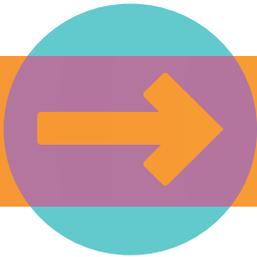


COMMUNITIES TACKLING FEMALE GENITAL MUTILATION IN THE UK



BEST PRACTICE GUIDE



COMMUNITIES TACKLING FEMALE GENITAL MUTILATION IN THE UK BEST PRACTICE GUIDE



This Guide presents learning from the Tackling FGM Initiative (TFGMI), which aims to strengthen community-based prevention of FGM among affected communities in the UK.

The Tackling FGM Initiative is funded by: [Trust for London](#), [Esmée Fairbairn Foundation](#), [Rosa \(UK Fund for Women and Girls\)](#), [Comic Relief](#) and the [Kering Corporate Foundation](#).

REFERENCING

This report should be referenced as:

Khalifa, S, Brown, E (2016), 'Communities Tackling FGM in the UK: Best Practice Guide', the Tackling Female Genital Mutilation Initiative and Options Consultancy Services Limited, London

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FOREWORD

Since 2010 the Tackling Female Genital Mutilation Initiative (TFGMI), has supported community-based preventive work to safeguard girls and women from the practice of Female Genital Mutilation (FGM), and played an essential role in changing UK FGM policies and legislation, thus ensuring greater protection for women and girls. In addition to stronger policies, there has also been increased community engagement and media attention which has enabled more survivors to seek emotional and psychological support.

One of the key achievements I have witnessed is affected communities coming forward and advocating against FGM without feeling any shame. These community advocates play an essential role in preventing FGM and linking women to support; as highlighted in the Best Practice Guide. The TFGMI has supported community based organisations for six years to actively develop models to tackle and prevent FGM in the UK. Throughout this time, models of best practice have emerged, new approaches have been developed and key principles for community engagement have been strengthened. The Best Practice Guide distils the learning of the TFGMI and highlights the importance of community engagement and outlines ways that organisations and local authorities can begin to undertake this engagement in their local areas using approaches which have been proven to be effective and contribute to changing attitudes and ending the practice of FGM.

The TFGMI has been a great supporter of my work as both an FGM campaigner and a psychotherapist. It is important to acknowledge the TFGMI's role in supporting and promoting grassroots community engagement. This engagement has resulted in an increased awareness of and opposition to FGM across a range of stakeholders, including religious leaders, parents and young people who may have been at risk of undergoing FGM.

I would personally like to sincerely thank the independent charitable organisations who collaborated to establish and fund this initiative: Trust for London, Esmée Fairbairn Foundation, Rosa the UK fund for women and girls, Comic Relief and Kering Corporate Foundation. The initiative was an essential life-line for many community based organisations working on FGM at a time when resources were extremely limited or non-existent.

We are only at the beginning of the journey and are on the right track, but there is still a very long way to go. We continue to face challenges in our drive to eliminate FGM. We need to persevere. A global change movement is gathering pace and a world without FGM seems more realistic than ever – however continued financial support, along with inspired and determined leadership, is needed to achieve long term change.



Leyla Hussein
FGM Initiative Advisory Board Member
July 2016

ACRONYMS

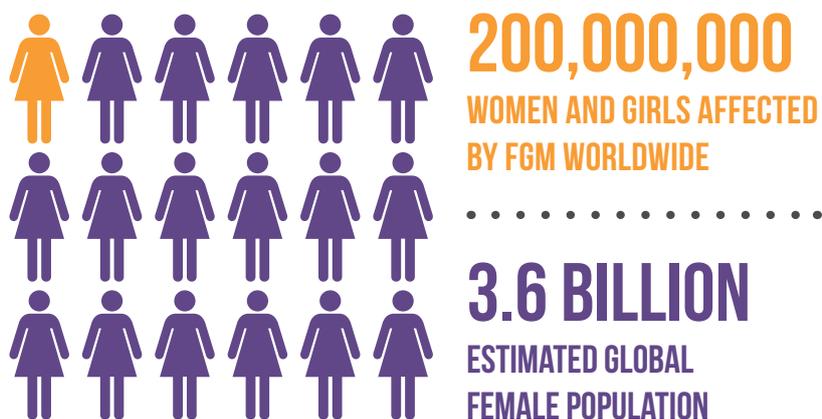
- AAF** – Africa Advocacy Foundation
BAMER – Black, Asian and Minority Ethnic, and Refugees
BAWSO – Black Association of Women Step Out
BME – Black and Minority Ethnic
BSCA – Bolton Solidarity Community Association
BSWAID – Birmingham and Solihull Women’s Aid
BWHFS – Black Women’s Health and Family Support
CBOs – Community Based Organisations
ECYPS – Enfield Children and Young People’s Service
FGC – Female Genital Cutting
FGM – Female Genital Mutilation
FGM/C – Female Genital Mutilation/Cutting
FORWARD – Foundation for Women’s Health Research and Development
MWNUK – Muslim Women’s Network UK
NESTAC – New Step for African Community
NGO – Non-Governmental Organisation
OSCA – Ocean Somali Community Association
PBUH – Peace Be Upon Him
PEER – Participatory Ethnographic Evaluation Research
PSHE – Personal, Social and Health Education
SOS Project – Support our Sisters Project
TFGMI – Tackling Female Genital Mutilation Initiative
VAWG – Violence against Women and Girls
WSP – Women Support Project
WHFS – Women’s Health and Family Support

INTRODUCTION

FEMALE GENITAL MUTILATION IN THE UK

Female Genital Mutilation (FGM) is recognised as a severe form of violence against women and girls and a human rights violation that affects at least 200 million women and girls ([UNICEF, 2016](#)) around the world. FGM is a practice that involves changing, altering or removing part of a girl or a woman's external female genitalia without a medical or health reason. The World Health Organization has classified FGM into four major types ranging from pricking the clitoris to narrowing the vaginal opening. Despite FGM being a deeply embedded social norm with complex and various socio-cultural justifications, it is a harmful and dangerous practice which can result in severe physical and mental health complications.

FGM is illegal in the UK and is a form of child abuse. The [FGM Act 2003](#) and the [Prohibition of FGM \(Scotland\) Act 2005](#) made it a criminal offence to perform FGM. The [Serious Crime Act 2015](#) has also tightened legislation on FGM and added measures to protect girls and women from undergoing the procedure. More information about FGM legislation is available in the [Multi-Agency Statutory Guidance on FGM](#) (2016).



FGM prevalence in the UK is difficult to estimate due to the hidden nature of the practice. However, the latest data on prevalence in England and Wales ([City University London and Equality Now, 2015](#)) estimates that: approximately 60,000 girls aged 0-14 were born in England and Wales to mothers who had undergone FGM; and approximately 127,000 women who have migrated to England and Wales are living with the consequences of FGM. In addition, approximately 10,000 girls (under the age of 15) who have migrated to England and Wales may have undergone FGM.

THE TACKLING FEMALE GENITAL MUTILATION INITIATIVE (TFGMI)

127,000 WOMEN WHO HAVE MIGRATED TO ENGLAND AND WALES LIVING WITH THE CONSEQUENCES OF FGM

60,000 GIRLS AGED 0-14 BORN IN ENGLAND AND WALES TO MOTHERS WHO HAD UNDERGONE FGM

10,000 GIRLS UNDER 15 WHO HAVE MIGRATED TO ENGLAND AND WALES MAY HAVE UNDERGONE FGM

The Tackling FGM Initiative was established in 2010 to strengthen community-based prevention work to protect the rights of children, with a particular aim of reducing the risk to girls and young women of undergoing FGM. The TFGMI was established by three independent charitable organisations: [Trust for London](#), [Esmée Fairbairn Foundation](#) and [Rosa \(the UK Fund for Women and Girls\)](#), and joined by [Comic Relief](#) and the [Kering Corporate Foundation](#) in the second phase.

The TFGMI invested £2.8 million over six years to strengthen community-based prevention of FGM, support communities affected by FGM, and document learning to influence policy. In total, 12 organisations were funded through the Main Grants Programme, and a further 39 organisations through the Small Grants Programme (established in Phase 2).

As a result of this investment it was concluded that working with FGM-affected communities is essential to a comprehensive and effective response to FGM. Community based organisations (CBOs) have an important and essential role to play in preventing, protecting and supporting women and girls at risk of and affected by FGM.

For more information about the TFGMI please see:

- [Trust for London – FGM](#)
- [Esmée Fairbairn Foundation – FGM Initiative](#)
- [Rosa \(UK Fund for Women and Girls\)](#)

PURPOSE OF THE BEST PRACTICE GUIDE

Ending FGM in the UK requires multi-agency working, including involving FGM-affected communities. This Guide documents, develops and highlights best practice that CBOs have developed. This Guide complements the statutory [FGM Multi-Agency Guidelines](#) which professionals must have regard to, and is aimed at:

- Community based organisations working on or planning to work on FGM
- Local authorities to support the development of good quality partnerships and joint working with affected communities and the CBOs who work with them
- Professionals charged with a legal duty to respond to FGM e.g. health professionals, maternity services, teachers
- Commissioners and local safeguarding leads, to understand how to work with communities and recognise them as assets to end FGM

The Practical Guidance for FGM Engagement section is divided into three key parts: Prevention; Access to Mental Health Care and Support; and Working with Statutory Professionals and local authorities – including FGM case work. Each of the three chapters details the rationale for each target group, outlines activities conducted by CBOs to reach this group and then highlights best practice.

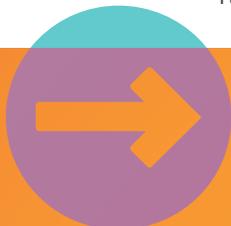


COMMUNITIES: WHAT DO WE MEAN AND WHO ARE THEY?

There is an increasing realisation that ending FGM has to be community-led, working together with a statutory-led response. There is good evidence that in areas where the TFGMI worked, it has resulted in people rejecting the practice on a greater scale.

The TFGMI defines 'FGM-affected communities' as not only women and girls directly affected by or at risk of FGM, but also other people within their social sphere: spouses, children and young people, religious and community leaders, who have all been essential in supporting women affected by FGM.

Assumptions cannot be made about population density, estimates of prevalence, ethnic and cultural groups and rejection of FGM. In many areas, people within affected communities may have openly rejected the practice, whereas other groups remain unreached. It is important that this is reflected in the way that community engagement is conducted, celebrating successes and change where it has been achieved.



A NOTE ON LANGUAGE

Given the sensitivity and complexity of FGM it is essential to be mindful of the language used when engaging on FGM. We need to balance strong messaging while avoiding harm to the girls, women and communities we seek to protect. It is essential that language and terminology is sensitive and appropriate to avoid stigmatising, alienating or traumatising FGM-affected communities.

The TFGMI uses the term FGM, not Female Genital Cutting (FGC) or FGM/C as we feel it does not fully cover all forms of FGM where there could be injury to the genitalia without any cutting taking place e.g. pricking, piercing and pulling.

In reference to communities, we talk about 'affected' and never 'practising' communities, as a reflection of the fact that communities have begun to abandon the practice and in recognition of the growing movement to end FGM in many countries.

IMPORTANCE OF COMMUNITY-LED CHANGE



The TFGMI has demonstrated the importance of community-led change. This means actively engaging and listening to the voices of survivors and communities who oppose the practice. Community champions, FGM activists and CBOs are accepted into many of the informal and community networks and spaces where much of the effective and in-depth conversations on FGM can occur.

[The Multi-agency statutory guidance](#) on FGM, produced by the government in 2016, highlights the importance of working with communities and CBOs, and states that:

‘Wherever possible, professionals should actively seek and support ways to reduce the prevalence of FGM in practising communities in the UK. **Agencies should consider how preventative work, delivered by community organisations/community change advocates, can be embedded within their organisation’s work on protection, with a focus on involving community support for girls and families at risk.**’

CBOs have local and in-depth knowledge of affected communities including methods of communication, local gatekeepers and spaces where communities congregate. This knowledge is essential in the development of effective projects and interventions that will engage communities. This is particularly important as FGM-affected communities are often seen as hard to reach and marginalised.

CBOs can be particularly effective at doing the precursor work, enabling communities to understand the purpose of safeguarding and protecting children's right to be safe from harm. CBOs are authentic carriers of the message that safeguarding is everybody's business. This is essential at a time when many frontline professionals are seeking to communicate with people from FGM-affected communities in non-stigmatising ways. FGM-affected communities may also have a mistrust of statutory professionals (especially of child protection) and create additional barriers for engagement. CBOs can overcome these barriers and facilitate working between statutory services and affected communities.



CBOs, working with local authorities, safeguarding leads and statutory professionals should be part of a comprehensive local response to implement strategies to end FGM. CBOs to date have been effective in various ways, including:

- **Awareness raising and prevention work.** The TFGMI model of 'peer educators' or 'community champions' has been shown to be effective in changing attitudes as well as building community confidence, cohesion and integration. Independent evaluation from the TFGMI has shown that where community prevention work is taking place, rejection of FGM increases.
- **Supporting engagement and relationships** between statutory professionals and affected communities, particularly through joint working or public forums with

IMPORTANCE OF COMMUNITY-LED CHANGE

professionals, policy decision-makers and people from affected communities to review and debate action being taken to tackle FGM locally.

- **Providing advice and consultation** on the development of projects and services so that they are more culturally appropriate, and respond to identified needs in local areas among affected populations.
- **Meeting the mental health needs of women and girls** who have experienced FGM, particularly in providing holistic and culturally competent support. CBOs can provide women, girls and men with access to social support networks which may help to meet some of their mental health needs.
- **Support in accessing specialist support services** – accompanying women to services, following up with individuals and explaining what the service could provide, informing and referring individuals to specialist services.
- **Training professionals** by supporting and supplementing professionals' training programmes. CBOs have expertise and in-depth knowledge on FGM, much of which has been developed through first-hand experience of engaging and supporting FGM communities. Many CBOs have supported professionals to develop their skills, confidence and willingness to use FGM child protection frameworks.
- **Developing resources** that are accessible and appropriate, and disseminating them in various spaces, including schools, religious settings, GPs and community spaces.

However, it is essential that local authorities and statutory professionals work with appropriate CBOs which have a clear understanding of safeguarding and accountability, and are working safely. Local commissioners may need to consider



ways they can support local CBOs to maintain quality standards. [The multi-agency statutory guidance on FGM](#) states:

‘When commissioning services, local authorities may wish to check whether community organisations are accredited. For example, the Imkaan Accredited Quality Standards set out standards for community organisations working with black and minority ethnic (BME) women and girls on harmful practices including FGM and so called honour-based violence’.

The inclusion of CBOs can ensure that: services are developed that meet the needs of services users; statutory professionals understand the issues related to FGM and address fears and misconceptions that may deter those affected by FGM from engaging with statutory professionals. CBOs can also play a role in ensuring that services and statutory professionals are held accountable, by lobbying, pushing forward the agenda and challenging. CBOs need to be integral to the implementation of projects to ensure better ownership of the issue and more sustained and sustainable engagement with community members.



CBOS NEED TO BE INTEGRAL TO THE IMPLEMENTATION OF PROJECTS TO ENSURE BETTER OWNERSHIP OF THE ISSUE AND MORE SUSTAINED AND SUSTAINABLE ENGAGEMENT WITH COMMUNITY MEMBERS.

GETTING STARTED ON FGM ENGAGEMENT

PRINCIPLES OF APPROACH

There are some common 'principles of approach' used by best practice projects to end FGM. These principles should work to higher goals within projects so as to empower women and children to end all forms of violence. They should work within holistic frameworks that consider prevention, protection, support and access to care.

The following principles of approach are not intended to be comprehensive, but to inform discussion of how projects to end FGM in the UK can have a common framework.

USE A HUMAN RIGHTS APPROACH

A human rights approach is a vital part of tackling FGM in all of its forms. It is important that FGM is placed within a wider context of 'Violence against Women and Girls' (VAWG) and that the root causes of gender inequality are addressed. There is a variety of women's and child rights that FGM projects can use in their work, including the right to bodily integrity and the right to be free of violence and safe from harm.

'DO NO HARM'

FGM is a complex, deeply sensitive, social norm, which lies at the heart of gender identity and gender relations. The 'Do no harm' principle extends beyond safeguarding and considers the range of harms that may arise even when those working to end FGM are well-intentioned. These present a risk to the efforts of community-led efforts to tackle FGM. The Girl Generation (an Africa-led movement to end FGM) has produced a [comprehensive guide](#) to the types of harm that may arise.

‘DO NO HARM’

‘Do no harm’ is an ethical principle underpinning much research and health and social programming. It means that those undertaking research and/or interventions should not, intentionally or otherwise, cause harm. There is a risk of social change interventions inadvertently creating social divisions or backlash from the community if they feel targeted and stigmatised. Negative effects are often unforeseen and unintended.



The types of harm include (but are not limited to):

- Presenting FGM and affected communities in negative and judgemental terms, such as ‘backwards’ or ‘barbaric’.
- An insensitive and potentially damaging reliance on FGM survivors to publicly campaign on FGM, without ensuring adequate support for them.
- Use of graphic and disturbing images, which may trigger survivors’ memories or cause discomfort to those watching.
- Presenting FGM as being practised by only one ethnic group or religion.
- Poor understanding of safeguarding processes has sometimes resulted in inappropriate handling of cases, potentially increasing risk and stigmatising communities e.g. discussing disclosures with a parent first; not assessing risk thoroughly.

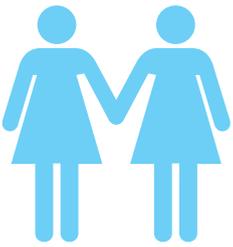
Projects, commissioners and statutory leads should consider the range of harms that may arise, and how these will be mitigated in their project approach:

- **Graphic imagery of FGM should not be used.** In particular imagery that could be triggering to those affected by FGM, negatively depicts FGM-affected communities or violates the dignity of FGM-affected communities.

GETTING STARTED ON FGM ENGAGEMENT

- Ensure that **approaches are non-stigmatising** and not associated with one particular ethnic group or religion. Many projects have used global prevalence maps of FGM to explain how widespread the practice is, across several continents and many ethnicities and religions.
- **Carefully choose images** so as not to associate the subjects with a particular ethnicity or religion. For instance, it is not considered best practice to only use images of women in the hijab. Some projects present images of women as silhouettes to avoid this harm.
- Resources which **celebrate change and success in the FGM campaign**, depicting people actively rejecting the practice, should be used as often as possible. This underlines the positive story of change and what has been achieved by the movement to end FGM.
- **A culturally affirmative approach works best.** Projects which celebrate and respect cultures have been more able to give messages about changing culture and tradition, of leaving 'harmful' tradition but maintaining positive traditions.
- The **needs of FGM survivors** need to be carefully considered, especially when they are part of public forums, training sessions for professionals, or part of multi-media resource production. This includes the need for mental health support, which may be ongoing once the project ends.
- A **good understanding of safeguarding** and of the levers available to support women to resist pressure to undergo or commit FGM, as well as a total commitment to reporting identified cases, are essential pre-requisites for all projects working to end FGM.

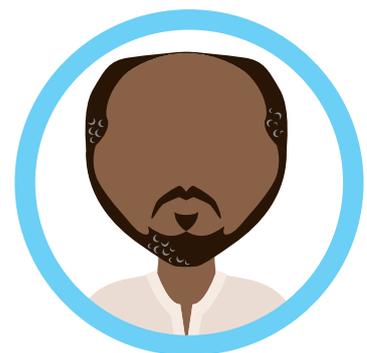
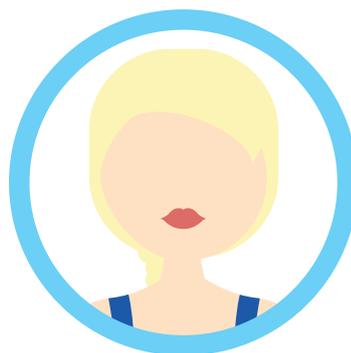
PLACE WOMEN AND GIRLS AT THE CENTRE OF PROJECTS



Projects should seek to empower women, providing support, building their confidence, and considering how their skills and capacities can be developed as part of their participation. The 'best practice' projects have considered women and girls as partners in their interventions. They should be involved in all stages of the project including design, delivery and analysing what more needs to be done to end FGM. Best practice projects invest in women's leadership to end FGM.

INVOLVE WIDER STAKEHOLDERS

FGM, as a form of child abuse and violence against women and girls, is everyone's business. It is important to include men (as husbands, fathers, siblings and future spouses), young people, community and religious leaders, and statutory professionals. Best practice projects carefully consider their target groups, and have developed good models of joint working, particularly between frontline professionals, strategic and safeguarding leads and people from affected communities. This builds political will locally to tackle the problem, and wider endorsement of child protection and safeguarding interventions.



PRACTICAL GUIDANCE FOR FGM ENGAGEMENT

PREVENTION

The TFGMI has defined prevention as ‘a shift in the attitudes and behaviours that continue to allow the practice of FGM to continue’.

The TFGMI has identified several proxy indicators to assess whether these shifts are taking place. These indicators include whether communities: are more aware of the reasons to end FGM; show declining support for any form of FGM; are skilled and confident to speak out against FGM; reject FGM on the basis that it is a violation of children and women’s rights.



This section outlines practical guidance for several different groups. It highlights the need to work with these groups and, more importantly, that each group must be engaged in a slightly different and tailored way.

GENERAL PREVENTION CONSIDERATIONS

- There is a need to explore and understand the rationales for FGM at the start of any interventions, because support for FGM can take many forms, with different, constantly-evolving justifications.
- Rights-based arguments have worked best in the long-term to address support for FGM, as they address underlying rationales and justifications for FGM and enable wider conversations on safety, protection and rights for girls and women. Rights-based arguments also provide the framework to ensure that the multiple reasons for FGM are addressed. A reliance on a single argument

against FGM (e.g. health) has led to modifying the practice of FGM (e.g. medicalising it) as opposed to ending all forms of the practice.

- Coordinated and comprehensive responses, where community-based prevention, statutory responses for safeguarding and detecting cases of risk, and linking women into care, have worked best. A more comprehensive response involves building the skills and confidence of CBOs to advocate appropriate responses, and incorporating CBOs in a local authority's response to FGM.

DEVELOPING AND BUILDING COMMUNITY CHAMPIONS

RATIONALE

COMMUNITY CHAMPIONS ARE OFTEN ABLE TO ACCESS INFORMAL SPACES AND SOCIAL NETWORKS AND MAKE CONTACT WITH HARD TO REACH GROUPS. THEY CAN ENGAGE THEIR PEERS AND QUICKLY CREATE TRUSTING RELATIONSHIPS.

'Community champions' – as the voices of communities affected by FGM speaking out against the practice – have been the driver of change in the FGM campaign. CBOs have developed effective training models to enable women, men, young people and religious leaders to actively engage in the campaign and become community champions or peer educators, providing them with the skills and confidence to publicly speak out within their communities and among their peers.

Community champions are often able to access informal spaces and social networks and make contact with hard

DEVELOPING AND BUILDING COMMUNITY CHAMPIONS

to reach groups. They can engage their peers and quickly create trusting relationships. They often work alongside project workers who provide high-quality information, but also have a multiplier effect, taking FGM messages back to their communities. Community champions also highlight that affected communities have responsibility and power to create change within their communities. Finally, many CBOs have indicated that the process of becoming a community champion is an empowering journey.

Community champions do not work in isolation, and need to be properly trained, resourced and supported throughout their journey. In the course of their work they may face difficult issues to do with safeguarding, as they actively seek to engage with those who support FGM. They may also be survivors themselves and need ongoing supervision and support.

ACTIVITIES: WHAT HAS BEEN DONE

Several CBOs have developed specific training schemes to enable individuals to become community champions. These training programmes typically cover topics such as FGM; VAWG; safeguarding and dealing with disclosures; confidentiality and professional boundaries; facilitation or public speaking skills; project or event planning; as well as the specifics of the project and the expectations placed on them. Many CBOs have found that working with those who already have a community role, and/or wide social networks, is an effective approach.

MANOR GARDENS

Manor Gardens has developed a training programme to enable community members, both women and men, to become paid Community Facilitators. The training





programme is an in-depth, 4-day training programme covering: FGM and health; legislation and safeguarding; presentation and facilitation; administration and finance. Community Facilitators are trained to deal with disclosures and also to be able to signpost, refer and support women to access a variety of services which can be both FGM and non-FGM related.

Following the training Community Facilitators organise FGM sessions with community members in an informal space, usually homes, or in the case of men in cafés or centres. It is important that the sessions are held in spaces where community members feel comfortable and safe. Sessions are always single gender, and Community Facilitators are accompanied by healthcare professionals with extensive knowledge of FGM.

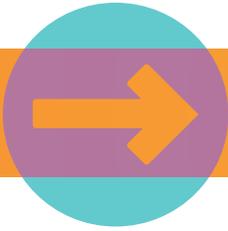


FORWARD

FORWARD has developed a Women's Health and Leadership Training Programme, working with women from affected communities to become Health Advocates. Women who already have community leadership positions are identified and recruited to the training programme.

The training programme consists of four full-day sessions which cover FGM and VAWG; safeguarding; monitoring and evaluation; communication; campaigning and leadership; project planning and development. The Health Advocates then undertake a small, local community project on FGM, where they can embed the FGM training that they have received in their daily work and networks. The Health Advocates have undertaken projects such as setting up a monthly coffee morning, doing a radio session on FGM, and running sessions for parents. They are included in the wider FGM campaign in their local area.





BEST PRACTICE - DEVELOPING AND BUILDING COMMUNITY CHAMPIONS

- **Clear and considered recruitment processes** through interviews and application forms ensure that community champions meet expectations and are able to deliver the work. It is important to recruit a diverse range of individuals who are bilingual, have experience of providing advice and support, have a strong commitment to safeguarding and have proven existing community links and networks.
- **Comprehensive training** is essential to ensure that community champions convey accurate information on FGM that adheres to known standards and that the work is of a high quality. CBOs should consider what additional training community champions require, including: public speaking; facilitation; campaigning and wider VAWG; health; human rights issues. CBOs should also consider how community champions can be practically skilled and supported e.g. shadowing opportunities and the provision of engagement opportunities.
- Community champions should be **trained on safeguarding** and be prepared to report when there is a child protection concern. CBOs can support them to do this by helping them think through implications and also by ensuring that they are not placing the onus of following up or investigating on community champions.
- Community champions should to be trained in **how to deal with disclosures**, how to manage emotions and trauma, and how to discuss the issue sensitively. Community champions need to be enabled to signpost, refer and support women to access specialist care not only on FGM, but on wider issues that may come up.
- Community champions should be trained and have the skills to **facilitate conversations that encourage discussion and**

debate allowing participants to explore the issue of FGM. Consider the use of informal discussions and prompts: 'what do you know/think about FGM?'; 'What does FGM mean to you?'.



- Support community champions to **identify and create safe spaces** where people will be able to discuss FGM openly. Safe spaces can be created by not using traumatising or triggering content, providing content warnings, allowing people time and space to process their emotions, having support services on hand, and discussing FGM sensitively.
- **Expectations and standards should be clearly set out** for community champions at the start of the training. These expectations should include monitoring and evaluation, role and responsibilities, practical guidance and administrative duties. Project workers should support community champions to adhere to the expectations. CBOs should consider how this information can be conveyed to community champions e.g. handbook or volunteer agreement.
- **Supervision and support** must be formally embedded into the work with community champions to identify and address any challenges they are facing in their work. It is best practice to consider the mental health and emotional support needs of community champions. Several methods of providing support and supervision should be considered, including but not limited to: one-to-one sessions; group support; practical support e.g. covering expenses; providing written materials about the work.
- **Accrediting Champions Programmes** can create a sense of recognition and acknowledgment for individual community members who participate, increase commitment, and formally develop the skills of individuals. Certificates should be provided to community champions who complete the training.

ENGAGING WOMEN AFFECTED BY FGM

RATIONALE

Through the TFGMI, women who have undergone FGM and are affected by it have been the key drivers of change. Their voice, leadership and dedication has been essential in: highlighting the issue of FGM; enabling professionals to understand it; the development of services as well as their commitment to ensuring the protection of their daughters from undergoing FGM.

Women affected by FGM may have multiple needs, including access to prevention information within a rights-based framework and support to access care. Women affected by FGM need to be provided space to understand the practice, its implications and to discuss their experiences. Given the influence and impact that women who have undergone FGM have had on the FGM campaign they should be provided the opportunity to build skills and confidence to enable them to become community champions thus conveying FGM information more widely into their families, networks and communities.

ACTIVITIES: WHAT HAS BEEN DONE

The creation of 'safe spaces' has been effective in working with women who have experienced FGM. Safe spaces are places where people feel comfortable to share and explore their views. They are usually informal settings where individuals engage with their peers, and support services are available. The creation of safe and informal spaces allows women to discuss and explore FGM and its harmful implications.



CASE STUDY - 'SISTER CIRCLES': NETWORKS OF TRUST



The Africa Advocacy Foundation (AAF) works through 'sister circles' to conduct community conversations around FGM in South East London, particularly Lambeth, Southwark and Lewisham. Sister circles are informal women's groups, where young and old women from FGM-affected communities can meet. AAF project workers recruit a few women, and ask them to bring more of their friends. In this way, they can rapidly set up a sister circle, and reach women who may not have any contact with other services. The sister circles are hosted by AAF's community champions. This enables the project to reach into Lambeth's diverse communities across language groups. AAF is currently working with four circles, with champions who speak Arabic, French, Swahili and Somali.

The sister circles rely on social networks and trust. Many of the women already know each other, and this allows women to talk about very personal issues in this 'safe space'. The sister circles are held in the women's own houses, faith centres or at community centres. The informal setting and relaxed atmosphere allows women an opportunity to talk in an open way not just about FGM, but about the issues that they face in their lives.

As Shani Hassan, AAF's FGM Services Coordinator, explained, sister circle conversations often start with women sharing their everyday problems, like parenting, but she can often find opportunities to raise the issue of FGM. Women with FGM may not recognise

CASE STUDY: CONTINUED

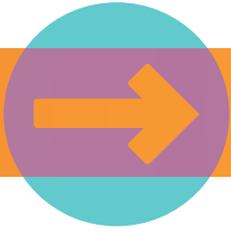
some of their health problems as being FGM-related, for instance. In some cases, when discussing difficulties that they face such as recurring bladder infections, project workers or trained volunteers explain the links to FGM, and encourage women to seek care from their GPs. The sister circles have thus had an important effect in linking women into services and treatment.

AAF also conducts outreach during 'henna nights', which are all-women parties the night before a woman's wedding. It's a celebration where older women will often provide instruction in married life to the bride to be, and in this context Shani can also talk about FGM, the importance of sexual pleasure within marriage, and women's rights to be free of FGM.

Women often also share their difficulties within their marriages, which is frequently as a result of FGM. Many women experience sexual difficulties such as pain and a lack of pleasure and intimacy, which affects their relationships with their husbands. Shani can then advocate for women to access FGM specialist services such as de-infibulation, which may ease these problems. Discussions of sexual intimacy are often highly stigmatised, but in these private settings, women are freer to talk.

As Shani explained, "If you provide the opportunity for people to have the conversation, they will open up. If it's a conference or workshop, they will hold back".





BEST PRACTICE - ENGAGING WOMEN AFFECTED BY FGM

- It is essential to **take time to develop 'safe spaces'** where women trust one another. Safe spaces tend to be single gender due to the sensitivity of FGM, although it may be helpful to have women from different groups and ethnicities to allow women to explore the various ways that FGM takes place and the various reasons why the practice occurs.
- In the development of safe spaces, conversations about FGM should be placed within the **wider framework of VAWG and human rights** as this supports women to explore the various rationales for FGM. It is also important to ensure that there is a facilitator present who is able to provide factual and non-judgemental information about FGM and dispel myths.
- Safe spaces should still **adhere to safeguarding procedures**. Prior to any FGM discussion, safeguarding, confidentiality and the implications of disclosures should be thoroughly explained.
- Women may find talking about FGM emotional and traumatic, particularly if they have not spoken about FGM before. For some women this may lead to an increased level of emotional distress as they come to understand their experience as harmful or abusive. It is therefore imperative to **provide emotional support for women** and be able to refer them to specialist FGM support services.
- Women who have experienced FGM may have complex needs including: experience of multiple forms of violence; asylum or migration concerns; concerns about welfare

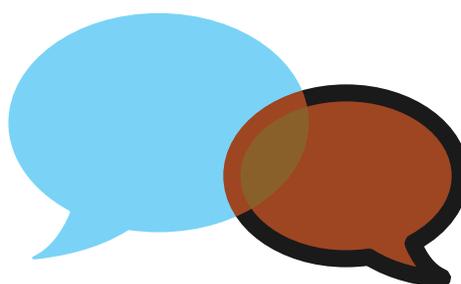


ENGAGING WOMEN AFFECTED BY FGM

or housing; and may have other health concerns. CBOs should **actively develop referral and support pathways** to address women's multiple and complex needs.

- When engaging with women it is important to consider that they often have **responsibilities around childcare**. Therefore measures should be taken to ensure that this is not a barrier. For example: the provision of crèche facilities; the timing and location of workshops that take into account school timings and women's schedules; the provision of child care expenses.
- It is important to **consider the inter-personal relationships** of individuals in the spaces. In particular they have found that it could be harmful or ineffective to have mothers and daughters in the same spaces, especially if a conversation about FGM has not previously occurred.

***THE CREATION OF 'SAFE SPACES'
HAS BEEN EFFECTIVE IN WORKING
WITH WOMEN WHO HAVE
EXPERIENCED FGM.***



ENGAGING MEN

RATIONALE



Men, in their roles as fathers and spouses, can play a vital role in ending FGM given that many of the reasons for FGM are linked to controlling women's sexual desires and ensuring virginity and fidelity. It is important that men come forward and challenge these reasons. Men also have a role to play as important decision-makers within families and potentially financial providers, to reject the practice of FGM and protect their daughters and other girls in their extended families.

ACTIVITIES: WHAT HAS BEEN DONE

Work with men starts by reframing FGM as an issue that affects everybody, including men. Successful messages that CBOs have employed include framing FGM as: a community or family issue; a marital issue; a human rights violation; a safeguarding concern.

CBOs ensure that they make FGM relevant to men and appeal to their sense of responsibility and their roles as 'protectors' within the family or community structure. CBOs have found that men may claim to know what FGM is, yet they are, in fact, unclear about the details, severity and harms related to FGM. Once men understand the specifics of FGM they are often able to understand why it should no longer be practised.

Some CBOs still encounter difficulties in engaging men. But where engagement has worked, men have become strong champions against the practice.

CBOs have been able to identify potential male advocates at public events and workshops, and from within their organisations. These are usually men who already believed that FGM was harmful and had strong links and influence within their local communities. CBOs trained and worked with these individual men to build their knowledge and confidence to engage and challenge other men about FGM.

CASE STUDY - INTERVIEW WITH HIRSI AHMED, MALE CHAMPION

"I am one of the community elders who lives in Bolton. There were times when I went to the BSCA (Bolton Solidarity Community Association) just to reach the community itself. Ibrahim (a staff member at BSCA) approached me and explained FGM. As a Somali man, I know in general what it is. I have three sisters, and all three sisters had been through this horrible practice when I was young, so I knew a lot about it. Ibrahim asked me if I can support them to start communication between BSCA and men in Bolton.

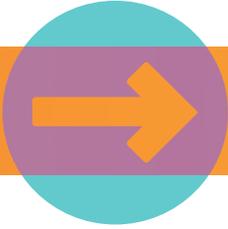
I never discussed FGM before. It was taboo. However, since we started this conversation I now have the confidence to talk to men. It was not easy at the beginning. We did it step by step.

I started with my close friends. I know some Somali men who are very close to me. Some of them are fathers and they have daughters. It started in a way where I said, "I have a daughter, you have a daughter. It is really something that is destroying young girls' lives. We need to spread awareness to the Somali men. It is a cruel practice". Some of the men were very clear that they didn't want to discuss it – they said, "You came here to discuss FGM. You have wasted and spoilt our time. It's not a good issue that we can discuss with you".

Some men even said that while these FGM discussions are happening we will stand outside. It was not easy. We told them it wasn't religious and it's not in the Quran, it is just tradition. Traditions can be good or bad and this is a bad tradition. It is time for us to discuss it.

The highest number of men that we have had in a workshop is 25. Some of the men were very open-minded, and after the first 10 minutes of the conversation they were open to us and supported us. They understood that this is a cruel practice and they supported the campaign because they have daughters in the UK. The majority of the men who supported us are fathers, and they are aware that FGM destroyed the lives of their sisters and their wives.

The main message that we are using now is: 'save your girls and save your daughter – this is saving a life'.



BEST PRACTICE - ENGAGING MEN

- Build FGM men's work slowly. It might be helpful to **start by engaging male community elders and local leaders** who can help you reach out to other men within the community. This will enable work to build on established networks and relationships in the community.
- **Informal engagement and conversations** about FGM with men can pave the way and enable men to be more receptive to discussions about FGM. More formal workshops can then take place.
- **Develop various forms of support for men.** This includes but is not limited to: training and capacity building; emotional support; feedback and validation. Group support for men affected by FGM (married to women with FGM) has been found to be effective.
- Men engaging on FGM need **extensive training and support** to build their confidence to be able to speak out against the practice. Given the difficulty of the subject and the barriers men have to overcome it is essential they are supported. This training should be continuously updated to ensure that they are confident responding to any issue that they encounter.
- Men who are engaging in the FGM campaign should be given **development opportunities and validation** and acknowledgment of the important and challenging work they are doing.
- Develop **extensive knowledge of informal spaces** where men from FGM-affected communities meet – such as small businesses, barbers, or coffee shops.



ENGAGING MEN

- Frame FGM as a community issue that all members have a stake in and **ensure that the importance, relevance and role of men** as fathers, spouses and brothers are clearly outlined. Include men in the conversation about protecting children and girls. It can be useful to appeal to men's roles as fathers, their role in protecting and safeguarding the family and more widely their role in ensuring community wellbeing.
- It is also important to **sensitively challenge gender-based norms** that may perpetuate not only FGM but also other forms of VAWG. Parallels should be drawn between some of the rationales for FGM such as women's sexual purity, and how these similar ideologies underpin other forms of VAWG.

*IT IS IMPORTANT TO SENSITIVELY
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FORMS OF VAWG.*



ENGAGING YOUNG PEOPLE

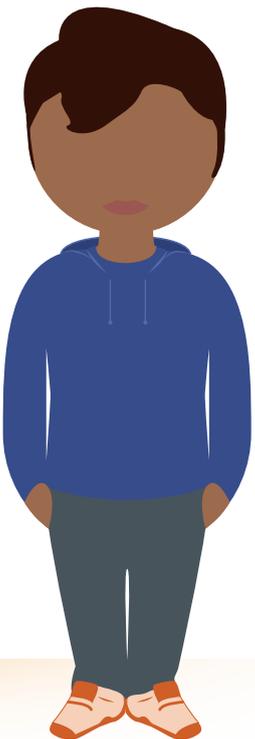
RATIONALE

CBOs working to end FGM have started to work with young people, actively engaging them to become 'youth advocates' and 'peer educators'. Young people, and in particular girls and young women, are directly affected by FGM and in some cases may have personally undergone FGM and so must be engaged. In addition, organisations acknowledge that young people have access to specific spaces and networks e.g. school, college, university and youth groups, where they can share information. The opportunity to be role models and peer mentors is also important in challenging attitudes that allow for violence and discrimination to continue. CBOs have identified young people's sense of justice, dynamism, passion, frankness, urgency, energy and courage as contributing factors to end FGM within a generation.

ACTIVITIES: WHAT HAS BEEN DONE

Several CBOs have actively engaged with young people to participate in and lead activities to raise awareness of FGM. Most of the CBOs have employed creative arts projects and approaches to engage young people including: art competitions and exhibitions ([Oxford against Cutting](#) and [OSCA](#)); plays and dramas ([Arc Theatre](#), [BAWSO](#) and [Integrate Bristol](#)); creative writing and poetry (AAF and [FORWARD](#)); writing songs and developing music videos ([NESTAC](#) and Integrate Bristol).

These approaches have engaged young people, enabling them to explore the complexities of FGM. The use of creative approaches is an effective distancing technique that allows young people to examine a difficult and sensitive issue without making it about their personal experiences. It also helps to develop empathy as young people can take on a character and another's shoes.



ENGAGING YOUNG PEOPLE

Usually CBOs will use the creative projects to develop youth-friendly resources including music videos, filmed dramas, art work, poetry collections and educational resources. They will then work with their young people to organise youth-led events to showcase their work. This is an effective way of not only raising awareness within the wider public and recruiting more young people, but also serves as a way to recognise and validate young people's efforts as well as developing their skills in a variety of areas.

THE USE OF CREATIVE APPROACHES IS AN EFFECTIVE DISTANCING TECHNIQUE THAT ALLOWS YOUNG PEOPLE TO EXAMINE A DIFFICULT AND SENSITIVE ISSUE WITHOUT MAKING IT ABOUT THEIR PERSONAL EXPERIENCES.

To deliver this intensive work CBOs have developed youth groups that meet regularly. The youth group setting offers the space for young people to learn about and understand FGM in the wider context of VAWG and human rights, share ideas and develop their projects, build skills and get support and time to implement their projects. All of the CBOs engaging in youth work recognise the importance of ensuring that the youth groups are made up of a diverse range of ethnicities and mixed genders as this encourages the message that FGM is everybody's business.

Some CBOs have developed specific training to enable young people to become youth advocates or peer educators. This training tends to be more structured and is run less frequently than the ongoing training that takes place in the youth group setting. Young people will receive training on FGM, safeguarding, campaigning and advocacy, facilitation and presentation. Young people are then enabled to talk about FGM and deliver sessions in a variety of settings including schools, youth settings, madrasahs and supplementary schools, or to deliver campaign projects in their local area with young people organising events at their university, speaking on their local radio or organising flash-mobs.

CASE STUDY - MOBILISING YOUNG PEOPLE – THE CHANGE AGENTS

A core aim of Integrate Bristol's work is to support young people's empowerment by directly providing forums for their political participation, or through confidence-building initiatives.

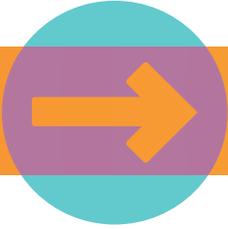
All of Integrate Bristol's projects are youth-led. Young people in the group have ideas for projects, and then work collaboratively with the trustees to make these happen. As Sami Ullah of Integrate explained, young people often have the best ideas for projects, and the funniest ways of getting ideas across. Sami emphasises the importance of listening to what young people really want. "For us, being youth-led works – it just needs someone to listen to them and propel (the project forwards) if you will". This approach builds their confidence and gives them a platform for ideas.

Young people have participated in a wide range of creative projects, including developing dramas, music videos and films on YouTube that are fun and informal. Providing opportunities for young people to be valued and have their voices heard can build their confidence. Young people's voices may be shunted aside by older people in some forums, but it is vital that projects lead the way in finding and being champions to support young people's voices.

Providing emotional support to young people so that they can talk about their life decisions or difficulties that they are facing is also important. All of Integrate Bristol's work includes messages on safeguarding, so that young people are aware of their right to protection. In some communities, young people can still be unaware of FGM, or of its long-term psychological consequences. It is important that they know how to offer each other support to resist pressure.

All of these projects have worked to build trust with the wider community to support their work with young people, particularly with parents. Integrate Bristol faced strong, public opposition when they first started talking about FGM. There were public demonstrations outside schools, led by a local councillor who objected to the young people's participation.

For Integrate Bristol, this was dealt with by trusting young people to know how to deal with people who oppose them. "We have a very loud and lairy group of teenagers – that helps!". Secondly, the group quickly gained the support from local parents, who could see that their sons and daughters were working to end a harmful practice. "They (parents) have had their eyes opened as well, after so many years of media attention and young people talking about it – they agree...mothers and fathers are now proud that they are doing what they do", said Sami from Integrate Bristol.



BEST PRACTICE - ENGAGING YOUNG PEOPLE

- Youth groups should be run with the consideration that there might be girls or young women who are affected by FGM in the group or young people who come from families who believe FGM is important. **Additional support for girls and young women affected by FGM** should be available if the need arises.
- **Youth engagement should always be safe.** Girls and young women should never be asked if they have undergone FGM unless there is a specific safeguarding concern. FGM awareness and engagement should not be graphic, have disturbing images, use shock tactics or be scary; particularly as this can be triggering to girls and young women affected by FGM. Resources and materials used should be appropriate, youth-friendly and sensitive.



- **Safeguarding and child protection.** Young people should understand safeguarding and be aware of the limitations of confidentiality. It is also important to obtain parental consent, actively engage parents and ensure young people's safety at all times.
- **Support** young people to access youth-friendly support services and have space for one-to-one conversations if needed. Include mechanisms to access support anonymously.



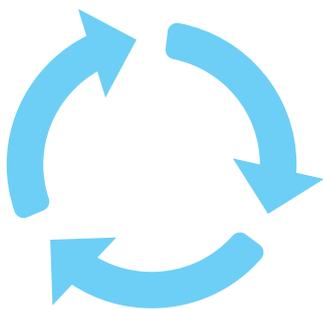
- Engaging young people should be a **participatory process** where they are trusted and given power, control and ownership to develop their ideas and their projects. Therefore, it is important to give young people responsibility and engage them in the initial creation of the project. Ways of doing this can include: having young trustees; setting up a youth advisory council; young people feeding into the funding and project proposal. This will ensure buy-in from young people and make recruiting young people easier. There should be a system for regular needs assessment to understand and identify issues that young people face and that they feel are important to them
- Develop ways to **meet young people's various needs and context** including migration history, language and learning needs, and the wider context of their lives. Young

people have rapidly changing lives and can face huge pressure during specific periods such as exams. Projects and youth group sessions should be planned with these considerations in mind. Youth group venues and timings should be accessible and safe for young people.



- FGM should be framed in a way that is **relevant to young people** e.g. in the framework of human rights, gender inequality, healthy relationships or VAWG. Young people should also understand their local context of FGM.
- Engagement should focus on **skills and capacity-building** of young people. This can be achieved through: formal training; informally challenging them and modelling behaviour; providing learning opportunities; and encouraging them to take on new challenges.
- Youth groups tend to be quite fluid and flexible therefore **continuous training and information sharing** should be embedded into the work to ensure that all young people have similar levels of information. This can be done through games, competitions and quizzes as these allow for project workers to assess knowledge and identify learning gaps.
- There should be a **range of roles and ways that young people can contribute** which are at various skill levels to ensure that young people always find something for them to do but also always feel like they are being challenged and can see the next place they need to progress to.
- Young people should be given the opportunity to **actively engage in the complexities of FGM**, examining the media coverage for example, or discussing the 'do no harm' principle, the wider policy and the political context. Discussion, debate and conversation should be encouraged.

- Youth engagement on FGM should be **fun, enjoyable, positive and empowering**, focusing on the change that young people can contribute to. Young people should be provided with practical and personal development support e.g. university advice, references, a person to confide in and get advice from, support with goals and aspirations.
- **FGM youth work should increase compassion and not just passion.** Young people should have a sense of responsibility and ownership, and believe that they can contribute to change. FGM messages and tone should balance the gravity of the practice with hope.
- **Build partnerships** with local schools and youth groups to enable trust and legitimacy in the CBO or project, facilitate recruitment, and ensure young people's wider support networks are aware of activities they can or may be engaged in.



YOUTH ENGAGEMENT ON FGM SHOULD BE FUN, ENJOYABLE, POSITIVE AND EMPOWERING, FOCUSING ON THE CHANGE THAT YOUNG PEOPLE CAN CONTRIBUTE TO.

WORKING WITH NEWLY ARRIVED COMMUNITIES

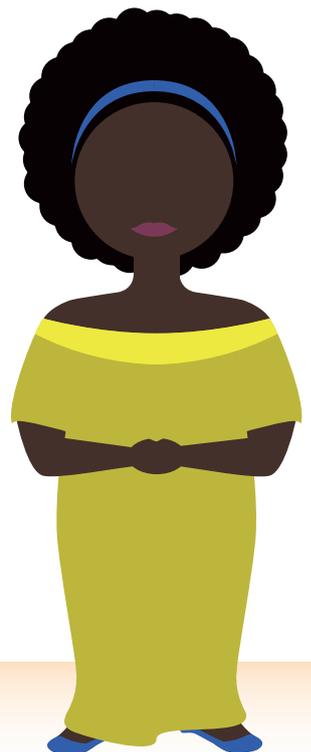
RATIONALE

'Newly arrived communities' is a term encompassing a diverse and wide range of individuals. In the context of this guide 'newly arrived communities' is defined as: refugees and asylum seekers; individuals, in particular women, who arrive through spousal visas; recent European migrants whose country of origin is an FGM-affected country. Through the TFGMI it has been observed that the needs of newly arrived communities vary and may be higher than the needs of more established communities.

It is often the case that newly arrived communities have limited or no knowledge of UK legislation on FGM, limited awareness of support services available, may have language barriers and may also have stronger support for FGM. Some CBOs have also found similar needs among isolated communities which have limited community networks. While we understand it is not always useful to identify communities as 'newly arrived', we have found that in some cases it helps with planning interventions and services to meet specific needs.

ACTIVITIES: WHAT HAS BEEN DONE

Several of the CBOs that have worked with newly arrived communities are based in the asylum dispersal zones and so are either part of the [Gateway Protection Programme](#) (the UK's contribution to the United Nations High Commissioner for Refugees global resettlement programme) or known and linked to first-contact services e.g. refugee resettlement team or the local refugee council. CBOs have set up partnerships with first-contact



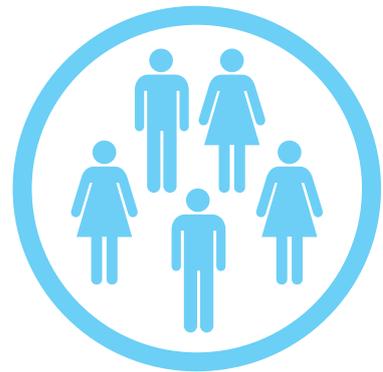
organisations and the local authority to provide services and support for newly arrived migrants, specifically refugees and asylum seekers.

BSCA

BSCA developed a partnership with their local Refugee Resettlement Team. They deliver FGM workshops to newly arrived, affected communities about FGM and offer a drop-in service for newly arrived communities to enable them to access services and support.

BAWSO

BAWSO works in partnership with specific teams that work with newly arrived communities within health centres. They have embedded questions around migration history into their assessments of new clients. **BAWSO** runs regular coffee mornings, providing spaces for people to talk about issues affecting them. This space is particularly important given that newly arrived communities often have complex needs and may have faced traumatic experiences throughout their migration journey. In these spaces project workers would slowly bring up FGM.

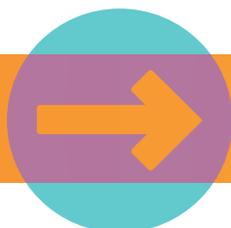


BWHFS

BWHFS developed a welcome pack for newly arrived migrants providing information about FGM which they have translated to several community languages ensuring accessibility. They undertake extensive outreach and actively engage with

WORKING WITH NEWLY ARRIVED COMMUNITIES

informal groups and networks to start conversations with newly arrived communities. They deliver specific workshops for newly arrived communities recruiting participants through their outreach work. Following the workshops they offer one-to-one support for individual women on a variety of issues and concerns that they may have.



BEST PRACTICE - WORKING WITH NEWLY ARRIVED COMMUNITIES

- Services should be **holistic and provide a range of support** as newly arrived communities can have multiple and complex needs e.g. welfare, housing, education, debt, utilities, employment. Newly arrived communities face multiple challenges and barriers to integrating in the UK and it is essential that these needs are also addressed so as to build trusting relationships between CBOs and newly arrived communities which will create an environment where they will be receptive to information about FGM.
- Incorporate **questions about migration history in initial assessments** to ensure the identification of the variety of needs that an individual may have. Be mindful that some individuals from newly arrived communities, particularly those arriving from conflict or war-torn areas, may have experienced several forms of trauma or violence.
- Newly arrived communities are very transient and mobile, particularly those being dispersed, and constant relocation can disrupt interventions. Therefore, it is essential to **develop strong information sharing protocols to ensure there is stability and continuity of care** e.g. a central database, internal handover mechanisms and information sharing protocols.

- Ensure that all written and verbal **information is communicated in an accessible format** and enables understanding among newly arrived communities. In some cases this means using a trusted and professional interpreter who understands FGM, or producing leaflets in different community languages. CBOs are best placed to support this work as they often have bilingual staff.
- There may be strong FGM support among newly arrived communities. Therefore FGM engagement needs to fully explain FGM and legislation. Project workers must **develop robust arguments against FGM**, be patient and allow time for individuals to understand how the practice is viewed in the UK. Utilising engagement activities that are approachable and not overly formal can help to create a safe and open environment that will enable newly arrived communities to be receptive to FGM information.

NEWLY ARRIVED COMMUNITIES ARE VERY TRANSIENT AND MOBILE, PARTICULARLY THOSE BEING DISPERSED, AND CONSTANT RELOCATION CAN DISRUPT INTERVENTIONS.

- **Develop partnerships and a coordinated response** between local CBOs, first-contact organisations, the refugee and asylum sector, and the wider VAWG sector. The complexity of issues faced by newly arrived communities and the fact that individuals may have faced multiple forms of trauma and violence means that multiple expertise may be needed in order to provide adequate and appropriate support.
- Social activities should be embedded into programmes as they can be an effective way of engaging newly arrived communities and **addressing the isolation** they may experience while building social networks, cohesion and integration. This also builds trust between CBOs and newly arrived communities.
- CBOs should ensure they are **aware of changes and updates in immigration legislation** to ensure they provide effective and strong support to newly arrived communities.

WORKING WITH RELIGIOUS LEADERS AND IN RELIGIOUS SETTINGS

RATIONALE

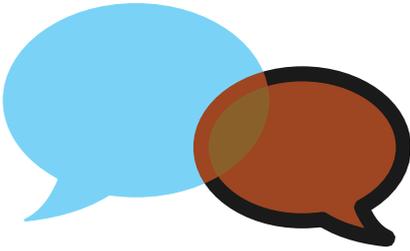
Throughout the TFGMI, perceptions that FGM is a religiously-endorsed practice have been consistently challenged. Consequently, in some areas there has been a major attitudinal shift, with some communities no longer believing that it is a religious duty or 'Sunna' (the sayings and actions of the Prophet Mohammed PBUH). This has been achieved in a variety of ways, including: working with religious leaders; working with religiously based arguments against FGM; and working in religious spaces and networks.

Religious leaders can play a pivotal and respected role in many affected communities and it can be strategic to engage with them to have access to their power and influence. However, this has not worked in all areas, and it is important to critically examine the added benefit of working with religious leaders as it can be quite labour intensive. Much work has been done to challenge religious justifications for FGM without relying on religious leaders' presence, using religious counter-arguments and edicts, for instance.

ACTIVITIES: WHAT HAS BEEN DONE

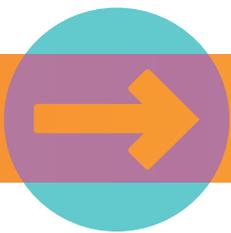
CBOs have developed various approaches to working with religious leaders, including: engaging religious leaders to become champions; asking them to speak at FGM events organised by the CBO; addressing FGM with their congregation either formally e.g. sermons or Khutbas (Friday Prayer) or informally.





CBOs have also engaged in religious spaces by organising talks and workshops, disseminating literature and conducting active outreach in religious establishments. Community champions and project workers have also engaged in informal religious spaces including religious or supplementary schools or 'madrassahs'.

To reach wider audiences and to ensure that FGM is not strongly associated with a single faith, CBOs have also organised inter-faith forums enabling a range of religious leaders to debate and explore FGM. CBOs have also worked with national religious establishments to produce resources such as leaflets and videos, which can support project workers to address religious arguments for FGM.



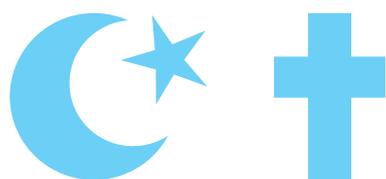
BEST PRACTICE - WORKING WITH RELIGIOUS LEADERS

- CBOs should **develop an understanding of their local religious establishments** before engaging them. It is important to identify which religious establishments and leaders cater to which community, how they operate and who the gatekeepers are.
- A **vetting process should be developed** to understand a religious leader's understanding of FGM and their willingness to speak out about FGM. The early stage of vetting, consensus building and training of religious leaders is very important and sufficient time should be allocated to ensure that this work is done effectively and thoroughly.
- **Only religious leaders who have a zero tolerance to all forms of FGM** and share similar messages to the

WORKING WITH RELIGIOUS LEADERS AND IN RELIGIOUS SETTINGS

wider FGM campaign should actively speak about FGM on behalf of a CBO. It can be more harmful to have a religious leader speak out with a vague or unclear message than to have no engagement from any religious leaders.

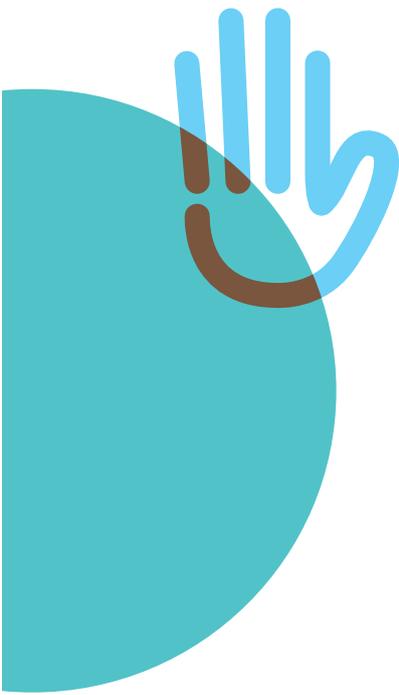
- Religious leaders should be **trained about FGM and supported to ensure they are equipped and confident** to respond to questions and address challenges that may be raised by their congregation, including push back from community members who continue to have a vested interest in FGM.



- Religious leaders and CBOs who want to actively engage with religious leaders need to have a **comprehensive and extensive understanding of the religious arguments and how to challenge them**. This should include having specific evidence from the holy texts and knowledge of how to counter arguments from secondary and tertiary religious texts.
- **Equitable, respectful and trusted relationships need to be built with religious leaders**. This can be achieved by: valuing and respecting their contributions and efforts; highlighting that they are part of an important team; providing evidence of impact of the work they do; providing them with opportunities for growth and development; and also hiring and paying them as other professionals would be. Partnerships should be transparent and honest and attempt to find ways in

which the relationship can be mutually beneficial while supporting the congregation and wider community.

- Engagement with religious leaders should **highlight their responsibility in tackling FGM** and present them with evidence of how FGM affects their congregation. Once religious leaders recognise the harms of FGM and its impact on their congregation, they may be more willing to publicly speak out.
- **Peer to peer learning and discussion** can be beneficial because it allows discussions to occur between individuals of similar status and background. If a religious leader has already been recruited they can undertake this work as they may be more effective at challenging religious leaders than project workers or other professionals.



ONLY RELIGIOUS LEADERS WHO HAVE A ZERO TOLERANCE TO ALL FORMS OF FGM AND SHARE SIMILAR MESSAGES TO THE WIDER FGM CAMPAIGN SHOULD ACTIVELY SPEAK ABOUT FGM ON BEHALF OF A CBO.

WORKING WITH SCHOOLS

RATIONALE

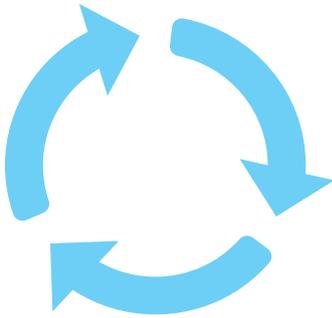
Schools are ideally placed to engage on FGM because they have safeguarding responsibilities and frequent contact with children at risk. Schools have a dual role of both preventing and safeguarding girls from FGM as well as supporting girls and young women to access care. Schools should consider how to incorporate various activities to ensure that they are able to meet both of these needs. School staff have regular contact and trusting relationships with their students which can decrease the barriers young people face around accessing support. They can also provide appropriate safe spaces for discussions around bodies, health, consent, rights and relationships. Further to this, schools should also consider their roles as safe and neutral spaces within communities and how that can be used to engage on FGM with parents and through wider community sessions and events, for example.

ACTIVITIES: WHAT HAS BEEN DONE

FORWARD

FORWARD has developed a National Schools Programme on FGM which delivers a range of holistic services to schools including staff training, student awareness sessions, parental engagement, outreach and support. The programme works in both primary and secondary schools, with student





awareness sessions being delivered to students from Year 5 to Sixth Form.

FORWARD's student awareness sessions are delivered by both project staff as well as Sessional Facilitators who are recruited and trained. Sessional Facilitators shadow experienced facilitators initially to build their confidence and are observed delivering a session to ensure quality control. Building on this work, FORWARD has developed a Train the Trainers scheme to train young people, youth workers and teachers to deliver FGM student awareness sessions, enabling them to expand their work and deliver sessions in Manchester and Birmingham through partnerships with other CBOs. FORWARD has developed several resources for FGM schools engagement work including a PSHE Association Quality Assured FGM lesson plan, short films and animations, a resource pack for school staff, and youth-friendly printed materials.

To ensure a whole-school approach, FORWARD delivers FGM training for school staff as well as parent engagement, usually delivered by a community champion or project worker. Informal sessions or coffee mornings provide parents, usually from FGM-affected communities, with information about FGM including health implications, legislation and where to access support. FORWARD also works with local authorities nationally, offering training to key figures and education professionals such as head teachers so that they can: explore the role of schools in a wider local and regional strategic response; link schools with each other and with relevant figures to offer mutual support and sharing of best practice.

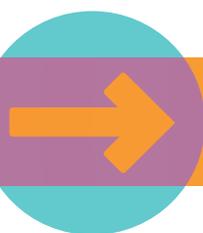
INTEGRATE BRISTOL

Integrate Bristol has similarly developed a Schools Dissemination Project that utilises young people as peer educators to deliver student sessions and FGM safeguarding training for staff. They have delivered this to schools across the UK and trained several organisations to deliver similar programmes. Peer educators tend to be young people who are already engaged in Integrate Bristol's wider youth work and volunteer to become a peer educator. They receive training on FGM, safeguarding, and the various educational resources developed by Integrate Bristol.



Peer educators build confidence and expertise over time by supporting: delivery and co-facilitating with more experienced peer educators; an internal process where peer educators are quality assured.

Integrate Bristol developed a 'train the trainers' scheme which enables more experienced peer educators to train young people to become peer educators. The scheme is used within the organisation to ensure a sustainable pool of peer educators, so that young people in schools and other organisations can deliver FGM lessons and dissemination in their local area. Integrate Bristol has also developed a range of educational resources including videos and lesson plans.



BEST PRACTICE - WORKING WITH SCHOOLS

- FGM schools engagement should include **a range of target groups, including school staff, students and parents.** Primary and secondary schools should be involved in FGM

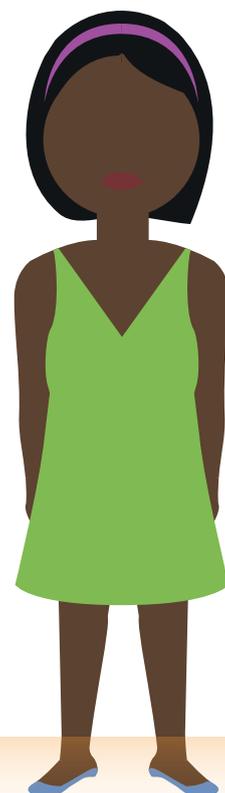
engagement with approaches tailored by age group.

- Schools should **engage with their local safeguarding teams** so that there is a clear referral pathway and a common understanding of thresholds. This will enable them to be better prepared in the case of disclosures or when risk is identified.



- FGM schools engagement should be a **long-term investment with continuous and sustainable work**. This could be by training teachers to deliver FGM sessions and embedding FGM into the curriculum. Thought should be given to how work can be built on. This is particularly important in primary schools where more sensitivity around FGM is needed. Programmes, lessons and resources should be flexible and adaptable so they can be tailored to the various needs and structures that schools and students have.
- **Staff should be trained on FGM and safeguarding before any student sessions take place**. Training should be comprehensive, including information about legislation, safeguarding and risk factors so staff are clear about their safeguarding pathways and what to do in case of a disclosure. Staff training on FGM should be embedded within a school's safeguarding training programme and should be regularly updated. FGM should be included in relevant documents such as schools' Safeguarding and Attendance policies, with procedures and pathways, and roles and responsibilities clearly defined and communicated.

- **Staff should be prepared for FGM student lessons** even when delivered by an external facilitator. They should consider how they can model appropriate and sensitive behaviour during FGM student lessons, respond to questions and disclosures, and have knowledge of their referral pathways and support services.
- Student awareness sessions should be **placed within the wider context of VAWG, healthy relationships and understanding of bodies**. FGM lessons should be delivered after students have learnt about genitalia. However, students' prior knowledge should not be assumed. FGM lessons should spend time checking students' knowledge of female genitalia.
- FGM schools work should play a part in conveying **wider messages about safeguarding, speaking out and building a culture where it is acceptable to ask for support**. FGM schools engagement should be positive and empowering. It might be helpful to think about how students can be engaged further in local campaigning activity and creating local change.
- **External facilitators and schools should have an initial assessment** to understand the school's context and needs, students' needs and what previous work on FGM and PSHE has already taken place. It may be helpful to develop an agreement with schools which outlines key roles and responsibilities.
- FGM schools engagement **should not stigmatise specific communities or individuals**. Ways to avoid doing this can

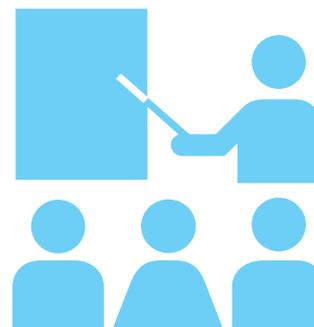


SINGLE GENDER STUDENT SESSIONS MAY BE MORE EFFECTIVE AS THEY ENABLE STUDENTS TO FEEL MORE COMFORTABLE DISCUSSING THE TOPIC. HOWEVER, THIS DOES NOT MEAN THAT BOYS AND YOUNG MEN SHOULD NOT ENGAGE ON FGM.

include: not mentioning specific countries in student lessons; student lessons being either mandatory for all students or optional for all students. Specific students should not be identified and selected to attend FGM lessons. It may also be helpful to have a conversation with students at the start encouraging them to think about how their reactions might affect other students.

- **Practical set up of FGM student lessons is essential to ensure they are effective and safe.** At least a whole lesson (40 – 60 minutes) should be dedicated to FGM (particularly if it is a stand-alone FGM lesson and it will not be revisited later in the curriculum). FGM lessons should be delivered to students in the same year group. Given the difference in understanding of bodies and relationships between year groups and ages it would not be effective to deliver an FGM lesson vertically (i.e. with several year groups in one class).
- Schools and external facilitators should **consider the need and effectiveness of mixed gender student lessons.** In some cases single gender student sessions may be more effective as they enable students to feel more comfortable discussing the topic. However, this does not mean that boys and young men should not engage on FGM. Lessons should focus on FGM's importance and relevance to boys and young men and the role they can play in prevention.
- Facilitators delivering FGM should be **skilled in engaging young people in informal ways on difficult and sensitive subjects.** They should be able to relate to young people, create discipline and have a strong understanding of FGM and related topics such as pregnancy, sex and relationships. Creating a safe space and opening discussions around genitals, the body, sex and

relationships can often generate questions and disclosures not directly related to FGM. Facilitators must be prepared to respond. However, in the case of external facilitators delivering sessions in schools, teachers should still have final responsibility for discipline, be present and support external facilitators with class management if needed.



- **FGM student lessons should be delivered in a way that is safe and supportive.** Ways of doing this include: agreeing ground rules; outlining the limitations of confidentiality; having an anonymous question box; letting students know that they can take time out during the lesson to seek support; providing a content warning; reassuring students that no graphic content will be used; clearly signposting students to where they can access further support. The use of explicit imagery and shock tactics should be avoided and lessons should be focused on conveying information in language that is neutral and fact-based.
- **'Sessional facilitators' and 'peer educators' should be supported and supervised.** This includes providing them with clear safeguarding procedures and strategies to deal with disclosures. It is important that the emotional wellbeing of facilitators is also considered because the work can be challenging and draining, particularly when disclosures are received.

ACCESS TO MENTAL HEALTH CARE AND SUPPORT

Access to physical, emotional and psychological care is an integral part of women's recovery from and understanding of FGM. Many studies have highlighted the physical health implications of FGM, but the mental health implications are less researched and understood. Women affected by FGM may face multiple and complex issues, due to their gender, race, ethnicity and migration history.

WOMEN MAY FIRST UNDERSTAND THE TYPE AND SEVERITY OF FGM THEY EXPERIENCED ONLY AFTER ACCESSING SPECIALIST SUPPORT AND BEING PHYSICALLY EXAMINED.

Many women have become FGM campaigners once they have undergone a healing process. Therefore, it is important to develop culturally appropriate therapy for women affected by FGM. Emotional, mental and psychological support should be embedded into prevention and care programmes.

CBOs and specialist organisations can play a role in: meeting these needs and referring women to specialist services; supporting women to identify their needs and understand the role that specialist services can play. This precursory work can ensure that women access support earlier and fully benefit from the services.

RATIONALE

Over the course of the TFGMI the important role played by emotional and psycho-social support in prevention has come to be recognised. Many CBOs have found that 'safe spaces' where women can discuss the harms of FGM are an important part of prevention. This is because this support enables women to understand and come to terms with their experiences of FGM and this is an essential first



ACCESS TO MENTAL HEALTH CARE AND SUPPORT

step in rejecting the practice of FGM. In addition, women may not necessarily recognise or identify their difficulties as FGM-related. Women may first understand the type and severity of FGM they experienced only after accessing specialist support and being physically examined. FGM usually affects marital, sexual partnerships and familial relationships and can therefore affect women's emotional and mental health and wellbeing.

Women who have experienced FGM may experience several mental health issues including but not limited to: cultural rejection or being rejected by their communities; estrangement from families; anger; isolation and depression; lack of trust; marital problems; sexual problems; self-harm; and suicidal thoughts.

Women who have experienced FGM may face several barriers in accessing mental health support and care services. CBOs can play a vital role in developing accessible care models and linking women into specialist support. CBOs can also play a role in providing an initial assessment of a woman's mental health needs and referring those with more complex mental health needs into more intensive psychological services. It is essential that all women who have experienced FGM be offered mental health support before they can play a wider role as community champions or public figures opposing FGM.



ACTIVITIES: WHAT HAS BEEN DONE

SOCIAL AND EMOTIONAL SUPPORT

CBOs have provided emotional support to women who have experienced FGM in one-to-one and group settings. CBOs have also worked to raise awareness of mental health and wellbeing and the added benefit of counselling and therapy, as a precursor to the provision of any mental health support or

counselling. This is to ensure that women will engage in and benefit from the counselling and emotional health support offered.

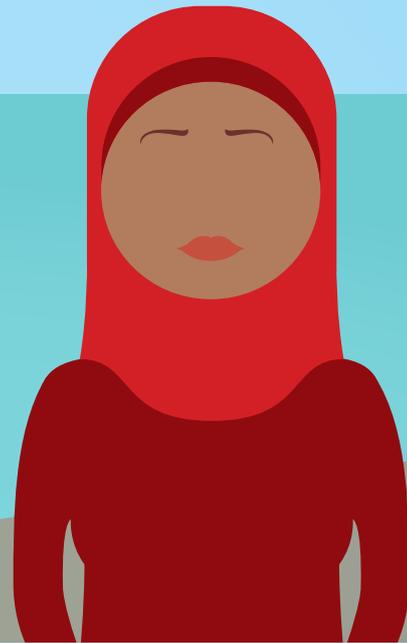
ENFIELD CHILDREN AND YOUNG PEOPLE'S SERVICES

Enfield Children and Young People's Services (ECYPS) offered counselling and emotional support to women who have experienced FGM. ECYPS provides monthly, culturally-sensitive emotional support in various community languages. In order to enable the effectiveness of the emotional support, they delivered a series of workshops about mental health. This work was necessary because many people from FGM-affected communities feel that counselling is not relevant to them or have a resistance to accessing counselling services. They also run coffee mornings as informal support spaces for women affected by FGM.



MANY PEOPLE FROM FGM-AFFECTED COMMUNITIES FEEL THAT COUNSELLING IS NOT RELEVANT TO THEM OR HAVE A RESISTANCE TO ACCESSING COUNSELLING SERVICES.

CASE STUDY - INNOVATIVE APPROACHES TO ADDRESSING YOUNG PEOPLE'S MENTAL HEALTH NEEDS



While awareness of FGM and mental health needs has been rising, access to mental health support is often through maternity services. Girls and young women affected by FGM, particularly in cases where risk is identified, also need access to support via non-clinical services.

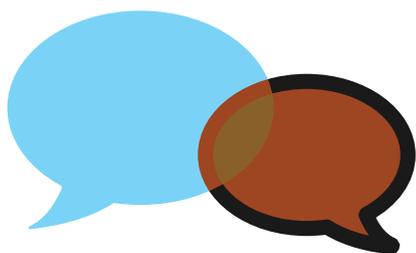
Fatuma Farah, a psychotherapist and FGM campaigner and survivor, has been working to develop mental health support for children in schools. Fatuma worked with schools-based counsellors and teachers to enable them to recognise symptoms of girls affected by FGM and provide mental health support. Awareness of FGM and safeguarding may have increased, but as Fatuma argues, there is still a need to support teachers on the frontline.

“(I have been) living in London in the last 20 years and I can see a lot of change. Last year there was a really big shift. Everyone knows about FGM. Every school has FGM training given to their staff... but there is still a gap in teachers talking openly about FGM, in reaching primary schools and young people”.

Schools can be an appropriate setting for offering mental health support to a young person affected by FGM as counsellors are often on site. Mental health support staff need to know how to offer the right support. FGM often leads to complex family relationships and mental health issues as it may take place in the context of a loving family. Young women may show signs of post-traumatic stress disorders, even if FGM took place years beforehand. In these cases, there is often a deep need for family psychotherapy, but counsellors need to understand how to work with children, young people and their parents.

MENTAL HEALTH SERVICES

HOLISTIC SERVICES IN SCOTLAND



A lead FGM organisation in Scotland offers holistic BME women's mental health and wellbeing services. Their model works with women from vulnerability to employability. They provide wrap-around support for women who have experienced FGM and any other form of VAWG. The services they provide include: practical and emotional support; art therapy and dance therapy; psychotherapy in six languages; reflexology, aromatherapy and massage. They also provide support to enable women to reach a move-on position. This support includes: language classes; training opportunities; parenting classes; social activities; and methods to sustain mental health. They work to support women towards active citizenship, integration and employability.

NESTAC

NESTAC offers the Support Our Sisters (SOS) project, consisting of culturally-appropriate counselling services and mental health support. The project supports families and women affected by FGM and offers one-to-one counselling and group support in locations across greater Manchester. The clinics were set up in partnership with an FGM specialist clinic and a children's centre. Women are offered six sessions of cultural counselling, during which time they are assessed. At the end of the six sessions women will either be referred for more extensive psychological support or discharged to the group support.

ACCESS TO MENTAL HEALTH CARE AND SUPPORT

Group support meetings occur monthly and include a range of activities including therapy, learning and skills-building, and social activities. Peggy Mulongo, who manages the SOS Project, and is the mental health practitioner delivering one-to-one sessions, says that the key questions women need answered are: 'How do I live with this? How do I see my life beyond FGM? How do I understand who I am?'. A support group has recently been established for male partners of women who experienced FGM, as they also have identified mental health needs.



CASE STUDY - HIGH-QUALITY PSYCHOTHERAPY FOR WOMEN AFFECTED BY FGM

An innovative model to provide better access has been developed by Leyla Hussein, who created the Dahlia Project. This was done in partnership with the Manor Gardens Centre and the Maya Centre in Islington, a counselling and psychological support service for women, including those affected by violence. Leyla, a qualified psychotherapist and an FGM survivor and activist, has long recognised the need that these women have for access to high-quality psychological support.

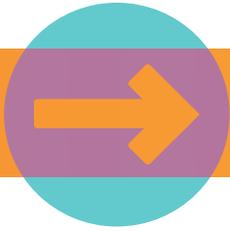
“The reason I set up the group in the first place, being a survivor myself, a couple of years ago when I was training as a therapist, I was on one-to-one therapy but my tutor suggested that I joined some sort of a support group. But at the time there wasn't a group for FGM survivors”.

The Dahlia Project's core aims are to offer services to women and train counsellors to be better able to provide therapeutic services to women. The Maya Centre, as a service for women affected by violence, run by women for women, also provided the therapeutic environment needed by women affected by FGM.

Leyla runs two support groups, for older and younger women. The sessions ran for 12 weeks (meeting once per week). Through this work, Leyla firstly found that women affected by FGM often present with highly complex needs and varied issues. New clients to the service start with a 90-minute assessment to determine whether they are able to join the group. Given that their immediate family may have supported the FGM in the first place it is important to establish whether they have other forms of social support in place.

Within the group sessions, women are able to discuss their experiences of FGM, and the trauma it has caused them in their life. When women do start to talk about FGM within their families, Leyla has also noticed that there is a ripple effect, as other people in the family – sisters, mothers or friends – start to talk about FGM, and recognise the harms that the practice has meant for them and their family.

Leyla has now established the next phase of the Dahlia Project by launching an outreach counselling service where women and young women can access counselling services in various settings including African Well Women Clinics, maternity departments, sexual health clinics, community organisations and schools.



BEST PRACTICE - ACCESS TO MENTAL HEALTH CARE AND SUPPORT

- Community-based work to **build awareness of mental health** and the ways that people can improve and manage their emotional and mental health is essential precursory work that should precede any provision of counselling or psychological support. This ensures that women access the service and benefit from it. Active outreach and engagement is necessary to enable women to access services. Considerations should be taken regarding suitable spaces for this outreach work.
- Therapy and counselling should be **culturally appropriate and sensitive**. Models and terminology should be developed to ensure affected communities engage and access the services. Mental health providers should be enabled to build their capacity and competence to respond in culturally appropriate and sensitive ways to women and girls who have experienced FGM. Cultural competency includes a strong understanding of FGM and the way that various identities e.g. gender, race, ethnicity, migration history, can affect how women understand and relate to their experiences of FGM. Psychological support and counselling should be provided in the woman or girl's first language.
- Specific provisions should be developed for **working with girls and young women** who may have different needs and various barriers. While psychological and emotional support for women who have been affected by FGM is minimal, similar services for girls and young women are almost non-existent. Schools may be a useful setting to begin to develop this necessary work.
- Different forms of support may work and **approaches should be flexible and developed in consultation with**



service users. For example, many women prefer one-to-one support for talking about deep trauma, violence and mental health.

- Individuals providing psychological and mental health support and counselling should be **adequately trained and qualified** to provide these interventions. With high-quality training in mental health support, FGM survivors can work well as community champions and help build women's confidence to access mental health support services.
- **Confidentiality and safety are paramount.** Organisations should have clear procedures around information sharing, publicising their work and the safety of both their clients and staff.
- **Services should be holistic.** Wrap-around support will address wider factors that may be affecting women's mental health. Prior to the provision of mental health and emotional support CBOs should establish referral pathways including pathways to accessing specialist physical health support and to intensive psychotherapy. Practical support and thorough needs assessments should be put in place.
- It is important to consider **the mental health needs of men** who are partners of women who are affected by FGM as they too may have mental health issues as a result of marital and sexual difficulties. It is also important to consider how men can be supported to understand the mental health needs for their female partners.

WORKING WITH STATUTORY PROFESSIONALS AND LOCAL AUTHORITIES

RATIONALE

It is important that a range of professionals engage on FGM as it is a safeguarding and child protection issue. Many professionals have a legal duty and obligation to identify, report and respond to cases of suspected or identified FGM. These include social services, police, education and health professionals. Further to this, local authority strategic and operational leads (such as safeguarding leads, VAWG managers, public health leads, children's services department heads and others) should strategically engage on FGM in their local area as part of their safeguarding, VAWG and public health strategies. The [Multi-Agency Guidelines on FGM](#) clearly highlight and identify the need for statutory professionals to engage on FGM.

CBOs should engage and work with a range of local professionals at both a delivery and strategic level to lobby, advocate and ensure that FGM interventions are appropriate, effective and resourced. This will enable a strategic response to FGM that takes into consideration local context and community needs.

CBOs work most effectively when their work is part of a well-defined local strategic response, and where multiple stakeholders work in a coordinated way to embed responses to FGM into the mainstream. In best practice areas, this has often relied on building long-term, trusting relationships between CBOs and strategic leads. CBOs have been valuable in their roles as mediators between professionals and communities, and feeding into approaches to ending FGM. They have also often advocated for culturally



MANY PROFESSIONALS HAVE A LEGAL DUTY AND OBLIGATION TO IDENTIFY, REPORT AND RESPOND TO CASES OF SUSPECTED OR IDENTIFIED FGM. THESE INCLUDE SOCIAL SERVICES, POLICE, EDUCATION AND HEALTH PROFESSIONALS.

appropriate and sensitive responses from frontline professionals, which has resulted in wider social endorsement to end FGM.

Community-based prevention and statutory responses have had greater opportunities to come closer together recently, and there have been many examples of joint work between professionals and CBOs. This has partly been driven by greater reporting requirements but also by actively seeking out ways to mainstream the prevention of FGM. CBOs, for instance, have often worked to build people's understanding of safeguarding, and this has been successful in positioning the end FGM movement as an integral part of protecting children. Joint messages – from CBOs and professionals – have worked best to shift perceptions that FGM is detectable and that the law on FGM will be implemented.

ACTIVITIES: WHAT HAS BEEN DONE

As detailed earlier, CBOs have worked with statutory professionals to provide a range of interventions and services including:

- Contributing to local FGM strategies, policies and guidance.
- Developing models of joint working with professionals to meet the needs of people affected by FGM, including supporting engagement and relationships between statutory professionals and affected communities.
- Lobbying for service provision for women and girls who have experienced FGM.

WORKING WITH STATUTORY PROFESSIONALS AND LOCAL AUTHORITIES

- Providing advice and consultation on the development of projects and services, particularly as they are community experts with in-depth knowledge and access to hard to reach communities.
- Training frontline professionals, and building their confidence, will and capacity to actively safeguard children from FGM.
- Engaging with statutory services to develop local resources, media campaigns and community awareness-raising and prevention work.
- Delivering support services in partnership with statutory providers e.g. FGM specialist clinics.
- Supporting with FGM case work.

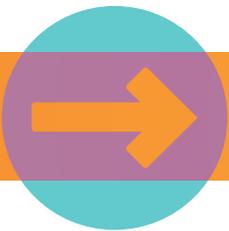


CBOs have become a part of training for FGM safeguarding leads and frontline professionals. There are currently no quality standards around training for FGM, but best practice projects have used interactive methods to build professionals' willingness and capacity to respond in cases where a risk of FGM may be identified.

In addition, CBOs may work with statutory professionals or in specific settings to conduct further FGM awareness-raising activities on behalf of or in partnership with statutory professionals. CBOs can undertake comprehensive community-based work to raise awareness of FGM and frame it in the context of child protection, highlighting the importance of a statutory safeguarding response to FGM. CBOs have also played a key role in supporting affected communities to understand the role of the police and social services, for example.

CBOs have contributed to the development of local policies, strategies and guidance including working with statutory

professionals to support the development of referral pathways, risk assessment tools and FGM resources. Involving community groups and CBOs in these ways is considered best practice because it results in better working partnerships and a more appropriate local response. For instance, where CBOs have monitoring and feedback activities, they will better understand gaps and further areas for work. This should inform commissioning models and joint work between professionals and CBOs.



BEST PRACTICE - WORKING WITH STATUTORY PROFESSIONALS AND LOCAL AUTHORITIES

- There is a mutual responsibility for all involved to **understand the needs of the community and advocate for a response to these needs**. This does not merely involve looking at demographic data, but should also include understanding the populations of those affected by FGM, their attitudes towards FGM and identified gaps.
- **Joint working works best where there is a wider local commitment to partnership-working** between CBOs and statutory leads. CBOs and statutory professionals should consider ways to build effective and equitable partnerships that acknowledge and recognise the added benefit of working together while attempting to mitigate the differences in working styles.
- **Local commissioners and statutory leads need to carefully consider funding strategies**. CBOs may have different approaches and client groups. Therefore statutory professionals and commissioners may need to work with and resource different community groups or organisations.
- People may have strong and different ideas about what works for prevention. **Strategic leads at local authorities and commissioners should consult with trusted CBOs** to

WORKING WITH STATUTORY PROFESSIONALS AND LOCAL AUTHORITIES

understand their local context and ensure that projects, interventions and services are effective.

- There is a need for **long-term development and capacity-building for CBOs**, and to situate FGM projects in organisations which are already trusted to work on safeguarding issues. Statutory professionals can support CBOs with safeguarding training to ensure effective responses to FGM.
- CBOs should consider how they can **demonstrate the impact of their work and that they are accredited to deliver this work**. This will give statutory organisations the confidence to commission them. It is essential that CBOs are competent and have a comprehensive understanding of safeguarding processes to be able to work effectively within statutory responses.
- **Statutory professionals should understand how to talk to, engage and support women** who have experienced FGM as well as knowing how to safeguard. Training that helps professionals to consider the different perspectives and experiences of the women they see, and to think about how they talk to and treat them can be helpful and can help to allay professionals' concerns about asking questions.
- **Appropriate CBOs should be utilised to supplement professionals' training where required**. The incorporation of CBOs presents an authentic voice and builds professionals' will and commitment to respond. It is important to note that there are currently national level guidance and online training tools for professionals, but in many local areas additional training is needed to build professionals' confidence and skills to respond. Given the absence of training standards on FGM, careful consideration should be taken to ensure FGM training is safe, effective and robust.



FGM CASEWORK

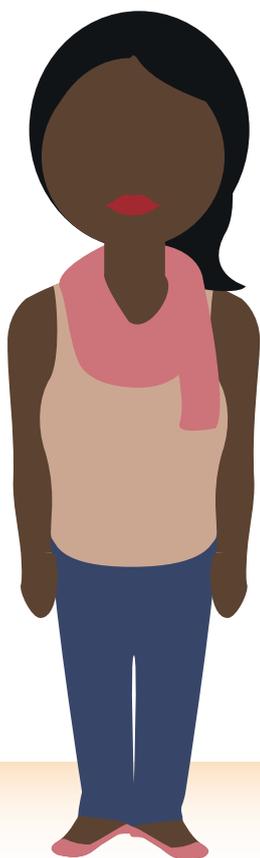
FGM case work tools and resources are still evolving. This guide defines FGM case work as when statutory services, in particular social services, are involved in a case with a girl under the age of 18 where FGM is either known or suspected to have happened or when there is a perceived risk of a girl under 18 undergoing FGM.

RATIONALE

The role of CBOs in FGM case work is not always well recognised or valued. This may be due to the low caseloads or due to the wide range of ways in which CBOs have been involved over the years. It is important to note that although caseloads are still considered low they have been steadily increasing in response to an enhanced statutory response. It is predicted that the caseload will continue to increase in the next few years as more professionals are trained and enabled to identify cases and due to the introduction of mandatory reporting.

CBOs often have to play a dual role, firstly in advocating for a comprehensive safeguarding response in cases where risk has not been adequately identified; and secondly in managing safeguarding responses where professionals' lack of training has led to disproportionate and inappropriate responses. Given that, in many local areas, CBOs are seen as the experts and may be the only agency with an extensive understanding of the practice, they may be placed in the position of inappropriately managing risk. This is particularly the case where FGM risk assessment processes are not clear.

On the other hand, CBOs have played a major role in



promoting wider understanding of FGM as a child protection concern, and of the necessity of a safeguarding response. This work has been invaluable in helping to mainstream FGM. Additionally, CBOs have played a very valuable role as mediator between social services, frontline professionals, and children and their families. Inevitably, organisations who have historically dealt with case management, such as VAWG and refugee/asylum seeker organisations have been better placed to understand the complexities of this role. This has enabled them to negotiate a clear delineation of their role and responsibilities. They are trusted locally by statutory professionals and this has facilitated their engagement in this sector.

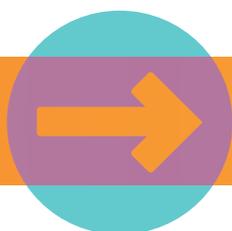


ACTIVITIES: WHAT HAS BEEN DONE

CBOs have engaged in a range of activities and services to support FGM case work. These include:

- Advice and support to professionals who have specific questions on how to respond to an FGM concern in their work setting. This could also include advocating for children's services to take on an FGM case.
- Providing expert evidence at FGM strategy meetings, where specific FGM cases are discussed and a care plan is put in place.
- Providing evidence at court to support obtaining FGM Protection Orders (FGMPOs).
- Family engagement with those who have been identified as affected by or at risk of FGM and are involved in an FGM. Family engagement work can include assessing attitudes or provision of long-term engagement with families who have been identified as supporting FGM.

- Accompanying health visitors or social services on family visits.
- Independent advocacy for clients who are involved in an FGM case. This can include supporting clients to understand the child protection procedures and processes, and to support them with the next steps.
- Advocating with children's services for appropriate and effective responses to FGM cases. Given the lack of systematic and standardised training, CBOs may be involved in scaling up safeguarding concerns or attempting to temper heavy-handed responses to FGM.
- Supporting women and girls who are seeking asylum due to concerns about the risk of FGM if they return to country of origin. This is an area of work that is still developing and is unclear due to current policy.



BEST PRACTICE - FGM CASEWORK

- **Trusting relationships should be built** between statutory professionals who have a responsibility for safeguarding and the CBO they are working with. CBOs have to be trusted to respond appropriately, must have clarity about their safeguarding duties, and should be able to communicate this to the family. It might be useful for statutory professionals to train the CBO they are working with on safeguarding to ensure that they are competent to work on child protection issues.
- CBOs and statutory professionals should consider **developing locally-based and appropriate resources and referral pathways**. This includes, but is not limited to: a risk assessment tool; FGM engagement resources, particularly

youth-friendly ones that explain FGM to girls. Local referral pathways should be clear and established. These pathways should be for safeguarding as well as for care and support.

- CBOs and statutory professionals should ensure that there is **clarity on confidentiality and safeguarding duties**. There should be a common understanding of this among all stakeholders.
- CBOs and statutory professionals should have **clarity about each other's roles**. CBOs should not be managing risk. CBOs should not be placed in positions where they are required to play dual and often conflicting roles e.g. being an interpreter and also advocating on behalf of the family.



- FGM case work, as with other areas of child protection and safeguarding, should be child-centric. **The focus of the work should be the safety and wellbeing of the child.**
- Social services, with the support of CBOs, should consider whether **long-term engagement can be offered to a family**, particularly when risk is not imminent. CBOs can effectively provide this engagement and support. However, they should be adequately resourced and supported to do this work.
- CBOs and statutory professionals should consider that FGM case work can lead to mental health and emotional

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issues within individual family members. Therefore, **family support for women, girls and other family members** should be incorporated into care plans. This work should be provided on a one-to-one basis.

- Social services should have **clarity about how families can exit an FGM care plan** and how families can show that they are no longer at risk of FGM. This is particularly important as two of the key risk factors are static: they are from an FGM-affected community; the mother/sibling has undergone FGM.
- Safeguarding professionals should **develop feedback mechanisms regarding the learning from FGM** cases to develop the evidence based on what works. Feedback, in appropriate formats, should be provided to other statutory professionals, CBOs and the wider community. The use of challenging cases can be useful in creating dialogue and trust within affected communities that statutory professionals are willing to learn and have positive intentions around protecting children.

APPENDICES

METHODOLOGY

The aim of the TFGMI was to strengthen the prevention of FGM. We used indicators of individual and community-level attitudinal shifts (for instance, confidence to speak out against the practice, rejection of FGM as intrinsic to cultural and ethnic identity). We also explored how community groups have supported an improved statutory response to preventing FGM and linking women to appropriate care services. Indicators of that would be: models of joint working between community groups and statutory agencies; evidence of better preparedness of the frontline professionals to implement and follow current national guidance (particularly around child protection); and evidence of a better response to the needs of women and girls affected by FGM and their communities. The definition of 'needs' and 'adequate response' is constantly evolving, and is often very context-specific.

For the development of the FGM Best Practice Guide we used evidence from the ongoing TFGMI monitoring and evaluation reports, and independent evaluation. The robust evaluation methodologies enabled us to identify key stakeholders for each area of work across prevention, support and access to care. To ensure that data was triangulated, we interviewed several key stakeholders for each area of work. A total of 26 interviews were conducted.

The TFGMI developed case studies on 'good practice' from individual organisations and as an area of work. We triangulated results, particularly with evidence from the final evaluation (which included PEER research, key stakeholder interviews and attitudinal surveys) to assess where organisations had been effective in meeting the needs of local communities and in leading change to end support for FGM.

This aim of this publication is to present a range of views on 'what works' and key considerations for effective and safe practice, while acknowledging that it cannot be 100% comprehensive. We are aware there may be areas of work and organisations that have not been included in the guide. Areas such as work with men or family support are still new and evolving. And in mental health, for example, there is a range of models but no consensus on the one with the 'best fit'.

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- FORWARD
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