



Department
for Education

The Mayor's Office for Policing and Crime Female Genital Mutilation Early Intervention Model: An Evaluation

Research report

January 2017

**Katie McCracken, Ana FitzSimons,
Sarah Priest and Kasturi Torchia
- Opcit Research**

With Nicky Stanley - University of Central Lancashire

Contents

Contents	2
List of figures	4
1. Executive summary	5
The project	5
The evaluation	6
Key findings	6
2. Overview of the project	8
Intended outcomes of the pilot	8
Activities of the pilot	8
The FGM clinic	8
Learning and protocol development	11
Engagement with men and communities	11
Training	12
Local context	15
Key findings from literature review	16
3. Overview of the evaluation	18
Evaluation questions	18
Evaluation methods	18
Changes to evaluation methods	19
4. Key findings	21
Impact of FGM on women	22
Women's views of FGM	22
Engagement with women who have undergone FGM	23
Midwifery services	23
Social services	24
Therapeutic services	25
Community advocacy services	26
Overall impact	27
Impact of the pilot on potentially-affected communities	28

Impact of the pilot on services and professionals	29
Lessons from the pilot	31
Professional practice	32
Social services	34
Mental health	37
Community engagement	38
Holistic, multi-agency working with community organisations	39
5. Limitations of the evaluation and future evaluation	42
6. Implications and recommendations for policy and practice	44
Appendix 1. Literature review	45
Appendix 2. Theory of change interview script	57
Appendix 3. Original theory of change	58

List of figures

Figure 1: Referral pathways	13
Figure 2: Work with men, learning, awareness-raising and training activities	14
Figure 3: Referrals to FGM clinics, by quarter	30
Figure 4: Referrals to FGM clinics, by country of origin	31

1. Executive summary

The project

The Mayor's Office for Police and Crime Female Genital Mutilation Early Intervention Model (MOPAC FGM EIM) pilot was established to implement and refine an effective strategy to prevent new cases of FGM among women and girls, while supporting those affected by FGM. To achieve these aims, the pilot brought statutory health and social services together with community organisations to co-construct an effective and sustainable intervention delivering support to women who have undergone FGM and safeguarding those at risk of FGM. The pilot was delivered across 3 local authority areas within London (the Tri-Borough, Tower Hamlets, and Waltham Forest), each of which has a high estimated rate of prevalence of FGM, relative to the average for England.

The work of the pilot included establishing FGM clinics located within hospital midwifery services and staffed by specialist FGM social workers, therapists, community and health advocates drawn from community organisations, and specialist FGM midwives. Women identified by health and other professionals as having undergone FGM – and, in particular, pregnant women identified by midwives – are referred to the clinic for support and safeguarding services. Women who have undergone FGM may also refer themselves to the clinic.

Advice on the law around FGM and safeguarding children, as well as more general support with accessing services, is provided by the specialist FGM social workers. The therapists offer emotional support and therapeutic services, while the community advocates act as essential mediators between clinic staff and the women who attend the clinic. The specialist FGM midwives provide advice on the type of FGM that women have; health issues women may face (including during pregnancy and labour) as a result of their FGM; and deinfibulation.

The model of the clinic was underpinned by a recognition that midwives are often best-placed to identify women who have undergone FGM, while social workers have the most highly developed expertise in safeguarding and direct work with families. The clinic aims to bring together the skills and expertise located within these professions in order to offer a high quality intervention that is co-designed with, and effectively facilitated by, community advocates.

Alongside work in the FGM Clinics, pilot staff undertook work to develop new, FGM-specific assessment and intervention tools and protocols; delivered training and events to relevant professionals; engaged with members of potentially-affected communities to identify local needs and strengthen efforts to raise awareness of FGM-related issues;

provided support and information to men affected by FGM; and engaged with local school pupils to raise awareness about FGM.

While the 3 boroughs each worked toward the same fundamental project aims, they had scope to implement the project in different ways and their approaches therefore varied.

The evaluation

The key questions examined in this evaluation relate to the aims of the pilot and how effectively it has achieved them. They are:

- What impact does the project have on service delivery, and on the working practices of professionals working to prevent new cases of FGM and support women who have undergone FGM?
- What impact does the project have on women who have undergone FGM and members of potentially-affected communities, including those who are at risk of FGM?

A review of monitoring data on case management provided by each of the pilot sites was conducted to understand the scale and outcomes of casework.

In-depth, one-to-one, semi-structured interviews were conducted with key professionals involved in the development and delivery of the pilot in each of the 3 local authority sites. These included interviews with the 4 project leads, the 4 specialist FGM social workers, the 3 therapists, 7 community advocates, 2 male workers, 2 specialist FGM midwives, and other relevant health and local authority professionals. The interviews identified how the pilot has been implemented in the different sites; what impact the pilot has had on both services and service users; and key lessons from the pilot, including the main enablers of, and barriers to, success.

A focus group with 4 women, and in-depth, semi-structured interviews with 6 other women who have been supported by the project were conducted across the 3 pilot sites to improve understanding of their experiences and views of the pilot.

Semi-structured observation of 5 stakeholder and community events organised and delivered by pilot staff was undertaken to assess engagement with key professionals, members of potentially-affected communities, and the public.

Key findings

Our research confirmed that FGM can often have a severe negative impact on health and mental health outcomes. It also found little evidence of support for the practice of FGM among families attending the FGM clinic. The FGM clinic was found to offer an effective,

holistic service to women who have undergone FGM, including the provision of high-quality health and mental health services; advice on effective safeguarding approaches; support to access wider services and benefits; links to community-based classes and activities; and considerable emotional and practical support. Confirmed figures demonstrate that over 235 women were seen in the clinics throughout the duration of the pilot. However, confirmed figures were not available for 1 out of 4 quarters at 2 pilot sites, and the actual number of women seen will therefore have been higher.

The model of co-working between highly skilled and reflexive health and social care professionals, therapists and community advocates was found to have enabled these professionals to develop strong working relationships and effective service protocols. Issues of inter-agency suspicion and mistrust that were present at the start of the pilot have largely been resolved. The working priorities of the different agencies involved in the model are now broadly viewed by pilot staff as complementary elements of an effective, holistic service.

The main risks to the success of the model include insensitive, unreflexive and heavy-handed professional practice; negative perceptions of social services and mental health services; and inappropriate forms of engagement with members of potentially-affected communities. The challenges in these areas are most likely to be overcome where services and professionals commit to delivering sensitive, reflexive, woman-centred practice; to ensuring all relevant professionals receive high quality training; and to engaging in effective two-way dialogue with members of potentially-affected communities.

2. Overview of the project

Intended outcomes of the pilot

The MOPAC FGM EIM pilot was established in order to implement and refine an effective strategy to prevent new cases of FGM among women and girls, while supporting women who have undergone FGM.

More specifically, MOPAC's stated intention is to ensure that the following 4 outcomes are achieved by the end of the pilot phase:

- Fewer girls will have been cut as a result of tradition, faith or cultural practices, with a primary focus on the prevention of FGM.
- Statutory agencies will be demonstrably working together effectively to identify and safeguard girls at risk of FGM through early help, providing the foundation for long-term safeguarding approaches to be developed. Tensions and barriers which have prevented this from occurring before will have been removed.
- Models of assessment and intervention co-constructed with affected community groups will have been developed, codified and implemented. Resulting high quality social work practice and multi-agency holistic responses will be improving outcomes for both women and children.
- Measurable attitudinal and behavioural change will occur within potentially-affected communities, which will mean that the prevalence of FGM and other harmful cultural practices decreases over time.

Activities of the pilot

In order to achieve these outcomes, the pilot has implemented a broad range of very significant changes to the structure of services and the working practices of professionals in contact with cases of FGM, most notably professionals from health, social care and therapeutic services, community advocates, and male workers. Flexibility was built into the model, and pilot sites have adopted slightly different methods of delivery.

The FGM clinic

A major achievement of the pilot has been to establish new FGM clinics located within midwifery services at hospitals in the pilot sites. One new clinic has been established within each pilot site, and the EIM has also been introduced within the one FGM clinic that was already in place in the Tri-Borough. These clinics bring health, social care and therapeutic services together with community organisations, facilitating close working

partnerships between specialist FGM social workers, therapists, community advocates and specialist FGM midwives.

Women who are identified by health and social care professionals as having undergone FGM are referred by those professionals to the clinics. In particular, there has been a strong focus on ensuring that, when pregnant women are identified during examination by midwives as having undergone FGM, the midwives make a referral. This focus makes sense not only because midwives are very often the first professionals with the opportunity to identify cases of FGM, but also because of the particular physical and mental health complications during pregnancy and childbirth that are associated with some types of FGM. (For example, deinfibulation – surgery that aims to reverse, as far as possible, the physical damage caused by FGM, which may include ‘re-opening’ the vagina – may be recommended before labour.) Additionally, women who hear about the clinics through word of mouth (for example, via friends and family members) can self-refer by booking an appointment.

Once at the clinics, the women see a range of professionals offering different forms of support. The specialist FGM midwives may conduct an examination and provide advice on the type of FGM women have; health issues women may face (including during pregnancy and labour) as a result of their FGM; and deinfibulation.

The specialist FGM social workers provide advice on the law around FGM and also strategies for safeguarding children. These may include, for example, strategies for remaining vigilant when daughters may be in contact with, or left in the care of, any family members who are supportive of FGM. Importantly, the specialist FGM social workers do not focus solely on FGM in their discussions with women: they offer a more holistic service by providing advice (for example, on accessing benefits) and signposting or referral to other services (for example, housing) where this is required.

The therapists offer emotional support and longer term therapy (such as trauma therapy). While this offer is presented as a normal part of the pathway through the clinic, women who do not wish to see the therapist may decline.

The community advocates act as mediators between the clinic staff and the women, and can be viewed as the lynchpin of the model. Drawn from community organisations with expertise in FGM, they offer significant emotional and practical support to women attending the clinic; translation where necessary and possible; and links to community activities and classes. Some of the community advocates telephone women with appointments at the clinic to discuss what to expect; meet the women at or near the hospital and show them to the clinic; and in some cases literally hold their hand through the process of attending the clinic.

Throughout this process, clinic staff identify whether any safeguarding risks exist. The model underpinning the pilot stipulates that daughters of women who have undergone FGM should be considered 'at risk' of FGM, until and unless a safeguarding assessment demonstrates low risk. If a woman attending the clinic has no daughters and is not pregnant with a girl, she is discharged and tracked. If a woman has daughters and/or is pregnant with a girl, she is referred to social services, who conduct a home visit in order to complete a safeguarding assessment. These visits may be conducted jointly or after discussion of the case with the clinic's specialist FGM social worker.

Waltham Forest and Tower Hamlets did not have established FGM clinics at the start of the pilot, and different referral processes were therefore established at the outset across the pilot sites. In Waltham Forest, all cases are referred by maternity at Whipps Cross Hospital to the Multi-Agency Safeguarding Hub (MASH) and received by the specialist FGM social worker at an early stage of the referral process, who then adopts an early help approach. This approach seeks to prevent issues from escalating to the point where the case requires statutory intervention. In Tower Hamlets, maternity services in the Royal London Hospital refer cases directly to the specialist FGM social worker. Both of these pilot sites have now established FGM clinics and this is reflected in their referral pathways.

In the Tri-Borough, women attending the clinic who have daughters or are pregnant with a girl are referred by the specialist FGM social worker to children's services, at which point a community advocate liaises with the family and may conduct joint visits with the allocated local authority social worker and health visitor. If women do not attend the clinic, the protocol is to refer them to social services, who will conduct the safeguarding assessment at a home visit. Clinic staff are universally keen to avoid this scenario, for reasons that we set out in more detail in the key findings section below, but which include a commitment to ensuring women receive holistic support and a recognition that heavy-handedness is likely to undermine the goal of ending FGM in the UK.

While an FGM clinic existed in the Tri-Borough prior to the pilot, this focused primarily on the provision of health services. A key feature of the pilot is that it has brought a new focus on pro-active prevention and safeguarding work, while providing holistic, woman-centred health, social care and therapeutic support to victims.

The model of the FGM clinics is underpinned by recognition that midwives are often best-placed to identify women who have undergone FGM, and that a number of specialist midwives have already developed high levels of expertise in the provision of FGM-related health services. Social workers, meanwhile, have the most highly developed expertise in safeguarding and direct work with families. The clinic aims to bring together the skills and expertise located within these professions in order to offer a high quality intervention that is co-designed with and effectively facilitated by community advocates.

One very crucial element of the pilot is that it has given clinic staff the flexibility to tailor their service to local needs and circumstances. The order in which women attending the clinic are seen by the different professionals has been determined on the basis of local professional judgement with regard to what will work most effectively to put women at ease and improve their experience of (and therefore engagement with) the clinic. This judgement is informed by recognition, not only of the needs and sensibilities of those who attend, but also of the individual professional styles of staff. Staff reported that this flexibility is key to the achievement of the clinic's aims, and should remain a part of any model that may be followed post-pilot.

Learning and protocol development

In addition to their direct work with women attending the FGM clinic, staff have engaged in a range of other activities to further the aims of the pilot. First, they have demonstrated a high level of commitment to ongoing learning and professional development. The specialist FGM social workers, therapists and community advocates attend regular 'core group meetings', as well as 'team around meetings' that are also attended by a family safeguarding nurse, a statutory safeguarding representative, male workers, and other statutory services as appropriate. During these multi-agency, collaborative meetings, staff discuss ongoing work, share learning, and form action plans for case management. All pilot staff also expressed a commitment to listening to and learning from the women they engage and other members of potentially-affected communities, and to refining local services in light of this learning.

Pilot staff have also undertaken work to develop and improve a range of service protocols. Health, social care and therapeutic professionals have collaborated closely with the community advocates to co-construct suitable assessment tools. These include, for example, an FGM-specific mental health assessment tool.

Engagement with men and communities

Male workers were recruited to engage with male family members of women who attend the FGM clinics. Engagement with men was reported in staff interviews as being key to achieving the pilot's desired outcomes. Staff emphasised that women's lives do not happen in a silo, and that FGM also has welfare implications for men (because, for example, it can affect the quality of their relationships and sex lives). The male practitioners have contributed meaningfully to interventions in family households, engaging fathers in discussion around the illegality and health and mental health consequences of FGM, as well as offering more general support to male family members. This focus on direct work with men constitutes innovative practice in FGM prevention efforts.

In addition to their direct work with families, the male workers in all pilot sites have conducted outreach work alongside community advocates to raise awareness of FGM-related issues among men, including holding discussions about FGM with Imams and other faith and community leaders. In Waltham Forest and Tower Hamlets, the male workers have brought together an inter-faith advisory group in order to develop an anti-FGM charter.

Other pilot staff have also undertaken a great deal of outreach and community-engagement work. They have arranged and attended community-based workshops and events with members of potentially-affected communities, aiming not only to raise awareness of and garner support for their work, but also to learn more about the cultural backgrounds of their cohort, and the diverse views held on FGM and public services. For example, one community advocate has hosted coffee mornings in schools to facilitate wide-ranging discussions among women affected by FGM and to highlight the services which are available to them. Another has been particularly effective in engaging major national media outlets in discussions of FGM, which have been broadcast to the general public.

Managers and frontline staff reflected on the importance of creating new opportunities for both boys and girls to engage in dialogue about FGM, given that effective, long-term social, cultural and attitudinal change requires attitudinal buy-in from younger generations. Outreach work with school pupils has been a particularly strong feature of the work of the pilot in Waltham Forest, although it has featured to a degree across all sites. Pupils have been engaged in a dynamic and direct manner by staff using personal testimony to bring issues to life. In particular, pupils have been encouraged to ask questions, to reflect on the physical and emotional implications of FGM, and to undertake creative campaigning and awareness-raising activities.

Training

Finally, pilot staff have provided expert training on FGM to a range of professionals. This includes training in identification and referral practices provided to hundreds of doctors and school teachers, and training in risk assessment and case management provided to social workers. The aims of this training vary according to need, but often include ensuring that professionals understand when and how to make referrals to the clinics, and how to interact with women who have undergone FGM in an appropriate and effective way at all times.

The activities of the pilot are summarised in figures 1 and 2 below. It should be noted that while the FGM clinic pathway was already established in the Tri-Borough when the pilot began, there were initially no FGM clinics in either Waltham Forest or Tower Hamlets. The FGM clinics in these sites were established after the pilot had begun. In the beginning phase of the pilot, referrals in these 2 areas therefore came via maternity

services in Whipps Cross Hospital (Waltham Forest) to the MASH team and the FGM social worker, and in the Royal London Hospital (Tower Hamlets) direct to the FGM social worker. The different referral pathways are shown in figure 1.

Figure 1: Referral pathways

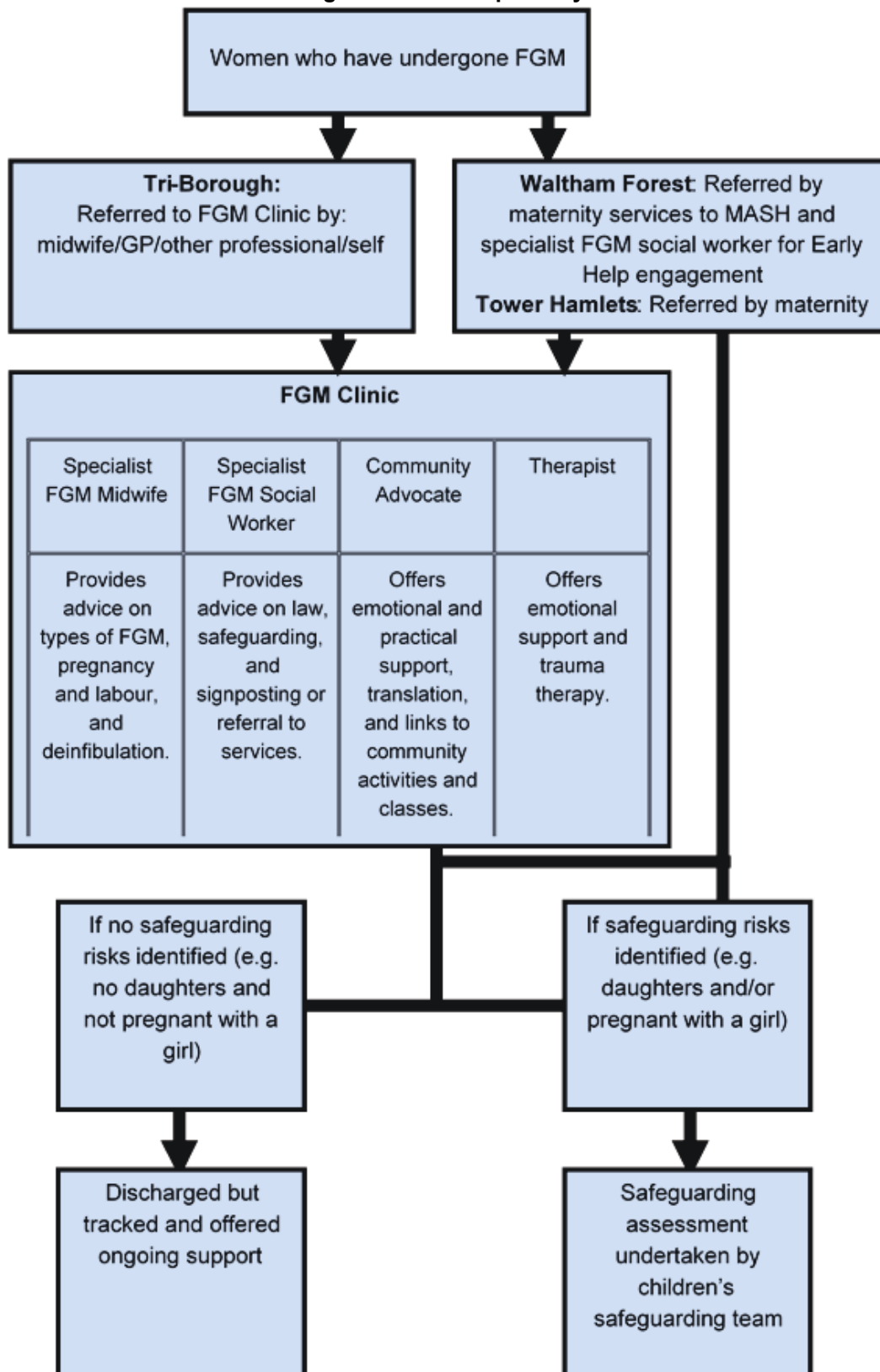
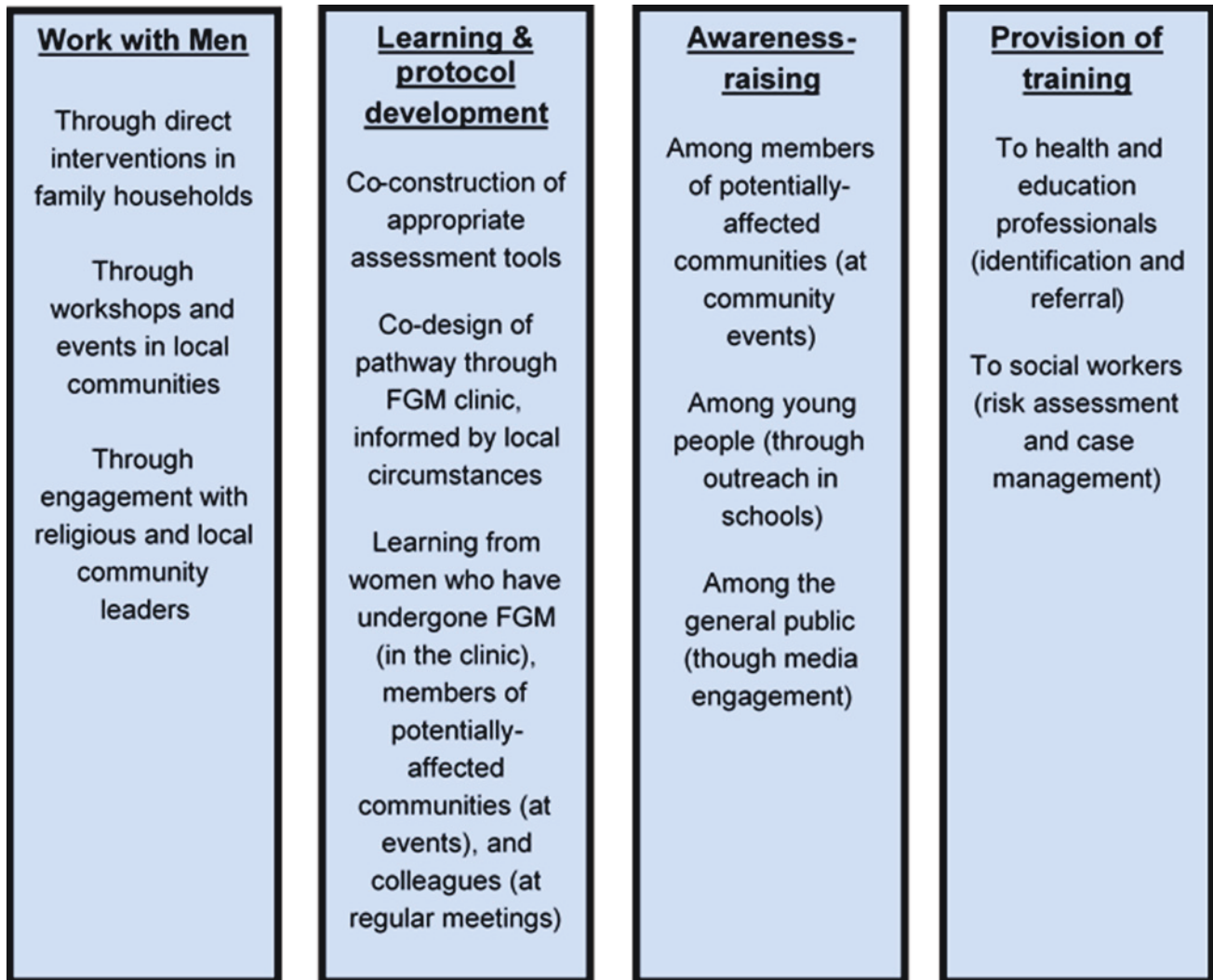


Figure 2: Work with men, learning, awareness-raising and training activities



Local context

The pilot has been run across 3 local authority areas in London: the Tri-Borough (Kensington and Chelsea, Hammersmith and Fulham, and Westminster), Tower Hamlets, and Waltham Forest. Research funded by the Home Office and Trust for London and conducted by City University London and Equality Now provides estimates of prevalence in local authorities across England and Wales.¹ Drawing on data from UNICEF on prevalence in 'FGM-practising countries', and data from the Office for National Statistics on women and girls living in different local authorities who were born, or whose parents were born, in 'FGM-practising countries', the research suggests that the pilot sites have a relatively high prevalence of FGM among their populations compared to the average across England and Wales of 4.8 cases per 1,000 population. Estimates of total prevalence and also of the number of maternities from 2005 to 2013 to women who had undergone FGM in each of the pilot sites are cited below.

Census data suggests that the total population of the Tri-Borough is 560,600.² In Kensington and Chelsea, it is estimated that 1,644 women have undergone FGM, representing a prevalence of 20.4 cases per 1,000 population. In Hammersmith and Fulham, an estimated 2,983 women have undergone FGM, representing 31.9 cases per 1,000 population. This constitutes the fifth highest level of estimated prevalence of any local authority in England and Wales. Estimates for Westminster suggest that 2,619 women in the area have undergone FGM, representing 24.3 cases per 1,000 population. The total number of maternities in the Tri-Borough from 2005 to 2013 to women who had undergone FGM is estimated to have been 7,210 (1,515, 2,978, and 2,717 respectively).

Tower Hamlets had a resident population of 254,100 at the time of the 2011 census and that figure was estimated to have grown to 295,200 by June 2015.³ The estimated total number of cases of FGM in Tower Hamlets is 2,401, representing a prevalence rate of 19.5 cases per 1,000 population. The estimate of maternities in 2005-2013 is 2,703.

¹ Macfarlane, A. J. & Dorkenoo, E. (2015) *Prevalence of Female Genital Mutilation in England and Wales: National and local estimates*, London: City University London in association with Equality Now

² Tri-Borough Local Authority (2012) *Census first release: July 2012, Tri-borough summary*, accessed on 17.06.2016 from <https://www.rbkc.gov.uk/pdf/KCP%20Sept%202012%20-%20Item%203%20-%20Census%20Appendix%202.pdf>

³ Tower Hamlets Local Authority (2013) *Language in Tower Hamlets: Analysis of 2011 Census data (Research Briefing)*, accessed on 17.06.2016 from http://www.towerhamlets.gov.uk/Documents/Borough_statistics/Ward_profiles/Census-2011/RB-Census2011-Language-in-Tower-Hamlets-2013-02.pdf

Waltham Forest Borough Council estimate the number of residents in the area to be 268,020.⁴ The estimated total number of women who have undergone FGM is 2,273, with a prevalence rate of 17.6 cases per 1,000 population. From 2005 to 2013, there were an estimated 4,187 maternities to women in the Borough who had undergone FGM.

Key findings from literature review

A literature review (included as Appendix 1) was undertaken at the start of the evaluation to identify existing knowledge around FGM, including recommendations for the design and delivery of services aiming to prevent FGM and support those who are affected by it. The literature search encompassed peer-reviewed journal articles and grey literature published in English since 2002. The recommendations that are most relevant to the evaluation are summarised below.

- Effective and meaningful engagement and co-production of services with key stakeholders is vital to prevention efforts. Relevant stakeholders may include women who have undergone FGM, other members of potentially-affected communities – including men, members of community and grassroots organisations, and religious and community leaders.
- Sensitivity, including cultural sensitivity, should be at the forefront of engagement with women and girls. Significant diversity in practices and attitudes around FGM means that professionals should ensure that their practice is tailored to individuals and communities in a highly sensitive and culturally informed way. Professionals working with women who have undergone FGM and their families should be alert to the particular need for sensitivity in their use of language and ready to adjust the terminology they employ in accordance with their clients' preferred terminology.
- Specialised services that understand the range and complexity of issues around FGM and which implement a gender-sensitive, victim-centred approach are best-placed to meet the specific needs of women and girls who have undergone, are at risk of, or are affected by FGM.
- Health, social care, education and other relevant professionals have an important role to play in identifying girls and women affected by FGM; reporting concerns; initiating protective measures for girls at risk of FGM; and ensuring appropriate care and support is provided to those who have undergone FGM. In particular, health, social services and education are a point of contact with, and provide opportunities for disclosure from, women and girls from potentially-affected communities. Therefore,

⁴ Waltham Forest Local Authority (2016) *Statistics about the borough*, accessed on 17.06.2016 from <<https://www.walthamforest.gov.uk/content/statistics-about-borough>>

relevant professionals should have a strong knowledge of best practice in cases of FGM, including an understanding of appropriate referral, assessment and prevention protocols, and a culturally informed and sensitive approach to engagement.

- Multi-agency working and collaboration is crucial to the identification of local needs and suitable prevention strategies, and to the successful provision of effective and holistic services to people who are or could potentially be affected by FGM. This requires effective information sharing and trust between agencies.

As the key findings of this evaluation demonstrate, both the design of the MOPAC FGM EIM and the professional practice of the staff who have implemented the model are very much in line with recommendations canvassed above.

3. Overview of the evaluation

Evaluation questions

The key evaluation questions relate to the aims of the pilot and how effective it has been in achieving them. They are:

- What impact does the project have on service delivery, and on the working practices of professionals working to prevent new cases of FGM and support women who have undergone FGM?
- What impact does the project have on women who have undergone FGM and on members of potentially-affected communities, including those who are at risk of FGM?

More specifically, the evaluation team has considered the following questions:

- Does the project increase the numbers of girls identified as being at risk of FGM and the numbers of women identified as having undergone FGM?
- Does the project provide effective support to women who have undergone FGM?
- Does the project improve how services and professionals react to, and progress, cases of FGM?
- Does the project improve the way different professionals in contact with cases of FGM work with each other?
- Does the project improve the way different professionals work with women who have undergone FGM and members of potentially-affected communities?
- Does the project improve levels of confidence and trust between professionals and members of potentially-affected communities?
- Is the project likely to reduce the number of new FGM cases in the longer term?
- What factors enable and enhance the efficacy of the project?
- What factors hinder the efficacy of the project?

Evaluation methods

A literature review was undertaken at the start of the evaluation to identify existing knowledge around FGM, including estimates of prevalence and insights into best practice within agencies in contact with cases of FGM. The literature search encompassed both peer-reviewed journal articles and grey literature, and was limited by language and time parameters. Only literature published in English from 2002 onwards was reviewed.

A review of case management monitoring data provided by each of the pilot sites was conducted to understand the scale and outcomes of casework.

In-depth, one-to-one, semi-structured interviews were conducted with key professionals involved in the development and delivery of the pilot in each of the 3 pilot local authority sites. During the interviews, researchers asked participants about a range of themes to prompt focused yet flexible discussion. The interviews were conducted with the 4 project leads, the 4 specialist FGM social workers, the 3 therapeutic support professionals, 7 community and health advocates, 2 male workers and 2 specialist FGM midwives. The specialist FGM social workers were interviewed at 2 time points in order to understand developments in working practices and case management, as well as community engagement. Additionally, interviews were conducted with 2 professionals from allied services and agencies: a Multi-Agency Safeguarding Hub manager and a consultant urogynaecologist and obstetrician.

The purpose of these interviews was to refine the theory of change underpinning the MOPAC FGM EIM in order to assist the early development of the project. A copy of the original theory of change is included in Appendix 3. Furthermore, the interviews identified how the pilot has been implemented in the different sites, what impact the pilot has had on both services and service users, and key lessons from pilot, including the factors that were essential to its effectiveness, and the barriers to success.

In-depth, semi-structured interviews were conducted with 6 women who have been supported by the project across the 3 pilot sites. Two of these were one-to-one interviews, while 4 were conducted with the assistance of an interpreter. A focus group was also held with 4 other women who have been supported by the project in one of the pilot sites. The purpose of the interviews and focus group was to improve understanding of women's views of FGM and its impact on their lives; their experiences and views of relevant public services prior to the pilot; and their experiences and views of the pilot.

Structured observation of 5 stakeholder and community events was undertaken in each of the 3 pilot sites in order to assess engagement with key stakeholders, including local authority staff, health professionals, social care practitioners, women who have undergone FGM, members of potentially-affected communities, school pupils and their teachers, and staff and volunteers from relevant charities. During this semi-structured observation, researchers remained unobtrusive while observing and taking notes on the content and reception of events.

Changes to evaluation methods

The methods described above were carefully designed to suit the purposes of the evaluation and did not change significantly throughout the evaluation period. In

accordance with the commitment of the evaluation team to reflexive research practice, issues and themes revealed in earlier interviews informed the iterative refinement of interview questions.

Fewer interviews were conducted with women who have been supported by the pilot than anticipated. The evaluation team encountered obstacles to reaching, and obtaining consent to be interviewed about such a highly sensitive topic from, women supported by the pilot, many of whom were pregnant or new mothers. Further, as the majority of these women declined to be audio recorded, the number of verbatim quotations from their interviews included in the report is limited.

The original research design included an e-survey, which was developed and sent to front-line professionals in contact (or potentially in contact) with cases of FGM. This was intended to establish the working practices of these professionals and their understanding of FGM generally, both at the pre-pilot baseline and during the pilot phase. However, while the e-survey was sent out to 94 front-line professionals from across a wide range of services, the response-rate was very low (n=8), despite reminders being sent. Our reflection is that the low response rate may reflect professionals' uncertainty about whether the issue relates to their experience and responsibility and so, on seeing a survey about FGM, potential respondents may have thought that it was not for them to complete. Consequently, the insights gleaned through that particular research method were necessarily limited. We have drawn upon data from our other research methods to gain insights into professional's experiences in working to address FGM.

4. Key findings

The research undertaken by the evaluation team has produced rich insights into how the pilot has worked in practice and how effective it has been in achieving its aims, as well as identifying several important barriers to, and enablers of, success. We begin our discussion of key findings with a summary of what was learned about the impact of FGM on women involved in the pilot and their views of FGM. We then move on to how the pilot engaged with women who have undergone FGM, members of potentially-affected communities, and relevant services and professional practices. We end with an examination of the lessons that have been learned from the pilot. We identify several areas of challenge and risk, as well as the kinds of responses that are required to avoid or overcome them.

The total budget for implementation of the pilot across the 3 pilot sites was £502,498. On the basis that this budget was shared equally across the sites, we have estimated the cost per case seen within each of the pilot sites as between £901 and £1536 per case, depending on which costs are counted. Please note 3 caveats to these estimates. First, the estimated cost per case is inflated, inasmuch as it does not take account of set-up costs. Second, as data were not available for 1 out of 4 quarters within the Tri-Borough (from October to December 2015) and within Tower Hamlets (from April to June 2016), the estimates are based on a figure of three-quarters of the funding received by these sites. Finally, and importantly, the costs quoted include a budget for community engagement work which was not targeted at individual women or families but at larger population groups and communities. This also inflates the per case cost.

On that basis, the Tri-Borough had a budget of £125,624 for three quarters and saw 112 cases during that time, resulting in a cost per case of £1,122. Tower Hamlets also had a budget of £125,624 for three quarters and saw 32 cases during that time, resulting in a cost per case of £3,926. Waltham Forest had a budget of £112,875 for the duration of the pilot and saw 93 cases during that time, resulting in a cost per case of £1,214.⁵ These figures demonstrate that 237 women were seen in the clinics across the 3 pilot sites, with an average cost per case of £1,536. However, as confirmed figures were not available for 1 out of 4 quarters within 2 sites, the actual number of women seen will have been higher.

⁵ An additional £53,750 was shared between Tower Hamlets and Waltham Forest to fund a male worker to provide outreach and engagement work with men in the community and psychological support for women who have undergone FGM. This has not been included in the cost per case calculation, as this work was mostly targeted at larger populations and community groups rather than individuals.

Setting aside project set-up, management and administration costs, the budget for Specialist Social Workers was £71,200 per quarter, or £284,800 per year. Considering only this budget for the quarters for which data are available, the average cost per case was £901.

Impact of FGM on women

We conducted interviews with 6 women and held a focus group with 4 other women who had undergone FGM and attended the FGM clinics at the pilot sites. They each reported various health problems resulting from their FGM. These included recurrent urinary tract infections, difficulty passing urine, 'blocked' periods, problems during pregnancy and labour, and difficulty, discomfort, pain or lack of sensation during sex. Some also reported mental health problems, including stress, anxiety and depression, which they associated with their FGM. FGM clinic staff confirmed that these particular health and mental health issues were prevalent across the cohort of women they had seen in the clinic, with therapists particularly emphasising the prevalence of symptoms of trauma.

However, staff also emphasised that not all women who have undergone FGM experience negative health or mental health consequences. Several factors, which include, but are not limited to, the type of FGM women have undergone, affect the consequences women may face. This suggests that, while services and professional practice should be sensitive to the possibility of trauma and other harmful health effects, they should also take care to avoid making unwarranted assumptions about the experiences of women who have undergone FGM.

Women's views of FGM

Every person interviewed during the course of the research condemned the practice of FGM. A range of different reasons were reported by women who had undergone it themselves, and many of these drew on their own very personal experiences and reflections. They included wanting to protect a well-loved daughter from the suffering they had endured; believing that it is 'wrong to have something like that taken away from you' and that it is no one's right to take it; believing that FGM is a harmful tradition from a time when the negative consequences were not well understood and which, given current knowledge, should now be ended; and a belief that, while supporters of FGM may attempt to justify the practice with reference to wrong-headed ideas about 'womanly purity', it is fundamentally about 'controlling women and girls' to make them passive in life in general and sex in particular.

FGM clinic staff in one Borough reported that they had not seen anyone at the clinic who had disclosed support for the practice or who they had suspected might support it. The FGM clinics in the 2 other Boroughs had each seen a family who had expressed some

surprise on learning of FGM's illegality in the UK and the level of risk of negative health and mental health consequences. Both families reported to staff that they had previously been ambivalent about the practice but were fully persuaded, given what they learned at the clinics, never to arrange it for any daughters they might have.

One of the specialist FGM social workers reported that, in her engagement with women who had undergone FGM, they had told her that they would not feel pressured by older generations or anyone else in their communities to arrange FGM for their daughters, and also that, within some communities, such social pressure was not present and people had good knowledge of the law.

These findings support the position that, while being born to a mother who has undergone FGM is treated by social services as a proxy for being 'at risk' of FGM for the purposes of safeguarding, service models and professionals should avoid both working and giving the impression of working on the assumption that women who have undergone FGM are likely to want it for any daughters that they may have. Indeed, one specialist FGM social worker stated that it is, in the overwhelming majority of cases, more appropriate to consider these women as victims who are key to keeping their daughters safe and of whom staff should view themselves as allies. Staff also reported, however, that who holds the power to make choices about FGM varies between families. Often, that power is not held by the mother but by, for example, fathers, fathers' families, aunts or grandmothers. This highlights the importance of the pilot's broader engagement with all members of potentially-affected communities.

Engagement with women who have undergone FGM

Midwifery services

Attendance at the FGM clinic gives women the opportunity to benefit from the support of highly-skilled midwives with specialist expertise in delivering care to women who have undergone FGM. Pregnancy can be a particularly challenging time for women who have undergone FGM, given the specific difficulties that can arise during pregnancy and labour as a consequence of FGM. Midwives provide information and advice to women on the full range of FGM-related health issues. They reported that many women do not know, prior to their attendance at the clinic, that the health problems they have experienced (such as urinary tract infections) are directly related to their FGM. Many women are also unsure of, or do not have the correct information regarding, what type of FGM they have. The midwives can explain the different types and offer to conduct an examination to determine what type they have.

The midwives can also then provide advice on whether the women might benefit from deinfibulation before labour. If an offer of deinfibulation is made and accepted, the

midwives will manage the process, including follow-up after the procedure. The impact of this aspect of the pilot is considerable. Not only are many complications avoided in labour as a result of deinfibulation, but it can also help to reduce urinary tract infections and other complications caused by FGM. Likewise, problems with passing urine can be resolved: one woman reported that she had not passed urine with such ease since she had undergone FGM as a five year old girl. The impact of this on her daily life was extremely positive. Where deinfibulation 'opens up' the vagina, problems with sex can also be reduced or resolved. In particular, while scar tissue remaining after the procedure can still effect the level of sensation, pain and discomfort are often reduced. A number of the women we interviewed spoke about how much easier they found sex after deinfibulation. Staff suggested that, once these physical problems with sex are resolved as far as possible, there may then be the opportunity for women to begin to work on the psychological issues they may have with sex that relate to their FGM. Not least, they may 'start to realise and assert their own sexual needs'.

Reflecting on their learning during the pilot, the midwives emphasised that they are there to support women through their pregnancies and that it is important to demonstrate this clearly to the women who attend the FGM clinics. They have learned that it is much better to begin with general discussions of pregnancy, and to ask about and try to address any concerns the women may have about their pregnancies, before broaching the subject of FGM. This helps to ensure that the women know the midwives are on their side, and to put them at ease before discussion of what is, for many, an extremely sensitive subject. As one specialist FGM midwife said, 'FGM is very, very, very sensitive and quite like a taboo from my experience, so you don't just go straight to the FGM. [...] I give them special attention, special care because they are a victim, so I just make sure they are comfortable, they are fine and the pregnancy is fine. [...] I've done it [discussed FGM] a few times at the beginning, but I've changed that definitely. I want to make sure they are comfortable.'

Social services

The specialist FGM social workers within the clinics conceptualised their roles as involving both safeguarding and provision of support to women who have undergone FGM and their families. In common with the midwives, they reported that general discussions should precede discussions of FGM in order, as far as possible, to put women at ease and ensure discussion is productive. Importantly, they provide a holistic offer of advice and support on, for example, access to services and benefits, not only signposting but also, in some cases, writing letters to professionals in local authority services. For example, housing is a particular issue for many women seen by the clinic (and also for the majority of the women we interviewed) and the specialist FGM social workers are well-placed to aid families in navigating housing services. As we discuss in

more detail below, this supportive work is key to the efficacy of the pilot and demonstrably bolsters, rather than detracting from, prevention work.

With regard to safeguarding, the specialist FGM social workers provide advice to the families on the law around FGM, although they also report that most women who attend the clinic report are already aware of the law. They not only begin the process of assessing whether parents present a risk to their daughters but also – importantly, given their judgement that the overwhelming majority of families seen by the clinic do not support FGM – provide advice on how parents can keep their daughters safe from others. While most families are not judged by clinic staff to want FGM for their daughters, they may still benefit from discussions about how to safeguard their daughters from, for example, family members who are supportive of the practice. As one specialist FGM social worker noted, ‘often it might not be something women want to actively think about, so actually having those conversations sometimes might open up their thinking, just to consider “okay there are things I might need to be wary of” as opposed to just “okay you can have her while I go to the shops”’.

They have found that taking an explicitly supportive and reassuring tone in these conversations has been key to ensuring positive engagement with their services and with the pilot as a whole. They may, for example, emphasise that while they are sure women know all of this information, they have a duty to go through it in detail as part of their commitment to keeping daughters safe.

The specialist FGM social workers are experts at discussing what is, for many, a highly sensitive topic. One of the women interviewed reported that while, after discussions at the clinic, she had tried to talk to her daughters about the subject, she had had real difficulty finding the right words to answer their questions. As a result, the specialist FGM social worker conducted a home visit to talk to the daughters and this was very much appreciated by their mother.

Therapeutic services

The therapeutic element of the model is an important part of the holistic offer that is made to women who attend the FGM clinics. Therapists note that FGM is strongly associated with trauma, and also that women who have undergone FGM are more likely, relative to the general population, to have experienced other forms of trauma (including, for example, trauma related to their experiences as refugees). There has been a fairly low uptake of offers of long-term trauma therapy, but the therapists have also provided more general support or, indeed, crisis support.

For some women, attendance at the FGM clinic is the first time at which they have held sustained discussions about their FGM. As we discuss further below, these discussions have the potential to be re-traumatising. Further, pregnancy itself may represent a

potential crisis point for women who have undergone FGM, who may be particularly worried about labour, or who may find being examined by medical staff while lying on the examination bed distressing inasmuch as they find the experience reminiscent of the process of FGM.

In the Tri-Borough, the offer of psychological support and therapy was originally opt-in. That is, the women were offered the support, but it was not presented as a normal part of the pathway through the clinic. The clinic found (for reasons we discuss in more detail below) that uptake was, as a consequence, lower than it might have been. As part of the pilot, they had the flexibility to change this. They now present a discussion with the therapist as part of the normal pathway through the clinic, from which women may 'opt-out' if they wish. This has resulted in an increase in the number of women seen by the therapist at that site. In Tower Hamlets and Waltham Forest, three-quarters (75%) of women referred for therapeutic support opted to engage with this service.

Community advocacy services

The impact of the community advocates on women involved in the pilot is marked. Indeed, the advocates are a crucial element of the model underpinning the pilot and vital to its practical functioning. They have generally been recruited from grassroots organisations that are situated within, and have strong links among, potentially-affected communities, and are often already known to, and well-liked by, women who attend the clinics. They are viewed as being firmly on their side and are, therefore, trusted. Several of the women we interviewed reported seeing their community advocate as 'a friend'.

All clinic staff reported that the community advocates are key mediators whose work has significantly improved levels of trust between families and services. They telephone women with appointments at the clinic to discuss what to expect, offer to meet the women at or near the hospital to show them to the clinic, and in some cases literally hold their hand through the process of attending the clinic. Where it is needed and possible, they may also provide translation during the clinic. Importantly, they play a crucial role in confirming what the other clinic staff do (which, as we discuss below, is often misunderstood – particularly in the case of the social workers) and addressing any anxieties or concerns women may have about attending. This significantly improves the experience women have of the clinic. In one Borough, staff emphasised that the work of community advocates has significantly reduced missed appointments and thereby helped to ensure that as many as possible of the women who have been referred to the clinic actually attend. As one community advocate explained, 'they feel helped, they feel like someone from the community is there to speak for them'.

The fundamental importance of the role of the health advocates to the functioning of the model was repeatedly emphasised by clinic staff. For example, one specialist FGM social worker explained that, 'the health advocate will liaise with the family to make that

initial appointment, because although they sound like minor issues, they are the ones that can make or break the level of awkwardness, and the way the family are towards the services, because the health advocate has a key role in reducing their anxiety, and just generally explaining what children's services are'. Another specialist FGM social worker made the point that, because some community advocates 'are victims themselves, the message is a lot more powerful when it comes from somebody who's 'been there, done that, wearing the t-shirt''.

The community advocates provide significant emotional and practical support to women throughout the process of attending the clinic and afterwards. They have stayed by women's sides after the clinic, including, for example, at appointments for deinfibulation, where women did not have, or want to ask, anyone else to attend with them. One community advocate described driving to a woman's home to pick her up and take her for her deinfibulation procedure, staying with her throughout the procedure, and driving her home again afterwards. They provide someone to 'understand the women's journey' when, in some cases, no one else will.

In-keeping with the holistic offer of support which is a hallmark of the model, the community advocates also do much to link women in with their communities, introducing them to classes (such as English language classes), and community events and activities. They report that this has been effective in helping some women who had previously been experiencing high levels of social isolation to make friends and become more integrated into community life.

Overall impact

Overall, then, pilot staff and service users reported that the benefits of attending the FGM clinic are considerable: women are given the opportunity to fill in any gaps in their knowledge and understanding of FGM, including about the type they have; related health and mental health issues; illegality; and good safeguarding practices. They may also be offered deinfibulation where appropriate, support to access the services and benefits to which they are entitled, links to community-based classes and activities, and considerable emotional and practical support. It is notable that staff at one of the clinics reported receiving thank you cards and small presents from a number of the women who had attended: these expressions of gratitude reflect extremely well on the quality of the service they provide.

Nonetheless, pilot staff also reported a number of areas of risk, many of which relate to the fact that discussion of FGM with women who may have been avoiding thinking about it for most of their lives can be distressing and traumatic for those women. We discuss these risks and challenges, as well as strategies for overcoming them, in the section below on lessons from the pilot.

Case study

Background

Mrs A reported that her daughter has been subject to an FGM Protection Order for several years. The family's involvement with courts has had a very negative impact on Mrs A's mental health, which she reported is far greater than the negative impact of her own FGM. Mrs A reported that she has no intention of committing FGM, understands how to safeguard her daughter, and is very keen to cooperate with UK authorities. She stated that the inability to go on a family holiday abroad was particularly distressing, not least because she believes that her children are missing out on important life experiences. Mrs A reported being asked the same questions several times by different professionals involved in her case, which has left her feeling misunderstood and distrusted.

The work of the MOPAC FGM Early Intervention Model

As part of the pilot, Mrs A has received ongoing support from one of the specialist FGM social workers, who has helped with accessing services, navigating the legal case, and arranging psychological therapy. Mrs A reports that her engagement with the pilot has made a positive difference to her life, not only because of the practical support she has received, but also because she finally feels that a professional believes her.

Impact of the pilot on potentially-affected communities

There is some evidence that, once conversation about FGM is opened up, people may continue the conversation in other settings. Two of the women we interviewed reported interest in receiving training in order to engage in awareness-raising work among community elders. Another said she would challenge any friends or family members who were supportive of the practice and, if unsuccessful, would lodge a report with Childline, the police, schools, or social services. The community advocates confirmed that they had seen conversations about FGM being carried through from the clinic to the community. As one explained, 'they're going from the clinic and going to their friends and spreading the word, going to the community and telling them FGM is a really bad thing – I've seen pictures, heard stories, this is really bad – so they spread the word, and with the right care they get from here, they take it further, because we never give them a negative experience'.

As part of the pilot, staff have also engaged in a great deal of work with members of potentially-affected communities who have not been seen at the clinic, including organising and delivering workshops and events to discuss FGM and related issues, and

to raise awareness of, and garner support for, their work. Within some communities, the subject of FGM is widely considered taboo, and pilot staff have emphasised that beginning these conversations with all members of potentially-affected communities in a sensitive and respectful way is crucial to raising awareness and improving understanding of the topic. In particular, raising awareness of the associated negative health and mental health complications, and also of how to tackle support for FGM among peers, is vital to prevention efforts. Such events also help to raise awareness of the FGM clinic itself and may go some way to normalising the idea that women who have undergone FGM may benefit from the support it offers.

Moreover, the very beneficial impact of engagement with potentially-affected communities on the pilot itself should not be overlooked. This engagement has afforded pilot staff opportunities to learn how to improve the service they offer. Staff have taken these opportunities to listen to, and learn from, the diverse views expressed on FGM, the FGM clinic, mental health services, and so on. Some have also attended cultural events organised by community organisations to enable them to learn more about the cultural backgrounds of the women and families they are committed to supporting. Pilot staff report that this two-way engagement has not only enabled them to ensure their services are well-suited to meeting local needs, but has been interpreted by many members of potentially-affected communities as a much-appreciated 'demonstration of good faith'.

The evaluation team conducted semi-structured observations of a number of these events and found them to be often well-attended and largely well-received, not least due to the sensitivity and respect with which staff have approached them. The male workers reported that outreach work with men from potentially-affected communities was often challenging, especially where the topic of FGM is regarded as taboo. As one male worker commented, 'trying to engage men in FGM work is a very gritty job, there is no glamour... We are approaching men who have never talked about FGM all their life'. It should therefore be considered a significant achievement that the workshops and events organised by the male workers, and held by the time of reporting, were well-attended and drew commitments from participants for continued participation in FGM-prevention efforts. In Tower Hamlets and Waltham Forest, the number of attendees exceeded expectations: 15 men and 13 men respectively. Further events to engage men from potentially-affected communities are currently being planned.

Impact of the pilot on services and professionals

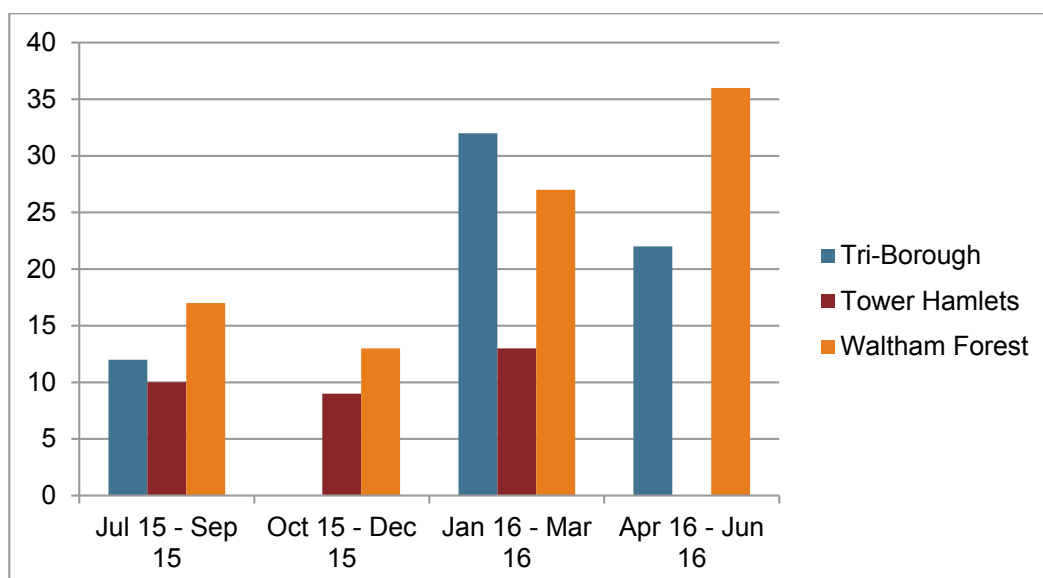
The pilot has had a number of positive impacts on the services offered to women who have undergone FGM and the practice of professionals in contact with cases of FGM, reported across a range of respondents.

Pilot staff have organised and delivered training to hundreds of professionals to improve understanding of FGM and of how to work with people affected by it. Health and education professionals (including midwives, GPs, and teachers) have received training on identification and referral of cases of FGM, while social workers have received training on how to conduct direct work with families affected by FGM and, in particular, how to approach home visits and complete FGM risk assessments.

The FGM clinic model of co-working between highly skilled social workers, therapists, community advocates and midwives has enabled these professionals to better understand each other’s roles, and all clinic staff report very strong working relationships with each other. At the start of the pilot, some staff had misconceptions regarding each other’s roles (and, in particular, felt a degree of suspicion and mistrust toward social workers). However, staff generally report that their relationships are now characterised by mutual respect and admiration. Moreover, while the priorities of different professionals were, at the start of the pilot, viewed by some staff as being in tension with each other, they are now largely seen as complementary elements of an effective holistic service. We discuss more of the challenges faced by and enablers of this multi-agency, holistic approach in more detail in the section on lessons from the pilot.

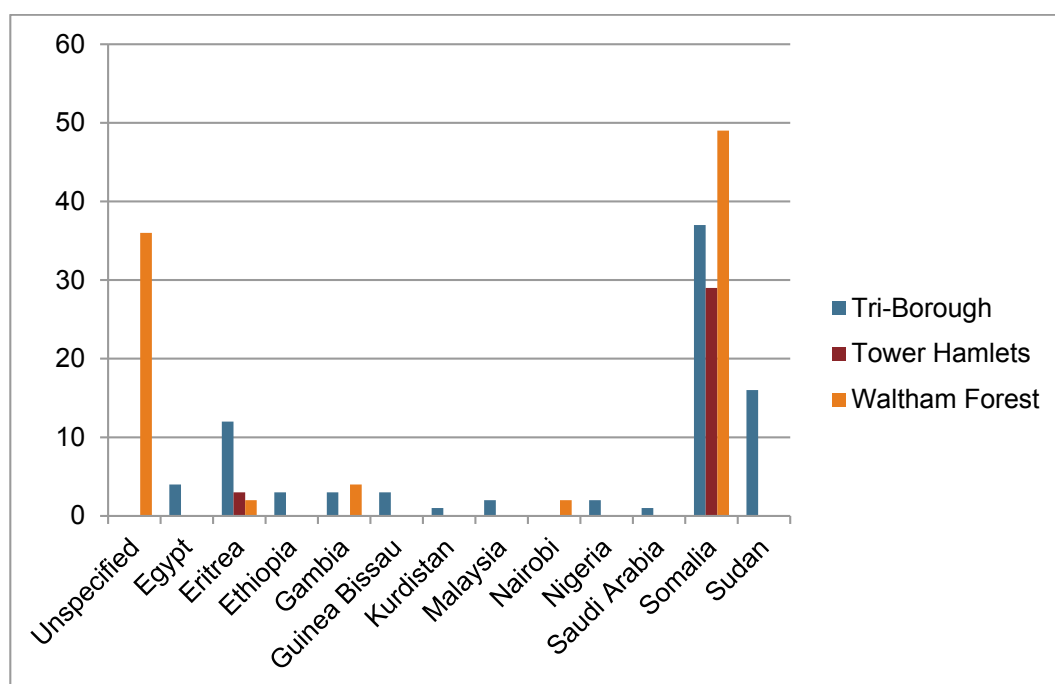
The numbers of referrals to each of the FGM clinics per quarter is indicated in Figure 3 below. No data was available on referrals to the Tri-Borough from October to December 2015, and a further 21 referrals in that area were not dated. Further, no data was available on referrals to the Tower Hamlets FGM clinic from April to June 2016. However, the chart does show an increase in the number of referrals to the FGM clinic during the pilot, which clinic staff reported was likely to be due to the training they had delivered to professionals regarding identification of cases and referral to the clinic.

Figure 3: Referrals to FGM clinics, by quarter



The countries of origin of the women referred to the FGM clinics is given in Figure 4 below. It is notable that the vast majority of the women seen within the clinics were originally from Somalia, although the Tri-Borough clinic has seen women who originally came from a far wider range of countries than both of the other sites. It was beyond the scope of this evaluation to determine whether these data simply reflect local demographics or, rather, the popular misconception that FGM is largely ‘a Somali issue’ and a lack of understanding about the practice of FGM in other communities, which may result in referring professionals identifying fewer cases among women who originate from other countries.

Figure 4: Referrals to FGM clinics, by country of origin



Lessons from the pilot

A number of important lessons have been learned throughout the MOPAC FGM EIM pilot, which may bring significant benefit to the design and delivery of any future FGM-focused intervention. In particular, there are several areas of challenge and risk that require appropriate responses in order to avoid or overcome them. These issues have been grouped into 5 central areas: professional practice, social services, mental health, community engagement, and holistic multi-agency working with community organisations.

Professional practice

First, a lack of understanding and inappropriate practice on the part of professionals in contact with cases of FGM risks creating highly counterproductive effects.

Staff reported that, too often, too much focus is placed on one or two groups among which the prevalence of FGM is relatively high, but which certainly do not exhaust the groups within which prevalence is relatively high. In particular, they warned against viewing or treating Somalis and Muslims as the main or sole focus of intervention efforts.

Some professionals involved in the pilot reported that, at first, and even despite their relatively high level of awareness of issues related to FGM, they associated FGM with these groups. On reflection, however, they noted that the danger of professionals holding these associations in their minds is that people who are not in these groups may be overlooked by services. Further, where certain groups are highlighted and engagement efforts concentrated on them, people who are not in these groups may think the services on offer are not for them. There is also the risk that people from these communities may feel, as a result of the focus on them, that they are being unfairly targeted, labelled, or stigmatised. This risk was a major concern for many clinic staff. As one specialist FGM social worker noted, 'you don't want to stigmatise, or you don't want to sort of pick on certain people just because of where they come from'. One of the community advocates also emphasised that 'this community is already stigmatised. [...] They don't want to be targetted'.

Services and professionals should, then, be aware that FGM is not solely 'a Somali issue' or 'a Muslim issue'. The picture of FGM prevalence is far more complex than this and FGM services should, consequently, take care to ensure they present themselves as existing for the benefit of all who are affected by FGM. Several pilot staff noted that providing high quality training to professionals in contact with cases of FGM is crucial to avoiding this potential pitfall.

That said, other pilot staff reported that it was important to retain a strong focus on the communities within which high prevalence of FGM has been identified, particularly where these communities have a relatively large presence within the area. These pilot staff felt it important to ensure that planning and delivery of support and prevention efforts reflect the cultures and practices of local service users. They emphasised that intervention work should retain its focus on communities within which high prevalence of FGM has been identified, while also expanding the reach of services to a wider range of potentially-affected communities. They recommended that mapping exercises should be conducted during the planning stage of service development and that co-construction of services with the communities that access them should be retained and strengthened in order to ensure services are welcoming and appropriately tailored to local needs.

Several staff reported that there is a real need for a unified message on FGM. It should be discussed at all levels – by government, local services, the media, and so on – and presented in training sessions delivered to professionals as an issue of violence against women and girls, a form of abuse, a crime, and a safeguarding issue. Situating FGM within the context of religious or cultural tradition was seen by these staff as counterproductive. In particular, they expressed concerns that relevant professionals who view FGM in terms of religious or cultural tradition rather than criminal violence may be more likely to feel that there exists a right to continue with the practice that should be respected, and that efforts to prevent FGM are necessarily racist. They may, as a consequence, be less likely to make appropriate referrals.

Some of the most severe risks to the achievement of the aims of the pilot are those resulting from insensitive and overly heavy-handed approaches to working with people affected by FGM. Staff reported a number of instances of inappropriate and counterproductive practice. These included the original wording of the letter sent to women to invite them to the clinic. This emphasised very bluntly that attendance was mandatory and failure to attend would result in a referral to social services. Staff noted that this was, quite understandably, interpreted by several families as threatening and disrespectful. Better means were available through which to inform women of the consequences of their referral, including, for example, conversations with the community advocates. The letter has since been amended to improve its tone.

Another example of inappropriate practice identified by staff involved a home visit conducted by a children's services social worker to complete a risk assessment. The social worker asked several questions intended to identify the nature and level of the family's religious commitments, without first seeking to confirm whether the family believed FGM was related to or mandated by their religion. Community advocates fed back to clinic staff that the family had told them they had found the experience distressing, and the specialist FGM social worker delivered further training to ensure better practice in future. As the specialist FGM social worker explained, 'it was a clumsy way of asking the questions, it did raise a lot of anxiety within the family, they felt that they were being stigmatised, so I've taken that feedback from the community advocate and now when I'm training social workers I do give examples of how you can ask the question, to get the information you need to get, but in a way so that the family don't feel targeted'.

All staff interviewed noted that every single encounter has a very important effect on future engagement with services. As one community advocate emphasised, one negative experience can 'spread like wildfire' through a tight-knit community, increasing feelings of being targeted, labelled, stigmatised, misunderstood, treated unfairly, or inconvenienced without justification. One specialist FGM social worker reiterated this point, stating that 'a lot of families do get a service they're happy with, but that's not really discussed in the

community a lot, because it's a sensitive topic, but then the families who have had a bad experience, unfortunately, word spreads much quicker of those experiences'. Clearly, this risks discouraging people from engaging with services and thereby diminishing the capability of services to deliver effective support and safeguarding work. Further, the risk that people from potentially-affected communities may, as a result of intervention, feel alienated from their local authorities is of particular concern in the present context, given current threats to social and race relations in the UK and the recent sharp increase (particularly in London) of racist incidents experienced by migrants. Finally, such incidents of inappropriate practice threaten the entire model of the project.

Representatives from one community organisation, from which some of the community advocates are drawn, stated that, 'if the kind of engagement driven by statutory services creates barriers rather than dismantles them, and government victimises communities or does not listen to grassroots organisations, [we] will stop running FGM projects' in conjunction with local services. They also, however, emphasised that this would be a last resort. They stated a strong commitment to working with services to resolve issues in order to provide the best possible service, and noted their belief that, overall, the pilot works well.

The lesson here is that all staff in contact with cases of FGM – from receptionists and administrative staff to medics and social workers – should receive training to ensure that they have an appropriate level of understanding of FGM and also an appreciation of the imperative to be sensitive and respectful and to avoid heavy-handedness in their direct work. Further, key positions at the FGM clinic should be filled by the right people: people who genuinely care and are willing to go the extra mile to build constructive relationships with service users and ensure all colleagues are on board.

Social services

A number of quite serious challenges relate to the role of social services in the pilot. It was repeatedly emphasised by staff that the women and families they engage, and members of potentially-affected communities more generally, very often associate social services with the removal of children from families. They noted that a social worker being based directly in the clinic can be a real source of anxiety and risks putting people off engagement if the right approach is not followed. As one midwife explained, 'people think of social workers, they think 'oh my god, I'm in trouble', they think 'they're going to take my baby away''.

A number of FGM clinic staff reported that women who are pregnant with their first child tend to be 'easier to engage' for the specialist FGM social workers – and for other clinic staff, too – than women who already have a child or children. It was speculated that this may be because, having no prior experience of pregnancy, they have less confidence than women who have gone through the process before and are therefore more willing to

accept support, 'even from social services'. In contrast, women who have a child or children may be less likely to feel the need for support and more likely to have concerns around the involvement of social services, particularly if they believe social workers' central focus is the removal of children.

Several factors were found to be key in addressing this risk of disengagement due to suspicion or anxiety about the involvement in the clinic of social services. First, the role of trusted community advocates in reassuring families that the role of the specialist FGM social worker is largely to support families rather than remove children was crucial to successful engagement. As one specialist FGM social worker stated, 'there are a lot of misconceptions about social workers, but because the woman actually sees you with the advocate and she's from the community, I think that goes a long way to helping them realise that she's not here to take your children away'.

Additionally, the sensitive, woman-centred, reflexive approach of the specialist FGM social workers themselves was vital to success. They found that focusing on supporting parents to keep their children safe tended to work well if, and because, they took care not to seem as though they judged the parents incapable of safeguarding. When a home visit by a children's services social worker is required in order to complete a risk assessment, the specialist FGM social workers take care to discuss the case with them and, if necessary, will conduct the visit jointly. With regard to the timing of the visit, at one site at the start of the pilot, visits would be booked without consultation with families to determine when would be most convenient. On reflection, however, staff felt that it was better to offer families, and particularly families where a woman is pregnant, a degree of choice over when the visit happens, from as soon as possible to up to 3 months after the birth of the child.

As mentioned above, community advocates have also played a crucial role in helping to improve social work practice throughout the duration of the pilot. They have followed up with women and families, often via a telephone call, to find out about their experiences with social services both in the clinic and during home visits. They have then provided relevant feedback to the specialist FGM social workers. All of the specialist FGM social workers reported that this feedback has been extremely valuable because it has enabled them to identify and address problems, weaknesses and mistakes, not only in their own practice but also, on several occasions, in the practice of local authority social workers conducting risk assessments in women's homes.

The offer of holistic support was also reported by the specialist FGM social workers to be of benefit to families' experiences of the clinic and their level of engagement. They noted that the offer of signposting to, and advocacy within, other services (such as housing and mental health services) had a fairly good uptake, and functioned to reassure women that the role of the social worker is not limited to removing children. Providing this more rounded service helped to develop good relations and led to more open, productive

conversations about FGM. One specialist FGM social worker emphasised that, if this broader package of support were not offered, many families might reasonably feel that they were getting nothing positive from their engagement with the social worker, particularly where the families had no intention of arranging FGM for any daughters and did not feel their daughters are at any risk. The offer of holistic support should not, therefore, be considered as diluting safeguarding work but, rather, as reinforcing it by helping to build good, open and honest relationships between social services and families. As the specialist FGM social worker stated, ‘the support always comes back around to safeguarding’.

Interviews with midwives and community advocates found that many of these professionals also often began the pilot with an attitude of suspicion and distrust toward social workers, and a view of their role as being centrally focussed on the removal of children. One community advocate reported that she had been quite seriously concerned about the potential negative consequences of being associated with social workers in the minds of members of her community. One of the specialist FGM midwives reported that she and her colleagues in midwifery had been extremely concerned at the start of the pilot that social workers would not have the skill and sensitivity required to work effectively with members of potentially-affected communities. They therefore worried that there might be a tension between their duty to care for their patients and the requirement to report cases to social services.

Clinic staff reported that joint working at the clinic has worked extremely well to allay these concerns, largely because the specialist FGM social workers have highly developed specialist skills and knowledge, and do take the kind of sensitive, reflexive, woman-centred approach that is so necessary to successful engagement. Joint working has enabled other clinic staff to recognise their genuinely caring approach and strong commitment to the wellbeing of everyone affected by the pilot. Community advocates have then been able to spread the word among their communities, while the specialist FGM midwives have spread the word among midwifery services, including through mandatory training.

Describing her change in attitude toward social services, one community advocate stated that, ‘I feel that our team here is a very good team, because we built a very good relationship together, so it’s going very smoothly. Everyone knows what their part is, so it’s going very good. In the beginning, I hesitated because I didn’t want my community to relate me or to link me with social services, because there is a social services phobia. In the beginning, I was afraid. Now, I go everywhere and speak about what social services do, and they have lots of services to offer to the communities and lots of help. So now, I feel more confident to [work] with social services.’ One (previously concerned) specialist FGM midwife echoed this sentiment, noting that ‘the social worker who is working with us just does go above and beyond, honestly, so it just works very well. [...] I give midwife

mandatory training once a month, so I talk about this project [and] the midwives see how it works very well’.

Some specialist FGM social workers also reported that they faced their own challenges, quite apart from those connected with their reputation among others. For example, they have had to adapt to the change from directional social work to more supportive, informal social work practice, which has required them to develop specialist skills. Some have also engaged in community outreach or delivered training to colleagues and professionals from other services, including presenting to large numbers of people for the first time. These new forms of work have generally been viewed positively, as an opportunity to broaden skills and further professional development.

Mental health

The pilot has faced a number of challenges around mental health. First, the process of dealing with cases of FGM can at times be difficult for staff themselves. They have benefitted from discussing problems with and receiving support from their colleagues, and also from clinical supervision. At one site, the therapist offers informal therapeutic support to the other clinic staff, which they reported has been of value to them.

Second, many staff reported that there is significant stigma attached to mental health among many members of potentially-affected communities, including among women attending the clinic. Women may feel that any psychological issues should be dealt with by themselves or kept as a private matter within their families. Staff reported concerns that this stigma may be resulting in a low uptake of support and therapy (including trauma therapy) when, with a more favourable attitude toward it, therapy might well be of significant benefit to many women who have undergone FGM.

These attitudes are not uncommon throughout society and, as such, the therapists suggested that much more work is needed to normalise mental health issues and therapy generally. They noted that this will take time and therefore requires a long-term commitment, and also that such work should be sensitive to the different strategies that may be effective among different people (including members of potentially-affected communities), given the diversity of reasons for rejecting therapy. Clinic staff also reported that the work of the community advocates is key to normalising and legitimising mental health services among women who attend the clinic. As one community advocated explained, ‘some of the women, they just keep it in their mind, they don’t want to discuss it, they just try to deal with it by keeping it there in the back of their head. So bringing it into a conversation is a bit difficult, but when they feel that you are coming from the same background, you might understand how they feel, what they went through, then they will try to come to a conversation’.

A third, very significant challenge around mental health is that the process of engagement with the pilot risks re-traumatising women who have undergone FGM. Staff at the FGM clinics expressed concerns that they may at times be dragging up a past that some women feel is best forgotten. Again, they reported that a highly sensitive, caring, woman-centred approach is central to minimising this risk. The holistic package of support offered by the pilot may also help to ensure women feel that they do get something from engagement, rather than that they have simply been required to do things they would really rather not do. Staff also mentioned, however, that while they often emphasise the potential benefits of mental health support, any choice not to take up an offer of support should be respected. Describing one of her cases, one of the specialist social workers noted, 'when I said 'would you like some counselling?', she said 'no, I would prefer to just not talk about it', and I think we have to recognise that these are adults who make choices and if she chooses not to talk about it [that's fine]'. Alternatively, where trauma therapy is sought, therapists emphasised the importance of committing to a long-term approach. As one therapist stated, 'if you open up a woman to years of trauma, I say you feel worse before you feel better; you need time to check coping strategies are working and, if not, why not'. That particular therapist has committed to carrying on her work with one woman after the pilot ends, in recognition of the long-term need.

Community engagement

The involvement of community advocates from similar backgrounds to the families with which they engage has been of enormous value to the pilot. All staff agreed that the community advocates are an essential element of the model. Nonetheless, some clinic staff reported that more thinking is required about how to work effectively with people who do not share a religion or language with any clinic staff. Generally, these staff felt that community advocates could, with appropriate training, develop the skills and confidence necessary to engage with a broader range of people.

Relatedly, some staff commented that communities which are less commonly associated with the practice of FGM do often have community organisations, even if they are less visible to services because there is no history of joint working or collaboration. It was suggested that embassies may be well-placed to point services in the direction of these groups. One member of staff stated her belief that, rather than thinking of communities as 'hard to reach', professionals should instead question how they can change systems and practice to make services more accessible.

Work with men and boys from potentially-affected communities is key to prevention, not least because the choice to arrange FGM for girls may be taken or driven by men. Further, where FGM is viewed as part of the preparation that must be undertaken before marriage, men have a role to play in dispelling that perception. One community group

has found that attempts to engage men and women simultaneously in discussion around FGM is often unsuccessful, given sensitivities about gender, and that separate sessions for men and women are more likely to have a constructive impact.

It was reported by some staff that powerful voices within communities are often very well placed to spread the word about the work of the clinic and to encourage changes in attitudes toward FGM. Religious leaders, for example, may be best placed to convince people that FGM is condemned, rather than mandated, by religion. Nonetheless, it is important that powerful figures are not assumed to speak for an entire community and particularly not for those who hold the least power within communities.

Holistic, multi-agency working with community organisations

The model followed by the pilot of holistic multi-agency working with community organisations is well-suited to achieving the aims of providing support to those affected by FGM and safeguarding those at risk. It does, however, present various challenges that pilot staff have had to work to overcome.

Firstly, when different agencies begin working together, there is the potential for tension to arise between them. Staff reported that such tension was present at the start of the pilot. As mentioned above, health and community staff were in many ways sceptical about the involvement of social services in the model. There was also a perception of tension between the priorities and approaches of the different professionals, and particularly between what was seen as the traditionally woman-centred support work of midwives and community advocates on the one hand, and the traditionally child-centred preventative work of social workers on the other. One project lead also reported having originally perceived some tension between the joint-working aspect of the model (in particular, multi-agency professionals jointly deciding how best to respond to local circumstances), and the need for agencies to lead on how their own services were organised and presented.

Staff commented that these issues were largely resolved over time as they got to know each other's roles and skills. Because the professionals involved are highly skilled and committed to promoting good outcomes for everyone involved with the pilot, tensions diminished as they became more familiar with each other's work. The priorities of the different professionals were recognised as complementary elements of a holistic, effective service. One professional, who reported having felt scepticism toward the project in its initial stages, described her colleagues as 'a dream team'. Core group and wrap-around team meetings (during which staff discuss cases to share learning, resolve issues, and formulate care plans) were particularly valued by staff as means of fostering positive collaboration and engendering trust between the various services involved. As one specialist FGM social worker stated, 'we share and learn a lot from each other' during these meetings.

A number of staff reported that community organisations hold a special place in the model, in the sense that they need to work with, but be demonstrably separate from, local authorities and statutory services. This distinction is key to maintaining their ability to broker trust between services and service users. As one community advocate stated, there is a 'delicate balance to be struck between integration and boundaries'. The pilot's model was considered to strike that balance well.

Multi-agency working has also operated between MOPAC, the participating local authorities, and the frontline staff delivering the pilot. This has brought together MOPAC's expertise in regional and national policy, strategic oversight and project management; local authorities' expertise in local policy and services; and frontline staff's expertise in specialist practice and building community links. Some pilot staff noted that it took time to build strong, collaborative working relationships between MOPAC and the Boroughs. However, it was also felt that significant benefits resulting from MOPAC's exercise of strategic management and coordination were evident, particularly in the practitioners' forums. During these regular meetings, the specialist FGM social workers, community advocates and male workers from all pilot sites come together to share best practice, address concerns, challenge perspectives, and develop plans for future collaboration. All forum attendees found them to be highly valuable, particularly as an opportunity for peer learning and support. It was reported by one of the pilot staff in a local authority that, in order to function as well as possible, the model required a dedicated local authority project manager to be leading from the start. This was felt necessary to enable the project to navigate, motivate, and make the best use of pre-existing local services.

A second risk with multi-agency working concerns how services are delivered. The specialist FGM social workers in particular emphasised the need to avoid asking women the same questions over and over again. As we have seen, FGM is often a highly sensitive topic for women who have undergone it. Any discussions should therefore be approached with extreme sensitivity and concern for women's psychological wellbeing, including concern to minimise any resulting distress or harm as far as possible. Moreover, of course, when women are repeatedly asked the same questions, they may become reasonably frustrated and less likely to engage with a system they view as either disorganised or distrustful.

The process of engagement requires refinement to ensure it does not unnecessarily repeat work in this way. Staff reported that protocols, tools and training are required to ensure that every professional in contact with cases of FGM understands their role and, importantly, what is outside of the scope of their role – in other words, what they should not ask. It was suggested that referral processes should be kept as simple as possible (for example, an email to the right person) rather than requiring professionals making referrals to ask women detailed questions about their FGM that would be better coming from FGM clinic staff with community advocates there to provide support. Staff also

reported a need for better systems to record what conversations have already been had, and to enable those records to be viewed by relevant professionals in order that they can avoid going over the same ground unnecessarily.

For example, describing a recently completed home visit, one of the specialist FGM social workers reported that, 'the lady was really angry. She said 'it just seems like you're asking me the same questions about something that happened to me when I was a child, and I've been made to talk about it again and again'. So I think listening to those kind of opinions, you have to then come away thinking 'actually, what do we need to do to make sure these ladies are not asked the same question again and again'. So one of the things I need to recognise is having better working relationships maybe with health, and if you recognise a woman as an FGM victim, it's about saying 'let's not ask that question again', but having a record on our files, so they're not having to repeat themselves again and again. I mean this lady seemed like she was really fed up of talking about it'.

Generally, however, clinic staff all reported that the pilot had achieved significant success in meeting its aims. It was described as having set in place the foundations of a highly valuable, highly effective service. Throughout the process, obstacles have been encountered and work has been done locally to overcome them. Systems have been smoothed out. All staff very much believed that the model should be continued. As one member of staff commented, 'setting all the foundations down will take the duration of the pilot, but if it is not extended you won't really get to see the benefit of the full, finished model in motion'.

5. Limitations of the evaluation and future evaluation

The methodological approach was well-suited to the task of evaluating the MOPAC FGM EIM pilot. In particular, the one-to-one, in-depth interviews conducted with women who have undergone FGM, pilot staff and relevant stakeholders revealed rich insights into how the pilot had worked in practice and how effective it had been in achieving its aims, as well as identifying several important barriers to and enablers of success.

One limitation of the evaluation is that it cannot provide an accurate measurement or estimate of the impact of the pilot on overall prevalence of FGM, or the number of cases of FGM that were, or will be, prevented (if any) due to the work of the pilot. Given the difficulties of measuring actual prevalence of FGM in English local authorities, prevalence rates have only ever been estimated. But estimates (such as those canvassed in the section on local context on pages 14 to 15) are not predicated on longitudinal methods and do not factor in the work of the pilot, so cannot provide a reliable picture of any changes from the pilot's baseline to the time of reporting. Our evaluation does indicate an increase in recorded numbers of identified cases referred to the FGM clinics and to safeguarding services in each site (see figure 3). This increase should not be interpreted as indicating any increase in prevalence but, rather, as evidence of the efficacy of the model in improving identification and referral practices among professionals. This (along with our other findings) supports the judgement that, if the model is continued in accordance with our recommendations, the prevention element is likely to be effective. But the success of prevention work will only translate into a decrease in prevalence years down the line, as the girls who have been affected by early intervention work grow up without undergoing FGM. Any reliable judgement of how many cases of FGM are prevented would require to be supported by research involving longitudinal tracking and experimental methods (perhaps using a control group) to support a counterfactual analysis.

Similarly, the evaluation cannot provide an accurate measurement or estimate of changes to levels of approval and disapproval of FGM among members of potentially-affected communities resulting from the pilot. The sample of people from potentially-affected communities interviewed by the evaluation team was not representative and, while the evaluation did produce a number of insights into attitudes toward FGM, no participants reported ever having supported the practice of FGM. Ultimately, the choice to arrange for a daughter or granddaughter to undergo FGM is informed and motivated by a range of often interrelated factors, including social norms and values. Changing these motivational factors will take time, and effective monitoring of any changes will likewise require a longitudinal approach.

Ensuring that the model followed by public services helps to engender, rather than militate against, positive and sustainable attitudinal change among those who support FGM is a complex, long-term task that requires a strategy for genuine persuasion. In the

absence of longitudinal data, the evaluation team remains confident that the MOPAC FGM EIM demonstrates an understanding of what delivery of that strategy requires: a commitment to woman- and child-centred practice, sensitivity, reflexivity, and effective engagement with members of potentially-affected communities. Our qualitative analysis provides good reason to judge that, if the approach is continued (and expanded) in accordance with our recommendations, it will contribute to long-term decreases in support for, and prevalence of, FGM, as well as resulting in better outcomes for those who have undergone, or are at genuine risk of, FGM.

Furthermore, collated training evaluation data from the organisation FORWARD (which was sub-contracted to deliver outreach work with men in Tower Hamlets and Waltham Forest) does suggest some change in reported attitudes to FGM held by men attending their events and workshops. FORWARD report a reduction in levels of approval of FGM among the men they have engaged.

Nonetheless, given the complex, subjective nature and generally (at least among large groups) slow pace of attitudinal and normative change, the evaluation team recommends that in-depth, longitudinal, qualitative research should be undertaken with members of affected communities to deepen understanding of what works in changing people's minds on FGM and why. We emphasise, however, that our recommendation of sensitive and reflexive practice extends to researchers. Any research must be undertaken with the highest degree of sensitivity, and informed by recognition of the difficulties many face in discussing the subject and the ethical imperative to avoid creating counterproductive research effects.

6. Implications and recommendations for policy and practice

On the basis of the findings outlined above, it is the conclusion of the evaluation team that the MOPAC FGM EIM has shown significant success in achieving its aims and, therefore, considerable promise as a model for preventing new cases and providing support to victims of FGM in areas of relatively high prevalence. The local systems necessary to continue the work of the model have been set up and refined within each of the pilot sites and, with appropriate funding, would be well-placed to continue to deliver effective prevention and support work. Our key recommendations for policy and practice are summarised below:

- The FGM EIM should be continued within the 3 pilot sites and expanded to other areas of relatively high prevalence of FGM.
- The flexibility of the model should be retained in order to enable staff to tailor services to local needs.
- Key roles, including within FGM clinics, should be filled by professionals who take a reflexive, sensitive, woman-centred approach to their work, in order to facilitate multi-agency working and effective service engagement.
- Community engagement and co-construction of services with members of potentially-affected communities should continue to be undertaken to support effective service engagement and wider attitudinal change.
- Community engagement activities should seek to involve as broad a range of members of potentially-affected communities as possible, including men and boys. Likewise, new links with relevant community organisations that do not have a history of collaboration with services should be fostered.
- Embedded community advocates should remain demonstrably separate from local authorities and statutory services in order to maintain their ability to broker trust between services and service users.
- Every professional in contact with cases of FGM should receive training to ensure an appropriate level of understanding about FGM and related services. Training should be designed to ensure clarity regarding roles and duties, including identification, referral, and what not to discuss with service users; appreciation of the range of diverse groups within which FGM has relatively high rates of prevalence; understanding of the situation of FGM within the context of criminal violence against women and girls; and recognition of the need for sensitivity in direct work to avoid re-traumatising or alienating women who have undergone FGM, and other members of potentially-affected communities.

Appendix 1. Literature review

This literature review serves a number of purposes for the larger aim of evaluating the MOPAC FGM Pilot: to identify potential ‘must haves’ and ‘should haves’ in developing a new approach to enable professionals to respond to FGM cases efficiently and effectively and make a difference to victims and communities, and flag approaches or behaviours that should be avoided in working with FGM victims.

Availability of evidence and link to the MOPAC FGM EIM

A wide-ranging online search was conducted to draw together existing peer-reviewed literature related to work with FGM victims. This was conducted using Google Scholar and university library databases, with a focus on academic publications focused on, for instance, social care, women’s health, social justice and feminism. Search terms used included ‘FGM/Female Genital Mutilation’, ‘FGM victims’, ‘barriers to tackling/addressing FGM’, ‘FGM prevention with girls’, ‘FGM and working with victims/communities’, ‘FGM and multi-agency working’. ‘FGC/Female Genital Cutting’ was also entered as a search term in order to widen the spread of available evidence, to reflect the debate in literature and practice about the use of language and the asserted merits of using ‘cutting’ in preference to ‘mutilation’, and vice versa. These searches produced literature in peer-reviewed journals exploring medical aspects of FGM (with a focus on reproductive health); socio-cultural aspects of FGM, including prevalence in the UK; types of FGM; motives for the practice and its consequence; the development and implementation of preventative measures from the standpoint of different agencies (the majority being within a clinical setting); how to care for and engage with women who have experienced FGM; the role and impact of legislation and criminalisation; and considering FGM within a human rights and/or violence against women framework.

The searches focused on evidence of interventions, clinical or cultural practice in a UK, European or comparable country context (for instance, Australia), to uncover evidence of best practice, successful interventions, and so on. This generated a number of peer-reviewed pieces concerned with either improving clinical outcomes, or focused on working with potentially-affected communities in FGM-practising countries. However, there is relatively little empirical research to draw upon (see EIGE, 2013). A wider search encompassing grey literature provided further evidence of recent intervention measures in the UK – including advocacy of community-wide work, but little was found which explored targeted work with mothers who had been cut to reduce the risk to their daughters.

The MOPAC project addresses a gap in knowledge and practice. It works with mothers and with communities more widely, in a multi-agency and collaborative manner, both to

support women who have been cut through a victim-centred approach and to prevent girls from undergoing the practice.

Summary

To summarise, the literature review highlighted the following issues of relevance to the MOPAC FGM EIM:

- Effective and meaningful engagement with key stakeholders is vital to prevention efforts. These stakeholders include community and grassroots groups, men from potentially-affected communities, religious leaders, and other relevant professionals such as teachers who have regular and ongoing contact with young people.
- Cultural sensitivity should be at the forefront of engagement with women and girls. Recognising regional and cultural diversity in FGM practice means that approaches should be tailored to particular communities in a culturally informed way, and practitioners should be alert to the need for sensitive use of language.
- Specialised services which implement a gender-sensitive, victim-centred approach are well-placed to meet the specific needs of women and girls who have undergone or are affected by FGM.
- Health, social care and other relevant professionals are key to identifying girls at risk of FGM, reporting concerns, initiating protective measures, and ensuring appropriate care and support if FGM has already been performed.
- Multi-agency working and collaboration is crucial to identifying local needs and suitable prevention strategies. This requires effective information sharing and trust between agencies.
- Pregnancy is often the first or only point at which women who have undergone FGM come into contact with services. Maternity services therefore play a pivotal role in identifying and recording FGM cases, as well as in prevention and protection.
- Social services provide a point of contact and disclosure for women and girls who are affected by FGM. Practitioners should therefore have strong knowledge of FGM and prevention tools, and a culturally informed and sensitive engagement approach.

Terminology and national context

The definition set by the World Health Organisation (WHO) is used widely in peer-reviewed literature, grey literature and by specialist organisations. It defines FGM as ‘all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons’, and sets out 4 classifications:

- Clitoridectomy (Type I): partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris);
- Excision (Type II): partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are “the lips” that surround the vagina);
- Infibulation (Type III): 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;
- Other (Type IV): all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area (WHO, 2014).

There is debate in the literature about the most appropriate or culturally competent (Baillot *et al*, 2014: 37) terminology to use in relation to the practice. Dustin and Davies (2007: 4) note that female genital mutilation came to replace ‘female circumcision’ as a term which could convey the damage done to women. The authors, however, advocate the term ‘female genital cutting’, arguing that FGM, ‘was intended to be a pejorative to convey the meaning that girls are physically mutilated in the practice. This can cause offence in the cultures where it is practised. Although the degree of cutting varies in different traditional practices, the term FGC is a more neutral, non-blaming term, which still graphically represents the injuries that girls suffer’. Similarly, Boyle (2005: 25) argues that whilst the term FGM is widely used by international actors such as the WHO, some African feminists and scholars have criticised the term for its ethnocentricity. Boyle favours FGC as a so-called non-politicised description of the practice.

While this debate raises some important considerations about sensitive and culturally competent interaction with women who have undergone the practice (which will be explored in greater detail below), this review refers to FGM in acknowledgment of the severity of harm to women and girls, and in accordance with the approach of intergovernmental institutions, statutory agencies, and specialist UK organisations such as FORWARD UK, IKWRO (Iranian and Kurdish Women’s Rights Organisation) and Asylum Aid.

Experts have recommended using the term ‘potentially-affected’ rather than ‘practising’ in a UK context, noting that work with communities from practising countries points to FGM as a ‘tradition in transition’ (Berg and Denison, 2013). Evidence suggests a process of gradual abandonment which should be recognised in engagement and research: ‘As long as we cannot see and acknowledge attitude change among immigrants, as long as we expect that the girls of every family from an FGM-practising country are at risk [...] we will act in a less than professional way’ (Johnsdotter, 2009: 11).

Engagement with girls and women from FGM-practising countries

Reflecting a similar trend in other Western nations, the UK has seen increased numbers of women migrating from FGM-practising countries. The UN High Commissioner for Refugees reports that around 20,000 women and girls seek asylum from FGM-practising countries of origin in the EU every year, with 2,410 women seeking asylum in the UK in 2011. More than 20% of women seeking asylum in the UK from 2008-2011 were from FGM-practising countries (UNHCR, 2013).

However, it is important to note that these figures represent regional and cultural variety in the types of FGM practised, bringing differences in short- and long-term consequences for women (Monahan, 2007: 24). Scholars and expert practitioners, therefore, stress the need for health care providers and others coming into contact with girls and women to receive training in order to respond effectively to such differences in the practice, including in the provision of appropriate clinical procedures, and to ensure cultural sensitivity in practitioners' interactions with women who have undergone FGM (ibid, and Baillot *et al*, 2014: 37).

Cultural sensitivity

The need for cultural sensitivity is emphasised widely across the literature surveyed, in recognition of the complex dynamics involved in the cultural belief that perpetuates the practice (Monahan, 2007: 33). Regional and cultural diversity in the practice of FGM means that approaches should be tailored to particular communities in a culturally informed way and make use of appropriate tools, including from the country of origin where possible and appropriate (Baillot *et al*, 2014: 42). This includes developing an understanding of any culturally-specific reasoning for the FGM performed and its importance from the perspective of those who practise it, so that agencies are able to better help families resist the practice (Dustin and Davies, 2007: 6).

This requires sensitive and informed use of language in engagement with girls and women. In stressing the importance of effective communication through a case study of Somali refugee women's experiences of maternity care in west London, Bulman and McCourt (2002: 375) reflect that, 'women who are unable to communicate with professionals find the service remote, confusing and, at times of stress such as birth, quite frightening, while midwives who are unable to communicate effectively with them fall back on the use of cultural stereotypes and distancing behaviour'. The authors note that many Somali women perceived that Westerners had both a lack of understanding and negative attitudes towards women who had undergone FGM, creating the potential for misunderstanding and poor clinical outcomes for these women. This perception of a

lack of support served to reinforce a sense of isolation and fear amongst these women, particularly for those suffering other forms of trauma, such as forced migration (ibid).

Similarly, scholars point to the risk of inducing feelings of shame if health care providers react with shock in an initial examination, which is a risk that, again, could be mitigated with training (Monahan, 2007: 31). An awareness of how language is used (this may include careful use of terminology, including consideration of the use of 'mutilation') and effective, sensitive communication that recognises the trauma endured and engages cultural sensitivity is advocated in the literature.

This should include awareness that discussing FGM with women who have undergone the practice risks re-traumatisation: 'sometimes the key figures would stand in front of a group, talk about the hazards of FGM and women listening would suddenly realise what was done to them and that some of their complaints were due to FGM, or they re-live their circumcision. Sometimes it got very traumatic' (Baillot *et al*, 2014: 26). Therefore, practitioners should recognise and manage their reactions to unfamiliar cultural practices and minimise discomfort to create a safe and confidential environment for women and girls (Costello *et al*, 2015: 1269). The importance of finding ways to build rapport with women and girls has been stressed (Dawson *et al*, 2015: 210).

A victim-centred approach

Much of the literature advocates a victim-centred approach in responding to FGM, which is framed within a violence against women and girls agenda and recognises FGM as gender-based violence (GBV) and closely tied to other forms of GBV, such as forced marriage. As Baillot *et al* (2014: 40) argue, adopting this approach – in contrast to, for example, one which treats affected women as complicit offenders (Goodey, 2004: 32) - can help to ensure a gender-sensitive and victim-centred approach to reporting, investigating, and prosecuting FGM (see also, Options UK, 2011). This is similar to the evolution in approach adopted in relation to victims of sex trafficking, who may face a similar range of barriers to accessing help, prejudice as members of immigrant communities, and practical problems such as a language barrier.

Trafficked women are not prioritised as 'innocent' and 'deserving' victims by criminal justice agencies in comparison to other victim categories that fulfil such stereotypes, and are often seen as complicit in their exploitation (Goodey, 2004: 33). This may be a factor to consider in interactions with women who have undergone FGM in relation to discussing the potential for risk to their daughters. The literature emphasises the need for a child protection context to safeguard girls, and also that a gendered approach to tackling and responding to FGM should support affected communities and professionals to identify and address the root causes of the practice (Baillot *et al*, 2014: 40), without creating an environment which stigmatises or criminalises women who have undergone

FGM, and which would thereby risk driving the practice underground (Antonazzo, 2013: 477, Monahan, 2007: 28).

It should be noted here, as Goodey argues in relation to trafficking for sexual exploitation, that recognising victimhood is not to construct a one-dimensional and powerless victim, but rather, 'recognition of the individual's status as a victim, as a result of a criminal offence, is desirable as long as it affords certain rights and other practical provisions' (Goodey, 2004: 34). This is supported by Kelly (2002), who notes that the term 'survivor' has come in to favour to address the so-called shaming and implied passivity and powerlessness of 'victim', highlighting the ways in which women and children resist abuse and endeavour to cope with its many consequences.

Kelly (2002) argues that, 'to elide the documentation of women's victimisation with a suggestion that feminists have created a notion of 'victimhood', or constructed women as inevitable victims is to conflate empirical reality with constructions of identity'; that is, the nature of gender-based violence and abuse can, and does, fundamentally remove women's agency. She argues for 'a conceptualisation that positions women and children as neither inevitable victims (or men as inevitable victimisers) nor as strong survivors for whom abuse has minimal consequences' (Kelly, 2002: 11). This relates to the concern outlined above that referring to 'mutilation' risks undermining women's agency and depicting a powerless victim.

Feminist scholars of GBV often advocate for a more complex understanding of identity and the lived experiences of women who have experienced trauma or abuse, encompassing a recognition of their status as victims, but allowing them agency in managing the consequences and coping mechanisms. In the context of FGM, women's empowerment in their communities could mean engaging in debate, changing attitudes and creating alternative ways of affirming their cultural identity (Dustin, 2010). This call in the literature for a victim-centred approach that is situated within a violence against women agenda should therefore be read alongside scholarship which advocates for a nuanced understanding of victimhood, in which individual agency and strength is recognised.

Clinical engagement with women from FGM-practising countries: prevention and protection

Hospital and/or medical records contain information about FGM and can contribute to the development of a comprehensive picture of FGM prevalence in the UK. However, limitations exist in relation to data collection and evaluation of this information, notably with potential under-recording due to the lack of knowledge of FGM among health professionals to adequately register the different types, whilst there are few available administrative recording systems for outpatients in medical and hospital records, and a

lack of data from primary care settings or by GPs (EIGE, 2013: 27). When women or girls are asked to self-disclose FGM to a health professional, this can bring further challenges, including a wish not to disclose their status; women and girls not recognising the terms used by healthcare professionals to describe FGM and/or typologies; health professionals not having the skills to adequately ask women and girls about FGM; and insufficient training for health professionals focusing on FGM and cultural competence (*ibid*).

There is therefore a dearth of adequate data with which to create an accurate picture of FGM practice, and with which to inform prevention and protection. In the literature addressing engagement with women and girls in a health and social care context, it is widely emphasised that these environments are crucial in terms of both prevention and protection; in ensuring effective clinical outcomes for women, and in terms of supporting an appropriate child protection response. Maternity services are judged to be of particular importance: as Baillot et al (2014: 37) observe, women who have undergone FGM often only come into contact with services when pregnant, and therefore maternity services play a pivotal role in asking about and recording cases of FGM; counselling and providing information about the law and support available to women, and in protecting girls from and preventing FGM.

As the authors explain, 'pregnancy was seen as a point at which professionals can sensitively initiate a discussion about a mother's future intentions for her daughter(s) and, critically, provide support to enable and empower parents to protect their daughter(s) from the practice'. Dawson et al (2015: 207) note that midwives are critical to the provision of high quality care for women who have undergone FGM, and that an informed and culturally sensitive approach in a midwifery setting is important to ensuring continuity of care. Nevertheless, fear and a lack of experience caring for women with FGM; barriers to the development of rapport with women; working with interpreters; cultural misunderstandings; inexperience with associated clinical procedures; and a lack of knowledge about FGM types, all hinder positive outcomes.

FGM has been identified as a blind spot for social services and child protection workers (Costello et al, 2015: 1260). Nevertheless, the social work context is highlighted in the literature as an important point of contact and disclosure for women who have undergone FGM, and therefore as a point at which prevention and protection work can be undertaken. Costello et al (2015: 1261) argue strongly for this multi-faceted social work role: '[they] have responsibilities...to protect girls from being cut; to advocate for services for affected women...and to engage with practising communities in processes to stop the practice'. Dustin and Davies (2007: 8) make the case for a strong grounding in cultural understanding of the practice for social workers, recognising that an understanding that there may be anxiety or resistance about what will happen if FGM is abandoned (for

instance, what the perceived implications may be for their daughters of being 'uncut') may prove helpful for social workers in their prevention efforts.

Moreover, Costello *et al* (2015: 1261) advocate 4 key areas of competence towards which social workers should work: FGM practices, prevalence and harms; the cultural complexities and social bases of cutting girl children; effective international prevention strategies and programmes; and culturally respectful strategies to engage sensitively with children considered at risk of being cut, women who have been cut and their communities. Scholars therefore set out a role for social workers, which encompasses a strong working knowledge of FGM and prevention tools, alongside a culturally informed and sensitive engagement approach.

Alongside the need for health and social care professionals to approach engagement with women and girls from FGM-practising countries in an informed and culturally sensitive manner, scholars provide evidence for the importance of effective multi-agency working, and point to the barriers of this being achieved. In their analysis of responses from professionals across a range of agencies who engage with FGM victims, Baillot *et al* (2014: 32) report that the 'overall impression from respondents was that there is some way to go in developing a consistent and effective approach to protecting women and girls from FGM in the UK, with a lack of trust existing between different agencies in terms of information sharing'.

Responses from different agencies pointed variously to an overly-guarded approach from medical professionals; to slow responses from social services, and either under- or over-reaction from police. Baillot *et al* note that training and guidance is particularly lacking on reporting and, specifically, how to respond to adult women survivors of FGM in maternity services. As the authors note, 'a lack of clarity was also apparent as to the appropriate child protection response, if any. A police respondent described a 'blockage' where girls born to mothers with FGM are concerned' (Baillot *et al*, 2014: 32). As evidence from scholars at the beginning of this section highlighted the importance of the maternity setting as often the first point at which FGM is disclosed, effective multi-agency working in this environment, including specific training and guidelines regarding how best to undertake protection and prevention in relation to a child whose mother has been discovered to have undergone FGM, would seem to be of paramount importance, enabling both a clinical assessment for the mother and a risk assessment (or form of engagement with the parents about potential harm) for girls in the family.

Baillot *et al* (2014: 40) also advocate that FGM be embedded within child protection and safeguarding training for professionals, with the specific causes and consequences of FGM highlighted in a child protection context. Reporting on the Scottish example, they argue that, in the context of an increasingly diverse population, with growth in communities potentially affected by FGM, there should be sustainability in mainstreaming an FGM approach to community development; the establishment of guidance and

services; and long-term sustainability of specialist knowledge across agencies to ensure that expertise is not concentrated in key individuals who may leave. Similarly, in their evaluation of the FGM Initiative, which supported community-based organisations in the UK to carry out FGM prevention work, Options UK (2011) stress that multiple agencies, including statutory organisations and community groups, should work together to identify local needs and suitable prevention strategies, with a focal individual acting as coordinator and champion.

Evidence from literature surveyed for this review therefore emphasises the importance of informed and culturally competent engagement in clinical and social care settings with women who have undergone, or are potentially affected by, FGM, stressing also that effective multi-agency working and a holistic approach to service provision is essential to protection and prevention efforts. However, this literature points to existing barriers (cultural, linguistic, stigma-related or service provision-related barriers) to establishing such best practice outcomes, and highlights a lack of best practice in seeking to overcome such barriers. As such, the MOPAC FGM pilot will contribute to a greater understanding about the impact of proactive information-sharing between different agencies, such as maternity services and social care; about how social work responses can be made more effective and proportionate in terms of identification and action taken; and about more effective and informed health and social care practice with victims or potentially-affected individuals.

Engagement beyond the clinical setting

There is a strong advocacy in the literature surveyed for engagement with men, extended families and communities, schools and civil society groups in order to challenge FGM practices and support women and girls from potentially affected communities. Baillot et al (2014: 26) quote a police officer reflecting on the importance of engagement with men: 'The role of men is typically understated but it is essential when trying to build community-driven solutions. When we're talking about a practice linked to the purity of women, which aims at controlling women's behaviour and sexuality, then we're looking at power and control'.

Baillot et al observe that men are becoming increasingly involved in discussions about FGM and stress that this is of paramount importance to ensure community-wide and –led solutions that reflect lived experiences. Engagement with men and women should be carried out separately initially, but men and women could also work effectively together. Dawson et al (2015: 212) note that the involvement of men is important both because men can also experience FGM-related complications both personally and in relation to their partners' suffering, and because they may be central to a decision about FGM for their daughters or de-infibulation for their partners.

Engagement with the wider community is advocated by scholars and experts for similar reasons: the decision to practise FGM may include those beyond the mother and father. As Macfarlane and Dorkenoo (2014: 3) argue, women aged over 50 who have had FGM themselves are also likely to exert pressure to continue the practice among their younger family members; three-fifths (60%) of these women were born in countries where FGM is almost universal. Macfarlane and Dorkenoo also note that younger generations are more likely to oppose FGM but may concede to pressure from extended families, with many British girls living in minority ethnic communities in the UK taken abroad to their family's country of origin during the school summer holidays to be subjected to FGM, although they state that there are no data on their numbers.

This is supported by Dustin and Davies (2007: 9), who cite evidence that in 16% of cases where FGM has taken place, either one of the parents may have opposed FGM but the decision is overridden by family elders or community leaders. Monaghan (2007: 33) advocates prevention efforts which work directly with potentially affected groups to provide them with information on which to base informed decisions, cautioning against actions which might be seen as overtly punitive by affected communities and thereby drive the practice underground. Costello et al (2015: 1270) support collaborative engagement and supportive relationships with community members, arguing that international research shows that this approach produces effective interventions. Ultimately, as Baillot *et al* (2014: 45) assert, 'without a genuine and effective commitment to the participation of affected communities in work on this issue, not only will we fail to understand the true levels of potential risk faced by women and girls... we will run the risk of further marginalising the community voices that are the most effective advocates for change'. Work with community groups is therefore of central importance in identifying local needs; tailoring solutions; and helping to deliver safeguarding efforts, although progress needs to be made on better resourcing and meaningful inclusion (*ibid*).

Evidence from the literature surveyed demonstrates that this work with potentially-affected communities can be bolstered by engagement with schools and with community or campaigning groups, all of which can play a role in prevention and protection. Baillot *et al* (2014: 29) quote an NGO worker reflecting that, 'I know myself of children who have been identified by nursery or classroom assistants...Schools can play a role in identifying girls', although they also report that evidence suggests that teachers are a group who have received very little training on FGM. The Options UK (2011) evaluation notes that most projects faced resistance when trying to work in schools, as many said that they did not want to address the issue for fear of stigmatising certain groups. However, Dustin and Davies (2007: 12) assert the importance of prevention programmes in schools, arguing that teachers need to become familiar with the language used to describe FGM and behaviour indicative of FGM, such as long periods in the toilet, and school absences.

References

- Antonazzo, M. (2003). Problems with Criminalizing Female Genital Cutting. *Peace Review: A Journal of Social Justice*, 15:4, 471-477.
- Baillot, H., Murray, N., Connelly, E., and Howard, N. (2014). Tackling female genital mutilation in Scotland. *A Scottish model of intervention*. Glasgow: Scottish Refugee Council.
- Berg, R., and Denison, E. (2013). A Tradition in Transition: Factors Perpetuating and Hindering the Continuance of Female Genital Mutilation/Cutting (FGM/C) Summarized in a Systematic Review. *Health Care for Women International*. 34:10, 837–859.
- Boyle, E.H. (2005). *Female Genital Cutting: Cultural Conflict in the Global Community*. Baltimore, MD: John's Hopkins University Press.
- Bulman, K., and McCourt, C. (2002). Somali refugee women's experiences of maternity care in west London: A case study. *Critical Public Health*. 12:4, 365-380.
- Costello, S., Quinn, M., Tatchell, A., Jordan, L., and Neophytou, K. (2015). In the Best Interests of the Child: Preventing Female Genital Cutting (FGC). *British Journal of Social Work*, 45:4, 1–18.
- Dawson, A., Turkmani, S., Varol, N., Nanayakkara, S., Sullivan, E., and Homer, C.S.E. (2015). Midwives' experiences of caring for women with female genital mutilation: Insights and ways forward for practice in Australia. *Women and Birth*. 28:3, 207-214.
- Dustin, D., and Davies, L. (2007). Female Genital Cutting and Children's Rights: Implications for Social Work Practice. *Child Care in Practice*. 13:1, 3-16.
- Dustin, M. (2010). Female Genital Mutilation/Cutting in the UK: Challenging the Inconsistencies. *European Journal of Women's Studies*. 17, 7-23.
- European Institute for Gender Equality (EIGE). (2013). *Female genital mutilation in the European Union and Croatia*, accessed online June 2015, available at <http://eige.europa.eu/sites/default/files/documents/eige-report-fgm-in-the-eu-and-croatia.pdf>
- Goodey, J. (2004). Sex Trafficking in Women from Central and East European Countries: Promoting a 'Victim-Centred' and 'Woman-Centred' Approach to Criminal Justice Intervention. *Feminist Review*. 76, 26-45.
- Kelly, L. (2002). From commonality to difference and back again? Reflections on international efforts to challenge violence against women. *Keynote speech: Expanding*

Our Horizons: Understanding the Complexities of Violence Against Women – Meaning, Cultures, and Difference. 18-22 February 2002. Sydney, Australia.

Johnsdotter, S. (2009). *The FGM Legislation Implemented: Experiences from Sweden*, accessed online June 2015, available at <<http://www.uv.es/CEFD/17/Johnsdotter.pdf>>

Macfarlane, A., and Dorkenoo, E. (2014). *Female Genital Mutilation in England and Wales: Updated statistical estimates of the numbers of affected women living in England and Wales and girls at risk. Interim report on provisional estimates*, accessed online June 2015, available at <<http://openaccess.city.ac.uk/3865/>>

Monahan, K. (2007). Cultural Beliefs, Human Rights Violations, and Female Genital Cutting. *Journal of Immigrant & Refugee Studies*. 5:3, 21-35.

Options UK. (2011). *Tackling FGM Special Initiative: PEER Research, full report*, accessed online June 2015, available at <<http://esmeefairbairn.org.uk/news-and-learning/publications/tackling-fgm-special-initiative-peer-research>>

UNHCR. (2013). *Too Much Pain. Female Genital Mutilation and Asylum in the European Union: A Statistical Overview*, accessed online June 2015, available at <<http://www.unhcr.org/531880249.pdf>>

World Health Organisation (WHO). (2014). *Female Genital Mutilation: Fact sheet No. 241*, accessed online June 2015, available at <<http://www.who.int/mediacentre/factsheets/fs241/en/>>

Appendix 2. Theory of change interview script

Problems and Solutions

What problems is the FGM National Centre project trying to address (for which groups)?

Why is it trying to address them? (for whom)?

Is it and how is it different from what was happening previously?

What assumptions do you have about how the project is likely to bring about change? (e.g. of assumptions: the community supports the project? There is diverse commitment from professionals and women and girls affected. There is an economic case for change)?

What are main ways that the project will work? (be specific about processes e.g. routine recording and referral, training for professionals, codifying risk for recording, what are the things the project does?)

What outcomes do you expect to observe in the short and medium term?

What outcomes in the longer term?

Inputs

What are the main inputs into the project? (e.g. money, staff time, accommodation)

Processes

What are the key processes involved in the project? (e.g. of a process: specialist social workers within social work settings, delegated social work, intelligence hub)

Outputs

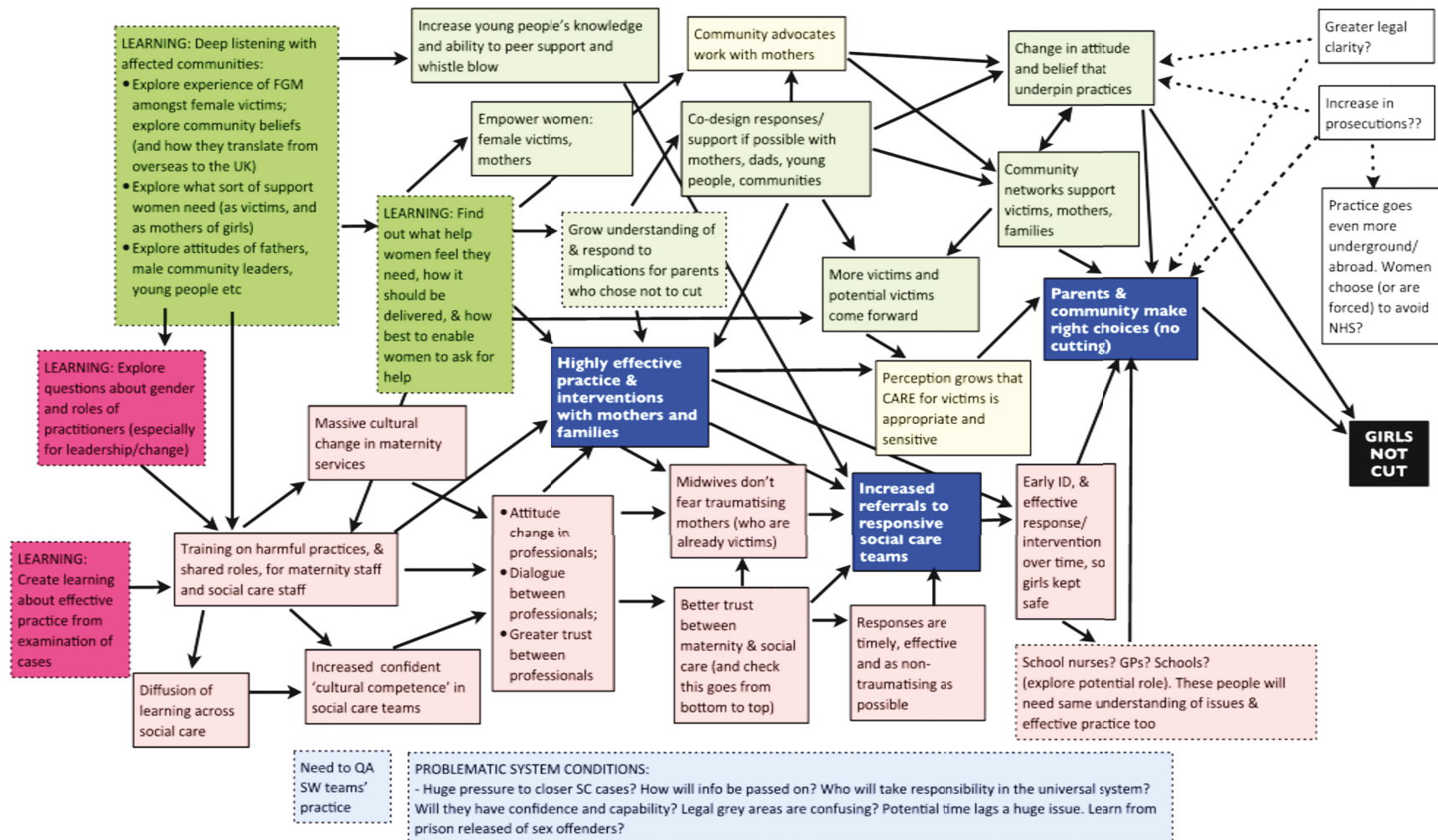
What are the main outputs?

Outcomes

What are the main outcomes and how do these relate to the processes and outputs?

What challenges do you expect the project to encounter, in terms of achieving its desired outcomes?

Appendix 3. Original (pre-evaluation) theory of change





Department
for Education

© Department for Education

Reference: DFE-RR540

ISBN: 978-1-78105-596-0

The views expressed in this report are the authors' and do not necessarily reflect those of the Department for Education.

Any enquiries regarding this publication should be sent to us at:

richard.white@education.gov.uk or www.education.gov.uk/contactus

This document is available for download at www.gov.uk/government/publications