Punishment.
- The African Charter on the Rights and Welfare of the Child, 1981
- African Charter on Human and Peoples' Right (the Banjul Charter) and it's Protocol on the Rights of Women in Africa.
- The convention on Elimination of All forms of Discrimination Against women 1979 – The Vienna Declaration and programme of Action 1993
- The Beijing Declaration on Women's Right 1995 and the United Nation Convention on the Right of the child 1989.

UK and Europe

- The European Parliament estimated that 500,000 women and girls.
- 180,000 are at risk each year in EU countries.
- The European Union and its Member States, have also committed to act against this for of violence.

Current activities in UK

- Lots of media coverage and interest.
- Government pledged £35million to prevent FGM, through education and by challenging culture. Community engagement.
- More Clinics to support women and girls.
- Young people speak out.
- Europe wide campaign.
- Community Engagement

Overview and Health Risks of FGM

The practice of FGM is a violation of Human Right and it is crucial that we raise awareness and protect children who are at risk.

- FGM denies Women and Children security, personal liberty and right to health.

The Extent and Evidence

- World-wide100-140million of girls and women have undergone some form of FGM.
- An estimated 6,000 are at risk per day worldwide and about 2million or more undergo FGM each year

Amended typology

Type I

Partial or total removal of the clitoris and/or the prepuce (clitoridectomy)

Type Ia, removal of clitoral hood or prepuce only

Type Ib, removal of clitoris with prepuce

90%

Type II

Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision)

Type IIa, removal of labia minora only

Type IIb, partial or total removal of clitoris and labia minora

Type IIc, partial or total removal of clitoris, labia minora and labia majora

Type III

10%

Narrowing of the vaginal orifice with creati of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).

Type IIIa, removal and apposition of the labia minora;

Type IIIb, removal and apposition of the labia majora.

Re-infibulation falls under this type.

Type IV

Unclassified: All other harmful procedures to the female genitalia for non-medical purposes, for example, pricking, piercing, incising, scraping and cauterization.

No prevalence data

Current Figures in the UK

- An estimated 103,000 women aged 15-49 compare to 66,000 in 2001.
- Over half of the women age 15-49 with FGM, 53,000 were born in countries with almost universal Type 111 FGM.
- Across government work is taking place to tackle FGM.

Type 1 – Clotoridectomy

Type 2 – Excision of the clitoris with partial or total excision of the labia minora

Type 3 - Excision of part or all the external genitalia and stitching/narrowing of the vaginal opening (also known as infibulation)

- Type 4

  This is unclassified – includes pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia, cauterization by burning of the clitoris and surrounding tissue; scraping of the tissue surrounding the vaginal orifice or cutting of the vagina, introduction of corrosive substances or herbs into the vagina to cause bleeding.

The Extent and Evidence

- About 10% of children and women die from the short term effects – such as haemorrhage, shock or infection.
- Another 25% suffer lifelong disability and may die from the long-term effects.

Reasons for FGM and the Age

- Tradition
- Religion
- Prevent Rape
- Income for circumcisers
- Preservation of virginity
- Promote cleanliness
- Age varies from tribe to tribe

Health Risks of FGM

- Shock, Pain, Urinary Retention
- Infection, Fracture or Dislocation
- Injury to Adjacent tissue, death
- Failure to Heal, Dermoid Cyst
- Psychological problems-Flash backs
- Recurrent UTI
- Fistulae (Rectum or vaginal)

Health Professionals: Roles and Responsibilities

- Protect and safeguard children
- Be alert to the possibility of FGM
- Be able to recognise FGM
- Be able to act when a child is at risk or may already undergone FGM

Looking into the Future

- More collaboration with all professionals and NGO's in order to more work forward
- Close working relationship with the police, teachers and immigration officers
- More links and work with Africa and other practising communities

Conclusion

- As we know FGM is practised among migrant and refugee communities who tend to settle in urban areas.
- The government policy of dispersing refugees and asylum seekers to rural, isolated centres has a major implications for women Who have experienced FGM.

Conclusion - contd

- A better knowledge and understanding of the cultural factors relating to FGM is important in order to change people's attitude.
- It is vital that FGM laws are fully implemented and that governments, agencies, professionals and communities work together to end FGM in one generation

Quotation from Clients

- “People are worried about their daughter’s future. If she did not have FGM, they think she might have intercourse before she gets married and if she gets married she does not have to say her sexual feelings to her husband as this will make him suspicious of her that she has had sex before”

Raising Awareness

- Multi-agency approach.
- Religious and community leaders.
- Working and reaching out to families.
- Advocacy – NGO/agency.
- Training all professionals.
- As part of core-curriculum for all.
- Legal framework.
- DoH and Health services.

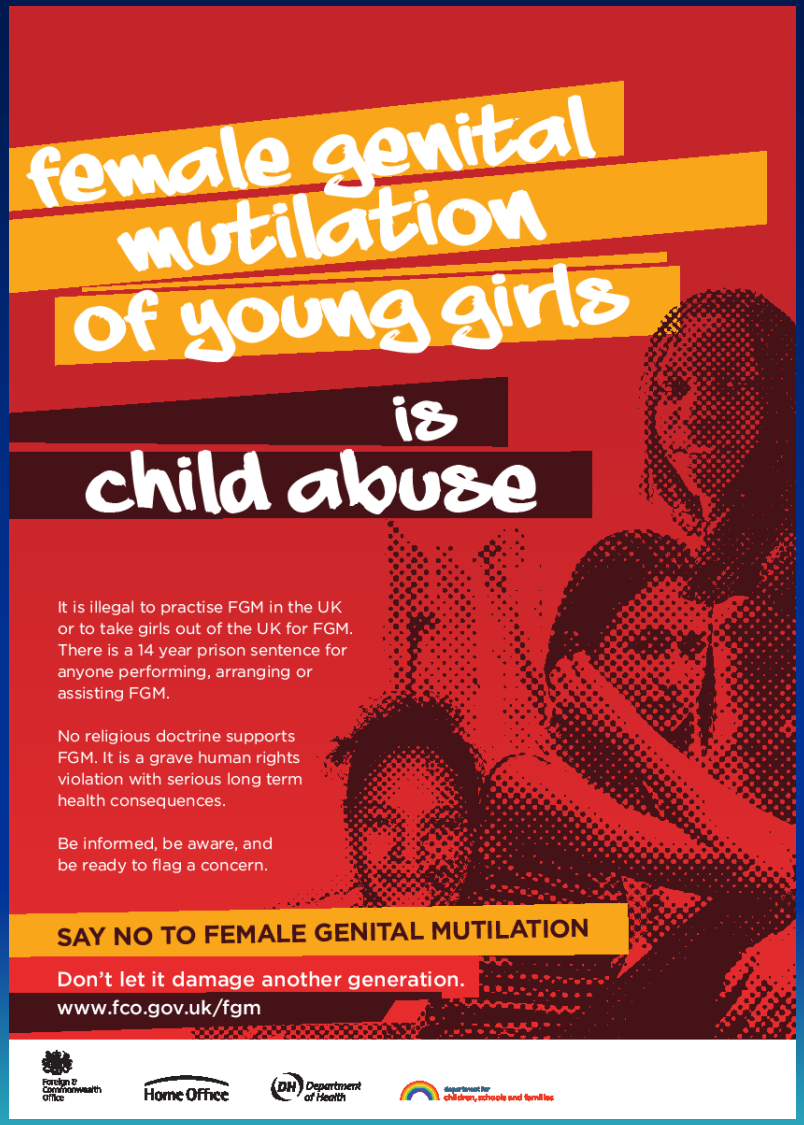
The African Well Woman's Clinic

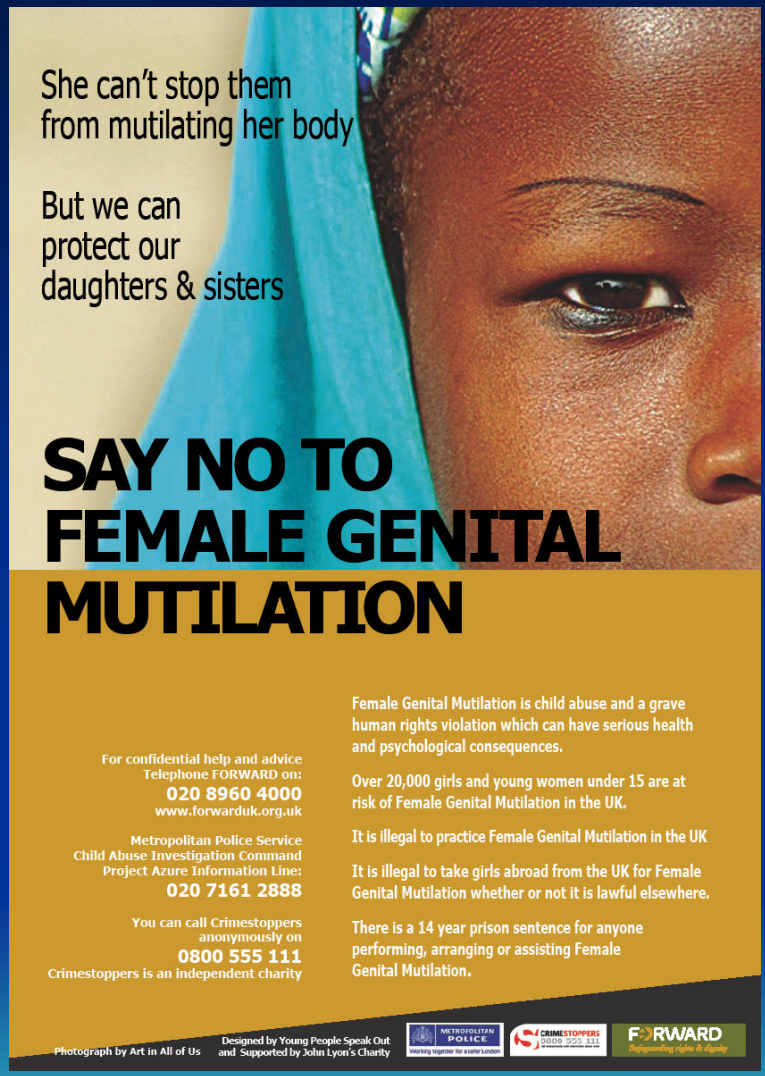
- The clinic provides support, information and advice to women/girls who have undergone Female Genital Mutilation. **We also provide a one stop clinic for surgical reversal of FGM.**
- For more information and referrals please call **Comfort Momoh FGM Specialist on 02071886872 or 07956542576 or page her on 08700555500 (Code:881018)**
  comfort.momoh@gstt.nhs.uk
- Also provide training, conference and seminars for all professionals world-wide

Statement Opposing FGM

- In November 2012 HM Government launched a one year pilot of the cross government declaration against FGM.
- ‘Health Passport’ a pocket-sized and it states the law and the potential criminal penalties that can be used against those allowing FGM to take place-pilot for a year


BE THE CHANGE YOU
WANT TO SEE IN
THE WORLD
THANK YOU


female genital mutilation of young girls is child abuse
It is illegal to practise FGM in the UK or to take girls out of the UK for FGM. There is a 14 year prison sentence for anyone performing, arranging or assisting FGM.
No religious doctrine supports FGM. It is a grave human rights violation with serious long term health consequences.
Be informed, be aware, and be ready to flag a concern.
SAY NO TO FEMALE GENITAL MUTILATION
Don't let it damage another generation.
www.fco.gov.uk/fgm
Foreign & Commonwealth Office
Home Office
Department of Health
department for children, schools and families


She can't stop them from mutilating her body
But we can protect our daughters & sisters
SAY NO TO FEMALE GENITAL MUTILATION
For confidential help and advice Telephone FORWARD on:
020 8960 4000
www.forwarduk.org.uk
Metropolitan Police Service Child Abuse Investigation Command Project Azure Information Line:
020 7161 2888
You can call Crimestoppers anonymously on
0800 555 111
Crimestoppers is an independent charity
Female Genital Mutilation is child abuse and a grave human rights violation which can have serious health and psychological consequences.
Over 20,000 girls and young women under 15 are at risk of Female Genital Mutilation in the UK.
It is illegal to practice Female Genital Mutilation in the UK
It is illegal to take girls abroad from the UK for Female Genital Mutilation whether or not it is lawful elsewhere.
There is a 14 year prison sentence for anyone performing, arranging or assisting Female Genital Mutilation.
Photograph by Art in All of Us
Designed by Young People Speak Out and Supported by John Lyon's Charity
METROPOLITAN POLICE
CRIMESTOPPERS
FORWARD

FGM Scrutiny in a Day

Female Genital Mutilation – a collaborative approach

Presenters

April Bald - Head of Service Assessment , Intervention & MASH , Children's Social Care

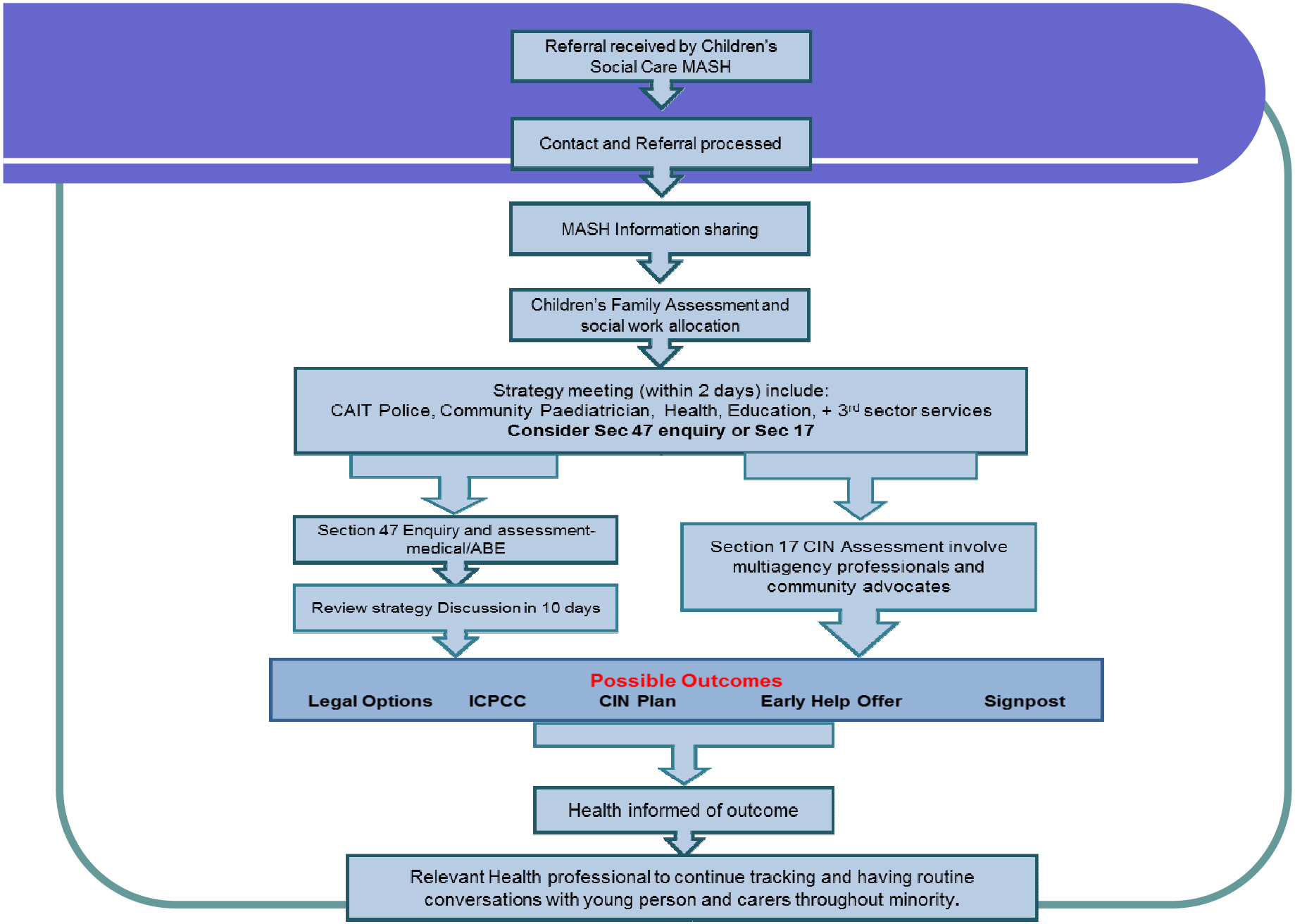
Angela Craggs - Detective Inspector Police Child Abuse Investigation team

Clarisser Cupid - Designated Nurse for Safeguarding NHS Southwark CCG

16 September 2015

Children Social Care

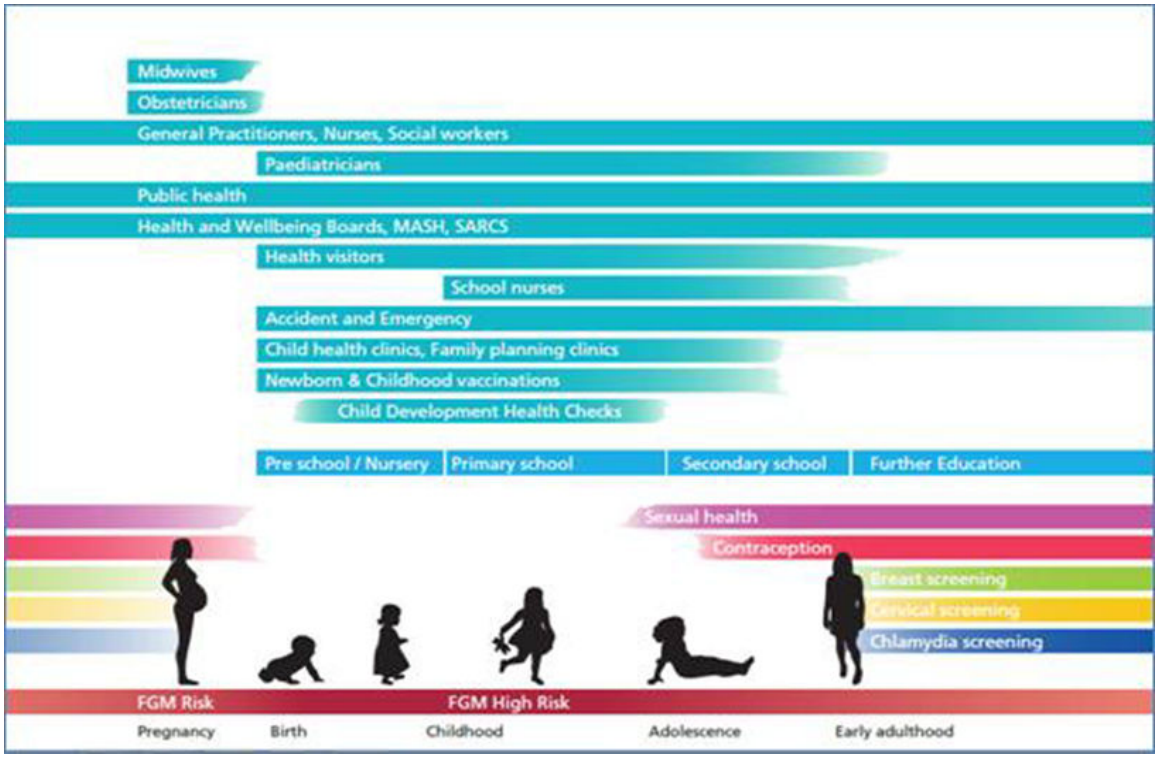
- Working Together to Safeguard Children – A guide to interagency working to safeguard and promote the welfare of children March 2015
- Supplementary Guidance = Multi Agency Practice Guidelines
- Role to prevent FGM and support those affected by the practice
- Southwark's MASH


Referral received by Children's Social Care MASH
Contact and Referral processed
MASH Information sharing
Children's Family Assessment and social work allocation
Strategy meeting (within 2 days) include:
CAIT Police, Community Paediatrician, Health, Education, + 3rd sector services
Consider Sec 47 enquiry or Sec 17
Section 47 Enquiry and assessment- medical/ABE
Review strategy Discussion in 10 days
Section 17 CIN Assessment involve multiagency professionals and community advocates
Possible Outcomes
Legal Options
ICPCC
CIN Plan
Early Help Offer
Signpost
Health informed of outcome
Relevant Health professional to continue tracking and having routine conversations with young person and carers throughout minority.

Case examples

- 17 year old Sierra-Leonean presented at Sexual health clinic – had unprotected sex with older man – She had had FGM aged 10 whilst back home .
- Adult sister (Sierra-Leone) who had FGM called – concerned about 10 yr sibling.
- GP referral – mother (Somalia) concerned about her daughter who had FGM aged 7 back home whilst living with her father and his wife
- Police – friend of pregnant Polish woman expecting a girl – Nigerian partner wanted her to have FGM
- Immigration at Heathrow – Child travelling with mother who had paraphernalia in bag indicating possible cutting instruments

Tracking through child's minority



Police action upon receipt of an allegation of FGM

A child who has undergone FGM
or
A Child at Risk of FGM
and
If at immediate risk of significant harm consider Police protection

- MERLIN entry
- CRIMINT entry – QQ SC&O5
- CRIS Report – Flag PG
- Referral to Children's Social Care
- Risk assessment
- Inform Inspector
- Consider Critical Incident

Police Investigation

- ABE Interview child/children and any female siblings if applicable. Consider significant witnesses.
- Medical Examination
- Assistance via intermediaries or Community/Voluntary organisations
- Investigative Strategy – identify established excisors and any intelligence opportunities
- Second Strategy meeting and continual liaison with other Agencies
- Consider Cultural and Community Resources Unit (CCRU) Contact details found on intranet
- Interpreters
- Liaise with local Crime Scene Management
- Consider assistance from international agencies and other agencies (i.e. Foreign Commonwealth Office, International Social Services, Borders and Immigration agency
- Early consultation between the police and CPS
- Counselling & support to any girl who has undergone FGM

The Law

- Prohibition of Female Circumcision Act 1985

Penalty – 5 years imprisonment

- Female Genital Mutilation Act 2003

Penalty – 14 years imprisonment

FGM Act 2003

- Offence to commit FGM [S1]
- Offence to assist a girl to commit FGM on herself [S2]
- Offence for someone in the UK to arrange or assist FGM outside of UK even if carried out by a person who isn't a UK national or resident [S3]
- NO AGE LIMIT - 'Girl = woman'
- Defence = If it is a surgical operation
- necessary for physical / mental health
- Mental health does not include belief that FGM is required as a matter of custom or ritual
- Consent is not a defence

New measures since May 2015

- Extension of extra-territorial liability to "habitual" UK residents
- Lifelong victim anonymity
- Parents and guardians liability for failing to protect a child from FGM
- Serious Crime Act 2015
- Civil Protection Orders for FGM
- Mandatory reporting for relevant professionals

There have been NO convictions under FGM legislation in the UK…

MPS Response

- Project Azure
- Dedicated SPOCS on each CAIT team
- Flow Chart with NHS England
- Tri Borough LSCB training
- Training for Police/UKBF/Health/Education
- Operation Limelight
- FGM Conference
- NSPCC Helpline
- Protocol with CPS

Requirements from Health

- 1st April 2014 the first FGM Prevalence Dataset was published
- All clinical staff MUST record in patient healthcare records when it is identified that a patient has had FGM
- All Acute NHS Trusts (Foundation and Non-Foundation) must provide monthly returns of FGM prevalence

Further Development

- FGM Enhanced Dataset builds on the previous dataset and contains more data items such as:-

  - Patient identifiable information
  - Demographic data

- Extended to include mental health trusts and GP practices

FGM Work through SSCB Health Subgroup

- FGM Steering Group started in June 2015 with partner agencies
- Development of terms of reference, work plan and a local guidance document supported by recent government legislation
- Specialist expertise advisor
- Audit plans

Public Health

- Public Health tasked with looking at the prevalence of FGM within Southwark.
- A crude estimate of those affected by FGM using estimates of the 2014 population of 15-49 year olds is 2055 girls.
- Further research is needed to establish a truer picture including the FGM type.

Joint Working Across Health

- Kings College Hospital Foundation Trust
- Guys and St Thomas' Hospital and Community Foundation Trust
- South London and Mausley Mental Health Trust
- Pathway within the acute
- Notification to GPs and HVs

Engagement from Agencies/ Services

- SSCB (Southwark Safeguarding Children's Board)
- Social Care
- Police
- Education
- Public Health
- Voluntary Services
- VAWG (Violence Against Women and Girls)
- Community Safety Partnership
- Adult Safeguarding (Future work planned)

Going Forward

- Listen to the voices of victims and survivors of FGM to inform practice and Strategy
- Detailed data collection and analysis to inform practice and commissioning
- Consider innovative ways for the commissioning of services, e.g. mental health
- Work together to create and encourage community awareness
- Train and develop champions to support the work in schools and the community (male and females).
- Strong partnerships and referral pathways with Local support organisations

Going forward (2)

- Training of all frontline practitioners including Primary Care – ensuring a workforce confident in undertaking thorough risk assessments and robust monitoring of children at risk throughout their minority
- Raise awareness in schools to encourage critical thinking and empowerment of young people .
- Increased use of Orders to protect and increased focus on the offenders
- Promote the ethos that FGM is a safeguarding issue and therefore should be treated as such

CITY UNIVERSITY LONDON

Estimating the numbers of women with female genital mutilation in England and Wales

Alison Macfarlane

Maternal and child health research centre,
City University London

Efua Dorkenoo

Equality Now

Funded by the Home Office and the Trust for London

Efua Dorkenoo, 1949-2014

Definition

Female Genital Mutilation / Cutting (FGM) comprises all procedures that involve partial or total removal of the female external genitalia and/or injury to the female genital organs for cultural or non-any other non-therapeutic reasons (WHO 1995).

WHO classification of FGM by type

I Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).

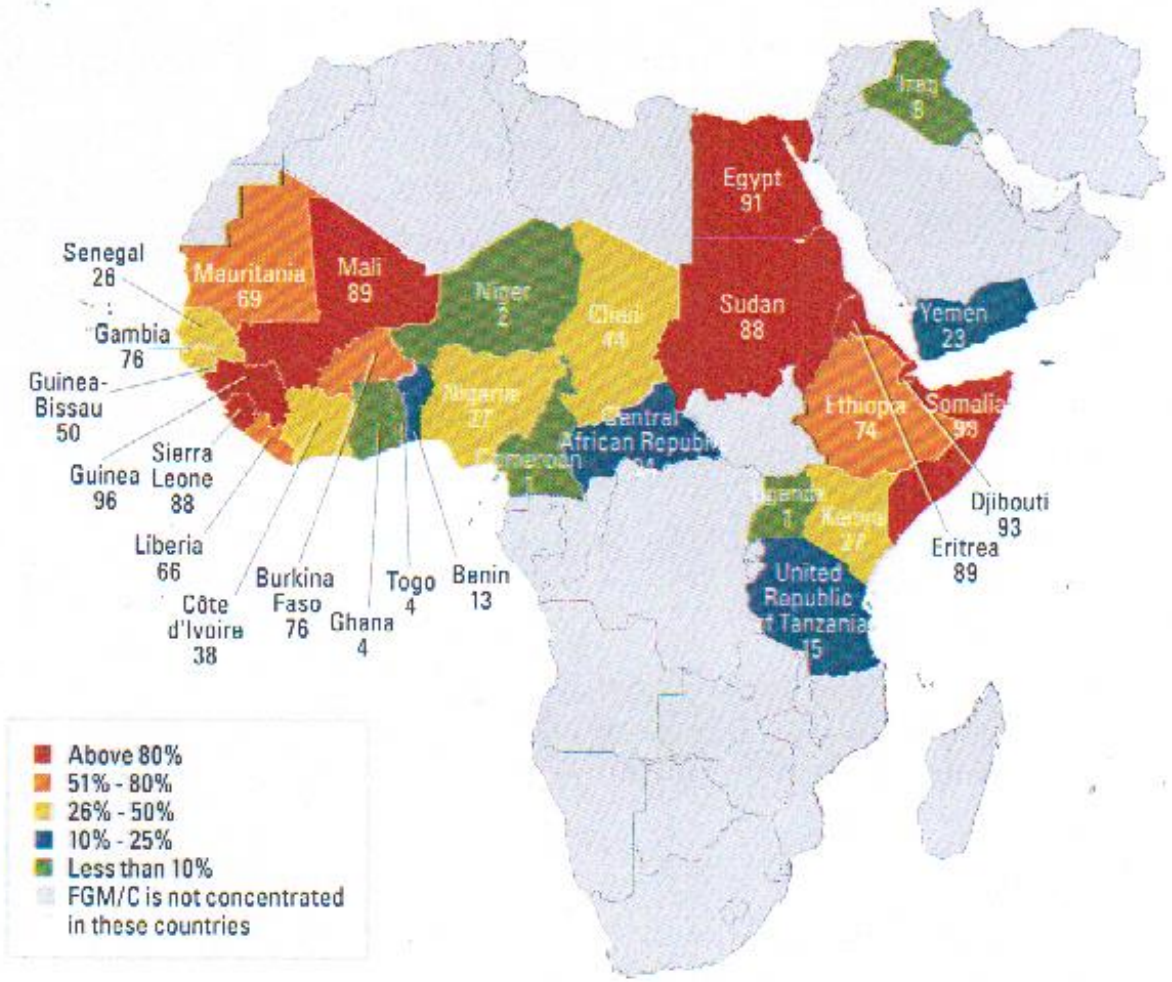
II Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).
minora and the labia majora.

III Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).

IV Unclassified: All other harmful procedures to the female genitalia for non-medical purposes, usually for cosmetic purposes.

Map 4.1 FGM/C is concentrated in a swath of countries from the Atlantic Coast to the Horn of Africa

Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, by country

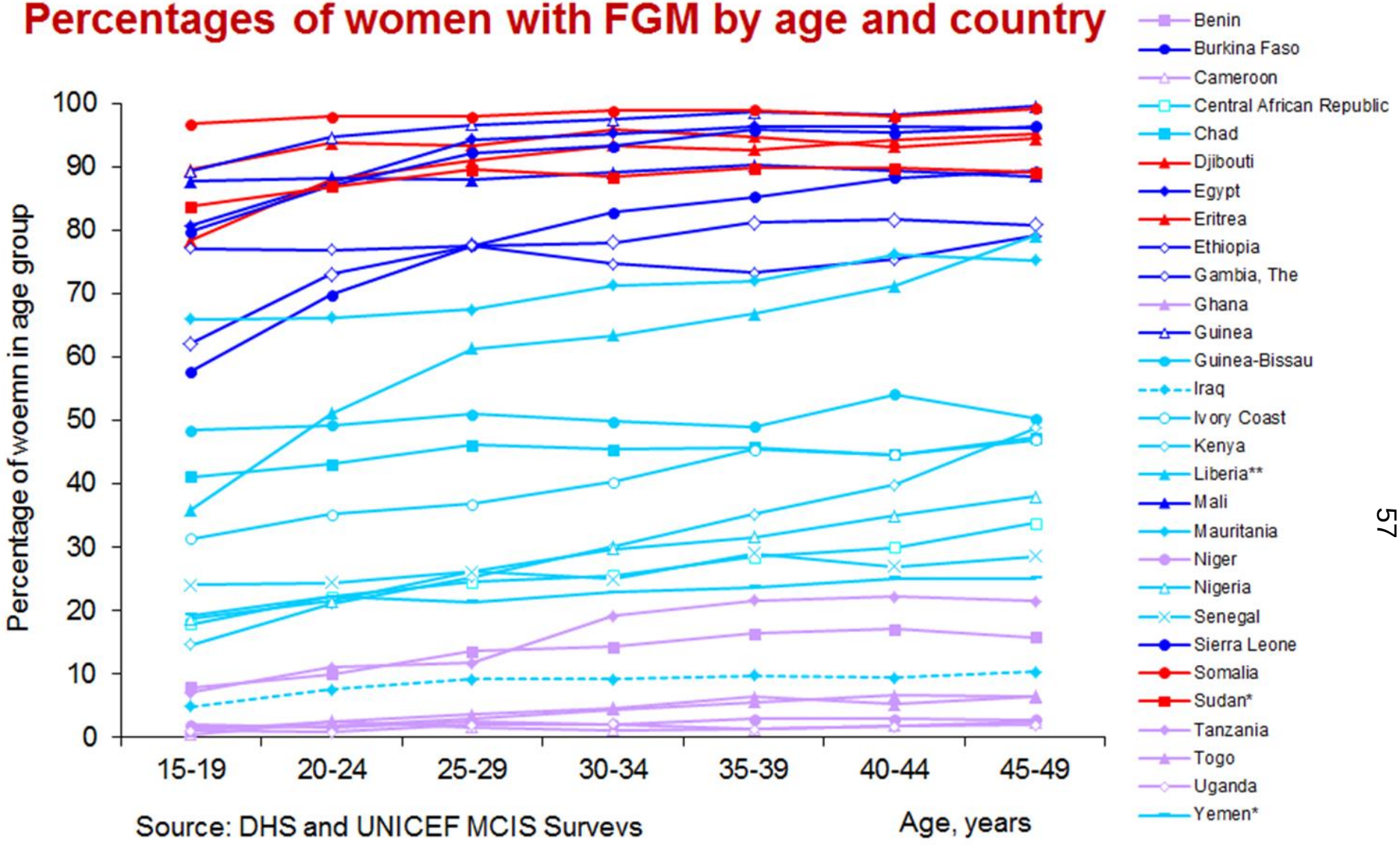


Source: UNICEF: Female Genital Mutilation/Cutting:
A statistical overview and exploration of the dynamics of change. 2013

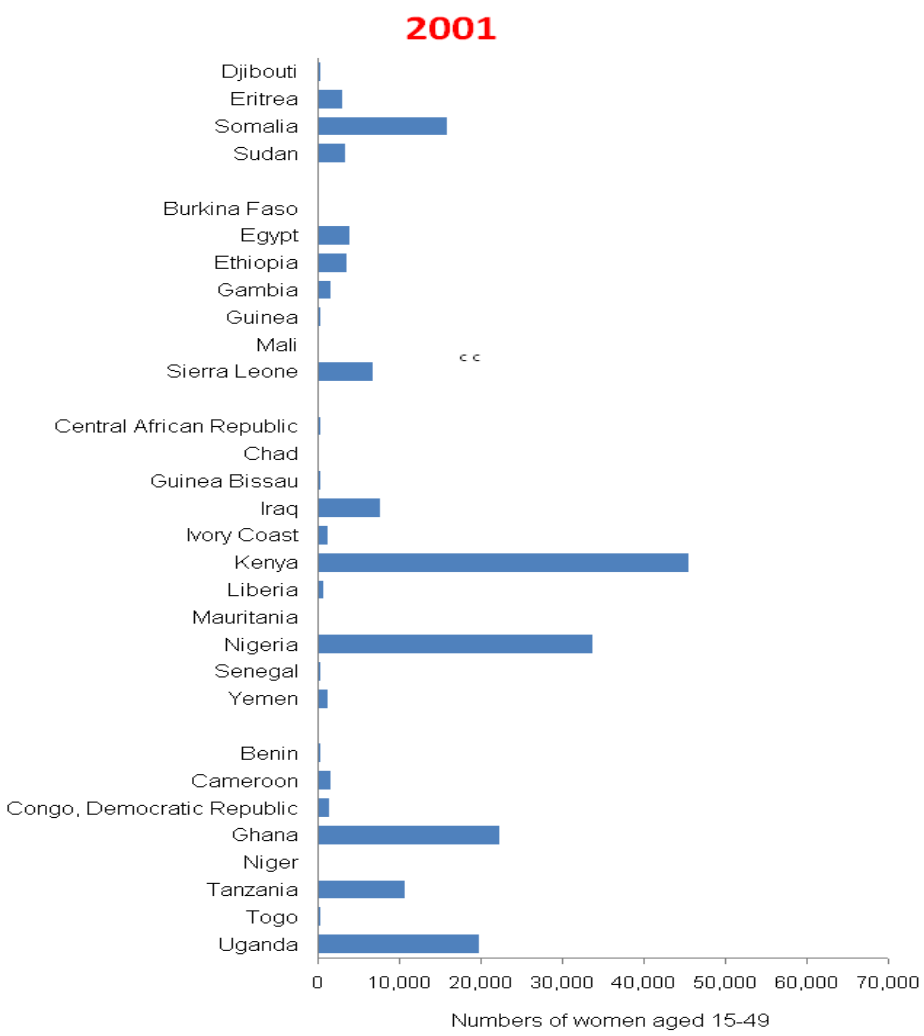
Grouping of countries by level and types of FGM

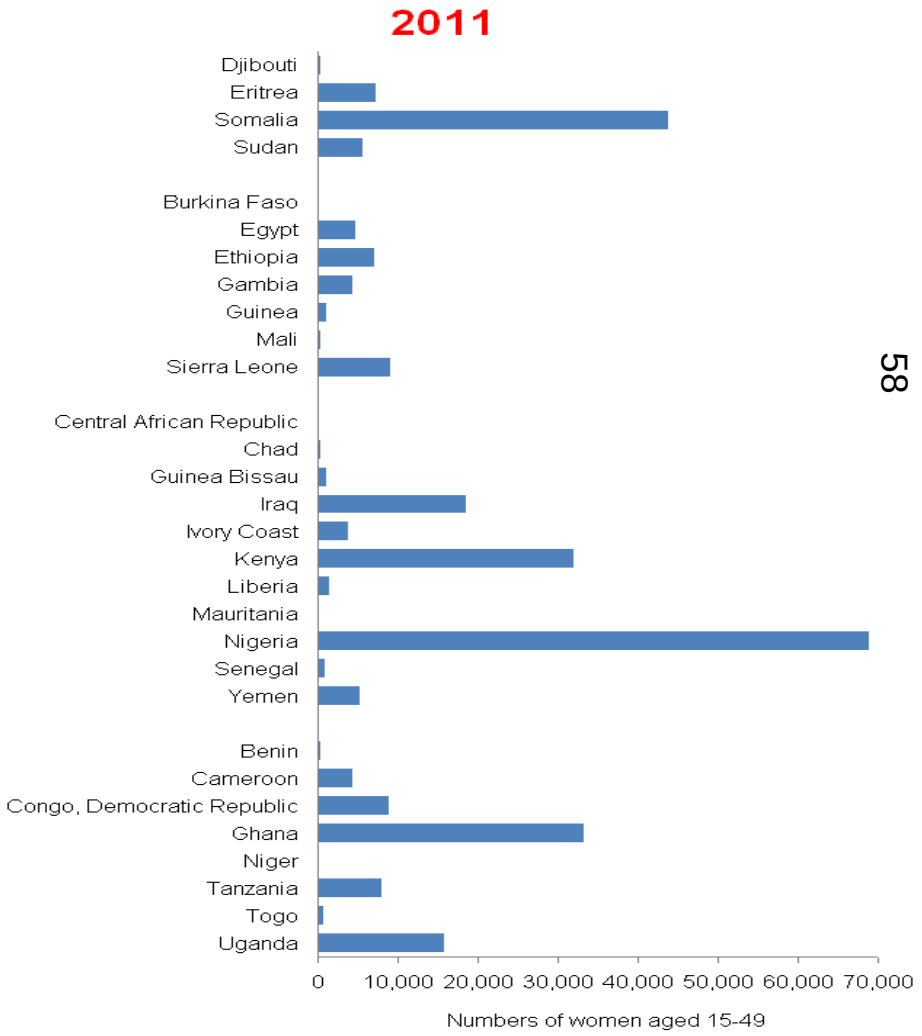
1.1	Almost universal FGM, over 30% WHO Type III	Sudan (north), Somalia, Eritrea, Djibouti
1.2	High national prevalence of FGM, WHO Types I and II	Egypt, Ethiopia, Mali, Burkina Faso, Gambia, Guinea, Sierra Leone
2	Moderate national prevalence of FGM, WHO Types I and II	Central African Republic, Chad, Cote D'Ivoire, Guinea Bissau, Iraq (Kurdistan), Kenya, Liberia, Mauritania, Nigeria, Senegal, Togo
3	Low national prevalence of FGM, WHO Types FGM I and II	Benin, Cameroon, Ghana, Niger, (Democratic Republic of Congo), United Republic of Tanzania, Togo, Uganda, Yemen

Percentages of women with FGM by age and country



Numbers of women aged 15-49 born in FGM-practising countries, England and Wales

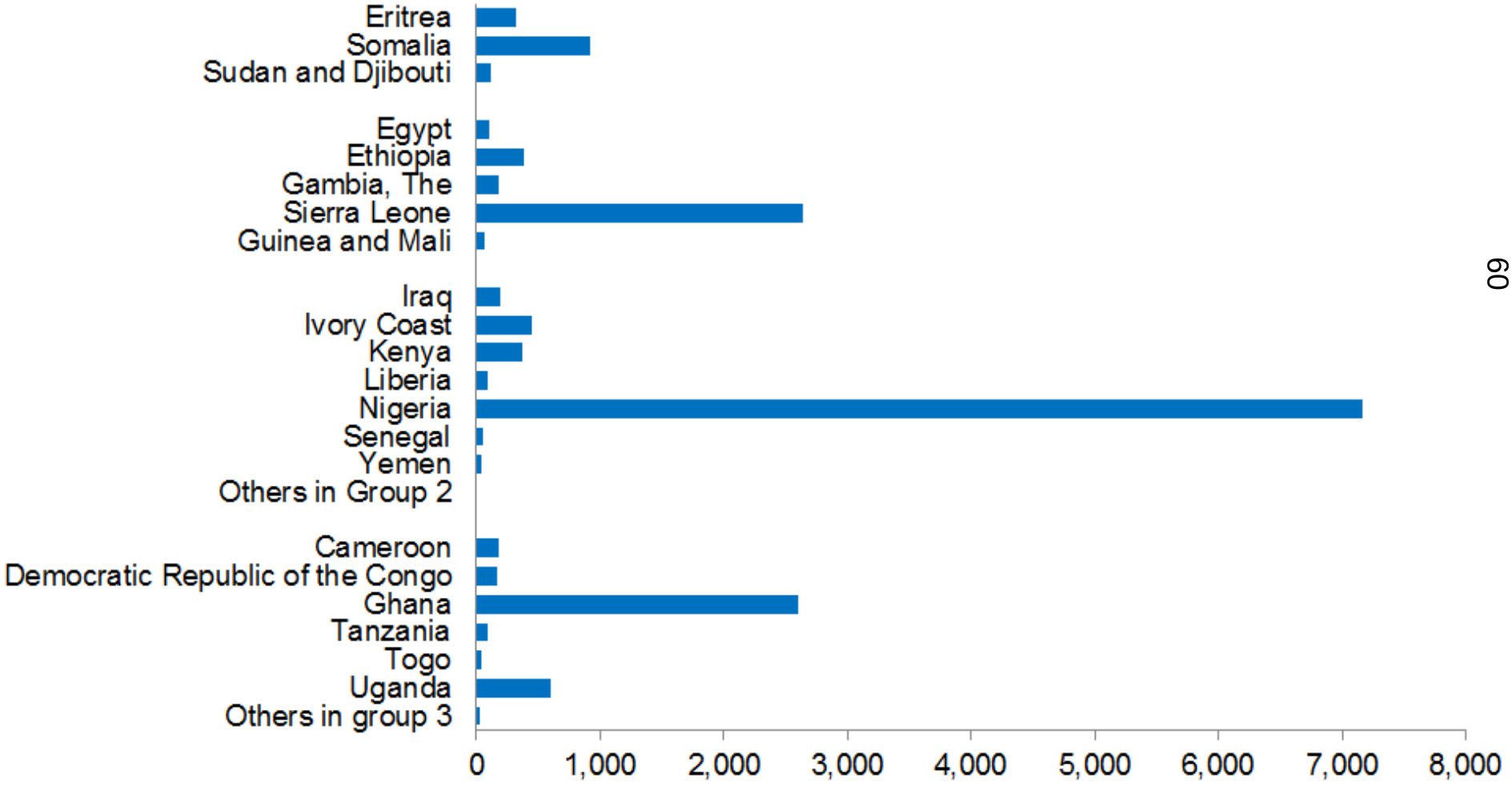




Numbers of women aged 15-49 born in FGM practising countries, England and Wales, 2001 and 2011

Country group	2001	2011
1.1	21,841	56,245
1.2	15,306	25,664
2	89,795	130,663
3	55,132	70,417
All	**182,074**	**282,989**

Numbers of women and girls of all ages permanently resident in Southwark born in FGM practising countries, 2011



Numbers of women and girls born in FGM practising countries, Southwark, 2011

Country group	Under 15	15-49	50 and over
1.1	47	1,056	248
1.2	109	2,646	618
2	390	6,054	1,930
3	98	2,542	1,067
All	**644**	**12,298**	**3,863**

Why estimates are needed

Estimates of the prevalence of FGM in England and Wales are needed:

To plan services for affected women

To inform child protection for their daughters

As numbers of women resident in England and Wales and born in countries where FGM is practised have increased, previous estimates based on 2001 census and births from 2001 to 2004 are out of date.

Aims

To produce for England and Wales and for each local authority area, estimates of:

1. Numbers of women with FGM in the population enumerated in 2011 census
2. Numbers of women with FGM giving birth, 2005-2013
3. Numbers of daughters born, 2005-2013 to women with FGM

Indirect estimates of prevalence of FGM

Used data on age specific prevalence by country of origin from surveys in FGM practising countries with data:

Demographic and Health Surveys (DHS) implemented by Macro International for USAID.

Multiple Cluster Indicator Surveys (MCIS) undertaken by governments with help from UNICEF or other UN agencies.

Indirect estimates of prevalence of FGM

Applied data on age specific prevalence to:

Numbers of women born in these countries enumerated in 2011 population census

Birth registration data about women delivering and numbers of girls born 2005-2013

Accessing data for analysis

Anonymised census and birth registration records were analysed in the secure environment of the Office for National Statistics' Virtual Microprocessor Laboratory (VML)

Disclaimer;

'This work contains statistical data from ONS which is Crown Copyright. The use of the ONS statistical data in this work does not imply the endorsement of the ONS in relation to the interpretation or analysis of the statistical data. This work uses research datasets which may not exactly reproduce National Statistics aggregates'

Estimating number of women with FGM

Census data:

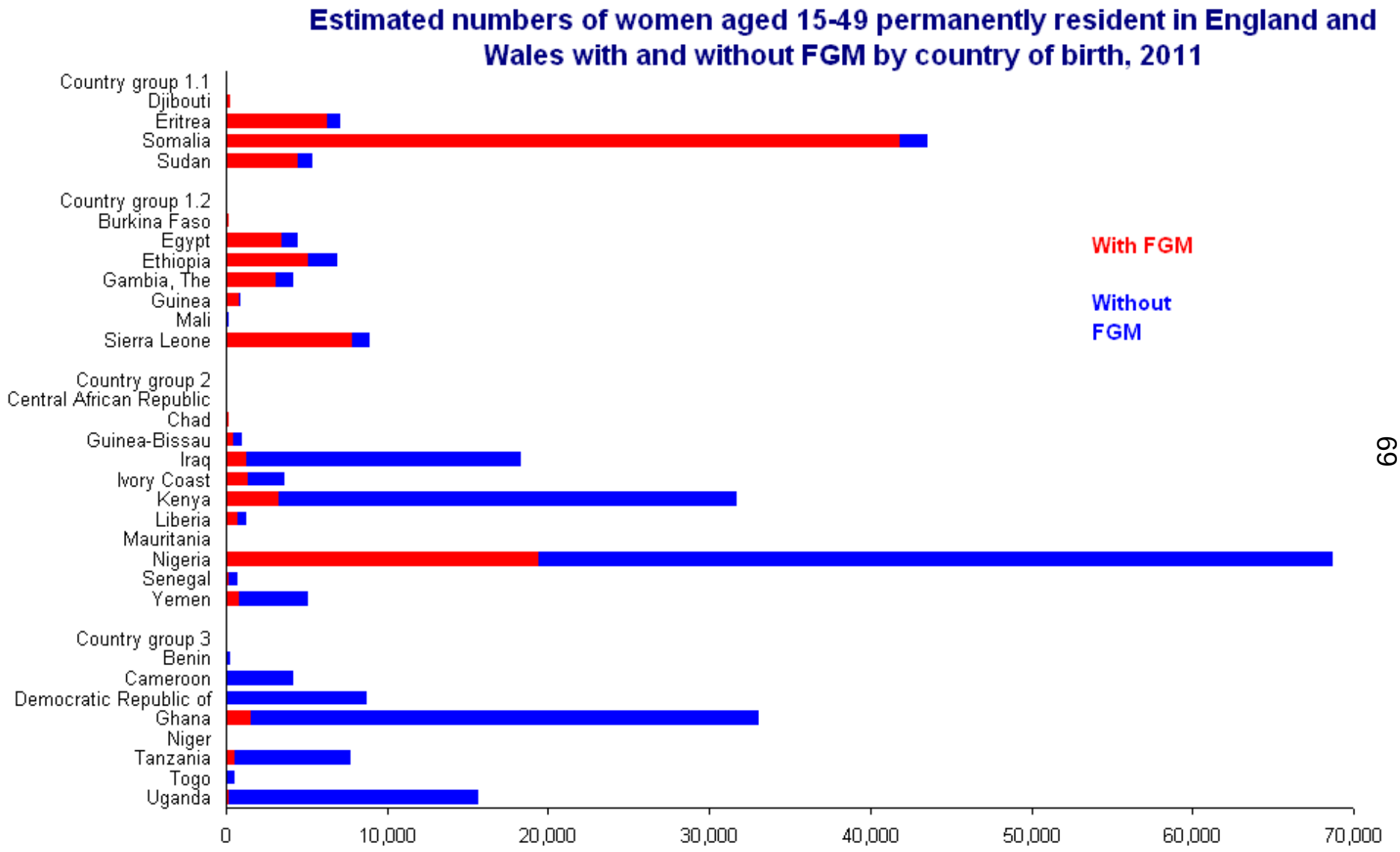
- Country of birth
- Age
- Ethnicity, standard categories
- Ethnicity, self reported
- Religion

Exclusions

- Hindu, Buddhist or Sikh religion
- White or South Asian ethnicity

Estimating number of women with FGM

- Tabulate anonymised census records by country of birth and age group nationally, regionally and for each local authority of residence
- Multiply numbers in each age group prevalence rates for each age group in country of birth, using rate for 15-19 for 0-14 age group and rate for 40-49 for 50+ age group
- Produce aggregated totals for 0-14, 15-49 and 50+ age groups


Estimated numbers of women aged 15-49 permanently resident in England and Wales with and without FGM by country of birth, 2011
Country group 1.1
Djibouti
Eritrea
Somalia
Sudan
Country group 1.2
Burkina Faso
Egypt
Ethiopia
Gambia, The
Guinea
Mali
Sierra Leone
Country group 2
Central African Republic
Chad
Guinea-Bissau
Iraq
Ivory Coast
Kenya
Liberia
Mauritania
Nigeria
Senegal
Yemen
Country group 3
Benin
Cameroon
Democratic Republic of
Ghana
Niger
Tanzania
Togo
Uganda
With FGM
Without FGM
0
10,000
20,000
30,000
40,000
50,000
60,000
70,000

Numbers of women aged 15-49 born in FGM practising countries and estimated numbers with FGM, 2011

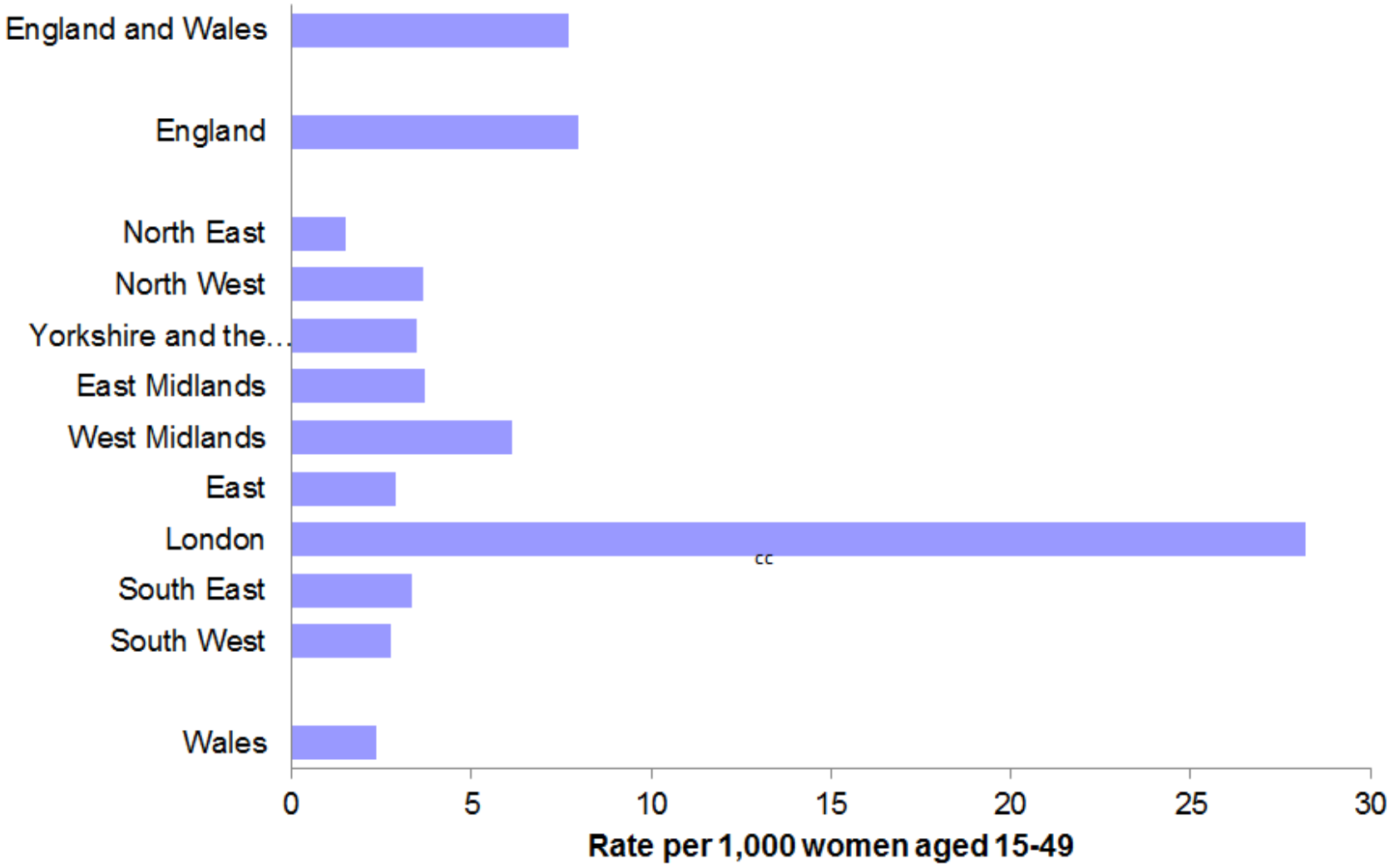
Country group	Enumerated	Estimated numbers with FGM
1.1	56,245	52,717
1.2	25,664	20,556
2	130,663	27,269
3	70,417	2,276
All	**282,989**	**103,177**

Estimates for local authority areas

Numbers related to numbers of women in population.

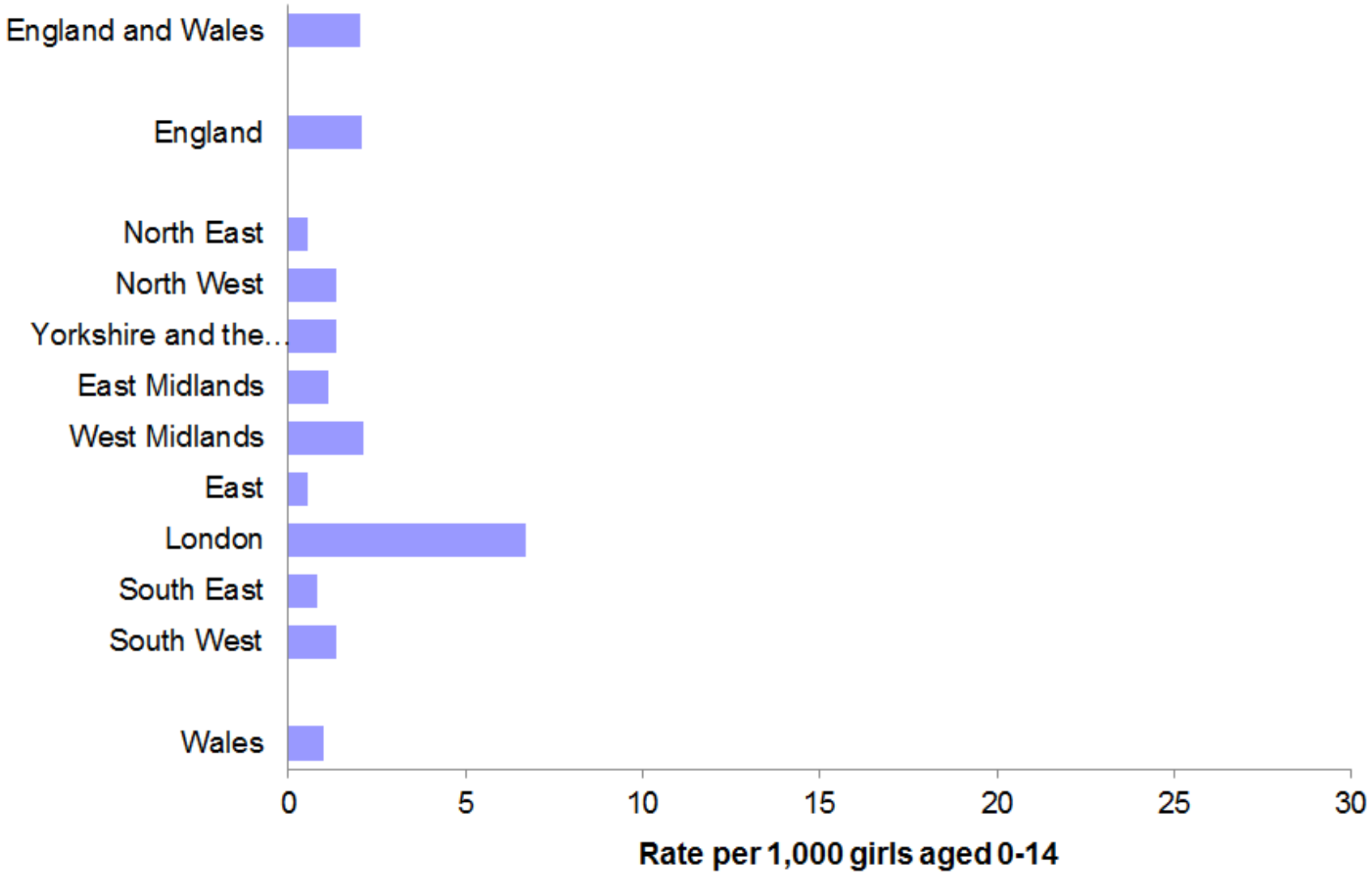
Prevalence = number per 1,000 women in area

Estimated prevalence of FGM among women aged 15-49 by region



Estimated prevalence of FGM among women aged 50 and over by region

Estimated prevalence of FGM among women aged 0-14 by region

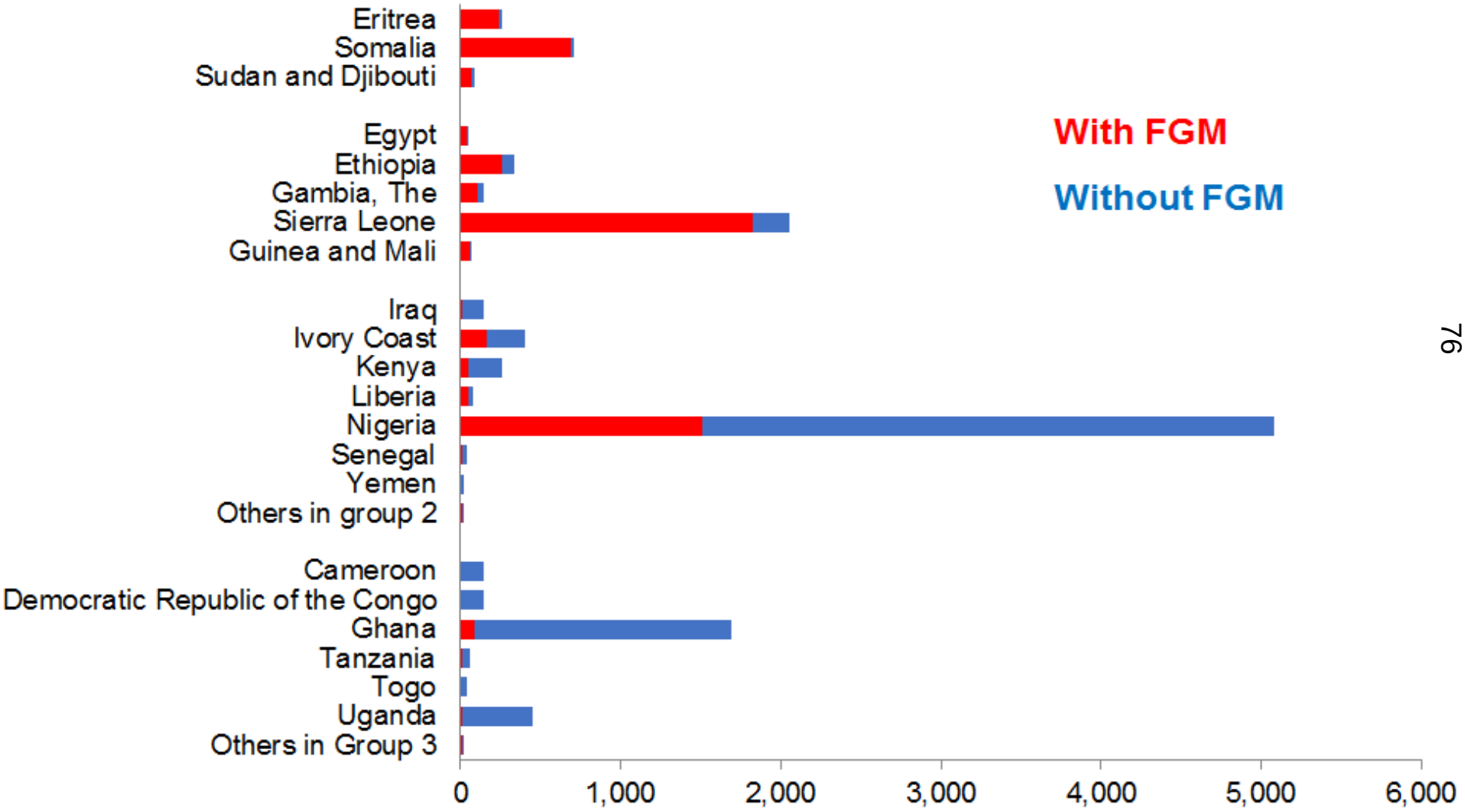


Estimated prevalence rates per 1,000 women in the population by local authority, 2011

For maps of prevalence rates, see:

http://gicentre.org/fgm2015/

Estimated numbers of women aged 15-49 permanently resident in Southwark with and without FGM by country of birth, 2011



Estimated numbers of women and girls born in FGM practising countries with FGM, Southwark, 2011

Country group	Under 15	15-49	50 and over
1.1	43	990	237
1.2	84	2,278	545
2	73	1,804	683
3	1	104	57
All	**202**	**5,176**	**1,523**

Numbers of women with FGM giving birth

Estimation of numbers of women with FGM giving birth and daughters born

Same principle as for census, but data more limited

- Country of birth of mother and father
- Age of mother
- Sex of child
- Number of children born – singleton, twins …

Ethnicity and religion not recorded so country and age specific multiplying factors derived from census data to estimate numbers of women who should be excluded.

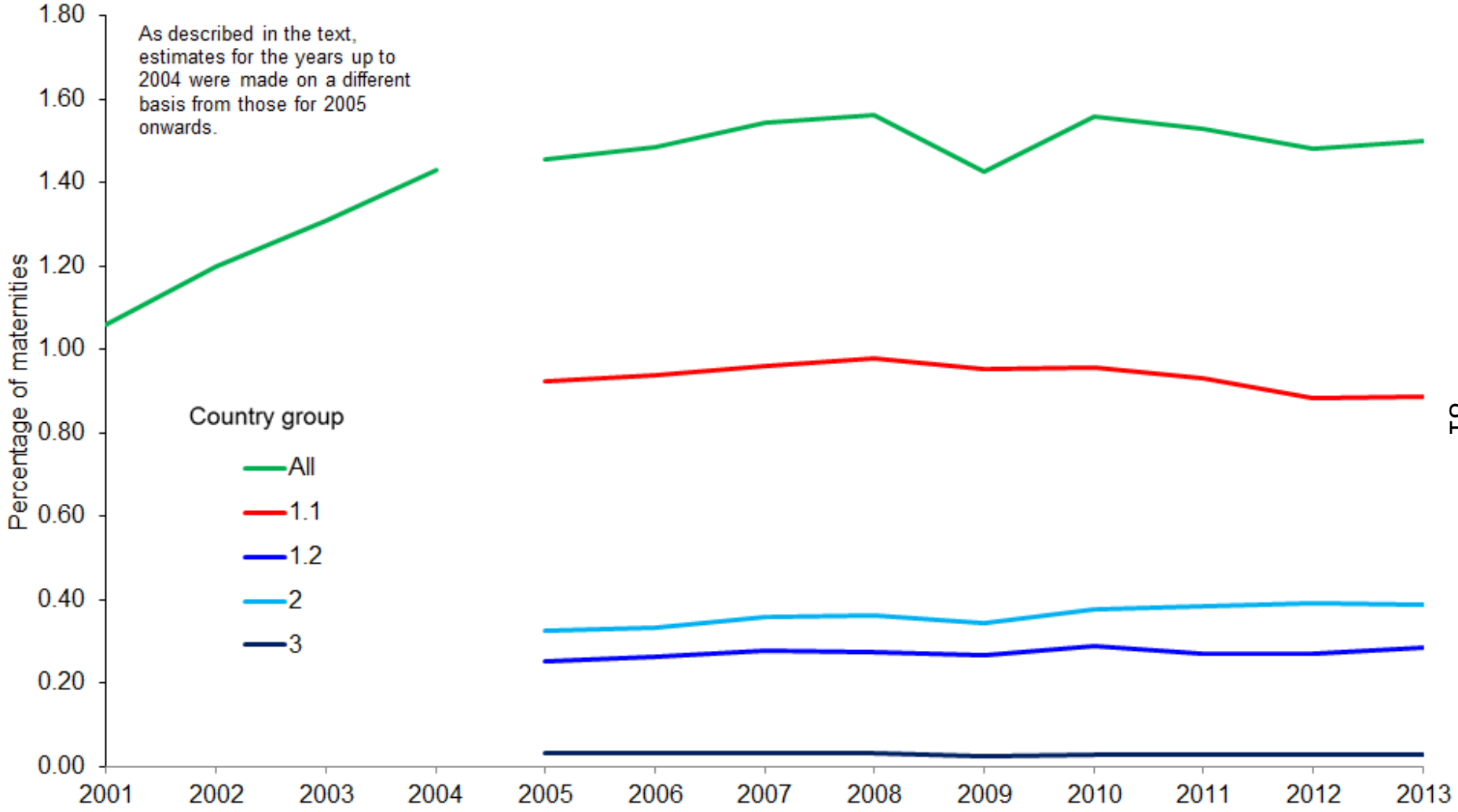
Definition

Maternity:

A pregnancy ending with one or more registered live or stillbirth

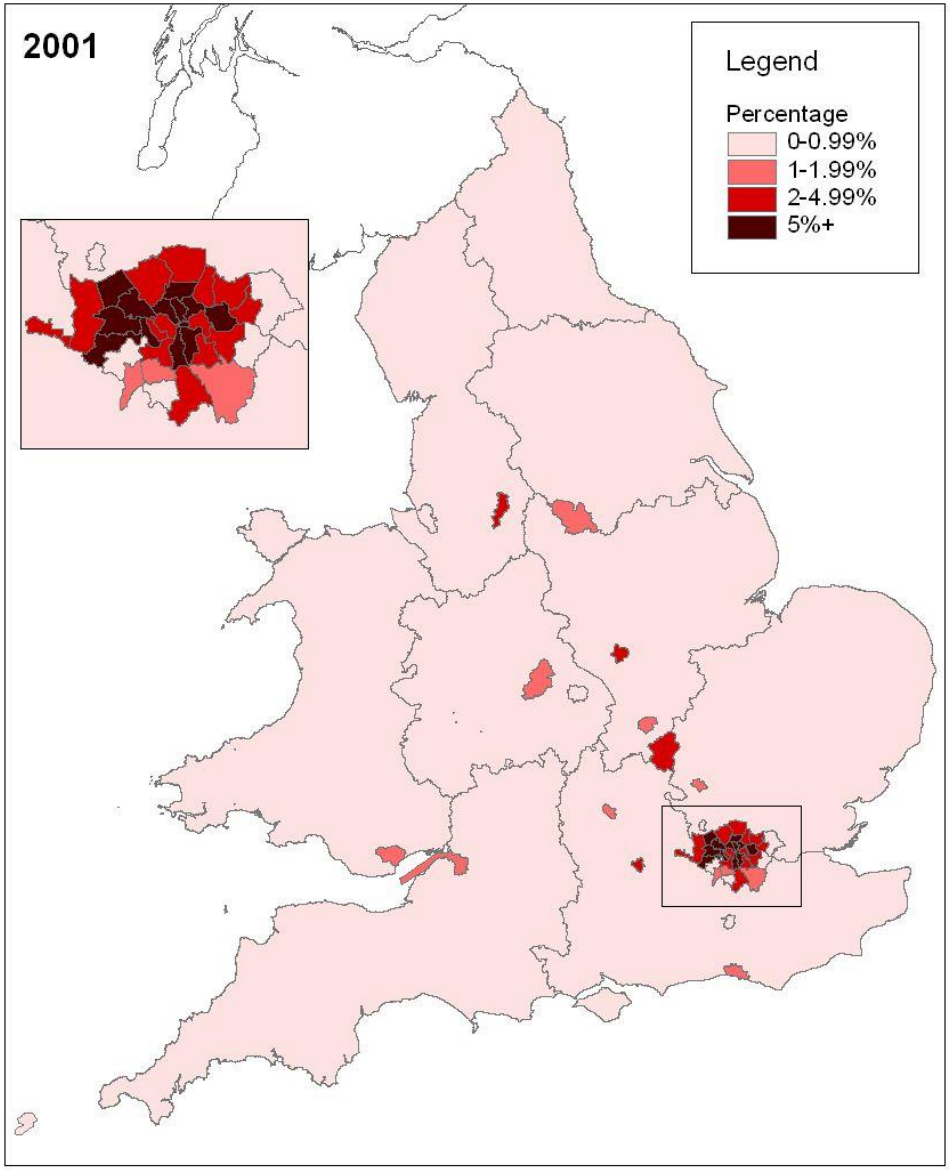
This is a measure of the number of women giving birth. If a woman has twins this counts as one maternity

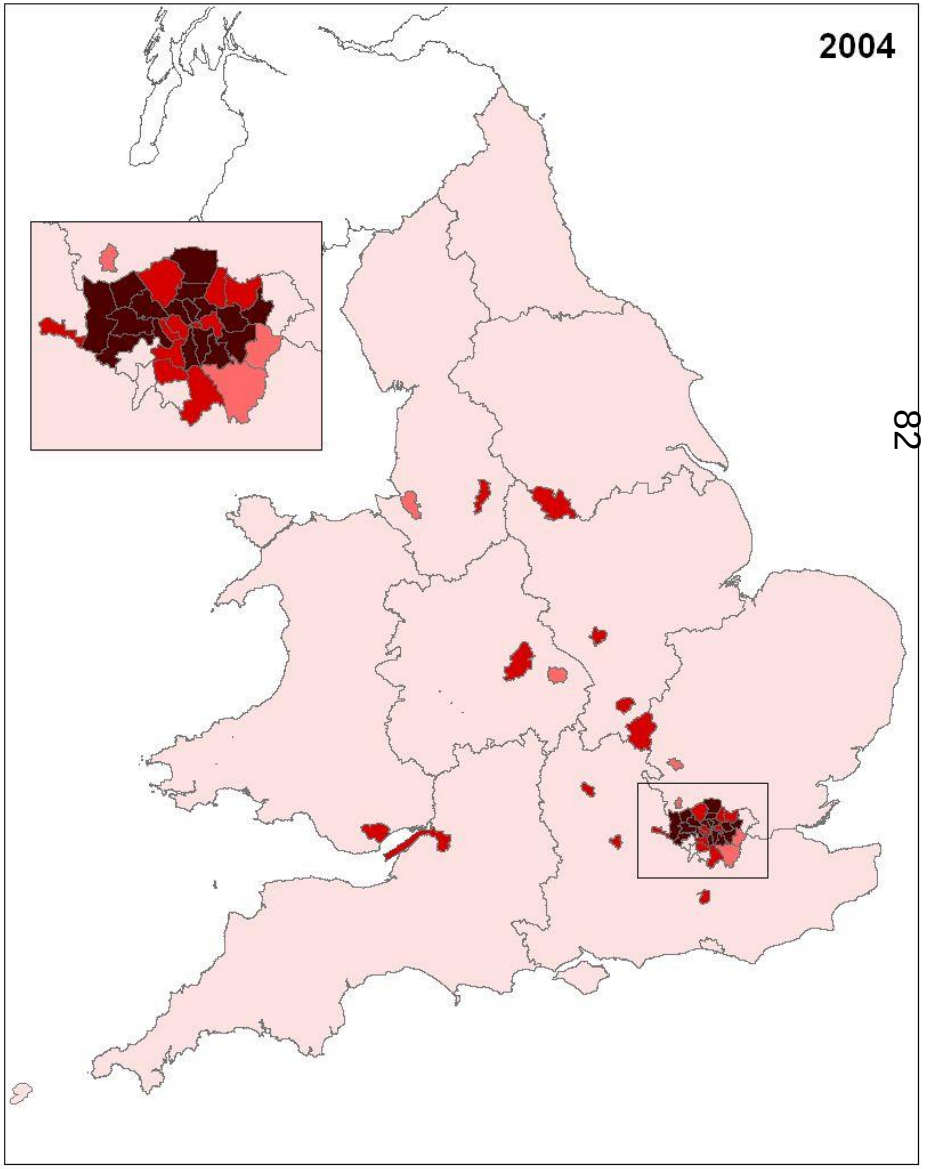
Estimated percentage of all maternities in England and Wales to women with FGM, 2001-2013



Source: Authors' analysis of ONS data

Estimated percentage of maternities to women with FGM in England and Wales, 2001 and 2004



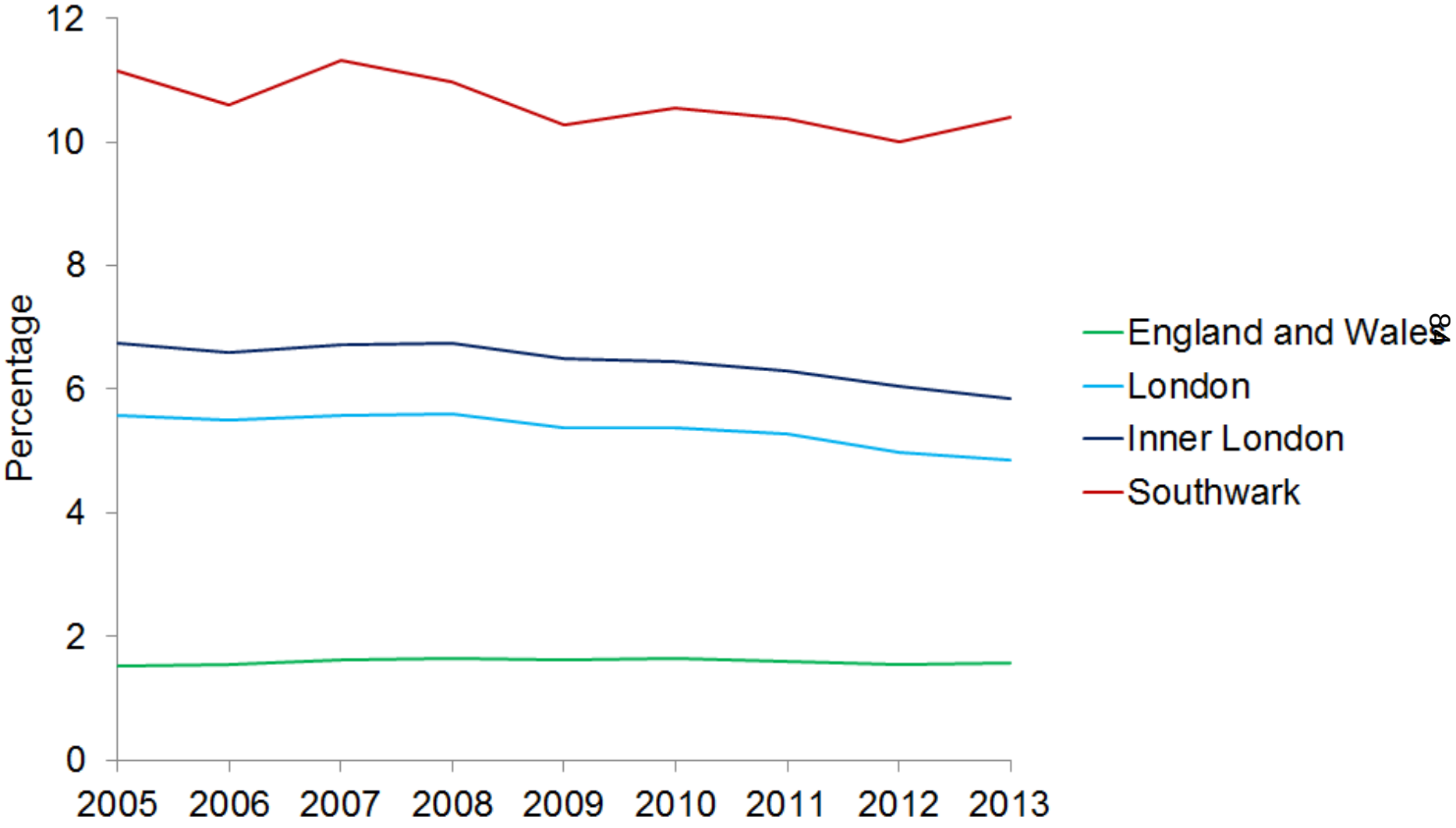


Estimated percentages of maternities which were to mothers with FGM by local authority, 2005-2013

For maps, see:

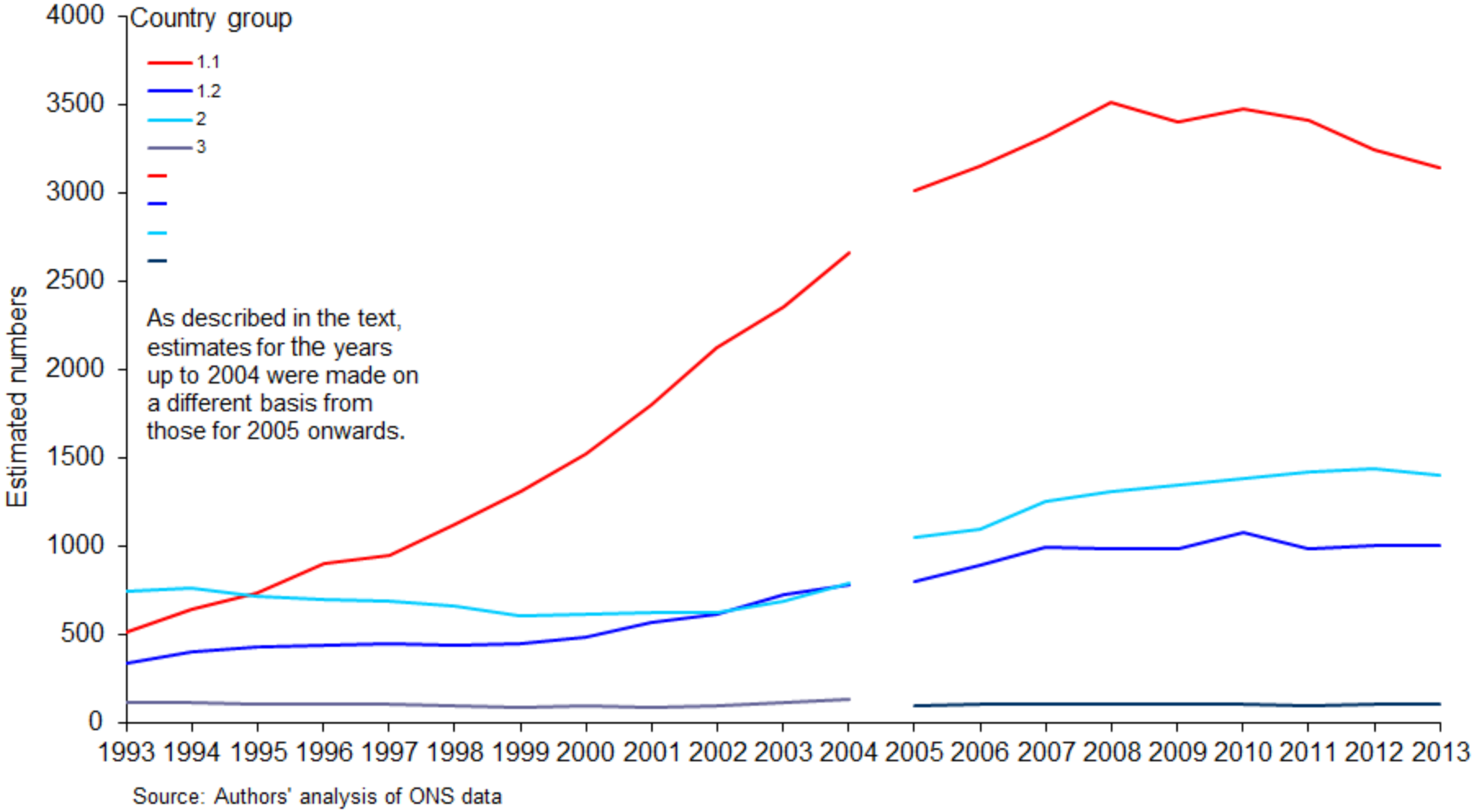
http://gicentre.org/fgm2015/

Estimated percentage of maternities to women with FGM, 2005-2013



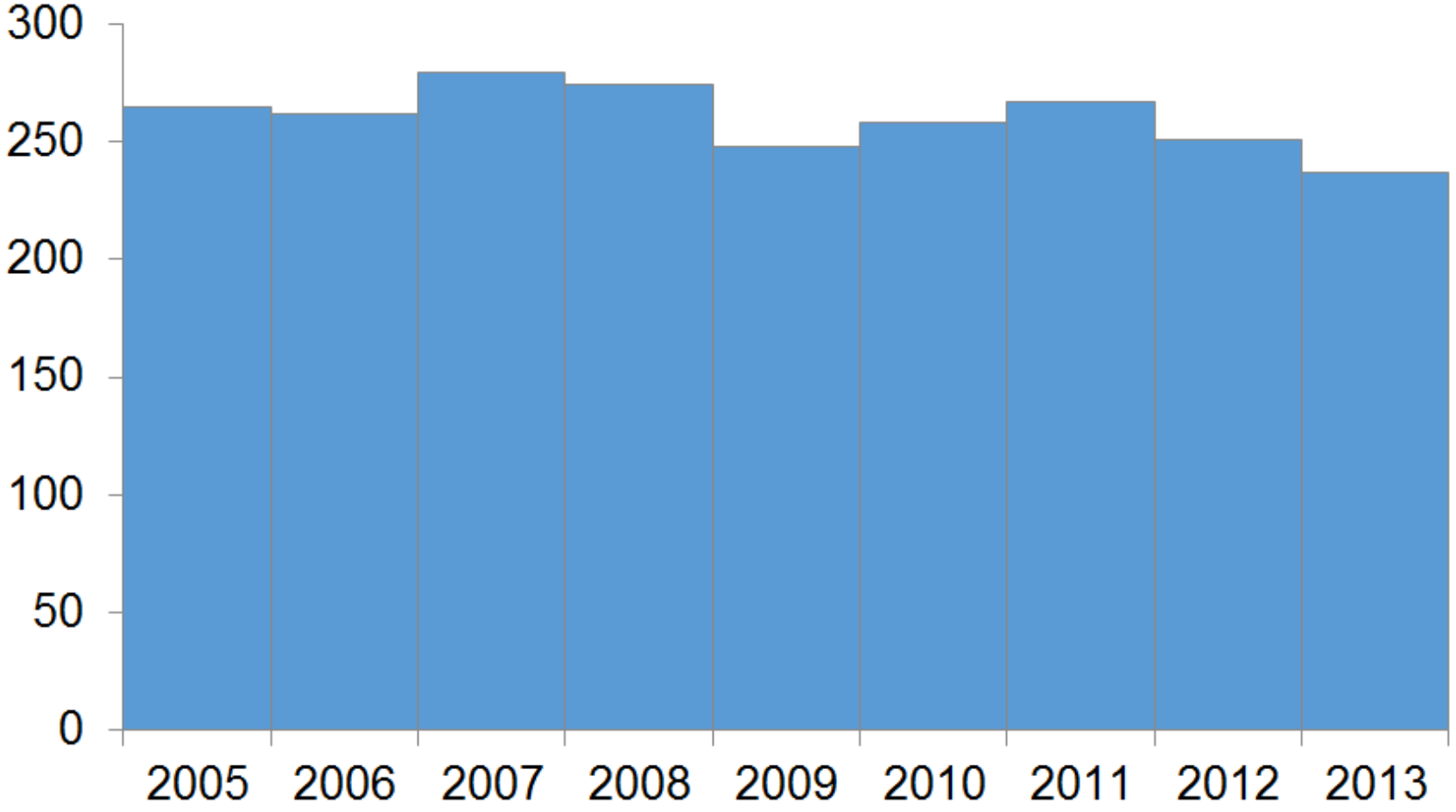
Numbers of daughters born

Estimated numbers of girls born to women with FGM, England and Wales, 1993-2013



Source: Authors' analysis of ONS data

Estimated numbers of girls born to women with FGM resident in Southwark, 2005-2013



Limitations

Prevalence in practising countries varies by region, ethnic and religious group.

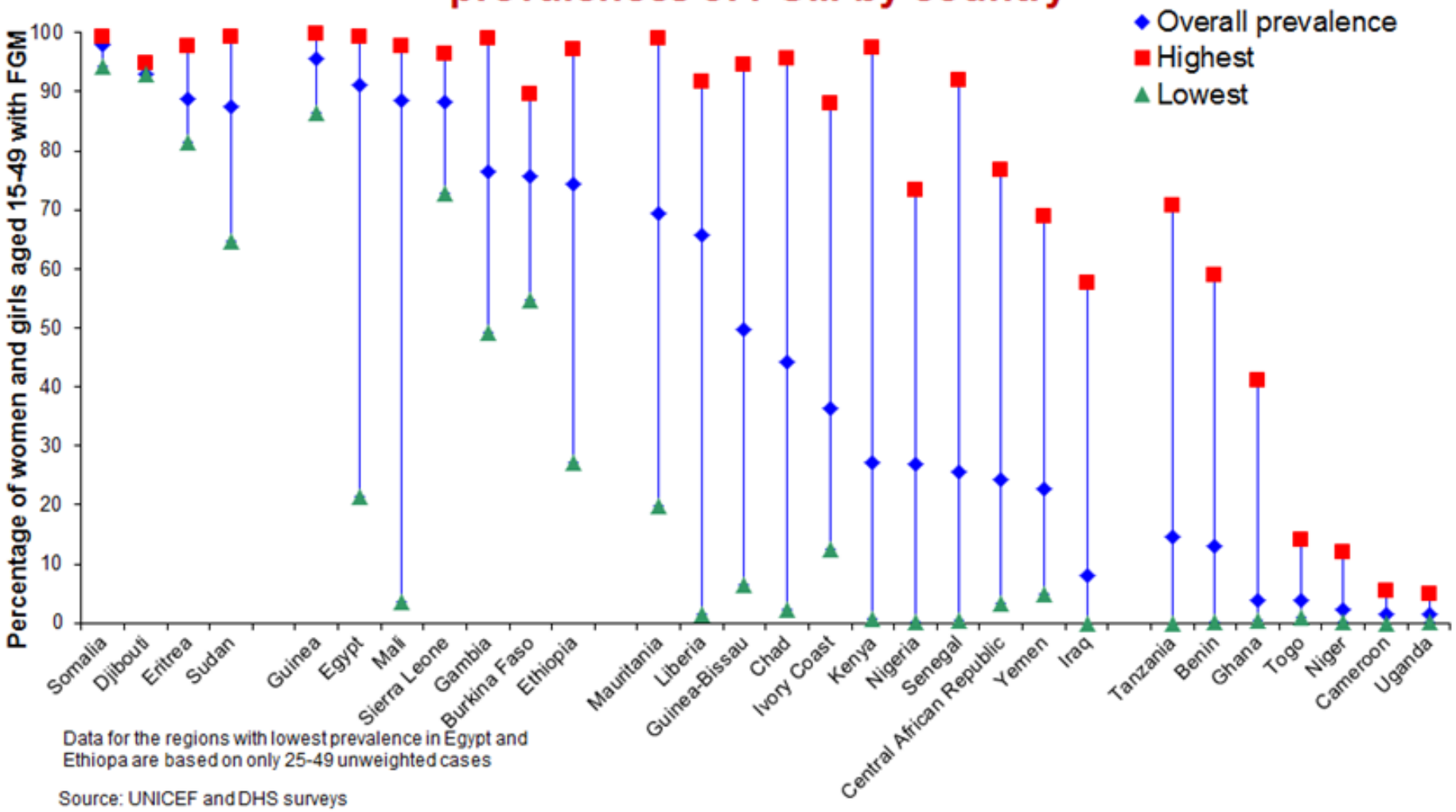
Regions of birth within countries are not recorded in data systems in the United Kingdom

Language spoken is not a useful proxy as many women give English as their main language in census

Ethnic categories used in England and Wales do not relate to those in women's countries of birth

Black women known to be under-enumerated in census.

Differences between regions with lowest and highest prevalences of FGM by country



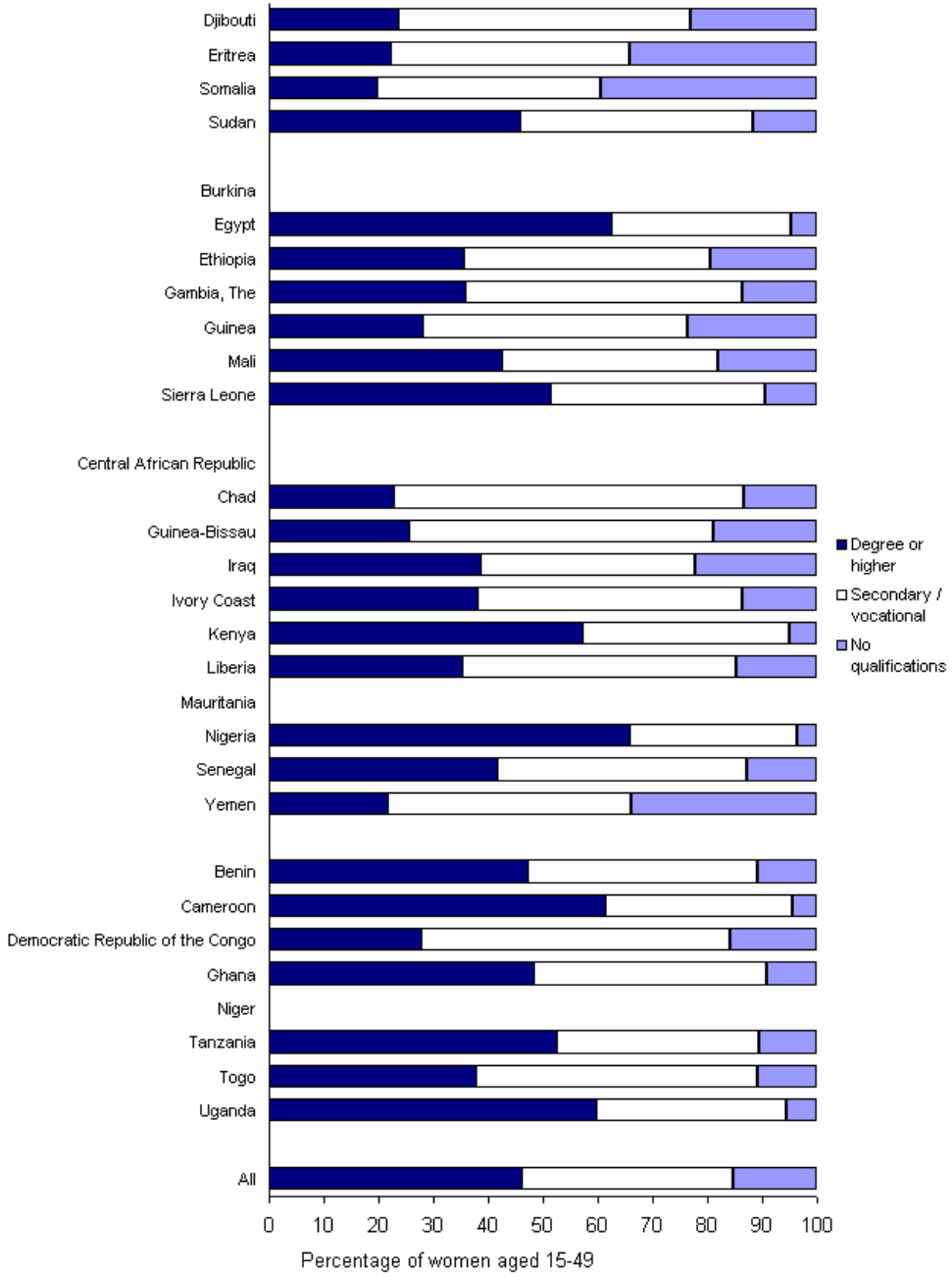
Data for the regions with lowest prevalence in Egypt and Ethiopa are based on only 25-49 unweighted cases

Source: UNICEF and DHS surveys

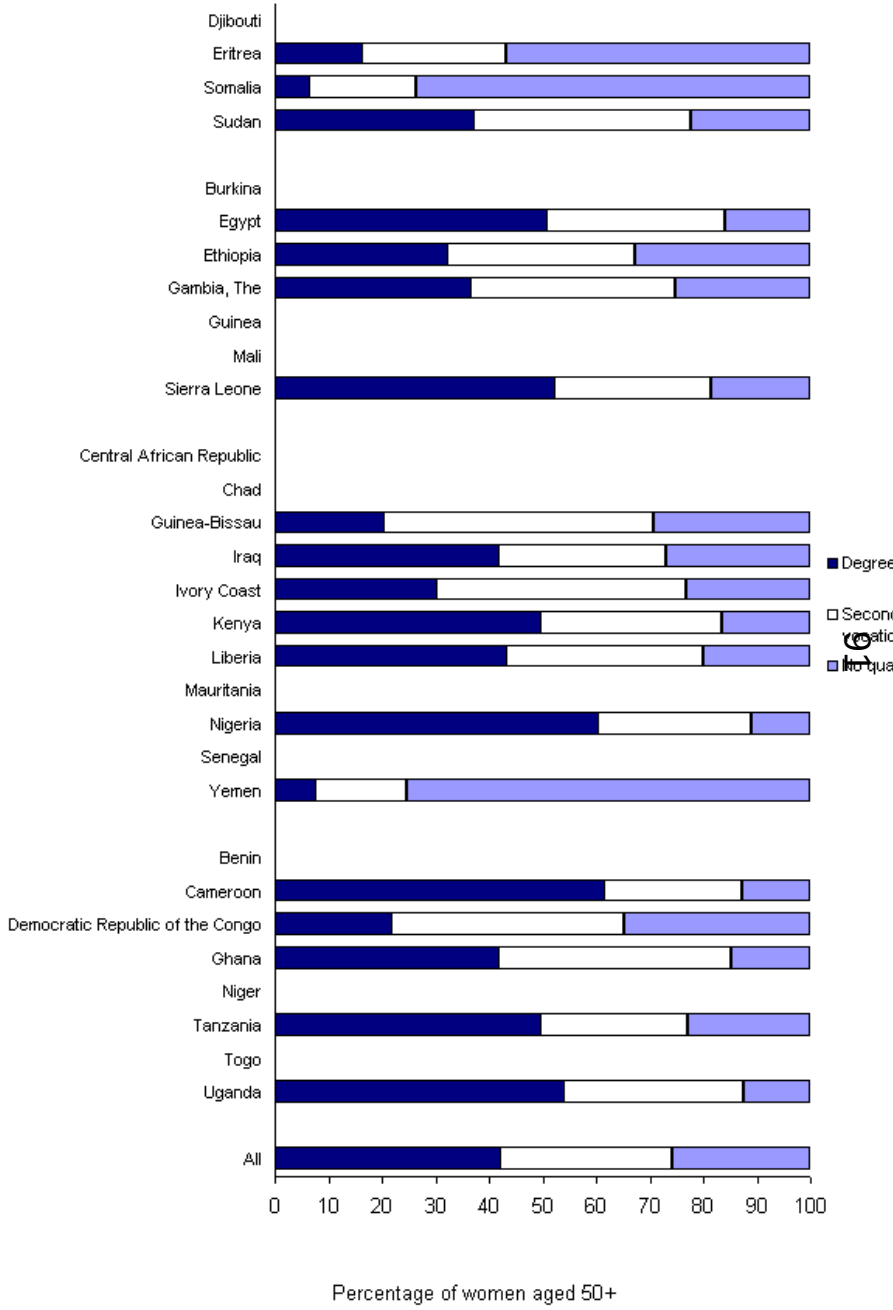
Selective migration?

- Reasons for migration to UK vary between countries and over time
- Women born in many but not all FGM-practising countries include a high proportion of graduates, especially in 15-49 age group.
- More educated women less likely to have FGM in some but not all countries

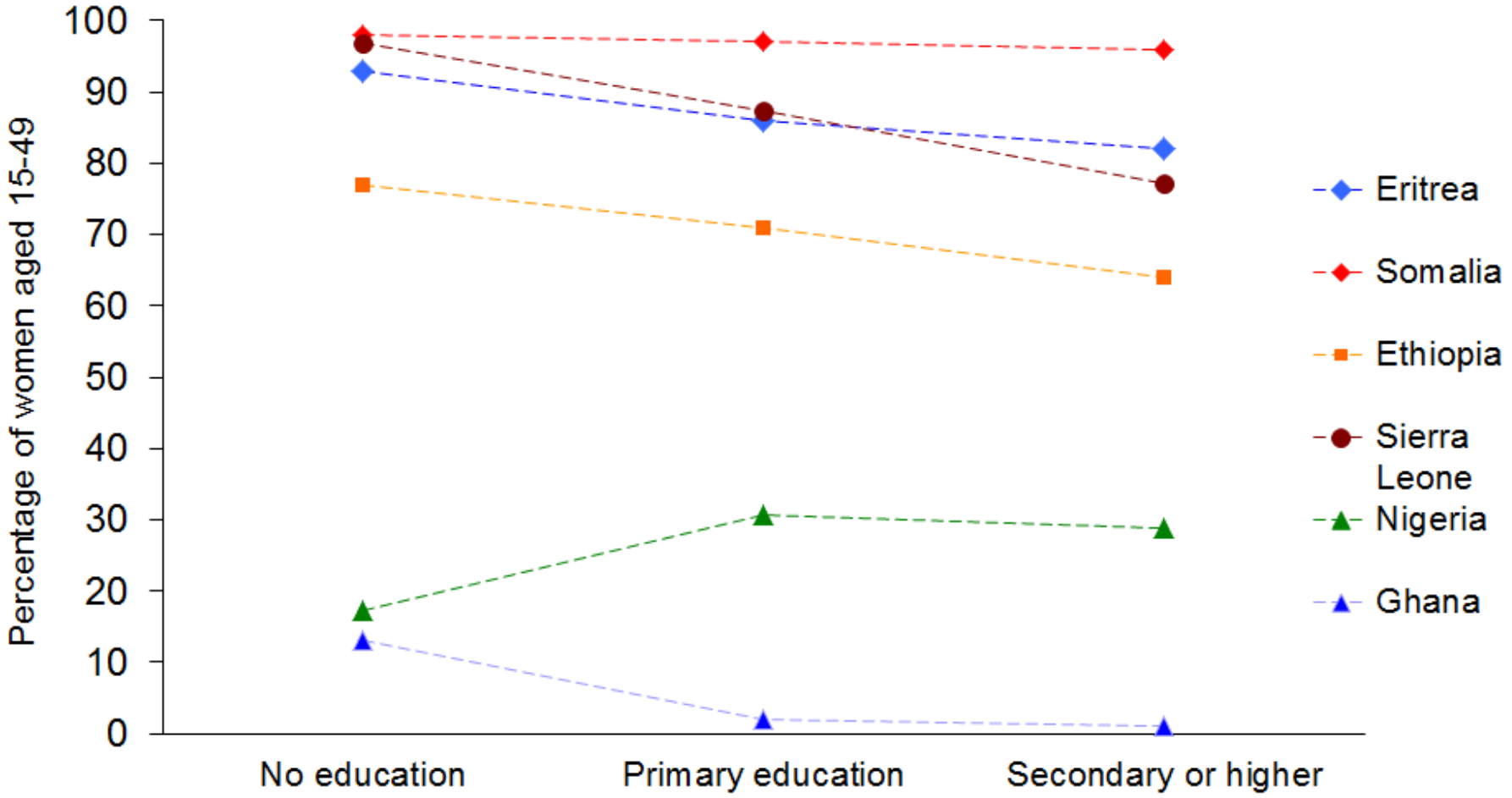
Educational qualifications by country of birth, women aged 15-49 resident in England and Wales, 2011



Educational qualifications by country of birth, women aged 50+ resident in England and Wales, 2011



Prevalence of FGM in country of origin by level of education, selected countries



Can we estimate risks to daughters born in England and Wales?

It is illegal to perform FGM in the UK or to perform it elsewhere on UK residents

Qualitative studies and news reports suggest that many families give up FGM on migration

Despite this, some girls born in the UK are subjected to FGM in their parents' countries of birth or other countries or in the UK

No reliable data to quantify this.

Use of estimates of prevalence of FGM

National and local estimates are signposts for planning services but should be supplemented by local information.

Lack of information about region of birth makes estimates problematic for populations with wide differences. Locally, health professionals can ask fuller details about women's origins within their country.

Women who migrate cannot be assumed to be typical of women in their country so this should influence interpretation of estimates.

Where to find the report

Web page

http://www.city.ac.uk/news/2015/july/no-local-authority-area-in-england-and-wales-free-from-fgm/_nocache

Report and tables

http://openaccess.city.ac.uk/12382/

Maps

http://gicentre.org/fgm2015/

For further information, contact

A.J.Macfarlane@city.ac.uk

AFRICA ADVOCACY FOUNDATION (AAF)

Agnes Baziwe

Chief Executive

Who we are:

- Africa Advocacy Foundation is a registered charity established in 1996 with the aim of promoting health, education and other opportunities for disadvantaged African and other BME people mainly in London.

- We support and empower some of the most marginalised individuals who often feel they have no active part to play in the society.

- This includes identifying appropriate pathways to enable our beneficiaries to address issues i.e. isolation, poverty, ill-health etc. leading to independence and better quality of life.

Our main activities include:

HIV Programme; This includes:

- Community awareness and prevention
- HIV testing clinic
- Family support (young carers with parents living HIV.
- Peer support services

Training:

- Community volunteer training
- CACHE accredited training in Health and Social care
- Job skills training including IT
- Contraception awareness training
- FGM training for frontline professionals

Female Genital Mutilation

- Children and family support
- Training for FGM Community Champions
- Group support and counselling for women with personal experiences of FGM
- Faith leaders and Men specific discussions on FGM
- Community awareness campaigns
- Outreach, 1:1 advice, information, guidance and referrals
- Referrals to statutory services and others

Method of delivery

- Community outreach: sister circles, madrassas centres, cultural centres.
- Community awareness workshops tailored to the language of the people e.g. Somali, Swahili, Yoruba, Arabic.etc
- Training of champions of different ages, faith and beliefs
- Young people from practising communities
- Survivors of FGM
- Faith leaders as champions
- Men from practicing communities

Community organisations engaged:

Southwark faith based groups:

- Camberwell Islamic Centre SE5
- BECA Masjid SE15
- Old Kent Road Mosque & Islamic Cultural Centre SE1
- Woolworth Methodist Church SE5
- Mountain Movers Chapel International SE17
- The Crypt St Peters SE17
- Family Life Church Old Kent Road SE1
- Divine Connection International Peckham SE15
- Shekinah Ministry in Camberwell SE5
- Christ Church Blackfriars SE1

Continued:

Other community groups:

- Aina Women Group in Peckham
- Southwark Somali Association
- ActionPlus Foundation
- Ethnic Health Foundation
- Involved in Violence against women and girls forums

Number of Southwark residents directly supported **2014/15**

- 243 women aged between 16- over 60
- In total across Lambeth, Southwark and Lewisham 861 people.

What we have learnt

- Lack of knowledge on the health effects of FGM
- Feeling of interference without insight into issues
- Lack of FGM specialist knowledge making it difficult for victims to seek appropriate advice and support.
- Lack of trust as a result of communities feeling targeted.
- Need for training and education within practising communities
- Need for training for frontline professionals
- Need for appropriate resources to facilitate learning in the community

Our Contact details:

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@africadvocacy

FGM Action Research workshop notes

28 Too Many – Louise Robertson

- FGM is a global issue
- Important to know your data and community in depth – need to know ethnicity
- FGM has a multitude of different issues and reasons for its practice so needs to be approached in different ways : e.g is perpetrated & justified by reasons of perceived beauty, health, to control women's sexuality, as a punishment. Therefor it needs to be tackled with reference to all those issues : health, human rights, gender equality, etc
- 28 Too Many have detailed country specific information to help build plans

Action Research – Ebony Riddell Bamber , Community Engagement

- Has to be conducted by experienced people in the community
- Reason is to come up with concrete proposals
- It addressed two questions:
  What is happening out there?
  What can we do?

Discussion points

Important to work with local organisations (e.g. African Advocacy Foundation and World of Hope) to understand existing knowledge

Need to establish what , and if, we need to know more about our local community

The statutory agencies have lead responsibility, but what about dialogue with communities

What about leadership from existing communities . eg Somlia community, what are the barriers to this happening

What is going to bring about cultural and attitudinal change

Some practicing communities are emergent in this country

African Advocacy Foundation have community champions from Somali and Sierra Leona

Community groups have managed to engage successfully with the Muslim community, partly as they wanted to disassociate from the practice given high profile media association of FGM and Islamic faith – a statement was issued clarifying that FGM is not part of Muslim faith - however less successful engaging Christian community eg Nigerian Pentecostal churches

FGM is being driven by older aunties (female elders) and faith leaders

Community change is more effective if there is a process of development that involves and empowers members of the community.

Discussion on building resilience with children in schools via PSHE curriculum & Pastor Power versus the responsibility for change lying with adults & wider community

Community action research could address some of these issues and questions.

A multifaceted approach is important eg law, persecution, child protection, information, with community & attitudinal change being one of the most important levers for change to end FGM.

FGM Day – notes from workshop on next steps

Suggestions:

Check multi-faith involvement in anti-FGM work

Can social care be funded to follow through on children who have been known to have suffered FGM?

Ring fence the funding? Could safeguarding money be diverted?

Shift the effort into prevention

Check teachers' awareness

More joined up practice across the relevant agencies

Involve embassies

Be more blunt about the damage done to victims

Make it personal – talk to men and boys about what could happen to women and girls in their lives as a consequence of FGM

Target strategies to different generations

Make a real effort to understand the mindset that accepts FGM

What could the committee work on:

Propose a Southwark strategy on FGM with suggestions about what works – focussing on education, awareness raising & prevention

Look for good practice on PSHE teaching re FGM and propose that to the Southwark headteachers

Consider whether shock value can be deployed – use of images, use of personal stories

Push for better recording – more hard data required

Ask Health & Wellbeing Board to support strategy

Propose confidential helpline for people who wish to report concerns

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EDUCATION & CHILDREN'S SERVICES
MUNICIPAL YEAR 2015-16

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