Open Agenda

Education & Children's Services Scrutiny Sub-Committee

Wednesday 23 March 2016
7.00 pm
Ground Floor Meeting Room G01A - 160 Tooley Street, London SE1 2QH

Membership

Councillor Jasmine Ali (Chair)
Councillor Lisa Rajan (Vice-Chair)
Councillor Sunny Lambe
Councillor James Okosun
Councillor Sandra Rhule
Councillor Charlie Smith
Councillor Kath Whittam
Martin Brecknell
Lynette Murphy-O'Dwyer
Abdul Raheem Musa
George Ogbonna

Reserves

Councillor James Barber
Councillor Catherine Dale
Councillor Renata Hamvas
Councillor Sarah King
Councillor Rebecca Lury

INFORMATION FOR MEMBERS OF THE PUBLIC

Access to information You have the right to request to inspect copies of minutes and reports on this agenda as well as the background documents used in the preparation of these reports.

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Contact Julie Timbrell on 020 7525 0514 or email: julie.timbrell@southwark.gov.uk

Members of the committee are summoned to attend this meeting
Eleanor Kelly
Chief Executive
Date: 15 March 2016

PRINTED ON RECYCLED PAPER

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Order of Business

Item No.	Title	Page No.
	PART A - OPEN BUSINESS	
1.	**APOLOGIES**	
2.	**NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT** In special circumstances, an item of business may be added to an agenda within five clear working days of the meeting.	
3.	**DISCLOSURE OF INTERESTS AND DISPENSATIONS** Members to declare any interests and dispensations in respect of any item of business to be considered at this meeting.	
4.	**MINUTES** The Minutes of the meeting held on 23 February 2016 are to follow.	
5.	**FGM REVIEW** The draft report is attached.	1 - 35
6.	**JOINT MENTAL HEALTH REVIEW**	
7.	**KIDS COMPANY REVIEW**	

Item No.	Title	Page No.

8. YOUTH OFFER REVIEW

DISCUSSION OF ANY OTHER OPEN ITEMS AS NOTIFIED AT THE START OF THE MEETING.

PART B - CLOSED BUSINESS

DISCUSSION OF ANY CLOSED ITEMS AS NOTIFIED AT THE START OF THE MEETING AND ACCEPTED BY THE CHAIR AS URGENT.

Date: 15 Marc 2016

EXCLUSION OF PRESS AND PUBLIC

The following motion should be moved, seconded and approved if the sub-committee wishes to exclude the press and public to deal with reports revealing exempt information:

"That the public be excluded from the meeting for the following items of business on the grounds that they involve the likely disclosure of exempt information as defined in paragraphs 1-7, Access to Information Procedure rules of the Constitution."

FGM

Report of the Education and Children's Services Scrutiny Sub-committee

March 2016

Southwark Council

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FORWARD Cllr Jasmine Ali, Chair of the Education & Children's Services scrutiny committee

The Southwark Education and Children's Scrutiny Committee is concerned with the high instances of Female Genital Mutilation (FGM) affecting women in our local communities.

Female genital mutilation, also known as female genital cutting or female circumcision, is the ritual removal of some or all of the external genitalia. The procedures are very different according to the ethnic group and the practice is rooted in gender inequality.

FGM has been outlawed or restricted in most countries that it is carried out in, but the laws are poorly enforced. Moves have been made since the early 1970s to stop this practice. In 2012 the United Nations General Assembly recognized the practice of FGM as a human rights violation. They voted unanimously to intensify efforts to prevent it.

More recently this issue has been given media attention. There is also increased willingness of women to come forward. There is of course an impact on our role, and on our legal responsibility for safeguarding.

Southwark is significant

Recent research reaffirms that Southwark has the highest rate of FGM in the country. The evidence we considered told us that a staggering 10. 4% of children in Southwark will have a mother who has been genitally mutilated. They are significantly but not exclusively from Somalia, Sierra Leone and Nigeria.

Stop FGM

The scrutiny committee is committed to preventing this practice and we have invited a wide section of professionals and the local communities to be part of the scrutiny committee's deep dive into the issue of FGM in Southwark. Our year-long research is driven by a commitment to better protect our women and children so that they are safe from FGM.

The following report details intelligence from leading experts and professional's like Dr Comfort Momoh from Guys and St Thomas', Alison Macfarlane – Professor of Perinatal Health and author of a recent report highlighting Southwark as having the highest incidence of FGM, Angela Craggs from Southwark Police, Clarissa Cupid of Southwark Clinical Commissioning Group and April Bald, Southwark Council social care lead on current work.

We held a 'scrutiny in a day' session and heard from community and voluntary groups, and then followed this up with a workshop from Coventry University on an EU wide community based behavior change action research programme. Our review activities and diverse participants all helped us develop our recommendations, the method and results of which are set out below.

The following report charts the results of the Education and Children's scrutiny committee's attempt to spotlight the services and partnerships set up to prevent FGM in the London Borough of Southwark and make a serious contribution to ending genital mutilation of all women and children.

INTRODUCTION AND BACKGROUND

1.1 This is the draft report of the review of Female Genital Mutilation (FGM). The Education and Children's Services Scrutiny Sub-Committee decided to conduct a review on 12 July 2014, and this was carried over to the following year. The aim of the review is to make recommendations to the Cabinet, the Southwark Children's Safeguarding Board and NHS Southwark Clinical Commissioning Group (CCG)

1.2 The review set out to address these issues in particular.

- Promote good practice in tackling FGM
- Bring together statutory partners and the community in finding solutions to safeguarding girls from FGM
- Establish a clearer picture of the prevalence and risk to Southwark girls

1.3 The sub-committee chose this subject because FGM poses the risk of significant harm being done to Southwark girls. Southwark has the highest prevalence of FGM in the country. A report published in July 2015 by City University London & Equality Now found that the highest prevalence rates in were in London boroughs, with the highest number being 4.7% of women in Southwark. The estimated percentage of girls born to Southwark mothers who are FGM survivors is 10.4%.

1.4 World-wide 100-140 million of girls and women have undergone some form of FGM. An estimated 6,000 are at risk per day worldwide and about 2 million or more undergo FGM each year. The European Parliament estimates that up to half a million women living in the EU have been subjected to FGM, with a further 180,000 at risk.

1.5 The work to tackle FGM globally has been going on for 35 years, however over that last few years there has been much greater publicity around the practice of FGM in the UK and London in particular. Awareness is much greater now and discussion of the issues is far less of a taboo. However the practice still raises difficult issues around sexuality, race, immigration, culture, poverty, privilege, gender equality, abuse, and violence within family systems. All these issues need to be dealt with if the practice is be ended and girls protected.

EVIDENCE CONSIDERED

Activities

2.1 The review first received a paper from Southwark social care and Southwark NHS setting report setting out current work being carried out by local statutory agencies to tackle FGM.

2.2 Following this a Scrutiny in A Day was held on 16 September 2015 to spend the day intensely looking at FGM and how to bring it to an end in Southwark. The first half of the day was devoted to looking at the current work of the NHS, social care, the police, followed by a presentation on recent research on prevalence. The afternoon was particularly dedicated to exploring community engagement as an important tactic in ending FGM, with the help of national and local voluntary providers specializing in ending FGM, alongside statutory agencies, frontline workers and the community.

2.3 The day was opened by leading FGM health professional, Dr Comfort Momoh, a pioneering midwife who in 1997 opened one of the first African Well Women clinics in St Thomas Hospital, which treats women with FGM. She now works internationally to support women with FGM and to prevent the practice.

2.4 A joint presentation was received from Southwark social care, NHS and Police on current work to tackle FGM, including examples of work being done to protect girls. Officers explained the statutory framework to safeguard girls and the plans of the created FGM steering group, a partnership established in June 2015 to tackle FGM.

2.5 Alison Macfarlane, Professor of Perinatal Health**,** City University London, then presented the recently published report on rates of FGM, 'Prevalence of Female Genital Mutilation in England and Wales: National and local estimates'. She provided an explanation of how the data had been arrived at and an overview of FGM prevalence and maternity rates in England & Wales, London and Southwark, drawing from data published in the report. She also provided further additional data, including the ethnic breakdown of the Southwark population at risk, including details of the types of FGM women & girls may be affected by.

2.6 The afternoon was focused on hearing from a woman who had experienced FGM, and the work of national FGM charities working to end FGM and the work of the local voluntary sector to tackle FGM. The was followed by a fishbowl discussion with the voluntary sector, officers from social care & the police, the committee and a broad range frontline practitioners (teachers, midwives) and community workers . The day ended with workshops exploring next steps and the scope for conducting action research with the community to end FGM.

2.7 Following the Scrutiny in a Day a workshop with the committee and some of the participants from the day was held on REPLACE 2 with Coventry University's Professor Hazel Barrett & Dr Katherine Brown. The programme is led by the university and is an EU wide community based behaviour change programme to end FGM. The programme academics presented on the

programme work since 2010 and the recently publish toolkit to conduct community participatory work with local communities.

Report contributors

Council & community partners:

2.8 Dr Comfort Momoh MBE , African Well Woman's Clinic at Guy's and St Thomas Foundation Trust in London, a support service for women and girls who have undergone FGM

2.9 Alison Macfarlane, Professor of Perinatal Health**,** City University London, joint author of the report on 'Prevalence of Female Genital Mutilation in England and Wales: National and local estimates'

2.10 Angela Craggs, Southwark Police FGM lead

2.11 Clarisser Cupid, Southwark Clinical Commissioning Group FGM lead

2.12 April Bald, Southwark Council social care FGM lead

2.13 Toks Okeniyi, FORWARD.

2.14 Agnes Baziwe & Shani Hassan, African Advocacy Foundation

2.15 Florence Emakpose, World of Hope

2.16 Hawa Sesey, FGM Campaign

2.17 Louise Robertson, 28 Too Many

2.18 Professor Hazel Barrett & Dr Katherine Brown, Coventry University

2.19 Kevin Dykes, Sarah Totterdell , Ebony Riddle Bamber – Community Engagement

Education & Children's Services scrutiny committee & officer support

2.20 Councillor Jasmine Ali, Chair
Councillor Lisa Rajan, Vice-Chair
Councillor Sunny Lambe
Councillor James Okosun
Councillor Sandra Rhule
Councillor Charlie Smith
Councillor Kath Whittam
Kay Beckwith
Martin Brecknell
Lynette Murphy-O'Dwyer
Abdul Raheem Musa
George Ogbonna

2.21 Julie Timbrell, scrutiny project manager and report author

Health impacts and the cultural reasons for FGM

3.1 Dr Comfort Momoh opened the 'Scrutiny in a Day' in September 2015. She is a midwife who set up the African Well Woman's Clinic at Guy's and St Thomas Foundation Trust in London in 1997. This pioneering service supports women and girls who have undergone FGM. She has won national and international recognition for her both her work with women FGM, and her work to end the practice in a generation.

3.2 Female Genital Mutilation (FGM) was introduced by Dr Comfort Momoh as abuse, and both a health and Human Right issues for girls and women.

3.3 There are different types of FGM. The WHO has classified FGM into four types:

Type I: Clitoridectomy – partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, the prepuce (the fold of skin surrounding the clitoris)

Type 2: Excision – partial or total removal of the clitoris and the labia minora with or without the excision of the labia majora (the labia are the 'lips' that surround the vagina)

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

3.4 Whilst some women report no ill effects at the most extreme can FGM can be deadly: 10 % of girls die from the procedure, and a quarter of women will experience significant disability.

3.5 The health impacts of FGM include the initial shock, pain and trauma, which can lead to later flash backs and psychological problems. Girls are often held down to perform the process and as a result of the ensuing struggle there can be fractures and dislocation of limbs and injury to adjacent tissues. Immediately following the procedure the cuts can lead to infection and failure to heal, with urinary retention. Longer term FGM can cause problems in childbirth and recurrent Urinary Track Infections and fistulae (rectum or vaginal).

3.6 As well as the adverse health impacts many women will also will suffer lifelong psychological & emotional trauma, as well as loss of sexual function & enjoyment.

3.7 FGM is popularly associated with the Islamic religion, however FGM is widespread in many countries, include Christian and Jewish communities, and is rarely practiced in some Muslim countries. FGM is more correctly described as a cultural practice that has many and complex meanings. FGM is a long-standing tradition, which has become inseparable from ethnic and social identity among many groups. Reasons given for practice vary and include:

- Tradition
- Religion
- Prevent Rape
- Income for circumcisers
- Preservation of virginity
- Promote cleanliness
- Aesthetic reasons : cultural perceptions of beauty
- Punishment

3.8 The age that girls usually undergo FGM is between infancy and 15, and it is most frequently performed on girls aged between ages 5-8, however occasionally it is carried out later.

3.9 FGM is associated with the curtailment of women's sexuality, and is frequently bound up with gender identity and with social rites of passage of girls to women. A women who has not undergone FGM in some communities may be considered less marriageable and not having attained full status as a women. In communities with a wide spread practice she and her family risk deliberate social exclusion to enforce the practice.

3.10 Dr Comfort Momoh emphasized that it is important to tackle FGM in a multifaceted way, as in some countries, such as Egypt, the procedure has become increasingly medicalized to counter wider appreciation of the adverse health outcomes. She also mentioned that practicing communities often raise the rapidly growing western fashion of designer vaginas, and how that can be very similar to Type 1, however they complained it is not described as FGM because it is associated with more privileged, white communities. Dr Comfort Momoh said that any procedure carried out for purely aesthetic reasons would be classed as Type 4.

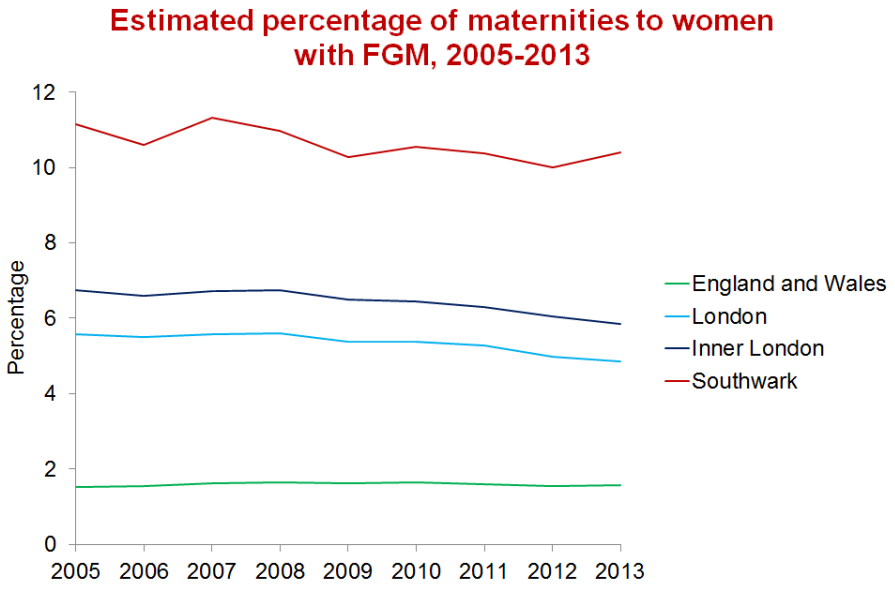
3.11 She emphasised that FGM is a procedure that needs to be seen as violence against women, abuse and one that endangers safety, liberty, bodily and sexual integrity, as well as physical health, but in relating to communities sometimes it is better to use less loaded terms, such as cutting or female circumcision.

Prevalence data and emerging community profile of practicing communities

3.12 The review set out to establish a clear picture of the prevalence of FGM locally and the risk to young girls. Scrutiny in a Day received a presentation from Alison Macfarlane, Professor of Perinatal Health on the recently published report by City University & Equality Now: 'Prevalence of Female Genital Mutilation in England and Wales: National and local estimates'. This provided data on both prevalence and maternity rates. Local statutory agencies also provided data.

Maternity

3.13 Proffessor Alison Macfarlane's data indicated that Southwark is the borough with the highest number of children given birth to by a mother with FGM. 10.4 % of girls will have a mother with FGM in Southwark; the highest rate in England & Wales.



Prevalence

3.14 Southwark also has the highest local authority prevalence rates in England & Wales: 4.7 % of women in Southwark will have FGM. The report estimated that around 6,901 women and girls in Southwark will have undergone FGM. Data presented by the local statutory agencies estimated that 2055 girls will be either affected by FGM or at risk.

3.15 Southwark is of course not an outlier here, as many other urban areas with high immigrant populations have similar rates. These figures do need to be treated with some caution they as extrapolated largely from secondary sources. However the both the national report and data provided by local statutory agencies highlight that Southwark is an area where FGM is a significant issue.

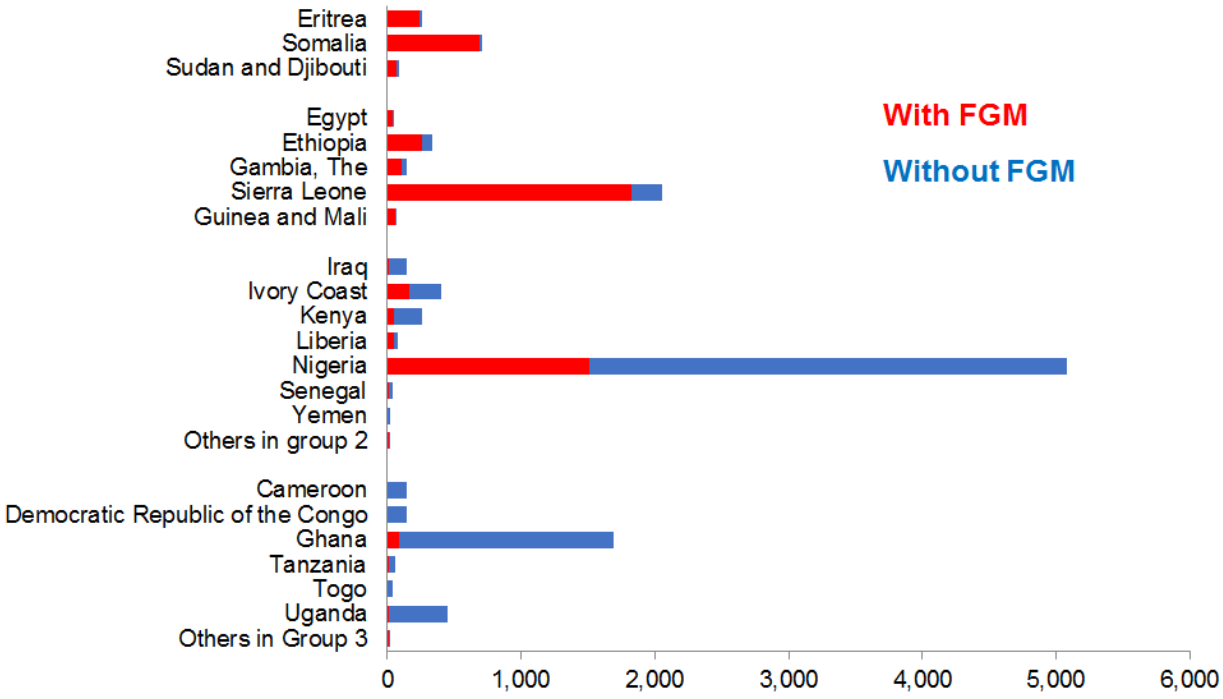
Breakdown of prevalence by country of origin and type of FGM

3.16 The communities in Southwark practicing FGM are diverse: from different countries, practicing different types of FGM, with different religions and cultural traditions.

3.17 Proffessor Macfarlane provided some additional data for her presentation on the ethnic breakdown of the communities practicing FGM and this identified that the majority of women living in Southwark with FGM will be from Sierra Leone, Nigeria and Somalia, but there will be significant numbers of other women from other countries including Eritrea, Ethiopia, Sudan & Dhibouti, Egypt, The Gambia, Guinea and Mali, Ivory Coast, Kenya, Liberia and Ghana.

3.18 Women with FGM in Southwark are largely come from the diaspora community originating from a group of countries from the Atlantic to the Horn of Africa, including parts of the Middle East. However FGM is practiced in other parts of the globe, particularly South East Asia. It is therefor important to keep in mind that there may well be some individuals and small pockets of communities who come from far and wide.

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



3.19 Women from Somalia, Sudan, Eritrea and Djibouti often have had the Type 3, the most severe form of FGM. Women from other countries are more likely to have had Type 2 or Type I.

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

3.20 Professor Alison Macfarlane advised that in undertaking work to stop FGM it is vital to know as much about your community makeup as possible as reasons for carrying out FGM vary from country to country and even within different countries. In Sierra Leone some tribes will not practice FGM, but although infrequent in Ghana it is practiced by the Northern Tribes, and in Nigeria it is more common amongst Christian, rather than Muslim communities. While generally FGM is associated with lower educational levels, in Nigeria it is associated by higher levels of education. She recommended making use of the data she has produced and further investigation into the ethnic make-up of Southwark community in order to plan interventions. Louise Robertson, of 28 Too Many also advised getting to know the Southwark FGM practicing communities well; by collecting good data and understanding the varying social norms that sustain the practice.

Recommendation one

Develop a community profile of the FGM practicing communities in Southwark, drawing on available statistical data and community knowledge. Update this regularly as more accurate primary data becomes available and local knowledge of practicing communities develops.

Social Care, Police & NHS work to end FGM

3.21 Statutory agencies presented work they are doing to get better primary data, improve child protection and increase the likelihood of a prosecution of perpetrators. Local efforts have been stepped up with the instigation of a multi-agency steering group in June 2015 and they are working on developing multi agency arrangements to share information and improve safeguarding.

3.22 The police reported that legislation prohibiting FGM has been strengthened, and this was considered very important to aid enforcement. However there have been no successful persecutions to date in the UK. Obtaining one was cited in the committee and Scrutiny in a Day discussions as important to send a strong signal out that FGM is a crime that will not be tolerated. This was tempered with reflections on the need to engage with practicing communities and take a more nuanced approach than just pursuing the criminal justice route. Legislation changes from May 2015 introduced Civil Protection Orders. These have already been employed in Southwark to help safeguard girls at risk and there is a commitment from the steering group to expand their use.

3.23 Mandatory reporting of FGM has been introduced for relevant professional. All clinical staff must now record in patient healthcare records when it is identified that a patient has had FGM and all acute hospitals must provide monthly returns of on FGM prevalence. Much better data is now coming through from health services: on 1st April 2014 the first FGM Prevalence Dataset was published. Local health data collecting has been improved and this will help provide more robust data on the local populations at risk in the future.

Community work to end FGM

3.24 35 years ago the World Health Organisation (WHO) called for end to FGM. The WHO, United Nations (UN), UNICEF, and other anti-FGM organisations have adopted various strategies in order to raise awareness and work towards ending FGM. These have centered on four main approaches:

- Bodily and sexual integrity;
- Human rights – as both an infringement of liberty & security and as discrimination & violence against women
- Legislative (outlawing the procedure)
- Health

3.25 More recently there has been increased investment in the a fifth approach of using community engagement to change the underlying beliefs that perpetuate the practice – Scrutiny in A Day sought to look at all these approaches and particularly dedicated the afternoon to exploring community engagement as an important tactic in ending FGM .

3.26 The afternoon was focused on hearing from a woman who had experienced FGM, the work of national FGM charities working to end FGM and the work of the local voluntary sector to tackle FGM in Southwark.

3.27 The Scrutiny in a Day heard moving testimony from a survivor of FGM, Hawa Sesey, who explained how an elder relation carried out the procedure on her in Sierra Leone, the traumatic impact it had on her then as a young girl, and how it later affected her married life. She has worked for many years with in her community to end the practice

3.28 Local organisations World of Hope and African Advocacy Foundation detailed their work with survivors and practicing communities.

3.29 World of Hope is committed to raising Youth Ambassadors that will become tomorrow's leaders through their mentoring, training, coaching, and citizenship programmes which equip young people to positively impact their communities. It works with young people on FGM directly seeking ambassadors to help end the practice and in July it held an African safeguarding children's conference, in partnership with CANUK, which in dealt with FGM.

3.30 African Advocacy Foundation has an established programme to support women with FGM and end the practice. The project employs a dedicated worker and their work includes training for FGM community champions and outreach with a wide range of Southwark faith based organizations (Muslim & Christian) and community groups. The project holds events that focus on a number of issues in an engaging way, for example FGM is often discussed within the context of sexual health to reach a wider audience. The community outreach includes work with Faith leaders, utilises sister circles, and also holds men specific discussions on FGM. Community awareness raising workshops are held tailored to the language of the people e.g. Somali, Swahili, Yoruba, and Arabic.

3.31 African Advocacy Foundation said they have identified a lack of knowledge on the health effects of FGM. They also reported that communities frequently feel there is interference without insight into issues and a lack of trust means that communities sometimes feel targeted. They advised that there needs to be more training and education within practicing communities and there needs to be appropriate resources to facilitate learning in the community.

3.32 Scrutiny in a Day concluded with two workshops on next steps and conducting action research with practicing communities. Participants thought there needed to be further awareness rising through publicity on the adverse impacts of FGM, and more in depth work with different communities to change attitudes. As well as reaching out to women of child bearing age to offer them support and safeguard children who may be at risk, it was also considered important to engage with boys and men, and vital to engage with older women. Grandmothers and 'Aunties' are often the ones carrying out the procedure and it is the older generation who set the social norms of the community. Elders in African and Middle Eastern communities are frequently given a high level of respect and review participants familiar with practicing communities identified that changing elder views could be pivotal to ending the practice.

3.33 African Advocacy Foundation in depth work with a wide range of faith and community groups using community champions from practicing communities was noted as particularly valuable. However African Advocacy Foundation has highlighted the need for continued financial support to continue and build on this work.

Recommendation two

Support the existing good work of community organizations, particularly African Advocacy Foundation.

3.34 A publicity campaign was suggested to highlight the impact of FGM , and participants discussed using blunter messages on the negative health consequences and more explicit information on the adverse impact FGM had on girls and women , however some review participants cautioned that this needed to be balanced with the need to build trust with communities and develop appropriate interventions which do not alienate communities .Experts advised that it is by knowing the community very well and always keeping the survivor voice center stage that these tensions can be resolved : the survivor voice is crucial to understanding the issues and building creditability.

3.35 Dr Comfort Momoh of the African Well Women's Centre is organizing a Female Genital Mutilation Music Festival to raise more awareness of FGM and to educate professionals and the public in a welcoming, friendly and fun environment. The aim is to make this a yearly event in July before school holiday and the cutting season. The event will include key people from the UK and abroad, as well as ambassadors, survivors and professionals.

Recommendation three

Raise local awareness of FGM through community events, publicity, media campaigns and via community champions. Work with the local voluntary sector groups & professionals; African Advocacy Foundation, World of Hope, FGM survivors and Dr Comfort Momoh of the African Well Women's Centre to support planned events and generate publicity material. Keep the survivor voice at the forefront.

3.36 The review participants identified faith communities, community groups, Embassies, schools and front line workers as key groups to work with.

3.37 The teachers who attended the Scrutiny in a Day suggested training materials are developed for PSHE lessons and that the school Safeguarding Leads are fully briefed on how to respond to FGM. FORWARD, a long standing voluntary sector organization who contributed to the review, have a schools programme offering a comprehensive range of services for schools to engage and empower young people and a training programme for front lime professionals. Young people and their peers need to have ways of raising alerts and getting support. It was noted that often it is siblings who raise safeguarding alerts. A confidential phone line was suggested, or exploring the Petals mobile-phone application which allows young people to find out more about FGM and source help discreetly on a smart phone.

Recommendation four & five

Work with schools on integrating teaching on FGM as part of the PSHE curriculum development and ensure schools Safeguarding Leads understand FGM and how to protect girls. Consider using the material developed by FORWARD.

Develop ways for young people to get help, information or report concerns, making sure that it is particularly tailored for girls at risk, their siblings and peers who can help safeguard them e.g. via a confidential phone line and /or the phone application Petals.

3.38 The African Advocacy Foundation said that survivors report there is a lack of FGM specialist knowledge making it difficult for women to seek appropriate advice and support and there needs to be more training for frontline professionals. The current FGM steering group has work both with schools and training of primary care professionals as an objective.

Recommendation six

Request a detailed report back in 6 months time of the FGM steering group work programme to train primary care professionals and other frontline professionals

3.39 Scrutiny attempted to engage with the Nigerian, Serria Leone and Somali Embassies; however none were able to attend the scrutiny in a day. It is unclear why this was; capacity may be an issue as all have small High Commissions. Participants recommended ongoing work with embassies to engage them in ending the practice, particularly as girls are at risk during the summer holiday of being taken back to their country of origin to undergo FGM during what is termed the ‘cutting season’ . Although FGM is now illegal in most countries, this is often very poorly enforced and the practice is prevalent in many countries of origin: it is very common in Sierra Leone and near universal in places such as Somalia. Girls visiting extended family could be at high risk: Hawa Sesey, FGM survivor, relayed a story of returning to her home country, Sierra Leone, with her daughter and needing to take steps to protect her child from harm from her extended family. A

Southwark child with her mother was intercepted at Heathrow with implements that may have been intended to be used to cut her child. Clearly there is a risk to girls being taken out of the country, though it is hard to quantify the extent of this.

Recommendation seven

Continue to seek to engage the High Commission of the countries where most families originate from, particularly: Sierra Leone, Nigeria and Somalia.

Community based behaviour change programme to end FGM: REPLACE 2

3.40 In November 2015 a workshop was held on REPLACE 2 with Coventry University's Professor Hazel Barrett & Dr Katherine Brown. Many of the committee attended and some of the participants from Scrutiny in a Day, including African Advocacy Foundation staff, FGM social care leads and community development lead.

3.41 REPLACE 2 is the second round of an EU wider behaviour change action research programme which focuses on community engagement to end FGM. The programme has worked with diaspora communities in Europe by engaging members of the practicing communities to understand the social norms that perpetuate FGM and then to provide intervention support to change beliefs and motivate social change. Coventry University lead the programme. The academic leads presented on the programmes work since its inception in 2010.

3.42 The academics explained that thirty years on since the World Health Organisation (WHO) called for the ending of FGM there is conflicting evidence as to whether the emphasis on a criminal justice, health and Human Rights approaches has led to a reduction in the practice. 15 years ago WHO called for application of behaviour change approaches to address FGM , however research concluded that there was a poor understanding of how to conduct this .

3.43 The REPLACE 2 programme uses a cyclic framework for Social Norm Transformation in relation to FGM. Community engagement is critical to the approach and focused on building trust and partnership with the community. The programme works with the community to design interventions whose content and messages align with those belief systems and norms that perpetuate FGM, in order to end the practice. The programme has recently published a toolkit to conduct community participatory work with local communities.

3.44 The workshop concluded with an offer by Coventry University REPLACE 2 programme to assist Southwark in adopting this approach, which was welcomed by attendees.

Recommendation eight

Conduct a community engagement programme to end FGM, in partnership with local voluntary sector and community organisations, using the expertise of the REPLACE 2 Coventry University programme and 28 Too Many.

4 Conclusion

FGM has a multitude of different reasons for its continued practiced; it is perpetrated and justified by reasons of perceived beauty, religion, health, to control women's sexuality, and as a rite of passage. This report has particularly emphasised the community engagement approach to change behaviour as the most underused approach in Southwark, however experts advised that to end FGM the practice needs to be tackled through a range of approaches: as a health hazard, a crime, abuse, and as a human rights and gender equality issue. Pursued all together they are most likely to end FGM.

RECOMMENDATIONS

1 *Develop a community profile of the FGM practicing communities in Southwark, drawing on available statistical data and community knowledge. Update this regularly as more accurate primary data becomes available and local knowledge of practicing communities develops.*

2 *Support the existing good work of community organizations, particularly African Advocacy Foundation.*

3 *Raise local awareness of FGM through community events, publicity, media campaigns and via community champions. Work with the local voluntary sector groups & professionals; African Advocacy Foundation, World of Hope, FGM survivors and Dr Comfort Momoh of the African Well Women's Centre to support planned events and generate appropriate publicity material. Keep the survivor voice at the forefront.*

4 *Work with schools on integrating teaching on FGM as part of the PSHE curriculum development and ensure schools Safeguarding Leads understand FGM and how to protect girls. Consider using the material developed by FORWARD.*

5 *Develop ways for young people to get help, information or report concerns, making sure that it is particularly tailored for girls at risk, and their siblings & peers who can help safeguard them e.g. via a confidential phone line and /or the phone application Petals.*

6 *Continue to seek to engage the High Commission of the countries where most families originate from, particularly: Sierra Leone, Nigeria and Somalia.*

7 *Request a detailed report back in 6 months time of the FGM steering group training of primary care professionals and frontline professionals*

8 *Conduct a community engagement programme to end FGM in partnership with local voluntary sector and community organisations and using the expertise of the REPLACE 2 Coventry University programme and 28 Too Many*

5 Appendices

I. FGM Scrutiny in a Day

II. FGM workshop with Coventry University on REPLACE 2

SCRUTINY IN A DAY

FGM scrutiny in a day: programme

Address: HENRIETTA RAPHAEL FUNCTION ROOM, Henriette Raphael Building, GUYS CAMPUS, King's College London, London, UK SE1 1UL.

Wednesday 16th September 9am – 3:30pm

9am – 9:30am **Registration & refreshments**

9:30am **Welcome and opening remarks: Cllr Jasmine Ali, Chair** of the Education & Children's Services scrutiny committee

9:40 am – 10:30am **Dr Comfort Momoh MBE** will set the scene by explaining the reasons for FGM, and the implications. She will explain why she established the African Well Woman's Clinic at Guy's and St Thomas Foundation Trust in London, a support service for women and girls who have undergone FGM.

10:40am – 11:20am **Alison Macfarlane, Professor of Perinatal Health,** City University London, presenting a recently published report on rates of FGM, 'Prevalence of Female Genital Mutilation in England and Wales: National and local estimates', which estimates that Southwark has the highest rates of FGM in the UK

11:30am – 12:00noon **Work to tackle FGM in Southwark** Overview by Angela Craggs Southwark Police; Clarisser Cupid, Southwark Clinical Commissioning Group and April Bald, Southwark Council social care lead on current work.

12 noon – 12:30pm **Lunch**

12:30pm – 2:pm **How can community & voluntary groups and statutory agencies work together to end FGM?** Presentation by Toks Okeniyi, FORWARD, followed by brief presentations on local initiatives : Agnes Baziwe, African Advocacy Foundation and Florence Emakpose, World of Hope and then a survivor working for change: Hawa Sesey FGM Campaign. Fishbowl discussion with contributions by national, London and local community groups , and embassy representatives of countries where the practice is common.

2:10 – 3:20pm **Workshop 1 Action research** discussion with 28 Too Many's, Louise Robertson, and Southwark's community engagement lead, Ebony Riddell Bamber, on carrying out action research with communities at risk and with survivors to establish the extent to which girls are at risk and how to best protect girls.

2:15 – 3:20pm **Workshop 2: Facilitated discussion on next steps for the review**. What further lines of inquiry would it be helpful for the scrutiny review to explore, focusing on at risk girls?

3:20 – 3:30pm **Closing remarks**

Dr Comfort Momoh

Dr Comfort Momoh is a midwife who set up the African Well Woman's Clinic at Guy's and St Thomas Foundation Trust in London in 1997, which offers a support service for women and girls who have undergone FGM. The specialist clinic offers midwifery, obstetric and relevant gynaecological care for women who have undergone FGM, including reversal. She has won national and international recognition for her work both with women FGM, and her work to end the practice in a generation.

Female Genital Mutilation (FGM) was introduced by Dr Comfort Momoh as abuse, and both a health and Human Right issues for girls and women.

FGM is popularly associated with the Islamic religion, however FGM is widespread in many countries, include Christian and Jewish communities, and is rarely practiced in some Muslim countries. FGM is more correctly described as a cultural practice that has many and complex meanings. FGM is a long-standing tradition, which has become inseparable from ethnic and social identity among many groups. Reasons given for practice vary and include:

- Tradition
- Religion
- Prevent Rape
- Income for circumcisers
- Preservation of virginity
- Promote cleanliness

The age that girls usually undergo FGM is usually between infancy and 15, however occasionally it is carried out later. The scrutiny in a day heard that on occasions it can be used a punishment; one incident was relayed of a women in her 30's being assaulted and cut by her estranged husband's family.

FGM is associated with the curtailment of women's sexuality, and is frequently bound up with gender identity and with social rites of passage of girls to women. A women who has not undergone FGM in some communities may be considered less marriageable and not having attained full status as a women. In communities with a wide spread practice she and her family risk deliberate social exclusion to enforce the practice.

There are different types of FGM. The WHO has classified FGM into four types:

Type I: Clitoridectomy – partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, the prepuce (the fold of skin surrounding the clitoris)

Type 2: Excision – partial or total removal of the clitoris and the labia minora with or without the excision of the labia majora (the labia are the 'lips' that surround the vagina)

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.

Whilst some women report no ill effects at the most extreme can FGM can be deadly: 10 % of girls die from the procedure, and a quarter of women will experience significant disability. As well as adverse health impacts many also will suffer lifelong psychological & emotional trauma, as well as loss of sexual function & enjoyment.

The health impacts of FGM include the initial shock, pain and trauma, which can lead to later flash backs and psychological problems. Girls are often held down to perform the process and as a result of the ensuing struggle there can be fractures and dislocation of limbs and injury to adjacent tissues. Immediately following the procedure the cuts can lead to infection and failure to heal, with urinary retention. Longer term FGM can cause problems in childbirth and recurrent Urinary Track Infections and fistulae (rectum or vaginal).

Dr Comfort Momoh explained that health professionals need to be able to able to recognise FGM, be alert to the possibility of FGM, be able to protect and safeguard children and be able to act when a child is at risk or may already undergone FGM.

Dr Comfort Momoh emphasised that it is important to tackle FGM in a multifaceted way, as in some countries, such as Egypt, the procedure has become increasingly medicalized to counter wider appreciation of the adverse health outcomes. She also mentioned that practicing communities often raise the rapidly growing western fashion of designer vaginas, and how that can be very similar to Type 1, however they complained it is not described as FGM because it is associated with more privileged, white communities. Dr Comfort Momoh said that any procedure carried out for purely aesthetic reasons would be classed as Type 4, and it is important to be aware of culture bias. She emphasised that FGM is a procedure that needs to be seen as violence against women, abuse and one that endangers safety, liberty , bodily and sexual integrity, as well as physical health, but in relating to communities sometimes it is better to use less loaded terms, such as cutting or female circumcision.

Tackling FGM successfully needs a multi-agency approach, and the participation of religious and community leaders, and outreach to families at

risk. All professionals need training and teaching needs to be part of the core curriculum, as well as a robust legal framework.

FGM is practised among migrant and refugee communities who tend to settle in urban areas, which is why ii is particularly concentrated in boroughs like Southwark and Lambeth . This concentration of communities does allow for specialised services to be developed. The government policy of dispersing refugees and asylum seekers to rural, isolated centres has major implications for women who have experienced FGM.

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

Alison Macfarlane, Professor of Perinatal Health, City University London, presented a recently published report on rates of FGM, 'Prevalence of Female Genital Mutilation in England and Wales: National and local estimates'. The report was produced to provide statistical estimates of the prevalence of FGM in England and Wales, and in local authority areas. Good data is needed to plan services for affected women and inform child protection for their daughters. As numbers of women resident in England & Wales who were born in countries where FGM is practised have increased, so previous estimates based on 2001 census and births from 2001 to 2004 are out of date.

The aim of the report is to produce data for both the whole of England & Wales, and for each local authority area, providing estimates of the:

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

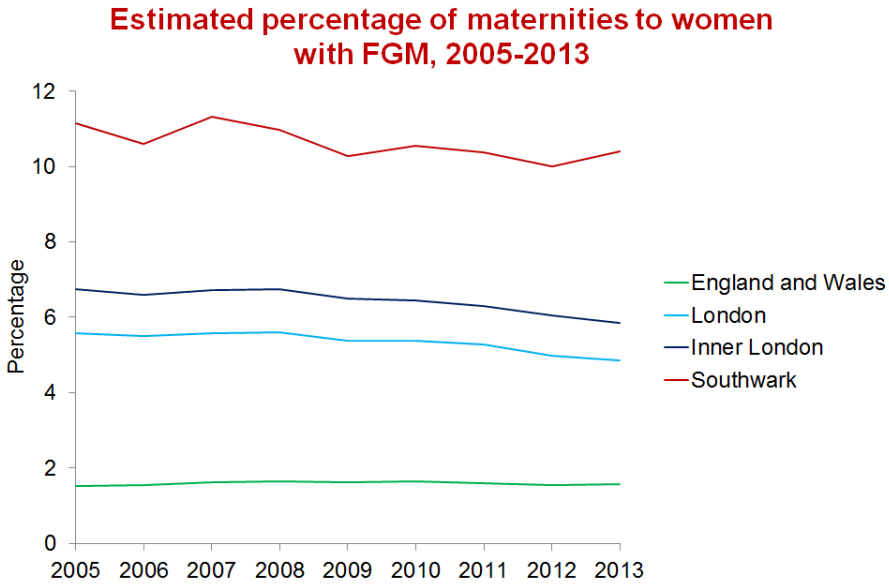
Prevalence

The report estimates that Southwark has the highest rates of FGM in the UK. Prevalence is measured by the numbers of women with FGM per 1000 of the population. Southwark has the highest FGM prevalence rates: 57.5 for women in the 15 – 49 age group, and 8.2 in the age range 0 – 14.

Southwark has rates which are similar to other inner London borough - detailed data estimates for England & Wales and each borough were produced for the report, and are available here:
http://gicentre.org/fgm2015/

Maternity

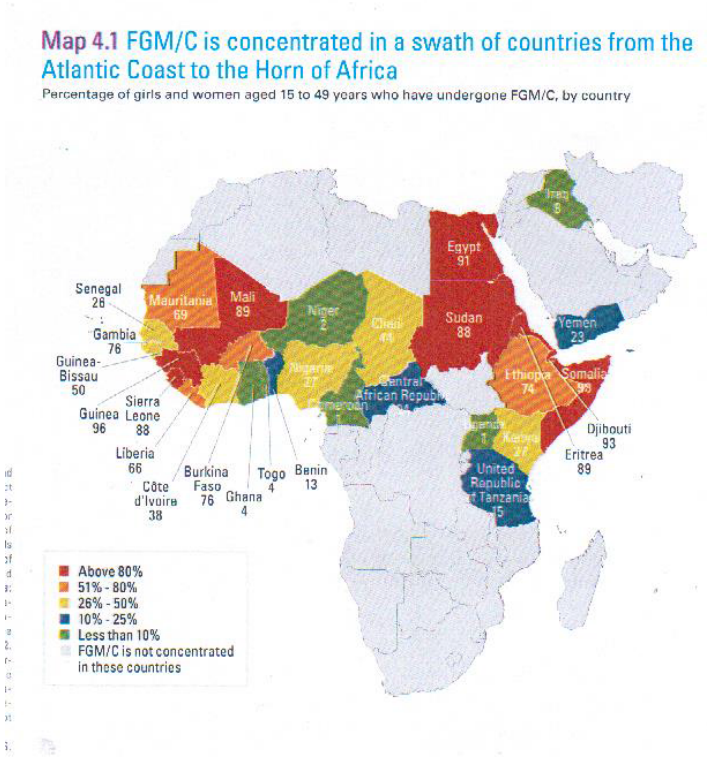
Maternity estimates were given for numbers of women with FGM giving birth and daughters born, with the caveat that the data is less robust as the country and religion is not recorded. Southwark is the borough with the highest number of children given birth to by a mother with FGM. More than one in 10 of girls in Southwark were born to mothers with FGM; the highest rate in England & Wales.



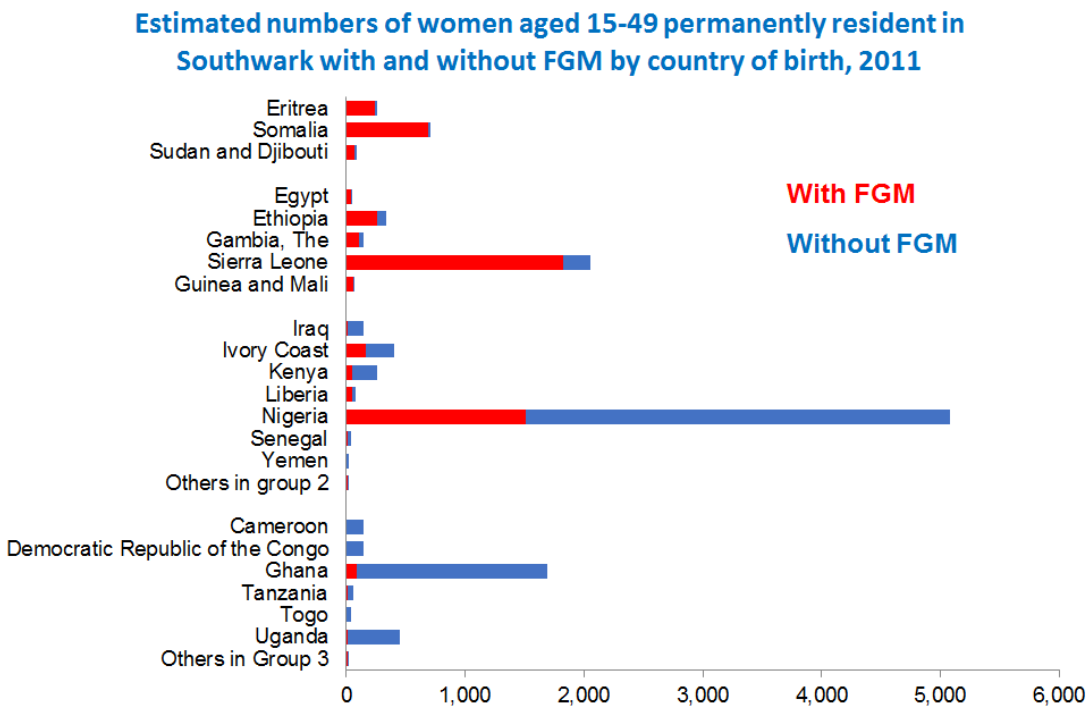
Ethnicity

FGM is concentrated in a group of countries from the Atlantic to the Horn of Africa, including parts of the Middle East, however it is also practiced in some other countries, particularly South East Asia.

Some countries have nearly universal FGM amongst the population (Somalia has 99%) whereas in some it is a minority (Iraq has 8%)



Southwark has high rates of FGM as it has a large immigrant population arriving from practicing communities. More detailed estimates for the ethnic breakdown of the Southwark population were provided for the presentation. Data was obtained by indirect estimates of prevalence of FGM using data on age specific prevalence by country of origin from surveys in FGM practising countries, alongside demographic, health and other survey data from the UK. Exclusions were then made for certain non- practicing populations e.g. Buddhist, Hindu or Sikh religion.



The data shows that the majority of women living in Southwark with FGM will be from Sierra Leone, Nigeria and Somalia, but there will be significant number of other women from other countries including Eritrea, Ethiopia, Sudan & Dhibouti, Egypt, The Gambia, Guinea and Mali, Ivory Coast, Kenya, Liberia and Ghana.

Women from Somalia, Sudan Eritrea and Djibouti will often have had the Type 3, the most severe form of FGM. Women from other countries are more likely to have had Type 2 or Type I.

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

Professor Alison Macfarlane advised that in undertaking work to stop FGM it is vital to know as much about your community makeup as possible as reasons for carrying out FGM vary from country to country and even within different countries. In Sierra Leone some tribes will not practice FGM, but although infrequent in Ghana it is practiced by the Northern Tribes, and in Nigeria it is more common amongst Christian, rather than Muslim communities. While generally FGM is associated with lower educational

levels, in Nigeria it is associated by higher levels of education, She recommended making use of the data she has produced and further investigation into the ethnic make-up of Southwark community in order to plan interventions.

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**

Angela Craggs Southwark Police FGM lead
Clarisser Cupid, Southwark Clinical Commissioning Group FGM Lead
April Bald, Southwark Council social care FGM lead

The officer leads for Southwark Social Care, the Police and NHS Southwark Clinical Commissioning Group (CCG) gave a joint presentation on the multi-agency work being undertaken to stop FGM.

An explanation was given on how agencies respond to incidents, and the referral pathway. Five examples were given:

- 17 year old from Sierra-Leonean presented at Sexual Health clinic – who reported unprotected sex with older man. She had had FGM aged 10 whilst back home.
- Adult sister from Sierra-Leone, who had FGM, called concerned about her 10 year old sibling.
- A GP referral regarding a Somalia mother who was concerned about her daughter who had FGM aged 7 back home, whilst living with her father and his wife
- The police were contacted by a friend of a pregnant Polish woman expecting a girl. The Nigerian partner wanted her to have FGM
- Immigration at Heathrow intercepted a child travelling with her mother who had paraphernalia in bag indicating possible cutting instruments

An explanation was given on how a child at possible risk is tracked through their minority and the methods employed to safeguard children, such as being moved into immediate police protection if a child or young person is considered to be an immediate risk of being cut.

The law has recently been updated and strengthened. The first legislation was the 'Prohibition of Female Circumcision Act 1985, with a penalty of 5 years imprisonment. With the introduction of The Female Genital Mutilation Act in 2003 the penalty increased to 14 years imprisonment and added extra offences of assisting 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.

New measures since May 2015 mean parents and guardians can now be held liable for failing to protect a child from FGM. The legislation granted lifelong victim anonymity, and introduced Civil Protection Orders. Despite these changes there have been no convictions under FGM legislation in the UK.

Mandatory reporting of FGM has been included in recent legislation and much better data is now coming through from health services: on 1st April 2014 the first FGM Prevalence Dataset was published. All clinical staff must now record in patient healthcare records when it is identified that a patient has had FGM and all acute hospitals must provide monthly returns of on FGM prevalence.

In Southwark an FGM Steering Group started in June 2015 with partner agencies and the voluntary sector. This group intends to:

- 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
- 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

Toks Okeniyi, FORWARD

FORWARD was founded in 1983 in response to the continuing practice of FGM among migrant communities in the UK. They have been working ever

since to frame the practice as a human rights violation, informing affected communities about the health implications and laws.

Forward is now one of the longest standing organisations tackling FGM in the UK and continue to work to support women affected and girls at risk of FGM through these key programmes:

- Community Programme: engaging affected communities through events, training and community development approaches

- Young People Speak Out!: empowering young people to help create change in their communities by providing skills, peer to peer training and support for youth advocates

- Schools Programme: offering a comprehensive range of services for schools to engage and empower young people about issues that affect them and raising awareness about the role that everyone can play in supporting girls and ending the practice.

- Training Courses for Professionals: offering a range of FGM training sessions, including accredited training for front line professionals including health, education, social services and the police, as well as to organisations from FGM practicing communities, and the voluntary sector at large.

Agnes Baziwe, African Advocacy Foundation

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. They 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 beneficiaries to address issues such as isolation, poverty and ill-health leading to independence and better quality of life. The main activities are a HIV programme, sexual health promotion, training and employment skills, and tackling FGM.

The FGM work includes:

- 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

The community outreach includes utilising sister circles, and working with madrassas & cultural centres. Community awareness raising workshops are held tailored to the language of the people e.g. Somali, Swahili, Yoruba, and Arabic.

The project trains champions of different ages, faith and beliefs, and develops faith leaders as champions. It works with men and young people from practising communities and survivors of FGM. It has directly supported 243 women in Southwark during 2014/15 .The initiative works with a wide range of Southwark faith based organisations (Muslim & Christian) and community groups.

The project holds events that focus on a number of issues in an engaging way, for example FGM is often discussed within the context of sexual health to reach a wider audience.

The project said they have identified a lack of knowledge on the health effects of FGM. Communities frequently feel there is interference without insight into issues. A lack of trust means that communities feel targeted. They advised that there needs to be more training and education within practising communities and there needs to be appropriate resources to facilitate learning in the community. Victims report there is a lack of FGM specialist knowledge making it difficult for women to seek appropriate advice and support and there needs to be more training for frontline professionals.

Florence Emakpose, World of Hope

World of Hope is committed to raising Youth Ambassadors that will become tomorrow's leaders through their mentoring, training, coaching, and citizenship programmes which equip young people to positively impact their communities. The project offers one-one support services to young people as well as group work activities, on issues such carrying weapons, teenage pregnancy, building confidence and improving family relationships. It works with young people on FGM directly seeking ambassadors to help end the practice and in July it held an African safeguarding children's conference, in partnership with CANUK , which in dealt with FGM.

Hawa Sesey – FGM survivor

The Scrutiny in a Day heard moving testimony from a survivor of FGM, Hawa Sesey, who explained how an elder relation carried out the procedure on her in Sierra Leone, the traumatic impact it had on her then as a young girl, and how it later affected her married life. She has worked for many years with in her community to end the practice and refused community pressure to cut her daughter.

Workshop 1 – Next Steps

The workshop participants made the following recommendations for next steps:

- 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 blunter 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 mind-set 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 – harder data required
- Ask Health & Wellbeing Board to support strategy
- Propose confidential helpline for people who wish to report concerns

Workshop 2: Action Research

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
- Keeping the survivor voice centre stage is crucial to understanding the issues and building creditability

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 we know about our local community, and where the gaps are.

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

What about leadership from existing communities. E.g. Somalia 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 and therefor particularly vulnerable to poverty, discrimination and are not fully integrated.

African Advocacy Foundation has 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 e.g. 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 residing with adults and the wider community

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

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

FGM workshop with Coventry University on REPLACE 2

11 November 2015

Professor Hazel Barrett & Dr Katherine Brown, Coventry University, presented on the REPLACE 2 programme, a community based behaviour change programme to end FGM. The programme academics presented and then held a discussion with participants. The workshop participants were a mixture of committee members, community engagement officers, the social care FGM lead and staff from a local voluntary organisation, African Advocacy Foundation, which is working in Southwark to end FGM.

Participants:

- Cllr Jasmine Ali – Chair, committee member
- Cllr Sandra Rhule - Committee member
- Cllr Kath Whittam - Committee member
- Cllr Sunny Lamb - Committee member
- Martin Brecknell - Committee member
- Agnes Baziwe – African Advocacy Foundation
- Shani Hassan – African Advocacy
- April Bald – Social care FGM lead
- Sarah Totterdell – Community Engagement
- Kevin Dykes – Community Engagement

Summary of the presentation:

The European Parliament estimates that up to half a million women living in the EU have been subjected to FGM, with a further 180,000 at risk. 35 years ago WHO called for end to FGM. The WHO, United Nations (UN), UNICEF, and other anti-FGM organisations have adopted various strategies in order to raise awareness and work towards ending FGM. These have centred on four main approaches: bodily and sexual integrity; human rights; legislative; and the health approach.

Thirty years on since the WHO called for the ending of FGM there is conflicting evidence as to whether these approaches have led to a reduction in the practice. 15 years ago WHO called for application of behaviour change approaches to address FGM , however research concluded that there was a poor understanding of how to conduct this .

The original REPLACE project was initiated to explore existing applications of Behaviour Change to FGM and worked with affected communities to explore belief systems –and through this work a theoretical framework developed based on behaviour change strategies A toolkit was produced in 2011 and this approach has been adopted by a number of European projects, as well as UK local authorities.

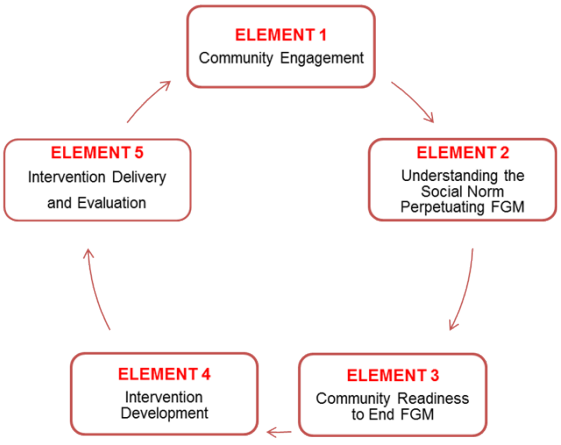
REPLACE 2 is the second round of an EU wider behaviour change programme which focuses on community engagement. The aims and objectives of REPLACE2 are to implement the REPLACE approach with 5 FGM affected African migrant communities in the EU, and following evaluation to develop and update the REPLACE approach applying recent and relevant developments from behaviour change and behavioural science.

There are seven European partners with different roles:

- Coventry University, UK – lead partner
- FORWARD UK – Sudanese women based in London
- FSAN, Netherlands – Somali women in Rotterdam
- Cabinet d'Estudis Socials, Spain – Senegalese & Gambian men and women in Banyoles
- APF, Portugal – Guinea Bissauan men and women in Lisbon
- CESIE, Italy – Eritrean & Ethiopian (Habesha) men and women in Palermo, Sicily
- ICRH, University of Ghent, Evaluation partner

The programme has worked with the above diaspora communities in Europe by engaging members of the practicing communities to understand the social norms that perpetuate FGM and then to provide intervention support to change beliefs and motivate social change. Coventry University lead the programme and Professor Hazel Barrett is the community participation expert and Dr Katherine Brown's speciality is behaviour change.

The REPLACE 2 programme uses a cyclic framework for Social Norm Transformation in relation to FGM.



Community engagement is the first step which is sustained throughout the programme. It is critical to the approach and focused on building a partnership with the community. The programme leads emphasised that building trust and

relationships with communities takes time and it helps to identify key people from the community to come with you on the journey through the cyclic framework.

The second step seeks to understand the Social Norms that are perpetuating FGM. It is important to recognise that different communities have different beliefs systems and social norms and that these change over time. It is only possible to design interventions whose content and messages align with those belief systems and norms once these have been understood. The programme recommends use of Community-based Participatory Action Research methods (CPAR) to achieve this.

The third stage is an assessment of community readiness to end FGM. REPLACE use a model of 9 stages of readiness to change. Stages range from 1 'no community awareness of the issues associated with ending FGM' to stage 9 'high level community buy in to end FGM. Identifying the stage helps identify target actions or behaviours for intervention development.

The fourth stage is focused on Intervention Development. It involves considering all of the possible target intervention actions that may help to move community to next stage of readiness to change and selecting those that are most feasible and acceptable to community, but that will push the community to change. The programme works with the community to develop support to address their needs, drawing on what is known about their underlying beliefs systems and norms. Help is given to devise materials and content to help community members carry out the target intervention action

An example is the Dutch Somali community. They identified as between community readiness stages 3 and 4 at project start (3: Vague community awareness to 4: Preplanning). The target intervention action agreed was for that Koranic school teachers deliver lessons in Koranic school addressing the belief that FGM or 'little Sunnah' is not a requirement of Islam. Work with the community identified that Koranic school teachers' needed support to know how to deliver such lessons. Training and support was provided including helping them to develop a lesson plan and asking an Islamic scholar to talk to them about the core arguments.

The fifth and final stage is the Intervention Delivery and Evaluation. As the intervention is implemented, so evaluation is conducted. The REPLACE approach recommends a mixed methods approach that incorporates assessments, pre & post focus groups, questionnaires or scaled measures of beliefs that are targeted by intervention content and keeping records of actions, numbers of people reached, and numbers of new community members who want to get involved in future work based on engagement with each target intervention action.

A new toolkit has been produced as a result of REPLACE 2, and copies were distributed to attendees and are available here www.replacefgm2.eu

Conclusion

The workshop concluded with an offer by Coventry University REPLACE 2 programme offering to assist Southwark in adopting this approach, which was gratefully received by the attendees.

The session concluded with an agreement to undertake a following up meeting and to bring more partners in, including the Southwark's FGM Health lead, as a project like this would need a longer time frame and additional capacity than is possible for scrutiny to deliver in isolation.

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EDUCATION & CHILDREN'S SERVICES
MUNICIPAL YEAR 2015-16

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