

Tackling Female Genital Mutilation in Scotland

A Scottish model of intervention

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Executive Summary

Introduction, scope and terminology

This scoping study carried out by Scottish Refugee Council with the support of the London School of Hygiene and Tropical Medicine identifies populations potentially affected by female genital mutilation in Scotland and explores interventions across the European Union (EU) in the areas of participation, prevention, protection and the provision of services, presenting a baseline of Scotland-specific data and recommendations for the development of a Scottish model of intervention.

Female genital mutilation (FGM) refers to '*all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons*' (WHO 2014). Such procedures have affected millions of women and girls across continents and belief systems for centuries. More than 125 million women and girls are affected today, predominantly in pockets of the Middle East and across central Africa from West to East (UNICEF 2013); but also, reportedly, in South Asia and in diaspora communities all over the world. Different terms are used to describe these procedures, including 'female genital cutting' and 'circumcision'; we use the term 'female genital mutilation' or 'FGM' throughout this report in recognition of the severity of the harm caused to women and girls.

Because of the limitations of global and Scottish data, we do not seek to definitively quantify the nature and extent of FGM in Scotland, referring throughout our report to '*communities potentially affected by FGM in Scotland*'. There are reasons of methodological accuracy for this, including limitations in prevalence data for countries such as Nigeria with significant communities in Scotland. We do not have Scottish data on country of birth by age, gender or ethnicity; nor do we have information on the influence of migration on the practice of FGM. The use of this terminology is also in line with best practice, avoiding the presumption attached to '*practising communities*', which '*may be wholly inaccurate*' in a migratory context (Hemmings 2011).

Communities potentially affected by FGM in Scotland

Our research shows that there were 23,979 men, women and children born in one of the 29 countries identified by UNICEF (2013) as an 'FGM-practising country', living in Scotland in 2011. The largest community potentially affected by FGM living in Scotland are Nigerians, with 9,458 people resident in Scotland, born in Nigeria. When weighted by the national prevalence rate in their country of birth (which varies dramatically from 27% in Nigeria and Kenya, to 98% in Somalia) Nigerians are still the

largest community, followed by people born in Somalia, Egypt, Kenya, Sudan and Eritrea. There are potentially affected communities living in every local authority area in Scotland, with the largest in Glasgow, Aberdeen, Edinburgh and Dundee respectively. The number of children born into potentially affected communities in Scotland has increased significantly over the last decade, with 363 girls born in Scotland to mothers born in an FGM-practising country in 2012, representing a fivefold increase over the last decade.

Effective interventions

In order to explore effective interventions, we carried out a scoping literature review and interviewed 16 key informants working at different levels across the EU. We also consulted with stakeholders and spoke to a small number of women from affected communities in Scotland. We structured our research around the 'Four Ps' previously used by the Scottish Government (Prevention, Protection, Provision of services and Participation) in an effort to maintain consistency with the strategic violence against women agenda in Scotland. Our findings describe interventions in England, Ireland, France, Spain, Belgium and the Netherlands and cover a wide range of different types of intervention. These include the development of strategic and policy frameworks; research methods; the longer term prevention of FGM in affected communities; the protection of individual women and girls from FGM; the provision of services to survivors of FGM; and, the participation of affected communities in work at all levels to tackle and respond to FGM.

Recommendations

Based on the findings of our research, we make a series of thematic recommendations towards a Scottish model of intervention to tackle FGM. Due to myriad ethical, legal and practical challenges of work in this area, we strongly recommend that these are read and understood in conjunction with the relevant section of this report, which we include below for reference.

Participation

- Policy makers and service providers should ensure that policy and practice development across all areas of work is shaped and driven by the experiences, needs and views of communities affected by FGM

Strategy, Policy and Research

- The Scottish Government should provide national direction to ensure that work on FGM is contextualised as violence against women and girls
- The Scottish Government should use Equally Safe as a vehicle to develop a resourced national action plan on FGM
- The Scottish Government and funding bodies should invest in support for affected communities to effect long-term behaviour change
- The Scottish Government should provide national direction to guide consistent recording of FGM in statutory services
- All statutory and voluntary agencies working with potentially affected communities should ensure that interventions are evidence-based and evaluation is built-in from development

Prevention

- The Scottish Government and relevant agencies should ensure that a strong criminal justice message is accompanied by investment in behaviour change interventions with affected communities, in particular:
 - a) Key community leaders
 - b) Young people
 - c) Men in affected communities
- All agencies working with communities potentially affected by FGM should ensure that community engagement meets national standards and a) builds on existing relationships of trust; b) is tailored to a particular community; c) involves women, men and young people; and, d) considers links to countries of origin.
- The Scottish Government should provide clear, national direction on the role of frontline professionals in the prevention of FGM and relevant professional bodies and agencies should develop training on FGM for frontline staff, in particular:
 - a) GPs
 - b) Maternity services
 - c) Schools
 - d) Other frontline professionals

- Statutory and voluntary agencies developing training and guidance for professionals should use and value the expertise of specialist NGOs
- All agencies carrying out campaigning and awareness raising work around FGM should ensure that this is non-stigmatising and evidence-based

Protection

- The Scottish Government, Police Scotland and the Procurator Fiscal should continue to ensure that the criminal justice response is perceived as being effective and that anyone found to have subjected a child living in Scotland to FGM will face robust criminal sanctions
- The Scottish Government should provide national direction for a multi-agency approach to protecting girls from FGM, fostering confidence within and between statutory services and clearly identifying roles and responsibilities
- The Scottish Government and local authority leads should provide national - and from that, local - direction on a clear child intervention response where an FGM survivor gives birth to a girl; not an automatic child protection referral
- Local authorities and local health boards should develop a network of named professionals with expertise on FGM across Scotland and ensure clear referral pathways are in place
- All relevant frontline professionals should be provided with a level of training on FGM appropriate to their role
- The Scottish Government should ensure that all women and girls living in Scotland are covered by legislation on FGM
- Police Scotland and the Procurator Fiscal should ensure that investigations into cases of FGM are victim-centred and take a violence against women and girls approach
- Immigration lawyers, asylum decision makers, and judiciary should have a good understanding of FGM to ensure that it is fully explored as a potential ground for international protection
- The Home Office should monitor and regularly audit asylum claims involving disclosure of FGM

Provision of services

- The NHS should establish a specialist, multi-disciplinary 'hub and spoke' FGM service in Scotland with clear links to named professionals across Scotland
- The NHS in Scotland should ensure that healthcare provision to survivors of FGM is culturally competent
- NHS Greater Glasgow and Clyde and other relevant health boards should consider establishing specialist GP and/or hospital consulting hours in Glasgow and other areas with significant communities potentially affected by FGM
- The NHS and the relevant professional bodies should ensure that health professionals are trained to carry out sensitive inquiry around FGM and that pregnant women are always asked about FGM

Conclusion

Female genital mutilation is an emotive topic. The question of the extent to which young girls living in diaspora communities within the EU are at risk of being subjected to FGM has attracted substantial media and academic interest recently. Our own research has been necessarily limited in scope, due to time and resource constraints. Without further qualitative research and improvements in data gathering, particularly across statutory services and among potentially affected communities, it will remain difficult to accurately quantify the size of any potential issue in Scotland.

However, our research makes clear that despite facing similar statistical challenges, other EU nations have developed effective interventions tackling FGM and supporting women and girls living within their borders to both resist and recover from FGM. We hope that this report provides a framework to do so in Scotland, where, as many respondents indicated, we have the opportunity to draw on best practice to begin to develop a Scotland-specific model of intervention.

In order for this to be successful, we suggest that all future work on FGM in a Scottish context is guided by the following overarching principles:

- FGM should be acknowledged as a form of gender based violence, closely linked to other forms of violence against women and girls, such as forced marriage. A gendered approach to tackling and responding to FGM will support affected communities and professionals to identify and address the root causes of the practice.

- Criminal justice and child protection provisions must be enacted effectively and fairly. For this to be possible, professionals from all sectors must be provided with clear and accessible risk assessment and reporting guidelines.
- Services should be assessed and designed using a cultural competency lens, to ensure that they are both accessible and useful to women and girls affected by FGM.
- Finally, work with communities is vital to all areas of intervention. For 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 in Scotland today, we will run the risk of further marginalising the community voices that are the most effective advocates for change.

Chapter 1 - Introduction

1.1 Scope of this report

This report presents the findings of a scoping project carried out by Scottish Refugee Council with support from the London School of Hygiene and Tropical Medicine, funded by the Scottish Government and Rosa Fund. The aim of the project was to identify populations potentially affected by female genital mutilation (FGM) in Scotland; explore prevention and response interventions in the European Union; and determine promising initial interventions for Scotland. The methodology will be explored in Chapter 2, however, it should be noted at the outset that the project did not seek to definitively quantify the nature and extent of FGM in Scotland, nor was it possible within the timescale and budget to engage widely with communities affected by FGM living in Scotland. The intention, rather, was to present a baseline of Scotland-specific information; and to suggest ways forward for the development of an appropriate response to FGM in a Scottish context.

This chapter covers definitions and terminology, and introduces FGM in the global and Scottish contexts. Chapter 2 discusses methods and the limitations of our data, including why the term 'prevalence' is not used in this study. Chapter 3 presents the statistical findings from our analysis of secondary data and administrative records. Chapter 4 presents the qualitative findings from our scoping literature review, key informant interviews and stakeholder consultations. The final chapter consists of a series of themed recommendations based on a discussion of our findings. Our scoping literature review summary, anonymised list of key informants, and key informant interview guide are presented in appendices.

1.2 Definitions and terminology

The World Health Organisation (WHO) defines female genital mutilation (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 classifies FGM into four types:

- **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).

FGM is internationally recognised as a violation of the fundamental rights of women and girls (WHO 2014). Sometimes also referred to as female genital 'cutting' or 'circumcision', in reality the term encompasses a range of harmful practices described and understood differently in different communities across the world. In this report, we use the term 'female genital mutilation (FGM)' throughout, in recognition of the severity of the harm caused to women and girls, and in line with the approach of specialist organisations in the UK, such as FORWARD.¹

1.3 FGM: the global context

The practice of FGM is an expression of deeply entrenched gender inequalities, grounded in a mix of cultural, religious and social factors inherent within patriarchal families and communities. FGM is not merely maintained by these inequalities, but gender inequalities are indeed sustained by the practice of FGM... The reported method, rationale and means of practising FGM are different in different communities, but FGM is fundamentally bound up with systems of patriarchy and... the repression of female sexuality. (EIGE 2013, p.23)

UNICEF estimates that more than 125 million women and girls in 29 countries around the world are affected by FGM today, with some 83 million survivors in Egypt, Ethiopia, Nigeria and Sudan alone (UNICEF 2013, pp.2-3). Reported prevalence rates vary dramatically across - and sometimes within - countries. The highest reported prevalence rates are found in Somalia (98%), Guinea (96%), Djibouti (93%), and Egypt (91%), where FGM is near universal. In 50% of practising countries, girls undergo FGM before the age of five years old; in the remainder, most FGM is carried out on girls aged 5-14 years old (UNICEF 2013, pp.2-3).

The historical origins of FGM are unclear, but it is a practice that spans over 5000 years, across continents, belief systems, and socio-economic status, from Europe, America and Asia to a swathe of central Africa from the

West coast to the Horn, where it is most concentrated today (Whitehorn et al 2002, p.162; UNICEF 2013, pp.2-3). As the global population becomes ever more mobile, the practice can now be found in diaspora communities all over the world, including in Europe (EIGE 2013).

FGM can have multiple long- and short-term physical and mental health consequences for the women and girls subjected to it, as well as consequences for the communities in which they are living (Ibid. pp.22-23).

Although there has been some criticism of a tendency to over-generalise about the severity of the harmful consequences of FGM (Obermeyer 1999; Shell-Duncan 2008), research conducted amongst migrant women living in Europe has tended to confirm that women living with FGM can experience recurrent sexual, psychological and physiological problems (Andro 2010; Vloeberghs 2011); and that particularly before and during childbirth, women who have undergone the most severe forms are likely to require specialist surgical and psychological interventions (Creighton 2010).

1.4 FGM: the Scottish context

Studies that have sought to estimate FGM prevalence in the UK to date have been based on census data for England and Wales (Dorkenoo et al 2007). At the time of writing there were no published studies looking at the scope of FGM in Scotland.²

The demographic picture in Scotland is different from that in the rest of the UK. With a population of 5,295,403³, Scotland is a small country, which has traditionally lost rather than gained people to migration (Mocollum et al 2013). However, 2011 census data on country of birth and ethnicity demonstrate that ethnic diversity in Scotland has grown over the last decade, with population growth becoming increasingly dependent on international migration. For example, the African population in Scotland has grown from 5,000 in 2001 to 30,000 in 2011 (Simpson 2014, p.1).

With the introduction by the UK Government of the dispersal of asylum seekers to Glasgow in 2000, new refugee communities have also begun to settle in Scotland.⁴ A recent report by the UN High Commissioner for Refugees observes that 2401 women from FGM-practising countries sought asylum in the UK in 2011, and over 20% of women seeking asylum in the UK from 2008-2011 were from FGM-practising countries (UNHCR 2013, p.5).

Given that in the last decade around 10% of people seeking asylum in the UK annually have been dispersed to Glasgow by the UK Government (Shisheva et al 2013, p.5), it is likely that some of these women now live in Scotland.

FGM has been illegal in the UK since 1985⁵ and in 2005 the Prohibition of Female Genital Mutilation (Scotland) Act came into force, changing the legal definition of FGM - 'to excise infibulate or otherwise mutilate the whole or any part of the labia majora, labia minora prepuce of the clitoris, clitoris or vagina of another person' -, introducing an extraterritoriality clause, making it an offence for UK nationals or permanent residents to carry out, aid or abet FGM abroad, and increasing the maximum penalty to 14 years' imprisonment (Mhoja 2010).

In recent years, organisations in Central Scotland have been working to raise awareness about FGM and to support migrant, refugee and asylum seeking women resident in Scotland who may be suffering from the consequences of FGM.⁶ A women's mental health and well-being organisation in Edinburgh has recently begun to provide services to women in Glasgow from FGM-practising communities. Unfortunately, it was not possible to obtain service level data or details about this service for this study. At the time of writing, we became aware of a new awareness-raising initiative in Glasgow being developed to work with men from communities affected by FGM.

In August 2013, the Women's Support Project and Scottish Refugee Council co-convened an FGM Strategic Group in Glasgow with membership from key statutory and voluntary organisations in the West of Scotland (some with a national remit), including Police Scotland, the Procurator Fiscal, Glasgow Social Work Services, Glasgow Education Services, NHS Greater Glasgow & Clyde, Glasgow Violence Against Women Partnership, Legal Services Agency, Scottish Government, Rape Crisis Glasgow, Amina, Roshni and Saheliya. The group identified a lack of robust data and information as a key concern. Areas identified for action included addressing this lack of data on FGM, improving service provision and training for professionals and interpreters, tackling legal issues including the difficulty of prosecution, and engaging with affected communities on awareness raising and prevention. This baseline scoping study seeks to address the first of these gaps, to inform the work of the Strategic Group and the wider strategic approach to tackling FGM in Scotland.

¹ For a list of community-specific terminology for FGM and FORWARD's rationale for using the term 'FGM' itself, see <http://www.forwarduk.org.uk/key-issues/fgm/definitions> (accessed 16 October 2014)

² The Edinburgh-based charity Dignity Alert Research Forum (DARF) published a baseline survey on the views and experiences of FGM practising communities in Edinburgh and Glasgow in 2010. The study is available online at: <http://www.darf.org.uk/page10.htm> (accessed 17 Oct 14).

³ <http://www.scotlandscensus.gov.uk/>

⁴ The 1999 Asylum and Immigration Act established a National Asylum Support System, which introduced the principle of dispersing destitute asylum seekers to accommodation on a no-choice basis in cities away from the south east of England whilst a decision is made on their asylum claim.

⁵ Prohibition of Female Circumcision Act 1985

⁶ See for example www.darf.org.uk and www.womenssupportproject.co.uk

Chapter 2 - Methods

2.1 Objectives and methodology

The study received ethical approval from the London School of Hygiene and Tropical Medicine in May 2014. We took mixed methods approaches to each of the four study objectives, which were:

1. To examine available secondary data sources to describe potentially affected communities in Scotland.
2. To conduct a qualitative study of prevention and response interventions in the EU using a scoping literature review and in-depth key informant interviews.
3. To determine, in collaboration with stakeholders, promising initial interventions for Scotland based on findings on potentially affected communities and relevant interventions.
4. To disseminate key findings through a national event, written output and media.

For the first objective, we asked:

Which communities living in Scotland are potentially affected by FGM and approximately where and how big are they?

We worked with the Scottish Government to examine available secondary data analysis of 2011 Census data⁷, birth registration data from 1993 to 2012, and the 2013 Pupil Census, containing data on pupils in publicly funded schools across Scotland. We also requested administrative records from stakeholders on the FGM Strategic Group and through snowball sampling, from other voluntary and statutory service providers across Scotland.

For the second and third objectives, we asked:

What FGM-related interventions have been tried in the EU, which appear successful or promising, and which have most potential for further development in Scotland?

We carried out a scoping literature review of interventions addressing the 'Four Ps' (Prevention, Protection, Provision, and Participation)⁸ in the EU, discussed in more detail below. We also carried out 16 key informant interviews with experts in the EU on interventions addressing the 'Four Ps', further contextual information, perceptions, and ideas for future work.

Finally, we convened a stakeholder consultation and two further workshops with community representatives to discuss initial findings and promising interventions for Scotland.

Below we summarise the methodology of the scoping literature review and interviews, discuss the limitations of data and outline the reasons for not using the term 'prevalence' in this study.

2.1.1 Scoping literature review

Our inclusion criteria for the scoping literature review were primary or secondary research articles and grey literature that:

- include more than one study participant;
- cover interventions in the EU, Norway and Switzerland;
- are available in a language in which a research team member is fluent (English, French, Spanish, Portuguese); and
- were published in the period 2007-2014.

In undertaking the review, we were guided by the Arksey and O'Malley framework (Arksey & O'Malley 2005), as updated by Levac et al (Levac et al 2010), which outlines a clear staged process for undertaking a scoping literature review as follows:

- Stage 1: identifying the research questions
- Stage 2: identifying relevant studies
- Stage 3: study selection
- Stage 4: charting the data
- Stage 5: consultation exercise
- Stage 6: collating, summarising and reporting the results

The total number of texts included for review at the end of this process was 68. A diagram summarising the process we undertook to carry out the literature review is included in Appendix 1. As the main audience for this report is policy-makers and practitioners, rather than include the full findings of the review here, we have integrated insights from the literature into the thematic sections of Chapter 4, and reference texts from the review throughout.

2.1.2 Key informant interviews

We interviewed 16 key informants, identified through snowball sampling for their known expertise in the UK or another EU country on FGM in one or more of the 'Four P' areas. We sought to identify a range of experts working at different levels.

⁷ We were limited within the scope of this project to examining data published by the National Records of Scotland. At the time of writing country of birth data was not available by age/gender.

⁸ We structured our review around the 'Four Ps' used by the Scottish Government (Prevention, Protection, Provision of services and Participation) in an effort to maintain consistency with the strategic violence against women agenda in Scotland. We note that the EIGE uses a different definition (Prevention, Protection, Prosecution and Provision of services) and includes a fifth, 'Prevalence'. We felt it was important to retain Participation, given the importance of involving communities in work to tackle FGM, and that 'Prosecution' fitted broadly within our theme of Protection. We address the question of 'Prevalence' later in this chapter.

Our final sample included professionals working in health, the police and education, legal practitioners, NGOs, academics, government officials, and a UN body. Due to our restricted budget and timescale for the project, we were limited in the number and location of interviewees. Among our key informants were at least one person from Scotland, England, Ireland, France, Belgium, the Netherlands, and Spain, and one person working at an international level (see Appendix 2).

Interviews were carried out in English or French by the Principal Investigator. 12 interviews were conducted in person and four were carried out over Skype. Interviewees were given information and asked to provide written consent to be interviewed. The interviews were digitally recorded where permission was given and transcribed professionally; where permission was withheld, the Principal Investigator took written notes. Transcriptions were corrected manually by the research team and coded using online qualitative data analysis software. Every effort has been made to anonymise quotes and findings from key informant interviews.

2.2 Limitations of statistical data and terminology of 'prevalence'

As many of our key informants were keen to underline, tackling FGM must begin with an attempt to establish baseline data on the possible scale of the problem in a particular context:

It is important to get accurate estimates of...prevalence for several reasons: for judging the relative importance of adverse health consequences, for the allocation of resources, and for planning interventions. (Yoder et al 2004, p.8)

Such calculations have been carried out in a number of EU countries in the past two decades, most notably in France (Andro et al 2009), Belgium (Dubourg 2011), the Netherlands (Exterkate/PHAROS 2013), Spain (Kaplan & Lopez 2009) and England and Wales (Dorkenoo/FORWARD 2007). The EIGE report (2013) provides a helpful summary of these. At the time of writing, the data for England and Wales was being updated by Equality Now and City University London to take account of 2011 census data (Macfarlane & Dorkenoo 2014).

Most of these studies have used census data to calculate the number of women and girls resident in the relevant country but born in certain countries of origin. These numbers are then multiplied by national prevalence rates for these countries, as taken from Demographic and Health Studies (DHS) and Multiple Indicator Cluster Surveys (MICS), and summarised in documents such as the UNICEF Statistical Overview (UNICEF 2013).

Although the resulting estimates of prevalence have been used to drive awareness and prevention campaigns, researchers acknowledge the limitations of this method of data analysis.⁹

These can be summarised as follows:

1. Unable to obtain data on undocumented migrants, refugees and asylum seekers from census data
2. Unable to obtain data on second generation women from census data
3. Unable to obtain data on ethnicity
4. No information on the type of excision
5. No information on the age at excision
6. No information on the influence of migration on FGM such as:
 - a. Age at arrival in Europe
 - b. Length of stay
 - c. Place of socialisation
 - d. Links with country of origin
7. No information on wider family/community situation and links

(Equality Now/FORWARD 2012, p.9)

In France, researchers have overcome the second of these limitations by combining census data with data from a 'Family History Study [*Etude de l'Histoire Familiale*]' which interrogated not just women's own country of birth but the country of birth of their parents. Combining these two datasets resulted in a graduated assessment of risk for three categories of women:

Category	Risk Level
Women born in a risk country who arrived in Europe > 15yrs	High
Women born in a risk country who arrived in Europe < 15yrs	Medium
Women born in Europe whose parents were born in a risk country	Low

(Andro et al 2009, p.12, translation from French by the research team)

⁹ In the course of our research, we were made aware of upcoming research, which aims to develop a more robust methodology for calculating prevalence in a European context (Academic EU 1).

However, this type of additional dataset was not available for Scotland at the time of writing. For our purposes therefore, the second, third and sixth of the points above proved to be of particular importance to our study. We explore these, and explain our resulting choice of the terminology ‘potentially affected communities’ rather than ‘prevalence’, below:

- Unable to obtain data on second generation women: The census statistics available to us are based on reported country of birth. Similarly, the available birth registration data is premised on the mother’s country of birth. It is particularly difficult therefore to estimate the number of girls born in Scotland to parents also born in Scotland, but where FGM may be a traditional practice affecting those parents or influential extended family members.
- Unable to obtain data on ethnicity: Yoder et al note that, ‘except for countries with prevalence rates above 90%, FGM prevalence varies widely within country by ethnicity’ (Yoder et al 2004, p.9). This is of particular relevance in Scotland given the wide variance in FGM prevalence in Nigeria, the country of origin of Scotland’s largest potentially affected community.
- No information about the influence of migration: Research undertaken with communities from practising countries who now live in Europe indicates that FGM is a ‘tradition in transition’ (Berg 2013). Although many of these studies are limited by small sample sizes and the risk of respondent bias in their self-selecting samples, a trend of gradual abandonment of FGM amongst certain communities is notable and we should be mindful of the findings of such studies:

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, p.11).

As a result of these observations, and further limitations imposed in the Scottish context by published census data not being disaggregated by gender or age at the time of writing, we avoid the terminology of ‘prevalence’ in this study and instead will use the available data to ‘describe potentially affected communities’ in Scotland.

This approach has two further benefits, beyond methodological accuracy. Firstly, using ‘potentially affected’ rather than ‘practising’ is in line with good practice recommendations developed elsewhere in the UK during PEER research:

Options UK recommends avoiding the term ‘practising communities’. This phrase assumes that people are still practising FGM which can perpetuate stigma and may be wholly inaccurate. Rather we suggest the term ‘affected communities’. (Hemmings 2011, p. 13)

Secondly, we will describe whole populations, not just because of the limits of our data but because as many of our key informants pointed out, the attitudes, opinions and behaviour of men and young people are key, both to understanding the perpetuation or discontinuation of the practice, and to creating sustainable efforts to prevent and ultimately eradicate the practice.

Chapter 3 – Communities potentially affected by FGM in Scotland

In this chapter we present the findings from our analysis of available secondary data from Scotland’s 2011 Census, birth registration data for 1993-2012, the 2013 Pupil Census, and administrative records provided to us by a range of statutory and voluntary sector stakeholders across Scotland. We conclude this section with a case study, which suggests initial pathways towards more robust community-level data that could overcome some of the statistical limitations outlined in 2.2 above.

3.1. Analysis of census and birth register data

We used 2011 Census data to estimate the size of communities living in Scotland originating from one of the 29 FGM-practising countries identified by UNICEF (2013).¹⁰ The total number of people (men, women and children) born in one of these countries and living in Scotland in 2011 was 23,979. As discussed, the data available to us was not broken down by age or gender, and is based on self-reported country of birth. This figure therefore does not include the children born in Scotland of parents born in an FGM-practising country. Figure 1 shows the size of communities in Scotland born in FGM-practising countries.¹¹

Figure 1 – Number of people living in Scotland born in an FGM-practising country

Country of birth	Total in Scotland
Nigeria	9,458
Kenya	2,743
Iraq	2,246
Ghana	1,658
Somalia	1,591
Egypt	1,322
Uganda	986
Sudan	749
Tanzania	681
Cameroon	406
Eritrea	399
Sierra Leone	377
Gambia, The	370
Ethiopia	258
Yemen	245
Ivory Coast	195
Guinea	74
Senegal	73
Liberia	71
Togo	25
Chad	20
Benin	18
Guinea-Bissau	14
TOTAL	23,979

The data available also enabled us to estimate the size of communities potentially affected by FGM in each local authority area. Figure 2 shows the total number of men, women and children born in one of the 29 countries¹², who were living in each Scottish local authority area in 2011.

Figure 2 – Number of people born in an FGM-practising country living in each Scottish local authority area

Area	Number of people
Scotland	24,012
Aberdeen City	4,241
Aberdeenshire	539
Angus	181
Argyll & Bute	171
Clackmannanshire	78
Dumfries & Galloway	194
Dundee City	1,126
East Ayrshire	82
East Dunbartonshire	263
East Lothian	190
East Renfrewshire	217
Edinburgh, City of	3,583
Eilean Siar, Orkney Islands, Shetland Islands	74
Falkirk	156
Fife	679
Glasgow City	8,647
Highland	400
Inverclyde	60
Midlothian	153
Moray	121
North Ayrshire	98
North Lanarkshire	311
Perth & Kinross	405
Renfrewshire	497
Scottish Borders	237
South Ayrshire	123
South Lanarkshire	515
Stirling	221
West Dunbartonshire	144
West Lothian	320

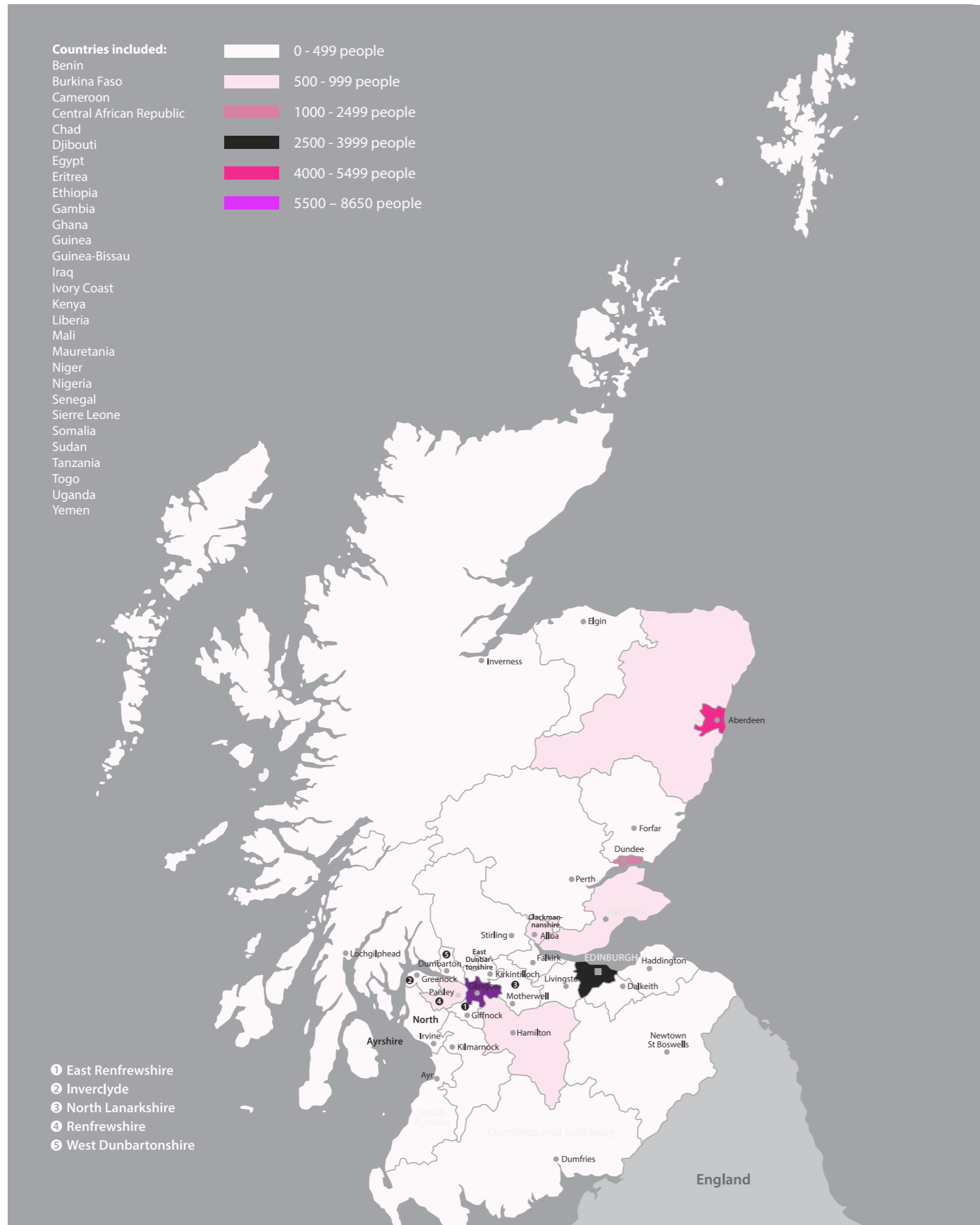
In Figure 3, we map this data on to a map of Scotland to highlight the geographical distribution of communities in Scotland potentially affected by FGM.

¹⁰ Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea Bissau, Iraq, Ivory Coast, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Sudan, Tanzania, Togo, Uganda, Yemen

¹¹ To protect against disclosure of personal information, the number of people born in each country was only provided where this was greater than 10. For this reason the totals in figures 1 and 2 differ slightly

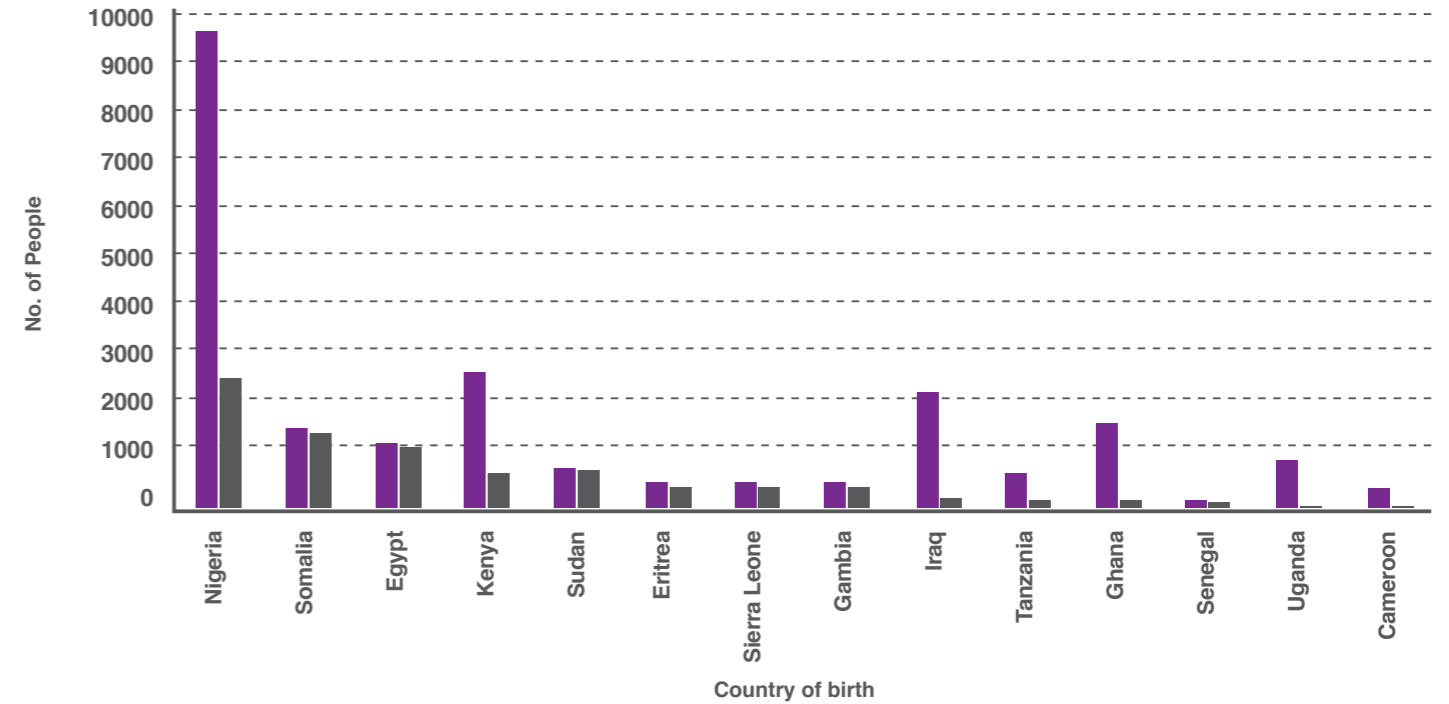
¹² Due to statistical disclosure and an error in which Democratic Republic of Congo (DRC) was initially included in a list of FGM practising countries, 14 people born in DRC are included in figures for council areas with small populations of people born in FGM practising countries. This does not affect the totals for highlighted council areas with larger populations.

Figure 3 – Size and location of communities potentially affected by FGM in Scotland



Country of origin data suggests that FGM prevalence rates vary considerably across different countries. In order to better approximate the size of potentially affected communities in Scotland, we took the largest communities and multiplied the total number of people living in Scotland born in these countries by the national FGM prevalence rate (UNICEF 2013).¹³ The results are shown in Figures 4 and 5.

Figure 4 – Size of communities in Scotland un-weighted (Purple) and weighted (Grey) by national FGM prevalence



Country of birth	Total Scotland	Prevalence rate	Adjusted for prevalence
Nigeria	9,458	27%	2554
Somalia	1,591	98%	1559
Egypt	1,322	91%	1203
Kenya	2,743	27%	741
Sudan	749	88%	659
Eritrea	399	89%	355
Sierra Leone	377	88%	332
Gambia, The	370	76%	281
Iraq	2,246	8%	180
Tanzania	681	15%	102
Ghana	1,658	4%	66
Senegal	73	26%	19
Uganda	986	1%	10
Cameroon	406	1%	4

Figure 5 – Size of communities in Scotland potentially affected by FGM weighted by prevalence (opposite).

To add to this data, we analysed the register of births in Scotland from 1993 to 2012.

Figure 6 shows the number of births to mothers born in an FGM-practising country for each year from 2001-2012; and Figure 7 demonstrates the increasing birth rate in Scotland for mothers born in FGM-practising countries over the period 2001-2012.

¹³ As the data available to us was for whole communities (men, women and children), this calculation is particularly crude. National prevalence rates in country of origin surveys are calculated based on the number of women aged 15-49 years who have undergone FGM.

Figure 6 – Number of births registered in Scotland to a mother born in an FGM-practising country

Year	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total Births	156	208	258	278	324	372	494	622	765	744	716	733
Female Births	67	100	109	133	161	190	234	314	358	370	351	363

Figure 7 – Births in Scotland from 2001-2012 to mothers born in an FGM-practising country

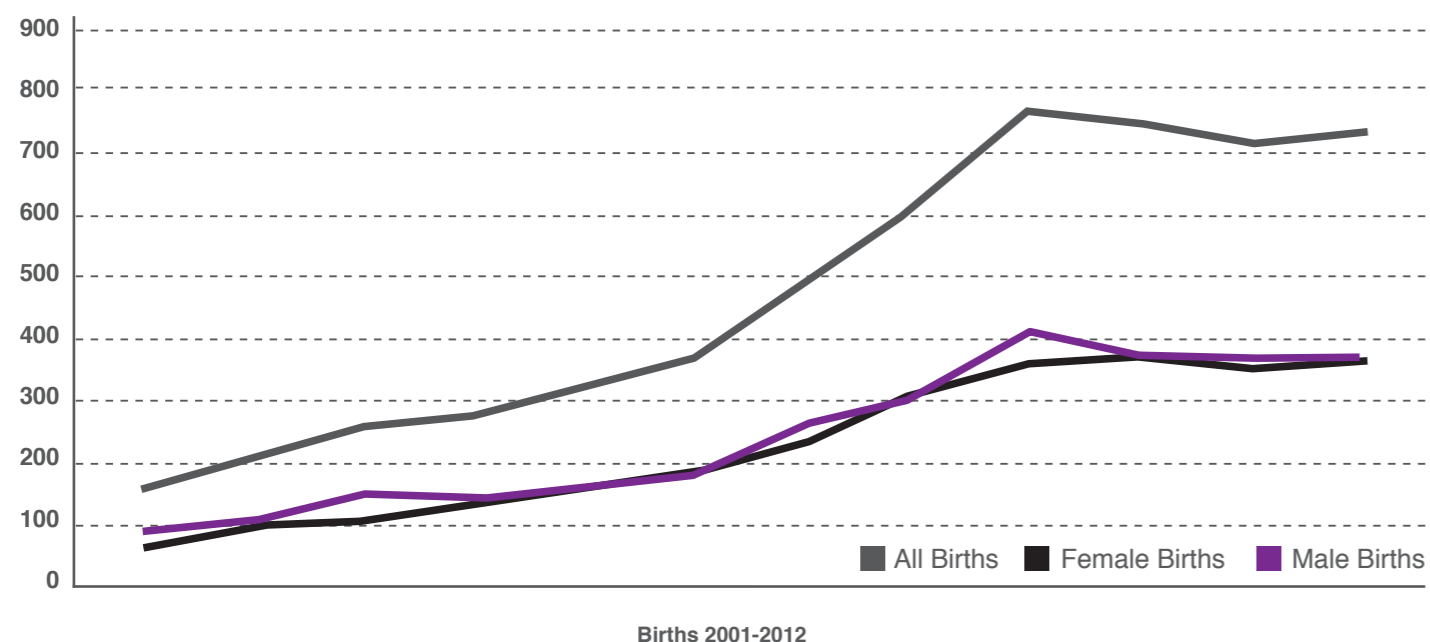


Figure 6 shows that in 2012, 733 children were born in Scotland to mothers from an FGM-practising country, of which, 363 were girls. Taking account of this and Figure 7, which illustrates a steady increase in the number of births to mothers born in an FGM-practising country, we can approximate a minimum additional 700 children per year born into communities living in Scotland potentially affected by FGM.

In Figure 8, we analyse the birth register data from 2012 further. Taking the five largest communities living in Scotland potentially affected by FGM (Nigeria, Somalia, Egypt, Kenya and Sudan), we can see that children born into these five communities make up around three-quarters of all births in Scotland to mothers born in an FGM-practising country.

The national FGM prevalence rate in the mother's country of birth is shown in the first column for information; however, extreme caution should be exercised in assuming a particular level of risk to girls born into these communities for the reasons discussed in Chapter 2.

In particular, we do not have information about the effect of migration on the practice of FGM, nor the ethnic and socio-economic origins or values of these particular communities living in Scotland.

Figure 8 – Number of girls born in 2012 into largest potentially affected communities

Mother's country of birth (FGM prevalence rate)	Number of births in 2012	Number of female births in 2012
Nigeria (27%)	381	186
Somalia (98%)	42	19
Egypt (91%)	13	10
Kenya (27%)	38	21
Sudan (88%)	32	15
Total	506	251

3.2 Administrative Records

In addition to analysis of the census and birth register, the research team sought information about what data on FGM was being recorded by a number of stakeholders in the areas of health, education, child protection, asylum, criminal justice and voluntary sector support services. The purpose of this exercise was to assess whether any administrative records could be used to inform our estimation of the size and location of communities potentially affected by FGM in Scotland; and to begin to build a picture of who is collecting data on FGM and any gaps.

The table in Figure 9 describes the information that was made available to the research team by the stakeholders we contacted. The data available is predominantly for Glasgow and Edinburgh, though some organisations provided Scotland-level data and one provided UK-level data.

Figure 9 – Summary of administrative data made available to research team

Source	Data available
Scottish Government Equality Unit	Analysis of 2011 Census and Birth Register - see section 3.1
Scottish Government Education Services - Pupil Census 2013	Languages spoken in publicly funded schools in Scotland 2013; Nigerian languages spoken by local authority area - see section 3.3
Police Scotland	FGM related incidents in Scotland April 2013-May 2014; nationalities involved; responses.
NSPCC	Calls to FGM helpline & Childline (UK wide); responses.
Legal Services Agency (Glasgow)	Asylum cases where FGM raised as an international protection issue 2013-14; nationalities; case details.
Glasgow City Council Social Work Services	Glasgow City Children and Families Services have information on five FGM related referrals April-Sept 2014.
NHS Greater Glasgow & Clyde	Number of women with FGM in midwifery and sexual health services 2011- June 14; number of referrals for de-infibulation; % of trauma service users disclosing FGM; number of disclosures of FGM in Asylum Health Bridging Team 2012-14.
NHS Lothian	Number of cases of FGM seen by Lothian Obstetrics and Gynaecology consultants; review of electronic maternity records currently underway (Oct 2014).
roshni	Number of service users who disclosed FGM (Jan-Sept 2014).
Rape Crisis Glasgow	Number of service users who disclosed FGM (May 2013-May 2014).
Scottish Refugee Council	Number, nationality, age and gender of newly granted refugees in Scotland who accessed Refugee Integration Service April 2013-November 2014; number of FGM-related disclosures by asylum seeking families who accessed Family Keywork Pilot Project December 2013-October 14.

A number of initial gaps were identified through this exercise. Firstly, FGM is not currently recorded as a specific category of child protection referral. This means that there is no national level data on FGM-related child protection referrals. Secondly, we received data and/or information on FGM from three of Scotland's health boards: Greater Glasgow and Clyde, Lothian, and Highland. Based on the statistical analysis presented in section 3.1, we approached health officials in Aberdeen and Dundee, but did not receive further information from those areas. Additionally, health officials we did speak to reported that only two of Scotland's 14 regional health boards (NHS Lothian and NHS Ayrshire and Arran) currently have electronic maternity records, making central recording and monitoring of disclosures of FGM in maternity services problematic. Thirdly, one of the main voluntary sector service providers working with communities affected by FGM in Central Scotland did not share service level data with the research team.

Due to the sensitive and confidential nature of much of the administrative data disclosed to us, we have not included the detail of the figures we were provided with by stakeholders. However, it is useful to highlight some key observations.

Firstly, the nationalities identified by stakeholders broadly align with the statistical data for potentially affected communities in the previous section. Disclosures of past experience of FGM to health services in Glasgow came most commonly from women of Eritrean, Nigerian and Gambian origin. The most common nationalities of families claiming a fear of FGM as a reason for seeking international protection to a specialist legal service in Glasgow were Nigerian, Gambian and Somali. The most common nationality of families where an FGM-related risk to a child had been identified in Scotland was Sudanese and then Gambian, with Nigerian and Kenyan also being mentioned.

Geographical areas in Scotland where disclosures of past experience of FGM or risk of FGM to a child were reported to the research team, also broadly correlated with our statistical findings, in that most available data on FGM disclosures or fear of FGM was for the Glasgow area, with Edinburgh reporting most instances of concern about a child to the police, and West Lothian and Aberdeen being mentioned in a small number of cases either of disclosure of past experience or a reported risk to a child. Numerically, even in Glasgow, health services reported a relatively small number of disclosures of FGM. Maternity services reported around 12 disclosures since 2011 to June 2014, and sexual health services, around 24 over the same period.

It is very likely that this represents significant under-reporting of cases. NHS Greater Glasgow and Clyde Asylum Health Bridging Team, which is based at the accommodation where most asylum seekers dispersed to Glasgow are initially housed, and where an initial health assessment is carried out, reported 86 disclosures of FGM in the year 2013-14. This constituted a 330% increase on the year to 2012, which is likely to be at least in part due to a tailored assessment questionnaire containing a specific question on FGM, framed within sensitive inquiry around gender based violence and torture.

Scottish Refugee Council service data indicates that 768 refugees (men, women and children) from FGM-practising countries accessed its Refugee Integration Services between 1 April 2013 and 6 November 2014, constituting 45% of its refugee service users.¹⁴ 275 of these service users were female (including girl children). It is worth noting that refugee communities dispersed to Scotland through the asylum support system, may choose to move elsewhere in the UK following a grant of leave to remain. Forthcoming research looks at the patterns of onward migration in Scotland and the UK providing useful context to these figures (Stewart & Shaffer, forthcoming).

The total number of referrals to Police Scotland was less than 20 from April 2013 to May 2014 and all related to concerns and/or potential risk rather than incidences of FGM having been carried out. Glasgow City Children and Families Services are aware of less than five FGM-related referrals to Social Work Services April-September 2014. Less than 10 service users each of two specialist voluntary sector support providers had disclosed FGM in 2014 when we received this data (Jan-September 2014 and May 2013-May 2014 respectively). Seven newly arrived asylum seeking families working with Scottish Refugee Council's Family Project had disclosed FGM or fear of FGM to their keyworker since the pilot project began (December 2013-October 2014).

The information we received from stakeholders should not be used to draw any conclusions about the risk of FGM to girls living in Scotland nor the size or location of potentially affected communities, as it almost certainly represents an underreporting of FGM related concerns or experiences to services in Scotland. There are many reasons why women may not disclose FGM to professionals and why reports or referrals of concerns about a risk of FGM might not be made. We approached stakeholders for additional information in relation to FGM in order to contextualise our statistical analysis and inform an understanding of what baseline information about communities potentially affected by FGM is currently being recorded.

3.3 Case Study: the Nigerian example

The statistical data presented in this chapter shows that people born in Nigeria are the largest community potentially affected by FGM living in Scotland. In this section, we explore some of the literature on FGM in the Nigerian context, in order to illustrate the limitations of nationality-based prevalence data and the need for further engagement with communities potentially affected by FGM living in Scotland.

The most recent Demographic and Health Study (DHS) for Nigeria (NPC Nigeria 2009) suggests that the prevalence of FGM differs by region, ranging from 53.4% in the south west, to 2.7% in the north east. UNICEF gives a 27% national rate for Nigeria (UNICEF 2013). However, more localised studies have consistently shown variation in prevalence by variables such as ethnic group, religion, age and education (Dare et al 2004; Snow et al 2002; Mandara 2004; Obi 2004; Onah 2001; Lawani et al 2014).

In a study carried out with women accessing a maternity clinic in south west Nigeria, Dare et al (2004) found a 69% prevalence of Type I FGM and a 31% prevalence of Type II. They also found that most FGM was performed on girls between the ages of 3-7yrs. Another study of women in urban southern Nigeria, also in a hospital setting, found a prevalence rate of 45.9% (Snow et al 2002). This study found that ethnicity was the most significant predictor of FGM, followed by age, religious affiliation and then level of education. The highest prevalence was found among Bini (69%) and Urhobo (61%) ethnic groups, and among those affiliated to the Pentecostal (61.4%) or traditional (76.5%) religions. The lowest prevalence was found among women aged 15-19 years (14.5%), Esan (32.5%) and Yoruba (28.9%) ethnic groups. 68% of women in this study had undergone FGM before the age of 1yr.

Another hospital-based study in north-central Nigeria found a 34% prevalence rate (Mandara 2004) but significant variation across different ethnic groups. Contrary to the findings of the study in southern Nigeria, there was little variance between religious groups, with 41% of Muslim and 37% of Christian women having undergone FGM. Educational levels were an important factor, however, with 38% of women with no education reporting that they would perform FGM on their daughters, but only 8% of those educated to tertiary level agreeing. Two further studies demonstrated a decreasing prevalence of FGM by age. Prevalence rates were much higher among older women, with one study finding a rate of 86.2% among women aged 41-45yrs and just 5.5% among women aged 16-20yrs (Obi 2004).

Given this variance in data from Nigeria, more accurate estimates of prevalence and risk amongst the Nigerian community in Scotland would require analysis of the region of origin, ethnicity, age, religion, and educational background of Nigerians living here. Neither do we have data on the influence of migration on Nigerian communities' practices and perceptions of FGM in a European context. Most community-based attitudinal studies have focused on communities of East African origin (for example, Norman et al 2009; Gele et al 2012; Vloeberghs 2012; Johnsdotter 2009) and thus cannot be considered as reliable guides to the dynamics of change within Nigerian communities.

Indeed, the only such study identified in our literature review that comprised a substantial sample from a Nigerian community found that many members of that community living in the study location (Hamburg) came from regions of high FGM prevalence and supported the practice of FGM. The risk for girls of being subjected to FGM - despite residence in Germany - was therefore assessed as being moderate to high (Behrendt 2011, pp. 47-53).

In the Scottish context, where many affected communities are thought to have a refugee background, work with Nigerians may be particularly important. One of our key informants (Participant 1) felt that Nigerian women were often associated with trafficking-based protection claims, and that professionals working with Nigerian women may not consider the potential for them to be affected by FGM.

We looked at data from the 2013 Pupil Census to find out more about the ethnicity of Nigerian communities in Scotland. As Figure 10 illustrates, we found that most pupils where a Nigerian language is the first language spoken at home are in Glasgow (49%), followed by Aberdeen (28%), Dundee (13%), and Edinburgh (10%).

Yoruba is the most frequent (52%), followed by Ibo/Igbo (25%), Hausa (18%) and Edo/Bini (5%). Most pupils from a home of Yoruba speakers are in Glasgow schools (49%), followed by 27% in Aberdeen. The same pattern is seen for Ibo/Igbo and Edo/Bini with 57% and 100% respectively in Glasgow. Most Hausa speakers (42%) are in Aberdeen, followed closely by 40% in Dundee.

¹⁴ On average, 88% of the total number of people granted international protection in Scotland access Scottish Refugee Council's Refugee Integration Services.

Figure 10 – Pupils in publicly funded schools in Scotland in 2013 for whom a Nigerian language is the first language spoken at home

Local Authority ¹⁵	Yoruba	Ibo/Igbo	Hausa	Edo/Bini	All
Dundee City	12 (6%)	10 (11%)	26 (40%)	-	48 (13%)
Edinburgh City	32 (17%)	5 (6%)	-	-	37 (10%)
Aberdeen City	51 (27%)	23 (26%)	27 (42%)	-	101 (28%)
Glasgow City	93 (49%)	51 (57%)	12 (18%)	20 (100%)	176 (49%)
Totals	188 (100%)	89 (100%)	65 (100%)	20 (100%)	362 (100%)

Although this information does not necessarily bring us closer to understanding the prevalence of FGM within Scottish-resident Nigerian communities, it does provide an indication of where resources could be targeted to explore the beliefs and attitudes to FGM among Nigerians in Scotland, and to inform training and guidance for professionals working with those communities.

In order to develop a broader understanding of the Nigerian - or indeed any other – potentially affected community in Scotland, there must be engagement with these communities. One way of doing this could be through research using PEER or PAR methods¹⁶ to establish whether interventions are necessary, and which could explore questions around where in the country of origin the community comes from; how long they have lived in Scotland; what their level of knowledge around FGM and Scottish legal provisions is; and what the prevailing attitudes towards FGM are in the community.

Finally, as we explore further later, any subsequent interventions should then be designed with - and not for - the community, recognising and building on work to tackle FGM in the Nigerian context:

Western feminists need to be aware that their articulations of concern...are often perceived as only thinly disguised expressions of racial and cultural superiority and imperialism. This is particularly so when they fail to acknowledge the decades of work by African women dedicated to ending FGM practices.

(Gunning 1992 as quoted in Dustin 2010, p.11)

¹⁵ These results exclude those cities where pupil numbers were too low to be reported numerically.

¹⁶ See section 4.2 for further information about these developing methods of community research.

Chapter 4 - Effective interventions in the European Union

In this chapter, we present the findings from our 16 key informant interviews complemented by references from our scoping literature review, consultation with stakeholders and workshops with community representatives. As discussed in previous chapters, we structured our review and interviews around the 'Four Ps' framework used by the Scottish Government in its strategic violence against women agenda: 'Participation, Prevention, Protection, and Provision of Services.' This proved to be a helpful framework for the research. Below, we reflect a further emerging theme, 'Strategy, Policy and Research'. As well as a section on 'Participation', we have also incorporated findings on 'Participation' throughout the other sections in recognition of the importance given to this theme by our respondents across all strands of work.

4.1 Participation

Across all contexts, above all, respondents emphasised the importance of working with communities to ensure that policy-making and practice development is shaped by the experiences, needs and views of those affected by FGM. A specialist NGO in the UK stressed that it was important for communities 'to actually recognise they themselves are a wealth of knowledge and can be instrumental in intervention' (NGO UK 1). This was emphasised in the literature:

Women's arguments against FGM, spoken fluently and in their own words and crucially, coming from within the community, provide an important resource for those working to end FGM.

(Norman et al 2009, p.12)

Statutory service providers too, stressed that 'nothing will be achieved unless we secure the support of the community' (Police UK 2). A participant in our workshops with community activists clearly articulated this:

Anything around FGM needs to be championed and developed with people affected at the centre and leading the work – we have voices of people with lived experience living in Scotland.

(Workshop Participant)

At an EU level too, taking a grassroots approach to working with communities and providing a framework for community voices to be heard, was seen as essential:

Finding ways and mechanisms to give [community organisations] that capacity, the framework and leverage for them to be heard [is] very important because I don't believe we can effectively abandon FGM in the EU...if those communities are not the ones...acting for the abandonment of FGM. It's a very important role and only they can actually do it.

(Participant 1)

Despite a consensus that tackling FGM is not possible without the participation of affected communities, respondents in different contexts saw 'direct work with communities and attitude on change directly rather than as the consequence of legal provisions' as a gap (Academic EU 1). The UK in particular was seen to be lagging behind in this regard:

In Holland, you've seen the example of them being much more engaged with the communities and working with them on these issues. In the UK we tend to have a piecemeal approach.

(NGO UK 1)

This view was backed up by the literature:

In the UK, efforts to reduce FGM have focused on punitive legislation without at the same time sufficiently empowering women in the communities concerned to engage in debate, change attitudes and create alternative ways of affirming their cultural identity.

(Dustin 2010, p.19)

The consensus, therefore, was that affected communities must be involved in all work on FGM, whether it is in the development of strategy and policy, child protection frameworks, public campaigning and awareness raising, service provision, or community based prevention interventions. As such, we have incorporated findings on participation into each of the remaining thematic sections.

4.2 Strategy, policy and research

4.2.1 Strategic framework

Our key informants were clear that in order to effectively tackle FGM, Scotland needs a strong strategic framework, which incorporates policy, legislation and engagement with professionals and communities across prevention, protection and provision of services, and which is outlined in a resourced, standalone national action plan:

... The creation of a national action plan... would give an impetus to all of the work... While the violence against women and girls strategy is necessary, it is not sufficient.

(NGO UK 1)

Examples were given of European countries (such as Ireland, Norway and Portugal), which have succeeded in taking forward such an approach, and it was suggested that Scotland could learn from and link to these experiences (Academic EU 1).¹⁷

The current approach to FGM in the UK was seen as 'very much target and task driven instead of strategy driven' and did not encompass 'the bigger picture'

¹⁷ Examples and further details of such national action plans can be found at: <http://www.endfgm.eu/en/resources/legal-framework/national-action-plans/>

(NGO UK 1). A national action plan should be multi-agency and developed in partnership with key stakeholders, including affected communities:

Authorities should... design a plan of action on FGM and... attach a budget to it and [it] should not only be developed by officials in their offices but... in collaboration with the communities themselves and with all stakeholders.
(Academic EU 1)

Respondents acknowledged some of the challenges to strategic work on FGM, including time and capacity pressures on service providers:

Our skills are where they are and that's in hospitals providing appropriate care...I can't cancel clinics to go to [meetings], so healthcare professionals are not involved as much as they could be...
(Medical Practitioner UK 2)

The National Clinical Group¹⁸ on FGM was referenced as a positive example of a forum incorporating strategic and service provision levels (Medical Practitioner UK 2); and in Catalonia, a multi-agency approach has brought different professionals together to encourage partnership working on this complex issue (Academic EU 2).

A further challenge is how to involve communities affected by FGM at the strategic level. One respondent felt that there was a lack of UK Government investment in the work of specialist NGOs tackling FGM at community level compared to other EU governments (NGO UK 1). It was emphasised that a strategic focus on prosecutions and legislation cannot stand alone and must be combined with action and engagement with professionals and communities (NGO EU 1).

A UK-based NGO felt that it was important that governments designate a national lead for FGM:

...we were very strong on the government having a lead person or co-ordinator to respond to FGM.
(NGO UK 1)

This was supported by other respondents, who noted that historically, the support of particular government ministers, who had taken on a quasi-formal role as FGM 'champions', had been vital to progressing work on FGM (Government EU 1; NGO EU 4; NGO EU 2).

Enabling policy environments that had contributed significantly to FGM being prioritised by governments were also described, for example, in France, where a series of FGM-related deaths in the 1980s coincided with the left

coming to power, a strong feminist movement, and a Minister for the Rights of Women being appointed. Combined, this was said to have been instrumental in ensuring FGM moved up the agenda (NGO EU 2).

The Europe-wide End FGM Campaign led by Amnesty International Ireland¹⁹ gave an important impetus to tackling FGM, structuring inclusive approaches and providing a mechanism for NGOs to have their voices heard at the European level (Participant 1; Academic EU 1).

I believe the Amnesty...campaign has ...enabled those voices to be heard in ways that wouldn't have been possible by individual NGOs on their own trying to push their agenda at local or national level.
(Participant 1)

Respondents referred to the EIGE report (EIGE 2013), the European Daphne Programme funding stream²⁰, and the Amnesty International campaign as having succeeded in coordinating and developing member states' responses to FGM, encouraging collaboration and sharing of best practice, and bridging gaps between law and policy (Participant 1; Academic EU 1). The work of UNHCR to evidence the prevalence of FGM as an international protection issue in Europe (UNHCR 2013) was also seen as critical to advocacy work to get FGM on the agenda of EU institutions (Participant 1).

4.2.2 Contextualising FGM

A number of respondents spoke about the importance of contextualising FGM as a form of violence against women and girls, acknowledging the role of gender, power and control in the perpetuation of the practice, and 'the need to situate FGM and analyse it within the wider continuum of honour based violence' (Police UK 2).

The Netherlands took the approach of incorporating FGM into existing work around child and domestic abuse, which had 'been a subject of importance for more than 20 years', seeing FGM as a 'special form of child abuse' (NGO EU 3).

In the context of asylum too, it is important to 'understand that gender component and the norms, the behaviours, the expectations placed upon all of the members of a community for the replication, the continuation of this tradition' in order for asylum decision makers to understand the links and relevance to the UN Refugee Convention' (Participant 1).

The importance of cultural context and finding ways to engage young people on the issues without alienating or stigmatising them was also noted. In schools particularly, it is important to take care to contextualise FGM to avoid stigmatisation (NGO EU 2). Talking about FGM within the context of human rights, the law, child abuse, and challenging patriarchy were also felt to be important by some:

I was talking to a couple of women who did not know they had rights for anything. That's why it's important for them to understand the definition of human rights and also FGM is against human rights.
(NGO EU 1)

4.2.3 Sustainability

Respondents in different contexts raised concerns about the sustainability of FGM interventions. A particular concern was that tackling FGM at community level requires long-term investment. Some felt that what was needed was significant resourcing by governments of community based organisations with the relationships and trust required to affect change; others were less specific, highlighting a need for longer-term investment in implementation and action beyond the development of protocols, frameworks and action plans (Academic EU 1; NGO EU 3; NGO UK 1).

It was also highlighted that there is a need to acknowledge and value the work of community based organisations, which are regularly approached for their expertise, but are rarely funded for this advisory role. One respondent claimed that community based organisations were overlooked in favour of larger and more established national charities when it came to government funding:

Clearly they respect our knowledge... They would come to us for...training and advice... but when it comes to giving the money, we're not given the money... community work is undervalued and under-resourced.
(NGO UK 1)

Another concern was the reliance of work to tackle FGM on individuals with a particular interest and commitment to the issue:

The difficulty with all new services is they're often very dependent on the clinician that's leading them... If you have a really...enthusiastic committed midwife, obstetrician or gynaecologist, then the services will develop... A keen midwife will run the service for two years...then she'll leave...and it all fizzles out.
(Medical Practitioner UK 2)

At an EU level too this was a concern:

It was one of the findings in [the] EIGE study that it depends very much on personal commitment...not only in the civil society sector but equally at political level.
(Academic EU 1)

4.2.4 Data collection

Respondents discussed data collection in a number of contexts, including health, asylum, criminal justice and prevalence. Overall, pockets of good practice were identified, but consistent recording was lacking in all contexts. Respondents felt that the mere collection of data was not necessarily enough and that analysis and publication of trends was needed to ensure appropriate monitoring of FGM and responses to it (NGO UK 1).

A number of issues with data collection in health services in the UK were highlighted, ranging from problems in the identification of FGM by health professionals to coding and recording the different types of FGM. Even where codes do exist for FGM in health services, accuracy depends on professionals recognising and recording FGM correctly (Medical Practitioner UK 2). That reliable identification of FGM by medical practitioners is still problematic is supported by several UK studies, where even doctors working in ethnically diverse areas and alongside specialist FGM units demonstrated a lack of confidence in identifying FGM (Relph 2013; Zenner 2013).

Respondents in the UK felt that there was a lack of guidance on recording FGM (Medical Practitioner UK 1), further hindered by a lack of common data sets across hospitals and health administrations:

In England there are no standard obstetric notes... It's included often in an area of high prevalence and you might have it in your local booking notes here but it might not be in booking notes throughout the whole of the UK. The questions are often not compulsory so if it's not ticked... you don't know if... it's just not been asked.
(Medical Practitioner UK 2)

In Belgium there has been an improvement in recording in hospital settings following the introduction of coding for different types of FGM accompanied by descriptive information cards to aid health professionals in identification (Academic EU 1).

In the asylum context, a respondent spoke of the need to evidence the number of asylum claims based on FGM in order to encourage the government to invest in a response. In the UK, the Home Office does not provide a breakdown of the grounds for asylum claims, unlike in Belgium, for example, where this data is published (Participant 1).

¹⁸ www.fgmnationalgroup.org

²⁰ http://ec.europa.eu/justice/grants/programmes/daphne/index_en.htm

¹⁹ www.endfgm.eu

4.2.5 Research and evaluation

In terms of specific interventions to respond to or prevent FGM across the EU, there is limited evidence of thorough evaluation having taken place. However, there have been developments in peer and participatory research methods as tools for informing and developing interventions:

For us, the participatory research has been a strategic tool for effective programming...a starting point for us to direct our interventions better.
(NGO UK 1)

However, the potential difficulties involved in undertaking such research must be taken into account, particularly given the possible negative reactions that peer interviewers may face from within their own communities:

Some interviewers saw themselves confronted with negative consequences in their daily lives... The fact that some interviewers experienced their social network weakened can be considered one of the most substantial difficulties faced by the project.
(Behrendt 2011, p.18)

In terms of evaluations of specific interventions, respondents noted in particular the lack of studies of health interventions responding to FGM (as outlined for example by Balogun 2012). There have been reviews of health services detailing the number of service users, but they lack data on patient satisfaction or outcomes, and no clinical trials have been carried out. Surgical procedures in particular are a little explored area:

Things like deinfibulation before delivery or in labour... there's no guidance as to what's best, so we do what we think is clinically best and sensible but there's no evidence base at all for any of this.
(Medical Practitioner UK 2)

A respondent from the Netherlands agreed that there was a need for more work in this area and referenced a group of doctors who were planning to publish a body of evidence on reparative surgeries in late 2014 (NGO EU 3). See section 4.5 for further discussion of surgical interventions in response to FGM. In terms of prevention interventions, in Catalonia, longitudinal studies have been carried out to evaluate the knowledge, attitude and practice (KAP) of professionals working in health and social care to inform the development of training and guidance for professionals (Academic EU 2).

A respondent in the Netherlands described their organisation as a 'knowledge centre' on FGM, dedicated to carrying out research, training and information campaigns with communities.

Of all respondents those based in the Netherlands provided the most examples of evaluated interventions. One example was a study currently in progress to evaluate a pilot in six regions of the Netherlands to provide dedicated information points on FGM at health centres (NGO EU 3; GOV EU 1). Community level interventions had also been evaluated, although only qualitatively, finding that taboos around FGM had lessened among communities (GOV EU 1).

A number of respondents referenced the EU-funded Replace and Replace2 programmes²¹, which were seen as innovative and positive contributions to peer research informed interventions grounded in a theoretical framework of behaviour change. These programmes are currently being evaluated (NGO UK 1; Academic EU 1).

4.3 Prevention

In this section, we present our findings on preventative interventions, which aim to create and sustain behavioural and attitudinal change within affected communities. These differ from protective interventions (see section 4.4), which typically focus on protecting the rights of individual women and girls.

Respondents agreed that preventive interventions are a vital part of an effective two-pronged approach to tackling FGM in a European context. Both French and Dutch respondents reported some success in changing attitudes and reducing FGM through a combination of prevention and criminal justice interventions, described by one respondent as 'two sides of the same coin, neither can succeed without the other'
(NGO EU 4).

In the UK too, it was agreed that prosecution and protection based approaches could not succeed without a parallel preventative, community based focus:

Given the deep rooted cultural nature of harmful traditional practices, we can mount as many arrests as we possibly can... but unless...an affected community changes their thinking, then we're never going to truly... prevent or...eradicate these practices.
(Police UK 2)

We have divided our findings in this area into three principal sections. In the first, we present what respondents told us about bottom-up approaches aiming to support communities to prevent FGM. In the second, we report on more traditional campaigning and awareness-raising approaches. Finally, we provide an overview of views on the role of professionals in preventative activities.

4.3.1 Community based interventions

In terms of community based prevention interventions, the EU-funded REPLACE 2 Programme²² was identified as a good example, described as 'innovative because it focuses on behaviour change, it works directly with the communities which is quite exceptional in Europe' and it is 'framed in a theory of behaviour change which really has a thorough methodology...; and also an evaluation' (Academic EU 1).

Essentially describing a Community Development process²³, another respondent outlined this approach in more detail: the first stage consists of participatory research to identify needs, which involves 'training community people to conduct the research, identify some of the issues and to also be part of the data analysis'; the next stage is 'analysis and reflection on what needs to be done and then you move on to action', which involved women from affected communities moving onto health leadership training and a health advocates programme working in schools and providing input to professionals during training sessions (NGO UK 1). A final stage in this process would be evaluation, which, in the case of Replace2, is currently underway. Working with women collectively in this way was identified as a model of good practice, 'instrumental in enabling women at the community level to not only understand the issues but also to be able to get the confidence and skills and be able to engage' (NGO UK 1).

In the literature, Brown et al's analysis of the complexities of behaviour change emphasises that such work must take into account the different dynamics that can perpetuate FGM, and so provides a useful theoretical basis for the planning of preventive community interventions:

Behaviour change approaches cannot only focus on the individual and thus neglect the wider social dynamics; nor can community based approaches... overlook interpersonal and intrapersonal aspects... at the community level.
(Brown et al 2013, p. 2)

It is equally important to acknowledge that behaviour change within communities can involve a painful process of internalisation for community members (Lien & Schulz 2013). The shift from acceptance of FGM as a custom or requirement, to the belief that it is a harmful practice can cause feelings of shame and lead to a painful re-assessment of self (Dieleman 2010).

A lack of awareness among communities and survivors of FGM, of their rights and the law was something that was highlighted by a number of respondents in different contexts (NGO EU 4; Police UK 2; Medical Practitioner UK 1). Community awareness raising was therefore seen as essential and integral to engagement around FGM:

The best way is education, education, education... community campaigns, people who know very well about FGM and about why they do it because these are deeply rooted problems and unless we get the roots, we can't eradicate the problem.
(Medical Practitioner UK 1)

With this in mind, we present below a series of recommendations for engaging with communities as identified by our key informants and in the literature, followed by an exploration of the different roles that can be played by leaders, young people and men within affected communities.

Key considerations in engaging with communities on FGM

In terms of engaging with communities specifically around the issue of FGM, our respondents highlighted a number of important areas to consider:

- Developing trust
- Tailoring approach to a particular community
- Removing barriers
- Using appropriate and specific tools and materials
- Linking to countries of origin

These largely confirm and build on the recommendations of research carried out on community-based preventive interventions in the UK (Esme Fairbairn 2013, p.4).

Developing trust

Building up trust and positive relationships with communities, families and individuals was seen as key to successful engagement, although it was acknowledged that, 'it does take a period of time but it's about how you build that rapport and that working relationship' (Police UK 2). Without those relationships, one respondent said that 'any work would be ineffective' (Education UK 1).

Another said that 'you have to build the bridge... When we talk about prevention, you can't... say if you do this, you're going to go to prison... you lose the trust between you and the community' (NGO EU 1).

²¹ www.replacefgm.eu

²² <http://www.replacefgm.eu/>

²³ www.scdc.org.uk

• Linking to countries of origin

Tailoring approach to a particular community

The importance of acknowledging that affected communities are not a homogenous group and that their attitudes and their reasons for practising FGM may be different was highlighted:

You have to know the community. Even the community itself has different cultures, different rules and ways of talking.
(NGO EU 1)

Another respondent cautioned that, ‘communities are very sensitive to this idea of “that’s my country, that’s not my country”’ (NGO EU 2). There is a danger that a non-tailored approach may at the very least have little effect, or, at worst, alienate communities:

The information only made the Gambian women feel sceptical. The messenger was a foreigner living in England, not a Gambian...and mostly talked about Somali customs. Her information was deemed irrelevant and not credible.
(Lien & Schulz 2013, p. 6)

The importance of recognising and responding to the emergence of new diaspora communities was discussed by respondents in France, who mentioned recent work with the Guinean community (NGO EU 4, NGO EU 2); and in the Netherlands, where a respondent described work with Indonesian and Malaysian communities among others in Asia and the Middle East (NGO EU 3).

Removing barriers

A number of respondents described the importance of acknowledging the barriers that may prevent communities from engaging on the issue of FGM and considering ways in which these could be addressed:

One of the things to understand is that these communities find it very, very ashamed to speak about genitalia because they have been brought up that...no-one should speak about it. So women find it very difficult to explain or express their ideas about FGM and find it more difficult to speak to someone who has no idea about it.
(Medical Practitioner UK 1)

The need to work with men and women separately before bringing them together was highlighted to ensure any barriers to discussing FGM in a shared space can be addressed (NGO EU 1). And the potential difficulties of working with interpreters around this issue were also raised (Medical Practitioner UK 1).

One respondent stated that when engaging with communities, it is better if the focus of an event is not solely FGM, but that approaching the issue by way of another context can be helpful:

When they know the focus is on FGM, none of them will come and support you because they know it’s scary; they know the hard subject and the heavy things we’re going to be talking about.
(NGO EU 1)

However, other respondents had engaged successfully even when an event was explicitly described as an FGM event, for example a recent conference on FGM organised by the Police was very well attended:

What was reassuring as an exceptionally brilliant catalyst for change was how well attended [the] conference was...What that was, was a clear signal that there is a coalition of community partners...motivated by the need for change.
(Police UK 2)

Using appropriate and specific tools and materials, and linking to country of origin

Respondents described using a range of tools and materials to engage with communities, including visual materials, films or plays to enable discussion about a character and materials produced in countries of origin, which were seen to be useful to demonstrate that practices are shifting back home (NGO EU 2). Other tools mentioned were web chats, fashion shows, music and campaigns in schools (Education UK 1; NGO UK 1; NGO EU 1).

Respondents noted that it can be helpful to make use of materials produced in countries of origin to demonstrate that practices are evolving there, and help to tackle the issue of diaspora communities holding on to ‘tradition to retain their identities despite being in exile’ (NGO EU 2). One explained that this can be an effective approach:

It’s not a question of turning up with one’s own knowledge, but of starting off with the knowledge of communities themselves, then building something together’
(NGO EU 2).

Additionally, prevention work can have an influence on the attitudes of families in countries of origin. For example, a letter provided to families travelling overseas by the Catalan Government outlining the illegality of FGM in Spain, enabled women to ‘talk with their sisters and friends...so all the explanation and all the sensitisation that the health professional has done [in Spain] is being replicated or duplicated in origin’ (Academic EU 2).

Similarly, another respondent noted that women talking to family members in countries of origin about criminal sanctions imposed in France can help to change attitudes (NGO EU 4).

4.3.2 The role of key figures within communities

Community leaders, or emerging leaders, were identified by respondents as having a key role to play in tackling FGM. Provided that they enjoy trust and respect within their communities, these ‘insiders’ can be central to bringing about behavioural change:

It came from her, a Gambian woman and a doctor, and was not Western propaganda, it was real.
(Lien & Schulz 2013, p.7)

An activist explained that while ‘it doesn’t need to be a survivor...you do need someone from that community’ (NGO EU 1). A UK respondent reiterated the effectiveness of the message when it comes from within the community:

We...brought a woman from Somalia to deliver [a] session on social services and safeguarding children. It was a different dynamic...and at the end of the day, it really transformed the women’s attitude because this is somebody from the community talking about these issues.
(NGO UK 1)

In the Dutch Chain Approach (discussed further in section 4.4) over 100 key community figures play an important role in protecting children, and in education and preventative work with communities:

They trained key figures to visit houses and educate their own community about the risks of FGM and they had meetings for men, for religious leaders, for youth, just to get the message out and to make sure there isn’t a taboo any more to talk about it.
(GOV EU 1)

Respondents identified a role for key community figures in facilitating access to communities and enabling dialogue within the community:

What you need is a voice from somebody in the community and then you can talk to your group and say this is what’s happening, this is how we can fight to end it.
(NGO EU 1)

However, taking on a leading role in the community is not necessarily easy and people need support to do so:

I don’t think they find it easy.
(Police UK 1)

While it is necessary to support strong community voices, ‘they have to be coached fairly well’ (Academic EU 1), and may require training and support to ensure that they are ‘prepared for what they’re doing’ (Police UK 1).

Several respondents described negative reactions, such as pressure and criticism from within their community, towards figures speaking out on FGM. Incidents in which respondents had been accused, for example, of making porn films, or received verbal abuse or threats were reported.

However, it was felt to be important to work through these issues:

That was difficult in the beginning to persuade people to do this because they were criticised from within the community, people saying, “You shouldn’t do this, you shouldn’t work with the white professionals, this is our stuff. Don’t speak about it. So it was hard but now the taboo has really diminished and it’s really great.”
(GOV EU 1)

Ensuring that key community figures and others carrying out community engagement on FGM have access to support services and know how and where to signpost people to when they engage with affected communities is essential, as one Dutch respondent recommended:

What I would do differently now is make sure there’s help for the women that are already circumcised because...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 and the key figures who are mostly volunteers had to deal with all these emotions and now I would say make sure when you organise educational meetings that there’s somebody to help these women deal with all this emotion.
(GOV EU 1)

Lastly, financial support and recognition of the time that key figures in the community dedicate to tackling FGM is important. One respondent described this work as ‘undervalued and under-resourced particularly when it comes to working with women as advocates. Everybody feels it should be free and women should have the time and energy to continue to give their time and effort without... the necessary remuneration’ (NGO UK 1).

4.3.3 The role of young people

Respondents identified young people as having a critical role to play in tackling FGM. The younger generation were seen as ‘advocates of change’ (NGO UK 1) who are more able to speak freely about FGM and more likely to become involved in community campaigning and activism. Creative engagement with young people is key not only because young women may be at risk of FGM but because they are the next generation:

If you want to create change, you work with the parents of the next generation. Because all you can do is try and protect girls who haven't been through it so far. Obviously prosecutions are important but prosecution means you're too late. The focus should be...on safeguarding and if you include the teenagers and the younger children now, the aim is to make sure the next generation is safe. (Education UK 1)

Examples were given of effective work with young people in the UK, including Daughters of Eve²⁴, Integrate Bristol²⁵ and FORWARD's youth work project.²⁶

In other European contexts too, young people were described as being ‘very useful...I'd say there would be a lot of young people who want to be the campaign leader or start doing activities’ (NGO EU 1). In Ireland, young people have been involved in ‘using films and resources to support...statutory professionals in schools and...other key people’ (NGO EU 1).

In part the ability to work successfully with young people was seen to be due to their being more able to speak out about FGM as compared to the previous generation who may be a ‘lot more reserved in what they say and their opinions... Lots of the girls have said, “I never spoke about this to my mother, let alone my father, I wouldn't have dreamt in a million years of having a conversation about this with my mother and now I'm sitting down talking about it with my father.” It does very definitely go from child into the community, there's no doubt about it’ (Education UK 1).

4.3.4 The role of men

Most respondents agreed that involving men in work to tackle FGM was essential. In the context of working with men, a number of respondents reiterated the need to contextualise FGM within the continuum of gender based violence:

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. (Police UK 2)

Men are often missing from work to tackle FGM:

Something that's really missing is when we talk about the community, we always target women, but what about the men, are they not part of the decision making? FGM is not only the woman's decision. (NGO EU 1)

Although the majority of respondents worked predominantly with women, men are increasingly becoming involved:

In the period from 1980 to 2000, there was a strict separation between men and women, when men said “it's women's business, you have to talk to them”, but since 2000...we can see a lot of understanding and a willingness [from men]. (NGO EU 2)

Women from affected communities highlighted to us the importance of engaging with men, though they stressed the need to initially work with men and women separately before bringing them together:

If the men and women were in one room, they wouldn't be talking. The husband will not like the wife to talk about their personal life at home. The wife would be scared to talk because he is there. (NGO EU 1)

It was noted that men in migratory contexts were far more likely to be involved than in countries of origin (Academic EU 3). In the Netherlands, involving men was common practice: ‘I never heard it was difficult to involve men and the men I've spoken with are very passionate’ (GOV EU 1).

Respondents did suggest that the role of men in work around FGM could differ from that of women. In the Netherlands, the majority of key community figures in the Chain Approach were women because it involved going into people's homes and talking about sensitive issues, which was seen to be a more appropriate role for women (GOV EU 1). As for women, the role of men was often speaking out against FGM, for example at a police-led conference, a number of men attended both to support their wives and partners but also to speak out against FGM and its impact on their relationships (Police UK 2).

Community representatives in our workshops cautioned that those engaging with men and women affected by FGM must be aware of the impact FGM has on relationships and the potential for it to cause tensions within families.

4.3.5 Campaigning and awareness raising

On campaigning and awareness raising, respondents stressed the need for a concerted effort to tackle FGM across multiple public-facing bodies encompassing the entire political spectrum, so that awareness raising reaches the general public, service providers and policy makers (Legal Practitioner UK 1). An ambitious and multi-level approach to awareness raising was seen to have many benefits.

At a UK level, respondents reported that collaborative campaigning and awareness raising had pushed the UK Government to respond to the issue of FGM and that campaigners have successfully brought in organisations working at the EU level to help influence (Academic EU 1; NGO UK 1).

In France too, an NGO described the positive impact of public campaigning and awareness raising on FGM:

From the beginning we worked on a double strategy: on one hand, the [criminal] trials were highly publicised in the media and promoted the message that it is forbidden by the law; and...we have had several national FGM prevention campaigns. (NGO EU 2)

Another respondent spoke of the positive impact of gaining high profile celebrity endorsement of a campaign:

First of all, a lot of people joined to meet celebrities and then they started seeing the message that we were trying to convey and then they genuinely wanted to be involved. (Education UK 1)

UK participants from a range of disciplines stressed the importance of targeting FGM awareness-raising campaigns towards young people and young women and girls in particular (Police UK 2; Education UK 1; NGO UK 1).

A number of participants mentioned the Europe-wide End FGM Campaign led by Amnesty International Ireland as providing an important framework for campaigning against FGM at European level. It was seen to have had significant impact establishing a mechanism for NGOs to have their voices heard (Participant 1; Academic EU 1; NGO EU 1). The media was seen by respondents to have significant power and impact on work to tackle and respond to FGM, confirming findings from previous research (Andro et al 2009; Vloeberghs et al 2011; Reig Alcaraz et al 2014).

Mostly, the impact was seen to be beneficial, if sometimes wearing (Medical Practitioner UK 2). One respondent did caution that media attention on work in a school context had led to an angry backlash from men in the community (Education UK 1).

For the most part, however, media attention served to raise awareness both with professionals and affected communities. In the case of professionals, survivor stories in particular increased empathy and understanding, helping to overcome cultural sensitivity as a barrier to the provision of care:

You can't deny that all of the survivor stories in the newspapers are heart rending and if people read them and realise that's what it means to a young woman or girl, then it may change what they think they can and can't ask people. (Medical Practitioner UK 2)

This respondent also saw a role for the media in raising awareness with communities about the law and illegality of the practice, suggesting that increased media coverage meant that ‘women from the communities are now very aware it's illegal’ (Medical Practitioner UK 2).

In other parts of the EU, respondents felt that the UK could do more to engender public debate and media coverage of the issue, although there was acknowledgement that the issue was now more prominent (Academic EU 2).

In France, a respondent suggested that what had peaked Western media interest in FGM was the realisation that girls were at risk here too (NGO EU 2). Another suggested that media coverage contributed to increased community awareness of services available to survivors of FGM, saying that ‘women who participated [in our research] were widely aware of the possibility of reconstructive surgery and this seemed to have been driven in large part by media...coverage’ (Academic EU 3).

4.3.6 The role of professionals in prevention

Respondents highlighted that in addition to protective and responsive roles, professionals can play a key role in the longer-term prevention of FGM as affected communities come into contact with services. This is confirmed in the literature (see for example Martin 2007; Krasa 2010; Cottingham & Kismodi 2009; Costello et al 2013; Reig Alcaraz et al 2014; Moore 2014). In the UK, respondents felt that this preventive role of professionals was not yet clearly defined or articulated (Police UK 2; NGO UK 1; Medical Practitioner UK 2).

²⁴ <http://www.dofeve.org/>

²⁶ <http://www.forwarduk.org.uk/programmes/uk-programmes/youth>

²⁵ <http://integratebristol.org.uk/>

A UK-based respondent was clear that the police role goes beyond criminal investigation to include partnership working on prevention, education and awareness raising, not only internally, but also among other statutory professionals including health and education (Police UK 2).

The preventive role of health professionals, in particular, midwives, obstetricians, GPs, school doctors and paediatricians, was also highlighted by many respondents in different contexts (Medical Practitioner UK 2; Legal Practitioner UK 1; Academic EU 2; Medical Practitioner UK 1; Police UK 2; NGO EU 3; Academic EU 1; NGO EU 1). A UK-based respondent felt that there was a need to communicate more clearly and recognise through a *'clear strategic framework...that health plays a critical role both in provisioning of services but also in prevention and protection'* (NGO UK 1).

A respondent in Spain spoke of work in Catalonia to train and raise awareness among health and other professionals with close links to families, such as GPs and paediatricians, suggesting this benefits both the families and the professionals themselves as they feel *'empowered by knowledge'* to raise the subject of FGM (Academic EU 2).

As a universal point of contact with communities, GPs in particular were identified as having the potential to play a key role in prevention through the provision of information about FGM to communities (Legal Practitioner UK 1; Medical Practitioner UK 1). However, they were also identified by many as one of the hardest groups to engage (NGO EU 2; Medical Practitioner UK 2; NGO EU 3; GOV EU 1; NGO EU 1). Different reasons were given for this; the most common being that for most, FGM formed a minor part of their workload and was often not seen as a priority (NGO EU 3; GOV EU 1). Time constraints also created difficulties (NGO EU 2; NGO EU 1). In England, work has been done to develop links from specialist services to GPs, to update them on developments and provide information on study days about FGM and clinics available (Medical Practitioner UK 2).

Maternity services were also seen to have a pivotal role to play in prevention (Medical Practitioner UK 1; Medical Practitioner UK 2). Maternity was seen as a key intervention point for education and awareness raising with women from affected communities:

It is the time during antenatal period to explain the consequences of FGM in the future for their kids and the UK law and child protection issues.
(Medical Practitioner UK 1)

However, this relies on the awareness of the first point of contact, and concerns were raised about the level of knowledge among professionals, with one professional in Scotland suggesting that *'most of the midwives don't have any idea about the types of FGM or the consequences'* (Medical Practitioner UK 1).

This respondent saw the obstetrician too as having a preventative and educative role. Specifically, the explanation of deinfibulation and the impossibility of reinfibulation was seen as an opportunity to discuss the law prohibiting FGM (Medical Practitioner UK 1). Education services were also seen to have a key role in prevention. In particular, primary schools, being universal, were seen as key intervention points (Legal Practitioner UK 1). Nursery teachers and classroom assistants are also important actors (NGO EU 2). A community activist recommended survivors or community representatives being invited to provide an input to encourage conversation and relationship building with teachers and schools (NGO EU 1).

In France, an example was given of how a region with a relatively small immigrant population had incorporated FGM into the curriculum in a way that it was felt avoided the stigmatisation of particular communities or children in a class:

I'll give you an example of what they've done in Normandy: they've included [FGM] into a more general module around sexuality... reproductive health...then [they] look at the particular issues of forced marriage and FGM. They explain that these issues concern large populations, without necessarily focussing on African countries and show that these are quite general issues that can affect large numbers of people.
(NGO EU 2)

Finally, very few respondents explored in depth the potential role for social workers in prevention, although they, like other groups of professionals, may well already have contact with families at risk (Academic EU 2). Costello et al argue that social workers too, whilst playing primarily a protective role, can engage in preventive work in coordination with other professionals:

Social workers and health and welfare professionals 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.
(Costello 2013, p.3)

4.4 Protection

A range of different policies and practices across the EU aims to protect women and girls from FGM. Previous reports provide detailed comparative analysis of these (for example Leye & Sabbe 2009; EIGE 2013), which we do not aim to replicate here. Rather, in this section, we present a synthesis of views on the approaches taken by different countries to 'Protection', and reflect upon the extent to which these echo the findings of previous studies. Our definition of 'protection' includes interventions covering child protection, risk assessment and reporting concerns about a risk of FGM or a child who has undergone FGM, the role of the law, prosecutions, and international protection.

4.4.1 Different approaches to protection

France

As the EU country with the largest number of successful prosecutions for FGM, France has frequently been referenced as a *'shining example'* in terms of protection policies (Guiné & Fuentes 2007; EIGE 2013; Bindel 2014). Yet as a French respondent emphasised, the approach to protecting girls from FGM in France is founded not on principles of punishment but on the best interests of the child:

The child has to be at the centre. Neither the French nor Scottish governments are interested in putting parents in prison; the best interests of the child take primacy over everything; it's really about children's rights, not women's rights.
(NGO EU 2)

Thus the approach in France is two-pronged and combines the preventive work discussed in the previous chapter, with a strong legal and child protection framework. An increase in the number of families in France abandoning the practice of FGM has been attributed to a number of high profile criminal trials (NGO EU 4). The threat of prison was seen to have a deterrent effect for some communities and well-publicised jury trials conducted at the highest possible judicial level were thought to have helped to break down taboos around the subject (NGO EU 4).²⁷

Integral to the French approach is the physical examination, including of genitalia, of girls up to the age of six, though it is important to note that this is standard practice for all children accessing specialist infant and maternal health clinics (*Centres de Protection Maternelle et Infantile*), regardless of ethnic origin.

While this was seen by French respondents as successful, some felt that it had the effect of transferring risk to older girls.

Respondents described situations where parents who persisted in practising FGM sent their children abroad in their early teens to be *'trapped'* into FGM and forced marriage (NGO EU 4).

Travel in general was seen as a risk factor, both to a parents' home country and within and across Europe (Academic EU 3; NGO EU 4). The training of education professionals is therefore key to the French approach, enabling teachers and other school staff to identify potential risk factors:

I know myself of children who have been identified by nursery or classroom assistants; it's often the person in that role who has identified little girls... Schools can play a role in identifying girls, without having to undress or examine children.
(NGO EU 2)

Some UK respondents supported the idea of physical examinations, for example, this police respondent:

I don't think it's a bad idea actually, not just for FGM but just a holistic medical approach... Are there signs of neglect? Has a child had all their inoculations?
(Police UK 1)

And, this legal practitioner:

Do we go down the French route, do we examine? If it saves girls' lives personally, I would be in favour of it. What is more invasive, having a quick check instantly on arrival, check again the next year... every year up to the age of seven? I would say that's less invasive and more protective...than the risk which is mutilation.
(Legal practitioner UK 1)

Others, however, did not. In Belgium, there had been *'fierce discussions'* on this issue:

I think it is a measure which is too repressive in nature... Why is this measure being proposed to detect FGM and not sexual violence or sexual abuse of children, in all children? I mean the cases of sexual abuse of children [are] so huge compared to FGM so you... have...double standards I think just because it's a migrant girl maybe...
(Academic EU 1)

As Johnsdotter cautions, in country sites where physical examinations are not routinely carried out on all children, proposals to institute such examinations only for girls from within certain communities could raise concerns around discrimination and racism (Johnsdotter 2009).

²⁷ This respondent was keen to emphasise that activists had campaigned for the first FGM trials to be held at the Cour d'Assises rather than at tribunal level as had originally been planned by public prosecutors. This was because legally, the injury involved was one of mutilation and so should not have been tried in an

administrative court; and strategically because it would raise awareness of the act and of its illegality thus having a deterrent effect.

French child protection laws have enshrined the concept of a ‘shared secret’, which enables professionals to share what would normally be confidential if it is in the best interests of the child (NGO EU 2). The law places a duty on professionals to report any cases of FGM they identify. However, even where this statutory duty to report cases of FGM exists, professionals often see it as a ‘*relative duty and balance it against professional secrecy provisions*’ (NGO EU 2) so reports are not always made. This respondent highlighted how difficult it is for professionals to assess risk of FGM happening in the future:

While there has been no crime, how can you tell whether the child is at risk? So you have to demonstrate through the application of objective criteria why you think that there is a risk; this is where professionals find it hardest... It is much easier to note that FGM has taken place... But what I want to know is how to prevent the mutilation - that is much more complicated for everybody.
(NGO EU 2)

Training, guidance and knowing whom to contact for advice were therefore seen as critical to professionals’ capacity to protect children. Where protection policies are implemented without investment in such measures, they are liable to lead to legal and ethical confusion (Johnsdotter 2010; Lien & Schulz 2014). To overcome these potential difficulties, a specialist NGO working in larger French cities described its relationship with organisations in other regions, forming a network of named specialists who could be contacted for advice (NGO EU 2). In regions with high concentrations of women from affected communities, every doctor is provided with a day of training on FGM annually (NGO EU 4), and specialist NGOs have succeeded in mainstreaming training for an array of professionals:

... We undertake both initial and CPD training for doctors, nurses, midwives, social workers, nursery teachers, nursery assistants – so we input...for example [to] modules on child protection, on human rights... We try to train those who already have an input in schools... [so] they can...broaden the impact of our work...
(NGO EU 2)

The Netherlands

The ‘*Chain Approach*’ [Ketenaapak] forms the core of the multi-disciplinary and partnership approach to protecting girls from FGM in the Netherlands, an approach seen by some as more integrated than that in France, despite the lack of criminal prosecutions thus far (Njieboer et al 2010).

The approach is premised on a clear five-step guideline for professionals on when, how and who to report concerns to; with a child protection referral to social services or the police being the final step. Reporting has been centralised to 20 designated child and family abuse reporting centres,

each of which has a specialised expert on FGM, who carries out a risk assessment and puts in place appropriate safeguarding measures, including referrals to health services and ‘*key community figures*’ to support families to protect their daughter(s). Key to the success of the approach is professionals feeling empowered and confident to report concerns and ‘*clear guidelines at different stages for different groups of professionals*’ (GOV EU 1). The involvement of affected communities in the Chain Approach was seen to be critical to its success and what made the Dutch approach different from others (GOV EU 1). Also key is the central focus on supporting parents to protect their daughters, rather than focusing on them as potential perpetrators.

Respondents described the involvement of the two-tiered Youth Healthcare system (national health provision for 0-4yrs and 4yrs and over) in the Chain Approach. A home visit two weeks after the birth of a girl born to a mother who is from a community affected by FGM is carried out, and then discussions may continue with a family up to when girls go to school: ‘*All the time, it’s being brought up*’ (GOV EU 1). A second intervention takes place when parents bring children to Youth Healthcare for general developmental check-ups:

We’ve made sure [health professionals] work with a digital registration system and when there’s parents from risk communities, they get a pop-up saying ‘FGM’.
(GOV EU 1)

Another Dutch respondent added:

We invest a lot in prevention, those talks with families before they go to the country of origin... that works well.
(NGO EU 3)

A specialist NGO supports the development of the Chain Approach, providing advice and delivering training to professionals. It emphasised that tackling FGM is: ‘*something which needs attention again and again... We... bring together all those professionals who are the specialists in each region... once a year...to ask for attention...[on] their task in the prevention of FGM*’ (NGO EU 3). Although there has been a lot of investment in training and guidance for professionals in the Netherlands, the focus on FGM has declined in recent years:

New professionals come in and they’re not trained like the old ones were five or ten years ago...we have to do...otherwise it will be paper policy and that’s a real danger here in Holland.
(NGO EU 3)

Unlike in France, the approach to reporting cases of FGM in the Netherlands is not a mandatory one, although professionals do have a statutory right to report:

[Mandatory reporting] leads to a lot of reports but they’re not all good reports so we didn’t want it and the professionals were really against that.
(GOV EU 1)

Another tool that has been used in the Dutch approach is a passport-sized government declaration, which states that FGM is forbidden in the Netherlands, punishable by a prison sentence and loss of the right to residency, and which families can carry with them when they travel overseas, ‘*really to support parents that don’t want to have their daughter circumcised but they feel family pressure; they can say it’s forbidden, it’s signed by the Minister of Justice and the Secretary of State for Health*’ (GOV EU 1).

This respondent suggested that the threat of prison and not being able to send remittances home was also a powerful deterrent.

The Netherlands had also tested protective tools that were found not to be effective:

We considered drawing up a contract for the youth healthcare... so they would provide information and the parents would sign they’re not going to do it. But we tested that... and it didn’t go well. The reason was talks from youth healthcare are 15 minutes and people didn’t want to sign anything that they hadn’t read and there was the language barrier. People couldn’t read it so it just wasn’t right and it felt... [repressive].
(GOV EU 1)

Spain

In Catalonia, a respondent described what they termed a ‘*repressive*’ police approach to safeguarding girls from FGM, which had led to cases of ‘*violation of the intimacy of the minor*’ and of the ‘*free movement of people*’ being taken to court:

...they go door by door knocking at the doors and taking the girls’ passports off the parents and they have to have genital checking every six months until they’re 18 years.
(Academic EU 2)

Our respondent explained: ‘*if you jump the first level, that is the preventive level – social care, health and education – you’re not following the protocol*’ (Academic EU 2). Furthermore, this approach was said to be resulting in girls being sent abroad to face forced marriage and FGM: ‘*As soon as they can send the girl, they will send her... This is not the way to do prevention, prevention is not for police. There’s another level first*’ (Academic EU 2). The role of law enforcement officers in child protection was therefore seen as important but described as the ‘*semi-final level*’.

It was suggested that a preventative approach based on a protocol - ‘*[for] schools... inspectors from schools, government, politicians, technical people from social services, from health, from hospitals*’ (Academic EU 2) - and training for professionals who are already in contact with families and have built up trust with them, is more appropriate:

You don’t need to invent another circuit, they’re normally in contact because of their work with the families so if you train them, they will transfer this knowledge... We believe this is an evidence-based approach, a respectful approach, a knowledgeable approach...
(Academic EU 2)

Like in the Netherlands, the approach in Catalonia also involves an official letter signed by government ministers outlining the illegality of FGM in Spain, which families can take with them when visiting relatives abroad:

...it’s very difficult for them to say [no]; you cannot contradict the authority of the elders. So that letter is like...saying...if you touch the girl you go to jail. If we go to jail, we don’t send you money... They talk with their sisters and friends...and so all the explanation and all the sensitisation...is being replicated or duplicated in origin. It’s a sustainable approach, respectful, knowledgeable and...it’s working.
(Academic EU 2)

Our respondent in Spain agreed that the threat of a prison sentence could be helpful when communicating with family members in countries of origin; however, without community engagement and the building of trust between families and professionals, a reliance on the threat of imprisonment was deemed to be ‘*very dangerous*’ (Academic EU 2).

Belgium

The child protection approach in Belgium was regarded as being behind that of the Netherlands in that professionals ‘*don’t really have any sound knowledge on FGM*’ (Academic EU 1). However, recent work with the Flemish Forum for Child Abuse has involved ‘*conducting a series of workshops...with the child protection sector...police and...educational sector to really see...what the gaps are*’ (Academic EU 1). This has led to a briefing on FGM and child protection being submitted to responsible ministers and departments, which has since resulted in the development of a new child protection protocol based on the Dutch model:

There was a protocol in the Netherlands developed. We invited key people from the Netherlands to hear, to discuss and to show us how they do it... We also designed...some questions on how to assess risk because it’s not so easy for a child protection professional to assess whether the risk is really acute...or maybe not so high.
(Academic EU 1)

As in other countries, specialist NGOs and academics have been involved in developing and delivering training for professionals. In Belgium, this was government funded and incorporated into a national action plan for tackling FGM:

In the first phase we trained health professionals in one province that had proven in the prevalence study [to have] the highest concentration of women and girls from FGM risk countries... Then in the second phase we went to the other provinces in Belgium to train ten hospitals.
(Academic EU 1)

Interesting developments have also occurred in Belgium regarding the protective role of immigration and asylum officials, which are explored further in section 4.4.3.

United Kingdom

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. One of the biggest challenges was seen to be a 'disconnect between safeguarding children who are safeguarded from other forms of harm and safeguarding children from FGM... Over and over again you get a situation where safeguarding professionals... go to training... [and] there's no mention of FGM.... So professionals do not see it as part of their role or responsibility... When there is a response, that response is also most always very drastic and repressive' (NGO UK 1).

Another respondent agreed that professionals in the UK were not necessarily aware of their role and responsibilities around protecting women and girls from FGM (Police UK 2).

A lack of trust between professionals with regards to information sharing was another challenge identified (Police UK 2; Education UK 1). One respondent felt that this came from the 'fine balance between under reaction versus overreaction by police', but also that 'medical professionals are far too guarded'. A need for 'mutual understanding and respect for other professionals' was emphasised, as well as a need for 'the police service [to] give and present that confidence to the medical profession about how they handle and manage that information' (Police UK 2). Another respondent admitted to a lack of trust in social services, noting discomfort with a police-led approach but highlighting difficulties 'in terms of social services that don't react as quickly as they could, information is not passed on. What we deem to be a serious risk they don't necessarily' (Education UK 1). Part of the reason for this could be the lack of training and guidance for professionals that was identified both in the literature and our own data (for example, Lavender 2009).

A respondent noted 'very little available within the wider NHS in terms of education for healthcare professionals' (Medical Practitioner UK 2); as well as a particular lack of understanding around whether or how to report a child who has undergone FGM:

I don't think it's because people don't want to do it, they don't know how to do it or they don't know they should be doing it... [there is a need for a] really clear referral service for when there's suspicion that a child's had FGM.
(Medical Practitioner UK 2)

Training and guidance was particularly lacking on reporting and, specifically, how to respond to adult women survivors of FGM in maternity services. In the next chapter, we touch on the clinical response for these women, but in common with many country sites (as surveyed in Leye & Sabbe 2009), 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 (Police UK 1). A health respondent saw it as their role 'to counsel [women] about their unborn child to make sure they're aware of the legal status and the health implications and if they've got other children, to make sure they're clear about that'. They acknowledged differences of opinion on reporting, however:

There's a call from government to say all of those women should also be reported to Social Services and the police... You can't refer hundreds of women to the police and Social Services who haven't committed a crime, who've had a crime committed to them years ago. But there needs to be some way of formalising identification and education... if you refer everyone, you'll overwhelm Social Services and the police for those women who need to be referred.
(Medical Practitioner UK 2)

Added to this was what another respondent saw as the difficulty of relying on a mother's assurances that she does not support the practice of FGM:

Even if that is genuinely her belief, and it may well be... it's not always that mother's decision about what happens, it's a much wider family issue... if... [the mother says] 'No, no, no'... what do we do?
(Police UK 1)

The recent Intercollegiate Guidance (RCM et al 2013) on FGM was referenced in the context of reporting adult survivors, but it was felt not to be unhelpful on this particular matter:

On one page it says all women should be referred to the police and the next page it says a referral should be considered or with the consent of the women. So it has two completely different policies within the same document... of course we would all refer a child we thought was at risk or had had recent FGM. But an adult pregnant woman, how do you assess who should be referred and who shouldn't... There's no guidance.
(Medical Practitioner UK 2)

Police respondents, however, were clear that all survivors of FGM should be reported to the police, comparing serious injuries caused by FGM to knife crime:

Is that any different to someone who is prepared to use a knife and stab someone? Injuries are the same as in the graphic cutting, the health implications, the mutilation, they're the same. What's the difference?
(Police UK 2)

In response to the resourcing concern raised by health professionals, the police felt that it was their responsibility to respond to an increase in workload (Police UK 1), and that ultimately where a crime has been committed, there is a duty to report:

If someone comes in with... [a] firearms injury, it's mandatory they will report that. If someone comes in with a stabbing injury and I'm in Glasgow Royal Infirmary, they will report that... Why wouldn't I then report a woman who has presented either as a domestic abuse victim or who's undergone FGM?
(Police UK 2)

Specialist NGOs, however, did not support this approach:

There was a recent... [recommendation] on mandatory reporting which meant that anybody who is seen to have had FGM irrespective of the age it was done should be reported to the police or social services... what does this mean? Does it mean for every woman who's gone through FGM, we're reporting her to social services because she's going to be at risk or she's going to be a perpetrator? Again this is very repressive and the approach on dealing with this has been very, very piecemeal.
(NGO UK 1)

Suggested solutions to some of these concerns in the UK context around reporting, confidence between agencies and information sharing, included making better use of existing structures and frameworks, such as Multi-Agency Safeguarding Hubs (MASH), to manage sensitive information appropriately and make informed decisions about particular cases:

We've already got the... Multi-Agency Safeguarding Hubs which operate in London and different parts of the UK... professionals sitting in those hubs with a firewall wrapped around them in how they're managing very sensitive information. We should be using those structures to put all the pieces of the jigsaw together to be making informed decisions around whether we break out that confidential information or not.
(Police UK 2)

Another recommendation was the development of a co-ordinated multi-agency approach to risk assessment that is based within specialist FGM clinics 'with links within those clinics for Social Services and police and all women [are] referred to the clinic for health issues, then that's where you'd... [coordinate] your Social Service referrals and information giving and education' (Medical Practitioner UK 2). Such an approach would enable both a clinical assessment for the mother and a risk assessment for girls in the family, with any serious concerns identified resulting in an appropriate referral.

Another suggested solution was the development of a coordinated response where single points of contact are identified in different agencies. A health respondent recommended that 'each hospital or trust should have a named FGM person and that could be a child protection person or whoever; if you've got areas of big density, that would be more than a person, it would be a service in Glasgow'; and it was felt to be particularly important that all maternity services have a named FGM professional (Medical Practitioner UK 2). The police in England and Wales already operate a system of Single Points of Contact (SPOCs), a named person in each child abuse operational team trained on FGM and linked in to other teams and agencies. In London, police SPOCs and named health professionals were encouraged to meet to ensure they knew their relevant counterparts (Police UK 1).

The development of training, guidance and resources for professionals was also seen to be a critical to a coordinated protection response. The police in England referenced work to develop pathways, training and support for other professionals, as well as for officers, investigators and prosecutors. Best practice guidance has been published online for police forces across England and Wales and brochures have been distributed to schools 'to raise awareness amongst teachers, for signs, symptoms... and things to look out for' (Police UK 1).

Although one respondent described work with young people to develop resources, such as films, to support statutory professionals in schools (NGO UK 1), teachers were otherwise identified as a group that has received very little training, not only in the UK, but across the EU (Education UK 1; Academic EU 1; EIGE 2013):

If there's a girl who's at risk of FGM or has had FGM, these conversations are not going to be happening at home so the only other place they're likely to happen is at school. If the teachers aren't trained and aren't comfortable, then that girl has got absolutely nowhere to go. (Education UK 1)

In terms of training for health professionals, one respondent described having delivered seminars on FGM to colleagues that had proven popular (Medical Practitioner UK 1).

Another suggested that training and guidance developed by NGOs should be brought into the statutory sector, rather than *'reinventing the wheel'*, and noted that the FGM Clinical Group was seeking to do this (Medical Practitioner UK 2). In the UK, as well as other contexts, GPs were seen as an important, but challenging, group to target for training (Medical Practitioner UK 1; NGO EU 2; NGO EU 3; NGO EU 1).

4.4.2 The role of law and prosecutions

In terms of the role of the law in protecting women and girls from FGM, respondents agreed that it was important for laws prohibiting and criminalising the practice to be enacted and that the law served to set out a protective framework that can be relied upon by affected communities, professionals, the police and the courts. However, as discussed above, opinions differed on the role of the law in protecting women and girls from FGM. The example above of some UK professionals feeling that the law should require professionals to report all cases of FGM they identify (Legal Practitioner UK 1; Police UK 1; Police UK 2), and others strongly disagreeing (NGO UK 1; Medical Practitioner UK 2), is an illustration of this difference of opinion among stakeholders.

Several respondents emphasised that enacting legislation that criminalises the practice is not enough to protect women and girls from FGM. It is essential that *'we...start talking about it publicly and educate the communities at risk'* (Legal Practitioner UK 1). Respondents highlighted that many women undergo FGM as infants and have grown up with its consequences, so they have *'accepted it'* and may not know that it is an offence (Police UK 2). Thus, communities must be aware of the law for it to be effective, and several of our key informants stated the need for a coordinated response from professionals to disseminate information about the law to communities:

There are certain organisations that see the groups at risk. [Asylum advice services are] one, primary schools are another, hospitals, GP surgeries... It ...needs the courage to speak out and speak openly about this and cut through the cultural taboos. (Legal Practitioner UK 1)

In discussing prosecutions, respondents highlighted the need for a victim-centred *'violence against women and girls'* approach, which strikes the correct balance between the needs of the victim and the need to eradicate the practice of FGM (Police UK 2). It was pointed out that one reason for the lack of prosecutions in the UK was that the police do a lot of proactive intervention and prevention work, going out and speaking to affected communities and professionals (Police UK 1).

It was suggested that in France, high profile prosecutions had had more influence on attitudinal change among communities than the simple knowledge that FGM is illegal. Other respondents cautioned about a focus on prosecutions, suggesting that successful trials in one country could lead to the practice being pushed across borders (Academic EU 1). Others agreed that close international working was required to tackle FGM as a transnational issue (Police UK 2). A respondent working at the international level reiterated the need for a multi-pronged response:

The abandonment of FGM will not be achieved solely through criminalisation. Deterrent we know is not the most effective way if approached solely through the angle of criminalisation. (Participant 1)

One of the key barriers to prosecution highlighted by respondents across different contexts is the likelihood that a victim will need to testify against her relatives, and the difficult question of how to balance this against the best interests of the child (NGO EU 4; Police UK 1; Police UK 2; Academic EU 1). There is also the difficulty of acquiring medical evidence. One respondent went as far as to say that the *'old principles'* of client confidentiality needed to be *'updated'* (Police UK 1). Another reflected further on this, suggesting that the lack of confidence among and between professionals highlighted in the previous section hindered investigations that could lead to prosecutions:

It's that balance between giving professionals, affected community members, victims' or potential victims' confidence of what we will do or won't do... I think there's a need for the police service to provide confidence to other professionals around how we're going to handle sensitively and confidentially that information. (Police UK 2)

Some respondents saw the legislation itself as a further barrier to prosecution. A respondent in England said that there must be clarification in law *'in relation to the nationality of the victim and/or suspect'*, as the 2003 Act leaves a gap in this regard (Police UK 2). Adjustments have been made to the legislation in some country contexts, in order to facilitate prosecutions, and at the time of writing FGM laws in Scotland, England and Wales were also under review. In the Netherlands, the law has changed to criminalise *'people who are not Dutch or living in Holland [who] circumcise Dutch girls'*, which could have far-reaching legal implications with criminal liability no longer solely resting with the parents. In the event that a grandparent, for example, performs FGM on a child in another country, on entry to the Netherlands that person can be taken into custody (GOV EU 1).

In France, the law makes parents criminally liable if they ought to have known that their child was at risk of FGM. As such, even if the parents did not perform FGM or arrange to have it performed, they can still be convicted of a criminal offence (GOV EU 1).

A lack of understanding and knowledge about FGM and affected communities among law enforcement officers was noted as another potential barrier to prosecutions (NGO EU 2). In breaking down some of these barriers, NGOs were seen to play an important role, providing training and awareness raising to the police and prosecutors:

We've been very instrumental in training the police to have a better understanding of FGM and be able to really understand the challenges around FGM as a special form of child abuse. (NGO UK 1)

England-based stakeholders (Police UK 2; NGO UK 1) reported helpful engagement between specialist NGOs, the police and prosecutors: *'[NGOs'] knowledge, advice, guidance and support has been absolutely instrumental and continues to be instrumental'* (Police UK 2). In France, NGOs can be civil parties to a legal case. According to one respondent this *'has been key to the approach'* taken to prosecutions in France. However, NGOs must be involved in the cases from an early stage to be able to provide background evidence, and this has not always been possible in practice (NGO EU 4).

In summary, respondents highlighted a number of barriers to prosecutions, some of which could be addressed through a victim-centred approach, training and awareness raising among both professionals and affected communities, and a focus on combining a strong legal framework with investment in prevention and the development of guidance and frameworks for reporting and information sharing.

4.4.3 International protection

A final area considered by respondents in relation to protecting women and girls from FGM, was that of international protection. Respondents highlighted some positive developments in FGM being recognised as an international protection issue at UK and EU levels; as well as some concerns around disclosure, awareness among legal representatives, monitoring, and a potential lack of equivalence in the protection available to women and girls seeking asylum based on FGM, to the protection available to women already living in the UK.

One respondent described the development of UK asylum case law around FGM following the *'seminal'* Fornah case²⁸, which for the first time accepted that women from affected communities who had not undergone FGM could be considered to be at risk of persecution under the 1951 Refugee Convention (Legal Practitioner UK 1). Another agreed, and noted the comparatively high recognition rate for asylum claims based on FGM in the UK compared to other EU countries observed by UNHCR (UNHCR 2013). One reason for this it was suggested was the positive development of UK asylum case law post-Fornah and the UK's relative experience in dealing with FGM cases over the last few years, compared to other EU countries in which FGM-related cases were newer and less common (Participant 1).

A respondent in France, however, did highlight the development of a positive response from asylum adjudicators in that context to the need to provide protection, developing an understanding of FGM as a form of *'political violence, not just family or domestic violence but something far bigger'* (NGO EU 2). The importance of developing a Europe-wide understanding of FGM as a form of gender based persecution was emphasised so that the linkages to asylum adjudication and the Refugee Convention were conveyed to decision makers (Participant 1).

The Amnesty International End FGM Campaign was seen to have played a role in getting international protection issues considered in work to tackle FGM at an EU level, placing *'the point of asylum in a wider framework'* (Participant 1). Combined with UNHCR's work to bring together statistical data on the prevalence of FGM-based asylum claims in Europe for the first time (UNHCR 2013), the campaign had led to improved EU-level communication on FGM and the development of a strategy to tackle the issue that for the first time reflects EU asylum legislation (Participant 1). One area of concern highlighted by respondents in Scotland, was the differing approaches of legal representatives to women and families seeking asylum from high prevalence FGM-practising countries, such as Somalia or Eritrea.

²⁸ [2006] UKHL 46

There was seen to be a ‘dichotomy of approach’, which could result in international protection issues around FGM being missed:

Some lawyers were what I would call proactive...if females would say it's a woman's problem, I would say what do you mean by that and tease out what they meant and ...“Is it to do with circumcision?” I thought that was good practice to get at the nub of the claim... I didn't feel I was putting words in their mouths but other lawyers said unless they come out and actually say it, I'm not going to probe and... say, “Is it this?” (Legal Practitioner UK 1)

This could lead to women or families seeking to lodge a fresh asylum claim as FGM had been missed during the initial claim:

When I said, “I note you've had your appeal, why haven't you raised it?” invariably they would say, “I wasn't asked.” (Legal practitioner UK 1)

This same respondent spoke of the difficulty of disclosing FGM in the UK asylum process, particularly where women come from communities in which such issues are not discussed and are heavily stigmatised:

... So in that kind of culture for a female to turn against their own culture and say, “I'm not having this done, I don't want it done,” and to speak about it openly in another culture they're unfamiliar with through an interpreter, possibly to a male lawyer or male Home Office presenting officer, a male court, a male judge, it's a big ask. (Legal Practitioner UK 1)

A further challenge to disclosure and successful recognition by asylum adjudicators was felt to be the time and resource constraints placed on legal representatives working in this area. A need for detailed medical evidence and cultural references to put asylum claims based on FGM into context, as well as the time needed to build trust to support disclosure, were seen as resource-intensive and potentially preventive for legal representatives (Legal Practitioner UK 1). In addition, some respondents felt that there was a particular risk of community pressure for separated asylum seeking girls to undergo FGM in host countries of asylum, to which professionals working with them were not necessarily attuned (NGO EU 2; Participant 1).

It was noted that many EU countries, including the UK, do not collate nor publish data on the grounds for asylum claims, making it impossible to monitor the number of asylum claims based on FGM. Belgian, on the other hand, has developed a useful system of recording and publishing the basis of asylum claims (Participant 1; Academic EU 1). Belgian immigration

officials also have an active role in protection interventions. Any family granted leave to remain on the basis of a girl's fear of future FGM is invited to present to the asylum decision-making body (CGRA [Commissioner General for Refugees and Asylum Seekers]) on a yearly basis and to present a medical certificate confirming that the girl remains ‘intact’ (Academic EU 1; Dieleman 2010). Sanctions are enforced if the family do not respond to this invitation. No evaluation of this initiative appears to be available and thus the benefits, when compared to the potential administrative and ethical complexities of allocating this role to immigration authorities, are unclear.

4.4.4 Summary

As we have outlined above, interventions in the realm of protection raise significant ethical, legal and practical issues. However, some common themes are apparent. These are:

- the importance of a strong and unequivocal criminal justice response, well-publicised amongst communities, which aims not only to punish perpetrators if necessary but to ‘convey the unacceptability’ of the practice (Costello et al 2013)
- a dual approach, combining the criminal justice response with significant and well-resourced work at community level
- an approach centred on the rights and best interests of the child
- the need for all interventions to be accompanied by clear national guidelines for frontline professionals across all sectors
- continuing work to ensure international protection is accessible to women, children, and families who seek asylum on the basis of fear of FGM.

4.5 Provision of services

In this section we present findings on the theme of ‘Provision of Services’, focusing on the service response to survivors of FGM. Our key informants recommended approaches to improving the accessibility of services and the development of specialist services. Cultural sensitivity and cultural competence were discussed, as were the complexities of disclosure. Discussions centred on health services as the main entry point to support services for women who have undergone FGM.

Several respondents noted that survivors of FGM often only come into contact with services when pregnant. Maternity services therefore play a key role in facilitating access; however, they cautioned that a reliance on maternity services as the main access point risks disregarding the needs of survivors who are not pregnant or of childbearing age:

Specialist services tend to focus around maternity services and that's because in general women with FGM may not seek to come into contact with healthcare professionals but the one time they will is when they're pregnant. (Medical Practitioner UK 2)

As a universal service, GPs were also seen as critical to the response to FGM (Medical Practitioner UK 1). However, respondents spoke of reluctance among survivors to disclose to GPs, and it was suggested that GPs might not have the specialist expertise to recognise when a woman's health complaints are linked to FGM if she does not articulate this herself (GOV EU 1).

In the Netherlands, a pilot offers GP consulting hours on FGM in six centres, and in France, work has been done to support GPs to have the tools to be able to offer treatments to survivors, such as a referral for deinfibulation or a ‘health certificate’ or letter from the GP recommending against sexual relations for a certain period of time if a survivor reports pain or distress (NGO EU 4).

A number of other barriers to access to services were highlighted by respondents, for example, a reluctance among survivors in some cases to approach services for fear of a shock reaction to their FGM from health professionals (GOV EU 1). This may be compounded by health providers' reluctance to open up discussions around FGM due to their own feelings of discomfort (Abdulcadir et al 2014). In the Netherlands, some communities had reportedly mistakenly believed that being a survivor of FGM was forbidden by law and so were afraid to disclose to services (GOV EU 1). A UK respondent said it was common for women with FGM not to want to see their GP, or perhaps not to have a GP at all (Medical Practitioner UK 2):

They don't always want to come. They come because they've been found and they're told they've got to come, and they come because they're worried about having [a] safe birth. (Medical Practitioner UK 2)

In a specialist service in London, around 50% of service users were referred by midwives. However, the service has seen an increased number of younger women self-referring for advice about de-infibulation ‘just because they're taking charge of their lives’, although self-referrals were still a minority at around 5-10% (Medical Practitioner UK 2). Self-referral options, however, were seen as crucial to ensuring accessibility of specialist services:

We were having women coming along and bringing their sisters or cousins to suss us out and at the end of the consultation...[they] would say, “You've just seen my sister, can I be seen now?” and I had to say, “No, you haven't got a hospital number and you're not booked here.” So we changed that so women can self-refer. (Medical Practitioner UK 2)

There was consensus among respondents that cultural sensitivity remained a significant barrier to responding to FGM, particularly in the UK:

It needs a multidisciplinary approach but most of all, it needs the courage to speak out and speak openly about this and cut through the cultural taboos and even religious taboos. (Legal Practitioner UK 1)

It was suggested that barriers to responding to FGM and referring on arose not just from cultural sensitivity, but also from a lack of knowledge among professionals:

Whether people are anxious about being really culturally sensitive, so sensitive that they can't bring these difficult issues up or they just don't think about it at all. There are barriers there. (Medical Practitioner UK 2)

In France too, a respondent highlighted what they saw as the damaging impact of cultural relativism in inhibiting work to tackle and address FGM, influencing the willingness of professionals to report suspected cases of FGM for fear that they would be accused of racism (NGO EU 4).

If cultural relativism can constitute a barrier, the literature suggests that improved cultural competency, as defined below, could improve the provision of appropriate services for women from FGM-practising communities:

Features of culturally competent health care provision... include respect and understanding of cultural norms, patterns, attitudes, disparities and diversity. Culturally competent care must surpass tolerance and good deeds, moving towards greater respect and acceptance of the similarities and differences between cultures, where increased understanding can improve communication and facilitate positive clinical outcomes. (Moore 2014, p.6)

Thus respondents highlighted, for example, how important it was to understand the complexity of disclosure of FGM for some women:

...We're asking them to do a jump via a plane going from a country that maybe doesn't even have a state, such as Somalia, where females aren't even educated, where they've been brought up in a culture and society...that says unless you have this done, you are not part of your family, community, ethnic group. In a culture where they know nothing else but circumcision... If seen from that point of view, how do we expect them to talk about this openly and bring it out at the first opportunity?

(Legal Practitioner UK 1)

A medical professional spoke of the value of being able to communicate directly with women in their own language and in medical terms rather than through an interpreter, who may not have a medical background:

...They feel better if they can translate things directly to me rather than translate it through interpreters because they think the interpreter has no medical background and to speak to someone who has a medical background gives them the feeling of comfort that they don't feel guilty or ashamed...

(Medical Practitioner UK 1)

Women affected by FGM are often from marginalised communities and may not have money to be able to travel to access specialist services. Named professionals with the training and expertise to respond to FGM in local areas are therefore important, although specialist procedures can be located in larger units so long as referral routes are clear (Medical Practitioner UK 2). An outreach element, which could be facilitated by a specialist or third sector organisation, is also beneficial and supports improved access for women (NGO UK 1).

The need for a multi-disciplinary approach to the health response to FGM was seen to be key by many respondents. For example, in London, a specialist centre offers 'three or four clinics a month... with outpatient de-infibulation procedures...inpatient surgeries...assessment by a midwife for safety for delivery... a team approach' (Medical Practitioner UK 2). In France, 'a woman will be assessed by a multi-disciplinary team including a gynaecologist, a sexologist, a psychologist before being offered [a surgical] procedure' (Academic EU 3).

In the Netherlands too, '[in] all six places [offering specialist services] there is a team behind it: sexologist, psychologists, gynaecologists, midwives' (GOV EU 1). In Belgium, a specialist clinic offers women '10 consultations, not only for clinical aspects but also for psychological and sexual aspects' (Academic EU 1). In particular, respondents were agreed on the need for psychological and psychosexual services for survivors of FGM. For example, in Belgium, specialist centres in Ghent and Brussels offer referrals to psychologists and sexologists (Academic EU 1).

In a specialist clinic in London, there is 'limited psychological support which [we have] been trying to build up in terms of psychological and psychosexual counselling' (Medical Practitioner UK 2). However psychological support has been identified by a multitude of studies as a significantly under-resourced and under-researched area of service provision for survivors of FGM (for example Liao 2013; Safari 2013; Andro 2010; Creighton 2010).

One respondent felt that it was particularly important to offer psychological and psychosexual support to younger women:

The really difficult group are the teenagers and women in their twenties who've had FGM done as a child... and they've come here where you're bombarded with images...throughout your life saying sex is good and healthy and enjoyable and having an orgasm is important for women. And actually they're stuck between two schools... They've had their clitoris removed but they're told sexual sensation is important and it's those women where psychosexual counselling is really necessary to address those difficulties.

(Medical Practitioner UK 2)

It is also important for service providers to understand that women from communities affected by FGM can find it difficult to speak out about mental health (NGO UK 1).

Another under-researched area and one in which our respondents were more divided, is the provision of surgical procedures for survivors of FGM. French respondents had a particular interest in this area, noting that 10 hospitals in France offer reconstructive surgery and that it is now offered free of charge for French residents. There have been improvements in the way that access to surgery is managed, with assessment by a multi-disciplinary team now a pre-requisite (Academic EU 3).

Respondents in France felt that the availability of this surgery was a useful tool to 'break the silence' around FGM, a view backed up in the literature, which suggests that despite ambiguities around clinical outcomes, the availability of such treatment in France has served to open up discussions around FGM within families and between clinicians and patients, suggesting a potential role in the identification of women and girls affected by FGM (Andro et al 2010).

However, respondents in the UK and at EU level reported concerns about the lack of research accompanying the development of surgical procedures on offer. One UK health professional in particular voiced concerns:

It's difficult because you want to help women... but doing an operation that has no scientific basis to it is not probably a good step... It is being done in the NHS here so some hospitals are already doing it. It's whether you just do it or whether you do an appropriately funded research study... [to] test sensation before and afterwards and do proper standardised questionnaires before and afterwards, patient satisfaction surveys.

(Medical Practitioner UK 2)

Dutch respondents noted that two surgeons currently offer reparative surgery in the Netherlands (NGO EU 3). In Belgium there is reportedly a demand for reparative surgery from survivors, but the lack of evidence was a concern (Academic EU 1).²⁹

One UK respondent was critical of the French study (Foldes et al 2012), on which much of the development of reconstructive surgeries is based:

...only 25% of women ever came back...many of them said they felt better but there was no appropriate psychological assessment...and the difficulty is...if you're [from] outside France, it costs about €6000...so assessing something you've paid for is really difficult... It is possible that it might help because it makes the genitalia look a bit more normal... Women may feel more empowered that they've taken hold of something that's been dreadful and has made them feel more positive. But what he's saying is it makes your clitoris work normally and there are no studies to say that's the case.

(Medical Practitioner UK 2)

In our workshops with community representatives, however, women from affected communities were positive about developments in surgery and said that where available, reconstructive surgery should be offered to survivors. However, a health expert felt that until better studies are available such procedures should not be offered to women as 'reconstructive' surgeries, but as 'cosmetic' procedures:

Cosmetic surgery is of benefit to women of course but then you should be clear and say this is a cosmetic procedure that will make it look better and you might have some benefit... until there are better studies around to show [reparative surgery] works and how it works and that it's safe for women, it's really not appropriate to be recommending it on a widespread basis.

(Medical Practitioner UK 2)

Finally, there was limited discussion among respondents about services for children, although respondents from England and the Netherlands provided some examples. A new service is under development in England for children under 18 and those over 18 with learning difficulties:

We are increasingly seeing younger children, 10, 11 and 12 year-olds with FGM and clearly a crime has been committed there...[the new service] will have a stronger legal arm to it which we don't have in the adult clinic, that's the purpose. It's not appropriate to see 12 year-olds in an FGM clinic full of pregnant women, they really need to be seen, but they take longer and you've got to be absolutely obsessive about documentation and legal issues.

(Medical Practitioner UK 2)

The children's service in England will have closer links to social services, the police and NGOs, and will be staffed by an FGM specialist and a community paediatrician. Respondents made a number of clear recommendations for potential service models in Scotland to respond to survivors of FGM. A key recommendation was the development of a hub and spoke approach across Scotland, which would include:

- Named health professionals in all hospitals/health board areas.
- Specialist services in high-density areas, such as Glasgow, offering FGM clinics staffed by a multi disciplinary team including a midwife, gynaecologist, obstetrician and psychological support with clear links and referral routes to social services.
- Clear pathways to advice and care including referral routes to sexual health services.
- Surgical procedures, such as deinfibulation in larger units.

You could have a map of Scotland that has the named individuals and they would be responsible for teaching and linking.

(Medical Practitioner UK 2)

A specialist NGO cautioned on the need for clarity around minimum standards for women who have experienced FGM so that any specialist service is aligned with best practice and minimum standards of care (NGO UK 1).

The importance of involving community organisations in the dissemination of information about services was also highlighted. For example, the Dutch Government funds a community-based organisation 'to do a campaign so they know to refer women to those [specialist] centres' (GOV EU 1). Participants in our stakeholder consultation were also keen to highlight that specialist services were often the first to lose funding in a context of budget cuts, and that mainstreaming of expertise must also occur to ensure sustainability of services.

²⁹ A symposium of experts looking at the question of reparative surgery was scheduled for December 2014 in Belgium.

Chapter 5 – Discussion, recommendations and conclusion

Based on our findings, in this chapter, we outline a series of themed recommendations, which, taken together, form the foundations of a model of intervention to tackle FGM in the Scottish context. Central to this, is the development of a targeted national action plan within the framework of Equally Safe, which takes account of all of these recommendations and is shaped and driven by key stakeholders on the Scottish Government's Short Life Working Group and wider reference group on FGM, and others, as appropriate.

5.1 Participation

5.1.1 Policy makers and service providers should ensure that policy and practice development across all areas of work is shaped and driven by the experiences, needs and views of communities affected by FGM

Throughout our research, what has come across most strongly is the imperative need to work with communities to ensure that policy-making and practice development is shaped by the experiences, needs and views of women, men and young people from communities affected by FGM. In the Scottish context, where we know little about the practices and beliefs of communities potentially affected by FGM, this need is even more pressing, in order to tailor effective interventions across strategy, policy, prevention, protection and the provision of services.

5.2 Strategy, Policy and Research

5.2.1 The Scottish Government should provide national direction to ensure that work on FGM is contextualised as violence against women and girls

Work to prevent and respond to FGM cuts across a range of policy areas, including health, criminal justice, asylum, children's rights and child protection. However, our research suggests that FGM is best situated within a violence against women and girls agenda, recognising that FGM is a form of gender based violence, and that it is closely linked to other forms of violence, most notably, forced marriage. Taking a gendered approach to tackling FGM can help to reduce stigma, for example, when addressing FGM within a school curriculum. Such a focus can help to ensure a gender sensitive and victim centred approach to reporting, investigating, and prosecuting FGM-related crimes. It is important that FGM is embedded within child protection and safeguarding training for professionals and that a consistent approach is taken to child protection for all communities living in Scotland; however, the specific causes and consequences of FGM should be highlighted in a child protection context. Most importantly, a gendered approach to tackling and responding to FGM will support affected communities to identify and address the root causes of the practice.

5.2.2 The Scottish Government should use Equally Safe as a vehicle to develop a resourced national action plan on FGM

Our findings suggest the need for a national action plan on FGM. Contextualising FGM within a broader violence against women and girls action plan, such as the Scottish Government's Equally Safe, is essential, but the scope of the issue requires the development of a range of actions, which encompass policy, legislation, services, and engagement with professionals and communities across the realms of prevention, protection and the provision of services. The action plan should have a budget attached to it, be cross-departmental and developed in partnership with all key stakeholders including communities affected by FGM. Learning can be drawn from countries, such as Portugal and Norway, which have developed detailed FGM national action plans. A national action plan must acknowledge and address the transnational nature of the issue of FGM and communities affected by the practice, with clear links to the UK, EU and international levels.

5.2.3 The Scottish Government and funding bodies should invest in support for affected communities to effect long-term behaviour change

There should be recognition at a strategic level that tackling FGM will require sustainable investment in community development work with affected communities. Scotland's population is becoming increasingly diverse, with growth in communities potentially affected by FGM, a trend which is likely to continue. Investment will be required initially to support community development approaches, train professionals, develop guidance and establish services. Respondents in EU countries where protocols and services for tackling and responding to FGM have been developed emphasised the need to ensure sustainability in work to mainstream an FGM response on the one hand, but also to maintain specialist knowledge where it is required. Examples were highlighted where key individuals with a passion and enthusiasm for tackling FGM have led on the development of interventions, but have later moved on and the work has not been sustained in the long-term. Furthermore, it is crucial to monitor, evaluate and adapt interventions on an on-going basis to ensure that they do not lead to changing patterns of behaviour and that new diaspora communities are engaged in the work.

5.2.4 The Scottish Government should provide national direction to guide consistent recording of FGM in statutory services

Currently in Scotland, the recording of data on FGM is not consistent. There is a need for consistent coding and recording of FGM in its different forms across health, child protection and other frontline services in order to better understand the level of risk to girls in Scotland and to inform preventive, protective and response interventions. Training on identification and recording of FGM should be provided to professionals working with affected communities. The Home Office should record and monitor FGM-related asylum claims, and break this data down regionally.

5.2.5 All statutory and voluntary agencies working with potentially affected communities should ensure that interventions are evidence-based and evaluation is built-in from development

Evaluation should be built into all interventions from the development stages to ensure an accurate baseline of data is gathered and that the effectiveness of output and outcomes can be measured. Our findings raise the need for caution in the absence of thorough clinical evidence when developing specialist services, such as reconstructive surgery for survivors of FGM. Consideration should be given as to how to involve affected communities and other stakeholders, such as frontline professionals, in research and the development and evaluation of interventions. Extreme caution should be exercised when presenting information about presumed 'prevalence' or 'risk' of FGM in Scotland based on current available data. Further engagement with communities potentially affected by FGM living in Scotland should be considered to find out more about practices, prevalence and risk, and the effects of migration on these in a Scottish context.

5.3 Prevention

5.3.1 The Scottish Government and relevant agencies should ensure that a strong criminal justice message is accompanied by investment in behaviour change interventions with affected communities

As we have emphasised, working directly with men, women and young people in affected communities is critical to achieving sustainable behaviour change towards the eradication of FGM. Learning can be drawn from tried and tested behaviour change programmes such as the EU-funded Replace and Replace2 projects. To achieve behaviour change, there needs to be sustainable investment in community development support for work with affected communities in Scotland, which would involve, 'collectively bringing about change by working with communities to

identify their needs, opportunities, rights and responsibilities; plan, organise and take action; and evaluate the effectiveness and impact of the action'.³¹ Particular areas of focus to consider for community engagement are:

a) Key community leaders

Our research provided examples of successful interventions in countries such as the Netherlands, to support the emergence of key figures in the community to take on roles in preventive and protective work to tackle FGM in affected communities. Trusted community leaders can facilitate access to a community and provide a respected, community voice for change. Caution must be exercised in facilitating this kind of work as it requires support, resourcing, and assistance, as key figures may face backlash and negative reactions from their community.

b) Young people

Young people in affected communities are more likely to be able to speak out on the issue of FGM than older generations, and they are the parents of the next generation with the power in their hands to affect behaviour change. Campaigning and awareness raising work should be cognisant of this. With the appropriate support and tools, young people can be agents of change within families and communities. With appropriate sensitivity and expertise, impactful work can be undertaken in schools, and creative tools such as social media, film, music, and drama, have all been employed to positive effect to engage with young people in other contexts.

c) Working with men in communities

Women from communities affected by FGM have highlighted that behaviour change and preventive work to tackle FGM must include men in their communities. Engagement with men and women should be carried out separately initially, but men and women can also work effectively together on this issue, although they may take on different roles. Our findings suggest an important educative role for men in speaking out and raising awareness, particularly with other men in their communities. Women can also take on such roles, but they may have additional roles such as providing support for survivors of FGM or intimate discussion with families for example.

³¹ Scottish Community Development Network Manifesto, www.scdn.org.uk (Accessed 28 November 2014)

5.3.2 All agencies working with communities potentially affected by FGM should ensure that community engagement meets national standards and a) builds on existing relationships of trust; b) is tailored to a particular community; c) involves women, men and young people; and, d) considers links to countries of origin.

Any agency, public body, or organisation working with communities should ensure that it meets the National Standards for Community Engagement.³² Specifically, on FGM, engagement work should consider supporting professionals with existing relationships of trust to engage with families; tailor approaches to particular communities; involve women, men and young people (though separately initially); and use appropriate tools, including tools from countries of origin where appropriate. The development of best practice guidance for engagement with communities in Scotland on the issue of FGM by an organisation with appropriate expertise should be considered.

5.3.3 The Scottish Government should provide clear, national direction on the role of frontline professionals in the prevention of FGM and relevant professional bodies and agencies should develop training on FGM for frontline staff

Frontline professionals have a role and responsibility for the prevention of FGM through awareness raising and the provision of information to affected communities as they come into contact with services. Our research suggests that some services in particular can play an important role in prevention and should be provided with the tools to do so:

a) GPs

As a universal service, GPs have the potential to play an important preventative and educative role through the provision information to people from communities potentially affected by FGM. Community representatives told us that GPs should have the confidence to ask women about FGM, and, in areas with large populations of affected communities, could benefit from specialist training, and could consider offering specialist consulting hours for women affected by FGM.

b) Maternity services

Maternity services were identified as having a pivotal role to play in responding to, protecting girls from, and preventing, FGM. Our research suggests that survivors of FGM are often reluctant to access health services until or unless they are pregnant, which is often the first point of contact with services at which FGM is disclosed. Midwives, obstetricians and gynaecologists were identified as having a key role in asking about and recording cases of FGM, as well as counselling and

providing information about the law and support available to women. 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.

c) Schools

Education services at all levels from nursery onwards have a role in ensuring awareness about FGM among teaching and non-teaching staff, and fostering an environment of trust where children and young people feel able to disclose and discuss any concerns about FGM. All staff should have a basic understanding of FGM as part of mandatory child protection training, with identified lead professionals in each school (in high density areas) or local authority area, as appropriate, with more in-depth expertise on the issue. Schools should consider incorporating FGM into the curriculum in a non-stigmatising way, for example, in the context of gender based violence and women's rights, and could invite community representatives to provide input to lessons as appropriate.

d) Other frontline professionals

There is a need for basic awareness training on FGM to be mainstreamed across all health, social work and other frontline service providers, including the voluntary sector, with more intensive training for professionals most likely to come into contact with affected communities in high density areas. In particular, travel health clinics were identified as a key potential location for the provision of information and referral for support if a family intends to travel to an FGM-practising country.

5.3.4 Statutory and voluntary agencies developing training and guidance for professionals should use and value the expertise of specialist NGOs

Specialist NGOs told us that they feel their knowledge and expertise on FGM can be taken for granted by professionals and organisations who approach them for advice and guidance, but do not always remunerate or consider the longer-term sustainability of such work, which is often undertaken on a voluntary basis. Governments, public bodies and other organisations should consult the expertise, guidance and advice of specialist NGOs and community representatives when developing interventions or dealing with complex cases; however, this work should be valued and acknowledged where possible through funding or remuneration.

5.3.5 All agencies carrying out campaigning and awareness raising work around FGM should ensure that this is non-stigmatising and evidence-based

Campaigning and awareness raising around FGM must be non-stigmatising and evidence-based. A focus on engaging young people in campaigning in particular can be very effective, and the use of creative mediums such as drama, music, and film can be powerful and have significant reach. Community and religious leaders can also be agents for change within affected communities and beyond. Traditional and new media has an important role to play in giving a voice to survivors and reaching a wide audience.

5.4 Protection

5.4.1 The Scottish Government, Police Scotland and the Procurator Fiscal should continue to ensure that the criminal justice response is perceived as being effective and that anyone found to have subjected a child living in Scotland to FGM will face robust criminal sanctions

As our respondents and the literature emphasized, an effective criminal justice response not only protects women and girls, but also provides an enabling environment for affected communities who wish to give up the practice, both in Scotland and potentially in countries of origin. Cultural sensitivity should not undermine nor confuse this message.

5.4.2 The Scottish Government should provide national direction for a multi-agency approach to protecting girls from FGM, fostering confidence within and between statutory services and clearly identifying roles and responsibilities

Our findings reveal a degree of mistrust between statutory agencies with a role in protecting women and girls from FGM. National direction on the roles and responsibilities of different agencies in protecting women and girls from FGM, in line with other forms of gender based violence, is needed. There should be a focus on multi-agency partnership working and coordination, making better use of existing tried and tested child and adult protection frameworks, such as GIRFEC and MARACs. Learning should be drawn from the Dutch model when developing this approach, for example, in the case of a child where risk factors have been identified (such as being born to a mother with FGM) a GIRFEC approach could be taken, where the named professional monitors the child and provides on-going support to parents to protect her from family or community pressure for her to undergo FGM. In the Dutch model, case notes are electronic and flag automatically to different professionals that a child has been born into a community potentially affected by FGM at different stages, from two weeks after birth onwards, to enable discussions to take place and appropriate support to be provided to families. A child protection referral is only undertaken where on-going monitoring leads to an assessment of immediate risk.

5.4.3 The Scottish Government and local authority leads should provide national - and from that, local - direction on a clear child intervention response where an FGM survivor gives birth to a girl; not an automatic child protection referral

Our research shows that an automatic child protection referral in the case of a woman with FGM, who gives birth to a girl, may not be appropriate. Rather, national guidance should stipulate a 'child intervention' response, recognising that birth into a family where FGM has been practised is a risk factor for a girl, but that immediate risk should not be assumed without on-going monitoring and assessment. Risk assessment should be culturally competent and undertaken sensitively by someone with expertise on FGM.

A supportive intervention could be considered, for example, by a specialist violence against women or BME organisation. The intervention must be focused on supporting parent(s) to protect their daughter(s) from FGM, in line with the suggested GIRFEC-based approach above, recognising the family and community context in which they are living. Clear national guidance should be developed for maternity services to support interventions. As with any other form of violence against women, an adult survivor of FGM should be supported to consider reporting the violence she has experienced, where appropriate.

5.4.4 Local authorities and local health boards should develop a network of named professionals with expertise on FGM across Scotland and ensure clear referral pathways are in place

Our research indicates that there are communities potentially affected by FGM living in every local authority area in Scotland. A network of named professionals with expertise on FGM should be developed, so that frontline workers across education, social work, health and police across Scotland know who to contact for advice and guidance on FGM, support with appropriate referrals, and child or adult protection responses. Health boards could consider a named professional in each health board area, maternity service, or hospital in high density areas.

5.4.5 All relevant frontline professionals should be provided with a level of training on FGM appropriate to their role

All mandatory child protection and safeguarding training for professionals should include a basic awareness of FGM. Qualifications in key professions such as teaching, social work, police, midwifery, gynaecology, obstetrics, health visiting, general practice and others, should incorporate appropriate levels of awareness and expertise of FGM. Lead professionals for safeguarding and child protection, and named professionals with responsibility in this area, should receive more in-depth training. Training should be developed with community and specialist organisations.

³² <http://www.scotland.gov.uk/Resource/Doc/94257/0084550.pdf>

5.4.6 The Scottish Government should ensure that all women and girls living in Scotland are covered by legislation on FGM

Ensure that the scope of the legislation on FGM clearly covers all women and girls living in Scotland, irrespective of immigration status.

5.4.7 Police Scotland and the Procurator Fiscal should ensure that investigations into cases of FGM are victim-centred and take a violence against women and girls approach

Any investigations leading to potential prosecutions under FGM legislation must take a victim-centred, violence against women and girls approach, ensuring compatibility with the rights of the child and ensuring the welfare and best-interests of the victim are at the heart of the process. Prosecutors and investigating officers could consider working with specialist community organisations or NGOs to ensure appropriate support and advocacy is available to women, girls and families involved.

5.4.8 Immigration lawyers, asylum decision makers, and judiciary should have a good understanding of FGM to ensure that it is fully explored as a potential ground for international protection

Legal representatives, asylum decision makers, and the judiciary should have a good understanding of the complexities of FGM, to ensure a culturally competent approach to FGM-related claims for international protection. This should include recognition of potential stigma and difficulties with disclosure, as well as an awareness of the high prevalence of FGM in countries such as Eritrea, Somalia and Sudan, where other, more obvious international protection grounds may be at play.

5.4.9 The Home Office should monitor and regularly audit asylum claims involving disclosure of FGM

In order to understand the size and location of asylum seeking populations in the UK with FGM-related claims, and monitor access to protection for women, girls and families presenting such claims, the Home Office should record, audit and make available this data.

5.5 Provision of services

5.5.1 The NHS should establish a specialist, multi-disciplinary 'hub and spoke' FGM service in Scotland with clear links to named professionals across Scotland

A specialist multi-disciplinary service incorporating maternity services, obstetrics and gynaecology, psychological and psychosexual services, with links to social work and the police, should be established in Glasgow with 'spoke'

services in each local authority or health board area across Scotland. Referrals could be made into this service for clinical assessment as well as specialist risk assessment where concern about a woman or child at potential risk of FGM is identified.

5.5.2 The NHS in Scotland should ensure that healthcare provision to survivors of FGM is culturally competent

Cultural sensitivity must not be a barrier to accessing care, however, the provision of care to survivors of FGM, must be culturally competent. Healthcare providers must have an awareness of appropriate clinical procedures in responding to different types of FGM, an understanding and respect for women from communities affected by FGM, and an ability to sensitively communicate with women and families from different affected communities (Moore 2014, unpublished).

5.5.3 NHS Greater Glasgow and Clyde and other relevant health boards should consider establishing specialist GP and/or hospital consulting hours in Glasgow and other areas with significant communities potentially affected by FGM

Our research suggests that there are significant barriers to women and girls affected by FGM accessing services. Cultural, linguistic and stigma-related barriers may prevent women from disclosing FGM to health professionals in a general practice setting, and many survivors of FGM are only identified if they enter maternity services. England, France, Belgium and the Netherlands all offer specialist consulting hours either in hospital or general practice contexts, to facilitate access to support and services for survivors of FGM.

5.5.4 The NHS and the relevant professional bodies should ensure that health professionals are trained to carry out sensitive inquiry around FGM and that pregnant women are always asked about FGM

Women from communities affected by FGM told us that many FGM survivors find that medical professionals do not address the issue, even during physical examination as part of gynaecological appointments. Sensitive inquiry should be undertaken with women from potentially affected communities, particularly during smear testing, maternity and gynaecology appointments. FGM disclosed should be consistently coded and recorded. Health professionals should have access to a named professional to refer to for advice on FGM and clear referral pathways should be in place to be able to offer multi-disciplinary services to survivors of FGM as appropriate.

5.6 Conclusion

Female genital mutilation is an emotive topic. The question of the extent to which young girls living in diaspora communities in Europe are at risk of being subjected to FGM has attracted substantial media and academic interest recently. Our own research has been necessarily limited in scope, due to time and resource constraints. Without further qualitative research and improvements in data gathering, particularly across statutory services and among potentially affected communities, it will remain difficult to accurately quantify the size of any potential issue in Scotland.

However, our research makes clear that despite facing similar statistical challenges, other EU nations have developed effective interventions tackling FGM and supporting women and girls living within their borders to both resist and recover from FGM. We hope that this report provides a framework to do so in Scotland, where, as many respondents indicated, we have the opportunity to use best practice from elsewhere to begin to develop a Scotland-specific model of intervention.

In order for this to be successful, we suggest that future work on FGM in a Scottish context is guided by the following overarching principles:

- FGM should be recognised as a form of gender based violence, closely linked to other forms of violence against women and girls, such as forced marriage. A gendered approach to tackling and responding to FGM will support affected communities and professionals to identify and address the root causes of the practice.
- Criminal justice and child protection provisions must be enacted effectively and fairly. For this to be possible, professionals from all sectors must be provided with clear and accessible risk assessment and reporting guidelines.
- Services should be assessed and designed using a cultural competency lens, to ensure that they are accessible and useful to women and girls affected by FGM.
- Finally, work with communities is vital to all areas of intervention. For 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 in Scotland today, we will run the risk of further marginalising the community voices that are the most effective advocates for change.

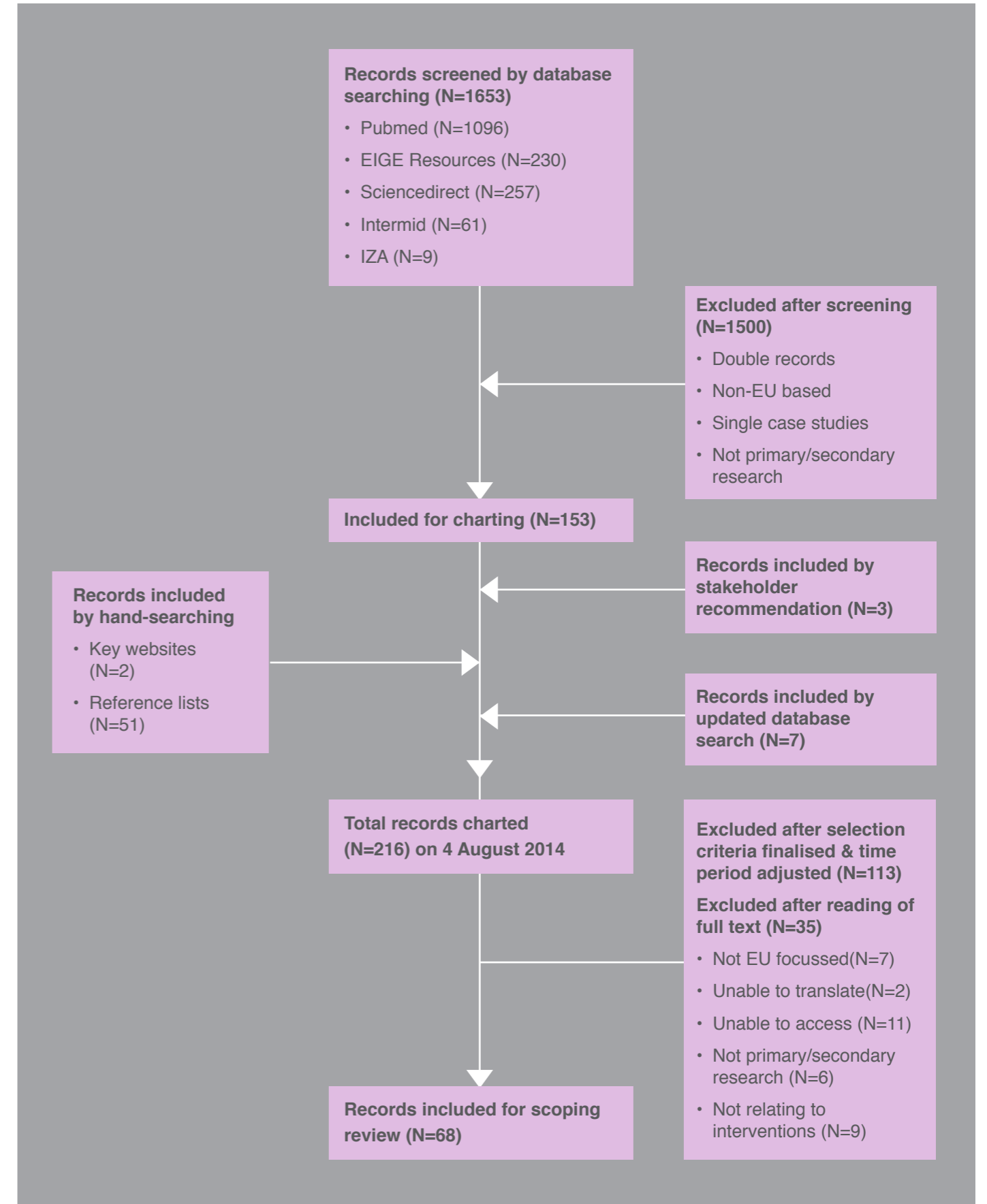
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Appendix 1 – Scoping Literature Review Diagram



Appendix 2 – Anonymised list of key informant interviewees

ID	Organisation type	Profession	Country location	Interview type (formal/informal)	Yes
Academic EU 2	University	Academic	Spain	Formal	Yes
NGO EU 2	NGO	Practitioner	France	Formal	Yes
NGO EU 3	NGO	Practitioner	Netherlands	Formal	Yes
Education UK 1	Education	Education professional	England	Formal	Yes
		Student			
GOV EU 1	Government	Policy	Netherlands	Formal	Yes
Academic EU 1	University	Academic	Belgium	Formal	Yes
NGO EU 1	NGO/CSO	Practitioner	Ireland	Formal	Yes
Medical Practitioner UK 2	Hospital	Practitioner (health)	England	Formal	Yes
Academic EU 3	University	Academic	France	Informal	No
Participant 1	International Organisation	Practitioner	Belgium	Formal	Yes
Legal Practitioner UK 1	Private	Practitioner (legal)	Scotland	Formal	Yes
Police UK 2	Police	Police	England	Formal	Yes
Police UK 1	Police	Police	England	Formal	Yes
NGO EU 4	NGO/CSO	Practitioner (legal)	France	Informal	No
		Practitioner (health)			
		Student			
NGO UK 1	NGO/CSO	Practitioner	England	Formal	Yes

Appendix 3 – Key Informant Interview Guide

Topic Guide

Please note that this is a draft topic guide. It is designed to guide interviewers during semi-structured interviews with key informants. It can and should be adjusted to suit the expertise of the individual respondents.

Introduction

- Summary of interview focus (interventions on FGM in EU members states, covering prevention, protection, provision of services and participation).
- Give overview of the four categories, including where these were developed.
- Summarise information sheet and give to participant.
- Complete consent forms.

1. Personal role & experience

1.1 What is your experience in working on the issues surrounding FGM?

- Prompt: current role / organisational affiliation
- Prompt: experience in EU
- Prompt: experience in countries of origin

2. Context-setting – reasons for FGM and impact of migration

2.1 What would you identify as the key reasons for the continuing practice of FGM?

- Prompt:

2.2 In your experience, how does migration affect communities' and individuals' perceptions and practices of FGM?

- Prompt:

2.3 How well do you feel that the design of current interventions in your country context / other EU countries takes into account the factors you have identified?

- Prompt:

In questions 3-6, focus should be on interventions carried out within EU countries, rather than in countries of origin.

3. Prevention

3.1 Can you describe any prevention programmes you have been involved in/are aware of?

- Prompt: education initiatives?
- Prompt: national action plans?
- Prompt: information provision e.g. booklets/films ?

3.2 How were these interventions designed and implemented?

- Prompt: data collection / evidence-gathering
- Prompt: partnership & consultation
- Prompt: community involvement

3.3 How effective have these interventions been?

- Prompt: how was effectiveness measured?
- Prompt: what was successful?
- Prompt: were there particular barriers or challenges?
- Prompt: would you recommend changes if these were to be implemented in future?

4. Protection

4.1 Can you describe any protection-focussed interventions that you have been involved in/ are aware of?

- Prompt: asylum-related provisions in law/policy?
- Prompt: prosecution /child protection laws?

4.2 How were these interventions designed and implemented?

- Prompt: data collection / evidence-gathering
- Prompt: partnership & consultation
- Prompt: community involvement

4.3 How effective have these interventions been?

- Prompt: how was effectiveness measured?
- Prompt: what was successful?
- Prompt: were there particular barriers or challenges?
- Prompt: would you recommend changes if these were to be implemented in future?

5. Provision of services

5.1 Can you describe any interventions that focus on provision of services to women and girls that you have been involved in/ are aware of?

5.2 How were these interventions designed and implemented?

- Prompt: data collection / evidence-gathering
- Prompt: partnership & consultation
- Prompt: community involvement

5.3 How effective have these interventions been?

- Prompt: how was effectiveness measured?
- Prompt: what was successful?
- Prompt: were there particular barriers or challenges?
- Prompt: would you recommend changes if these were to be implemented in future?

6. Participation

6.1 Can you describe any interventions that you have been involved in/ are aware of, that aimed to encourage the participation of affected communities?

- Prompt: which communities?
- Prompt: how were communities identified and approached?

6.2 How were these interventions designed and implemented?

- Prompt: data collection / evidence-gathering
- Prompt: partnership & consultation
- Prompt: community involvement

6.3 How effective have these interventions been?

- Prompt: how was effectiveness measured?
- Prompt: what was successful?
- Prompt: were there particular barriers or challenges?
- Prompt: would you recommend changes if these were to be implemented in future?

7. Concluding questions

7.1 Are there opportunities for effective interventions on FGM within your own country context / other EU member states, in addition to those already discussed?

7.2 Conversely, are there challenges for current and future FGM interventions, in addition to those already discussed?

7.3 Are there examples of particular good practice in this field, in addition to those already discussed?

7.4 Is there anything else you would like to add about interventions on FGM?

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