Appendix one

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

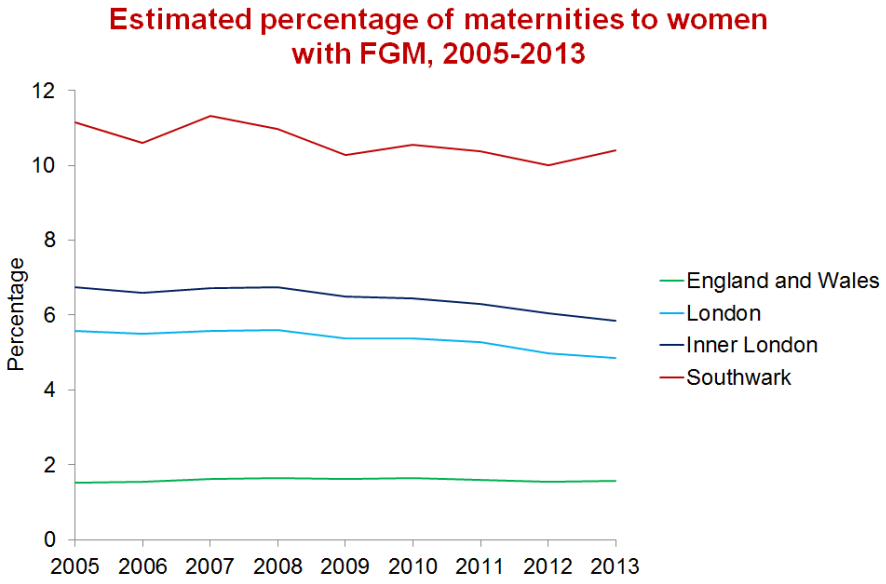
Prevalence

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

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 ethnicity and religion are not recorded at birth registration. Southwark is the borough with the highest proportion of children born to mothers with FGM. More than one in 10 of girls in Southwark were born to mothers with FGM, the highest rate in England & Wales.

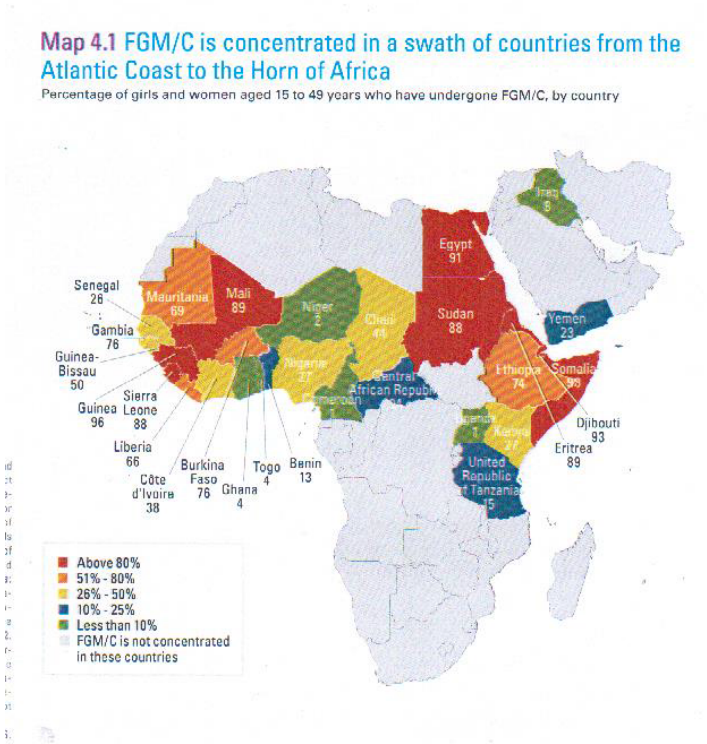


Source: Authors' analysis of ONS data

Mothers' countries of birth

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, for example it is estimated that 98% of women born in Somalia have been subjected to FGM, whereas in others it is a minority, for example only 4% of women born in Ghana have been subjected to FGM.



Source: UNICEF
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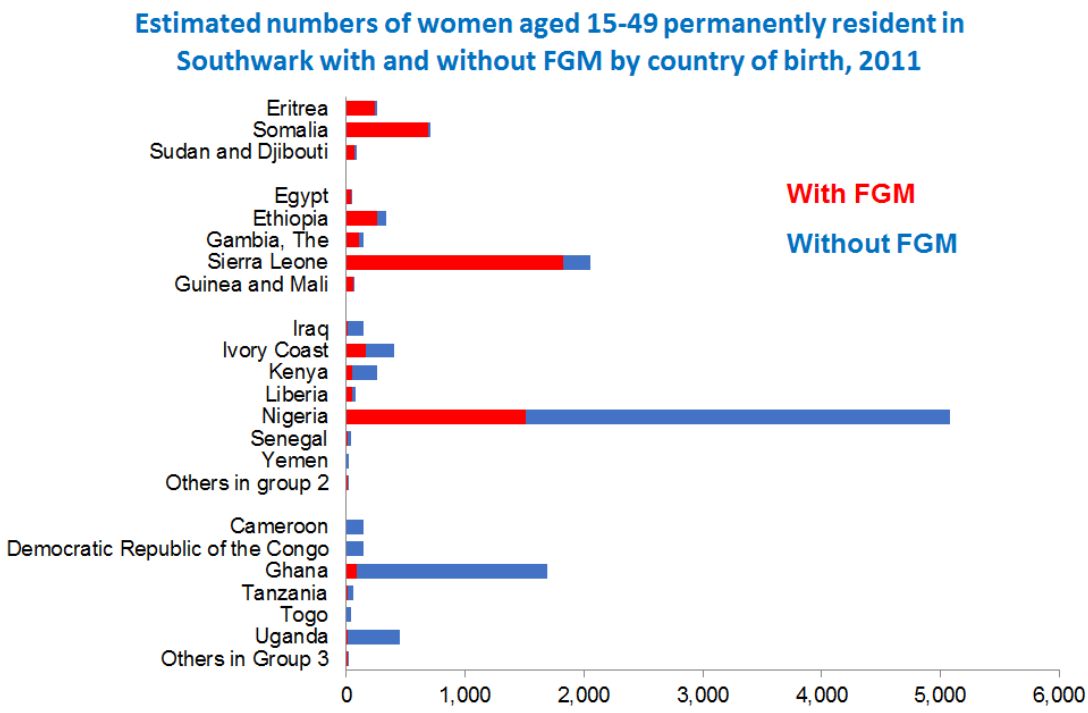
Southwark has high rates of FGM as it has a large immigrant population born in practising countries. More detailed estimates for the country of birth breakdown of the Southwark population were provided for the presentation. Data was obtained by indirect estimates of prevalence of FGM using data on age specific prevalence by country of origin from surveys in FGM practising countries, alongside census and birth registration data for England and Wales. Exclusions were then made for certain non- practicing populations e.g. Buddhist, Hindu or Sikh religion.



Source: Author's analysis of ONS data

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, Djibouti, 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. Although infrequent in Ghana it is practiced by the Northern Tribes, and in

Nigeria it varies considerably between regions of the country. 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 combined with further local investigation into the origins of the 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**

Source: Author's analysis of ONS data

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 Female Genital Mutilation Protection Order. Despite these changes there have been no convictions under FGM legislation in the UK.

Mandatory reporting of girls with FGM has been included in recent legislation, and came into effect in October 2015. Much better data is now being collected and 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.