



Department  
for Education

# **National FGM Centre: an evaluation**

**Research report**

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# Executive Summary

## Brief contextual summary of project and evaluation

The vision and purpose of the National FGM Centre is to work in partnership with statutory agencies, government departments and grassroots organisations to end new cases of Female Genital Mutilation (FGM) among women and girls living in England, within the next 15 years. The National FGM Centre is a partnership between Barnardo's and the Local Government Association (LGA).

Whilst FGM is known to have acute and multi-faceted harmful effects on the girls and women who undergo it, existing evidence suggests that the number of cases of FGM in England and Wales is growing (Dorkenoo *et al.*: 2007). The response by frontline services and agencies has previously been inconsistent and inadequate, particularly in areas with low prevalence.

The National FGM Centre was designed to address the needs not only of Local Authorities (LAs) with relatively high numbers of identified FGM cases, but also those with a lower number of identified cases where there may be limited experience of working with those affected by FGM. Its initial focus, in terms of the pilot areas in which it operates, was 6 LAs with relatively low prevalence of FGM: Essex, Norfolk, Hertfordshire, Suffolk, Thurrock and Southend.

The National FGM Centre intended to achieve system change in social work to provide professional expertise and good practice in the provision of social work services for girls and women from potentially-affected communities. It also aimed to foster change in attitudes towards and understandings of FGM, including among women and men, girls and boys, of potentially-affected communities.

To realise these goals, the National FGM Centre offered a continuum of intervention that combined work with Children's Services, other statutory agencies and organisations with community outreach. It provided Senior Social Workers (SSWs), Social Workers (SWs) and Project Workers (PWs) to Children's Services to directly manage cases of FGM, with either full delegated responsibility or responsibility for selected delegated duties. The Year 1 cost of this service offer was set by the National FGM Centre at £659,478. The National FGM Centre supported the continuing development of professional expertise by providing consultancy support, practice development and training to professionals who may be in contact with FGM cases. The Year 1 cost of consultancy and practice development was set at £145,592. It also provided an online Knowledge Hub, with an interactive forum that professionals working with FGM could use to access relevant national and international data, information, and resources. The Year 1 cost of the Knowledge Hub was set at £148,328. Finally, the National FGM Centre engaged with a variety of stakeholders and potentially-affected communities through conferences,

outreach workshops, and local events. This community outreach work budget was set at £207,180 for Year 1.

The National FGM Centre was a pilot project funded through the Department for Education's Children's Social Care Innovation Programme for two years from April 2015-March 2017. This evaluation assessed the effectiveness of the National FGM Centre, a partnership between Barnardo's and the LGA, in achieving its stated aims during the first year.

## Methods

To understand the central processes, challenges and models of good practice in working to end FGM, interviews were undertaken with 14 Barnardo's staff, including senior managers, SSWs, SWs and PWs from the National FGM Centre. Three in-depth case studies of FGM case management were also conducted in 3 different pilot sites to explore these issues in greater detail.

Additional interviews were conducted with 9 senior stakeholders from LAs, including directors, managers, commissioners of adult and children's services, and safeguarding leads to refine the theory of change underpinning the National FGM Centre's model (see Appendix 3), and to identify how and why the model was adopted within the pilot sites.

Case studies and practitioner interviews were undertaken to understand how and why the LAs have engaged in different ways with the various elements of the continuum of intervention, the outcomes of their engagement for service users, direct delivery staff from the National FGM Centre, and local authority (LA) senior managers.

To evaluate the effectiveness of the National FGM Centre's community outreach work and engagement with stakeholders, interviews were held with 6 Barnardo's SSWs, SWs and PWs, as well as with members of FORWARD (Foundation for Women's Health Research and Development), an organisation that was contracted by the National FGM Centre to run a series of community outreach events. Semi-structured observations of the conferences, community outreach workshops and stakeholder events hosted by the National FGM Centre were also carried out.

The National FGM Centre also conducted a rapid PEER (Participatory Ethnographic Evaluation and Research) study with FORWARD into views on FGM within the migrant community in Essex and Norfolk.

## **Main Findings**

### **FGM case management**

The National FGM Centre SSWs, SWs and PWs embedded within local children's services took a highly informed and holistic approach to engaging with children and families. LA senior managers and staff reported that National FGM Centre workers had expert knowledge not only of the different types and national or cultural variations of FGM, but also of working with refugees and asylum-seekers, immigration and nationality rules, potentially-allied issues such as forced marriage and 'honour'-based abuse, and the effect of family networks in safeguarding or putting children at risk. The National FGM Centre strove to protect girls and prevent FGM. In the period from October 2015, when the service started in LAs, until 31<sup>st</sup> March 2016, the National FGM Centre worked with 123 children across the 6 pilot sites. The work was varied, including direct work with families and children as well as assistance and advice to other professionals working with families and children at risk of FGM (Section 3).

### **Achieving system change in service provision**

#### **Embedded preventative work**

A core aspect of the National FGM Centre model involved specialist staff working with children's social care in the local authorities, embedded in the Multi-Agency Safeguarding Hub (MASH) or its equivalent, as a member of the local team and recording directly into the local authority's case management system. Because the work of embedded National FGM Centre staff was ring-fenced, and their time protected from being absorbed into general case work, they were able to make the case for, and undertake, work to prevent new cases of FGM. For example, in some pilot sites, FGM Centre staff engaged with cases designated as requiring no further action, providing support to girls and women when the statutory involvement of the LA ended (Section 3).

National FGM Centre staff also conducted scenario work that examined not just the immediate context but potential future risk factors. Scenario work recognises that risk factors and protective factors may change over time, and highlights the importance of signposting to local community groups and other support services. There is a question about whether this scenario work is sustainable in social work practice, given the significant resource challenges it currently faces. While this element of the National FGM Centre's offer could therefore be seen as unique, sustainable sources of funding for it were not apparent at the time of writing. National FGM Centre staff were working on a business model for this aspect of their preventative work. A major challenge is that in many cases of FGM, the risk may be long term and fluctuate according to a variety of factors.



## Referral pathways

The presence of embedded staff in children's services with specialist expertise in FGM both necessitated and enabled systems change in referral pathways. Notably, it created a referral route to the National FGM Centre SSW, SW or PW within hub systems (such as the Multi Agency Safeguarding Hub), to ensure that all cases that are flagged as potentially being at risk of FGM reach embedded National FGM Centre staff. This raised the profile of embedded staff within services and agencies across the local authorities, and ensured that specialist knowledge was available across all incoming referrals (Section 3).

## Improving the capacity and knowledge of professionals

### Embedded work

Existing frontline staff in services and agencies across the pilot LA sites often reported a low level of knowledge and confidence in managing FGM cases (Section 3).

National FGM Centre staff embedded within local children's services worked to address inadequate or inappropriate referral practices, particularly in health and maternity services. Local staff can sometimes lack knowledge or confidence about when to refer cases; what conversations to have with women and children who they suspect may have undergone, or are at risk of, FGM, and the specific conditions of Mandatory Reporting<sup>1</sup>. As a result, referrals were made in the absence of adequate information or relevant grounds. National FGM Centre staff played important roles both in investigating and identifying whether there were grounds for further engagement in particular cases, and also in increasing knowledge among professionals about when and how to refer.

National FGM Centre staff and LA staff reported that the National FGM Centre's expertise and involvement was valued by professionals based at the pilot sites because they encouraged care and caution, ensured that cases were escalated when necessary, and helped to reduce the unnecessary escalation of cases. National FGM Centre SSWs, SWs and PWs providing case management and engagement with families were therefore generally welcomed by the 6 pilot site staff (Section 3).

### Training, events and consultancy

Training packages offered by the National FGM Centre to pilot site LAs and relevant external agencies were reportedly well received, however monitoring and assessing training outputs and attendance was not the focus for this evaluation. The National FGM

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<sup>1</sup> Section 5B of the 2003 FGM Act introduces a mandatory reporting duty which requires regulated health and social care professionals and teachers in England and Wales to report known cases of FGM in under 18s which they identify in the course of their professional work to the police. The duty applies from 31 October 2015 onwards.

Centre reported that accredited training was provided across 3 pilot LAs to 95 professionals (from health, social care, the police and community groups) in Norfolk, 57 in Thurrock and 129 in Essex. Survey responses showed that attendees felt that training had increased their knowledge about FGM and their safeguarding responsibilities. The CPD-accredited training package was offered free to pilot areas, and senior managers from the 3 other LAs expressed strong interest in taking up the training offer.

The National FGM Centre reported that it provided accredited FGM training to 671 professionals during the year to 31<sup>st</sup> March 2016. This figure includes training provided in other local authorities across England.

The National FGM Centre held 3 stakeholder events in London, Birmingham and Sheffield. They were run in partnership with local voluntary sector organisations that provide services to women from potentially-affected communities, and were attended by a variety of stakeholders, including social workers and social work managers, community advocates, FGM-specialist community organisations or campaigning groups, solicitors, teachers and others working in prevention and safeguarding. These events promoted engagement with the work of the National FGM Centre by offering stakeholders the opportunity to share best practice.

Engagement with the voluntary sector and expert professionals was generally found to be strong and effective, providing practical resources and being undertaken with care not to duplicate work already being undertaken (Section 1).

Ad hoc consultancy work was undertaken in response to particular requests or opportunities. An assessment of this consultancy work fell outside the scope of this evaluation, but examples include the provision of a proposed protocol for ambulance services providing care to pregnant women who have undergone FGM, engagement with Operation Limelight (an airside operation run by the Metropolitan Police with partner agencies that examines inbound and outbound flights to FGM 'countries of prevalence'), identification of possible offences, and undertaking awareness-raising and preventative work (Section 1).

### **The Knowledge Hub**

The Knowledge Hub provides a central access point for guidance, research and best practice about FGM. It was found to be generally welcomed and well-resourced by professionals who were interviewed as part of this evaluation. The National FGM Centre recorded Knowledge Hub contacts: it was accessed by professionals on 2,859 occasions in the period to 31<sup>st</sup> March 2016.

In conjunction with stakeholder events and conferences, the Knowledge Hub helped to cultivate and reinforce links between the National FGM Centre and services, agencies and other groups working in the field of FGM.

## Engagement with potentially-affected communities

The National FGM Centre offered expertise and tailored outreach events where potentially-affected communities may be small and isolated. Community engagement and outreach events were held in pilot sites in partnership with local community groups. This collaborative outreach model appeared to be successful in engaging local women from potentially-affected communities. It brought together the National FGM Centre's specialist expertise with local community partners who are drawn from or have long-standing relationships with potentially-affected communities (Section 3). The National FGM Centre's aims and objectives, as agreed with the DfE for its first 2 years, did not include extending community engagement in large geographical areas or areas with heavy FGM caseloads. It will explore this further as it develops its sustainability plan.

## Summary of implications and recommendations for policy and practice

The National FGM Centre pilot was well received in the LA pilot sites. The SSWs, SWs and PWs appeared to have been able to engage with families and build a high standard of practice that colleague social work teams have reportedly been impressed by. This supports the case for sustainability.

SSWs and SWs were able to maintain a distinct identity from mainstream social workers, while being integrated into LA safeguarding teams. The extent to which this may continue to be possible, where full delegated authority is granted more widely, is not known and represents a potential risk to the project. A notable reason for SSWs and SWs maintaining a distinct identity may be linked to the independence of funding as a result of the Innovation Programme investment. Should LAs have to adopt responsibility for meeting the costs of this work, it is possible that role independence could be compromised. Further research into the next phase of the pilot will be valuable for understanding this risk.

### Note on the evaluation

At the end of year 1, direct services had only been provided for a maximum of 6 months in each LA, and the focus of the first year's evaluation was on understanding the process of start-up. The effectiveness of delegated authority as a model to bring about system change in the provision of social work services to children and families affected by FGM has not yet been demonstrated: transition funding was awarded because there has not been sufficient time to evidence outcomes. However, this will be an important focus of the evaluation in year 2.

# Section 1. Overview of project

## Intended outcomes of the pilot

The National FGM Centre had an overall aim of ending new cases of FGM among women and girls living in England within 15 years, while supporting those girls and women who have already undergone FGM. Estimates suggest that 22,000 girls under the age of 16 years are at risk of FGM and 279,500 women already resident in the UK have undergone FGM (Kwateng-Kluytse, 2004: 25). Approximately 60,000 girls aged 0-14 were born in England and Wales to mothers who had undergone FGM; and approximately 103,000 women aged 15-49, and approximately 24,000 women aged 50 and over, who have migrated to England and Wales, are living with the consequences of FGM. In addition, approximately 10,000 girls aged under 15 who have migrated to England and Wales are likely to have undergone FGM (Macfarlane and Dorkenoo, 2014: 3). A 2014 study pointed to 65,000 girls at-risk and 170,000 having undergone FGM (Bindel, 2014: 6).

The National FGM Centre aimed to provide LAs with a cost effective solution to FGM case management that reflects best practice. The National FGM Centre met the costs of providing specialist staff, through funding from the Department for Education Innovation Programme Grant. Whilst there may have been additional in-kind costs incurred by the pilot LAs, for example, through the provision of desks for the National FGM Centre workers, the provision was cost neutral or minimal costing for the LA participating.

The National FGM Centre aimed to improve levels of wellbeing for girls and women who have been affected by FGM by identifying them and ensuring that they have access to medical, psychological and social support services, and to drive reduction in support for FGM among potentially-affected communities.

It sought to achieve these outcomes by working in partnership with relevant stakeholders to drive system change in social work provision to ensure best practice, and to foster changes in attitudes and practices around FGM, including within potentially-affected communities.

In particular, the National FGM Centre worked to achieve a number of specific intermediate outcomes:

- to improve the understanding and knowledge of professionals in contact with cases of FGM across England (including professionals within social work, health, education and the police)
- to achieve system change to ensure referral pathways and other protocols followed by services and agencies in contact with cases of FGM reflect best practice
- to drive wider changes in attitudes and practices in connection with FGM

Fourteen theory of change interviews were conducted with all FGM Centre staff, including senior managers, and project, social work, and policy staff, to gauge commonalities in perceptions of the 'problem', local conditions and demographic characteristics, perceptions of the 'solution' and expectations about how the intervention will work in practice, including any obstacles and important outcomes.

Staff articulated a clear, shared understanding of the foundational principles and intended outcomes of the National FGM Centre. There was an expectation that the National FGM Centre would work in areas with low prevalence of FGM where there is a particular need for better support for members of potentially-affected communities and improvements in professional knowledge. Staff expected a change in social work practice alongside community engagement to address and challenge attitudes. There is a lack of evidence about prevalence rates and support needs in the pilot LAs, however, women and girls from affected communities living in low prevalence areas are likely to be more isolated and in greater need of targeted support (City University London *et al.* 2015: 1). The Department of Health suggest that areas of low prevalence are unlikely to have specialist FGM services, such as holding a regular FGM clinic with published opening times, and that commissioners may find it challenging to develop and maintain clinical expertise given the relatively low numbers of patients who may be seen and treated (Department of Health, 2015: 21). As one LA senior manager explained:

'It is harder to raise awareness and develop good practice standards in an authority like ours, where the likely population of communities that are possibly more prone to practise FGM are much lower than [some London boroughs]...somewhere like [our LA] has very little experience, and it seemed to me it was a good opportunity.'

A range of senior staff respondents within the National FGM Centre also emphasised the FGM Centre's focus on preventative work, which they felt was important. They noted that social work tends to centre on assessments of parenting capacity, but that parenting capacity to meet basic needs other than avoidance of FGM is generally not an issue in FGM cases in the cases experienced by the SSWs, SWs and PWs. Safeguarding a girl at risk of FGM requires different ways of working as the risk may be long-term, intermittent, and fluctuating. This is an interesting finding, which should be treated in the context of existing research that suggests FGM frequently co-presents with other harms such as child marriage, 'honour'-based violence and spiritual abuse (see for example, WHO). It was felt that if prosecution were pursued for cases in which FGM has already been undergone, that would represent a failure in terms of safeguarding the child.

For senior stakeholders from LAs, including directors, managers, commissioners of adult and children's services, and safeguarding leads, the objectives of the pilot included establishing or improving the LA's understanding of FGM and potentially-affected communities in the area, developing appropriate strategic and policy responses,

improving referral pathways, and improving professional competency and practice at the individual and multi-agency levels.

In some sites, the appeal of the pilot lay in the anticipated ability of the National FGM Centre staff to enable or improve engagement with potentially-affected communities. One Children's Services manager noted that affected families are generally not coming to LA attention at early, preventative stages of support but, rather, when their case reaches a later, more escalated point - the stage of the Section 47 enquiry. At that point, the LA is obliged to investigate the circumstances of children considered to be at risk of significant harm. Given recognition of the significant emotional, physical and psychological effect of FGM, there is a desire to allow consideration of FGM survivors' individual needs to inform LA practice, and to strike the right balance between child protection and family support or education.

## **Intended actions to achieve these outcomes**

### **Provision of delegated social work duties in 6 pilot sites**

The National FGM Centre developed an offer for LAs in areas of low FGM prevalence to coordinate multi-agency responses to FGM cases and to provide case management and expert guidance to LA professionals. These offers provided specialist SSWs, SWs and PWs who are managed by the National FGM Centre and embedded within but not directly employed by LAs.

LA pilot sites were areas of low FGM prevalence, which often have a fragmented multi-agency response, seemingly low referrals in relation to estimated need, insufficient action plans and strategies, and generally low levels of staff expertise and confidence in managing cases of FGM. Sites were selected by identifying LAs with low FGM prevalence which nevertheless do not have the resources or clear pathways to provide support and safeguarding in relation to FGM. Early negotiations with a small number of LAs in the east of England during the development of the National FGM Centre model identified regional interest. Neighbouring LAs expressed interest as the model became operational in the first 3 pilot LAs, in part reflecting a regional partnership approach to managing referrals and providing specialist services, which is seen to be effective (City University London *et al.*, 2015: 3).

The SSWs, SWs and PWs were able to take on delegated duties in the LAs' social care responses to FGM. Such duties ranged from full delegated child protection authority through which the FGM Centre SSW holds and manages cases entirely, or partially delegated authority where National FGM Centre staff undertake specific aspects of children's social work such as leading or joint home visits to families, providing advice and information regarding FGM to LA social workers and referring agencies. The range of duties delegated to National FGM Centre staff varied between pilot sites.

National FGM Centre SSWs, SWs and PWs were geographically dispersed within multi-agency teams such as the Multi-Agency Safeguarding Hub (MASH) or similar multi-agency teams dealing with FGM referrals across all 6 pilot sites: Hertfordshire, Essex, Suffolk, Norfolk, Thurrock and Southend.

The social workers and project workers were recruited to employ their specialist expertise in the very diverse practices and traditions around FGM (including regional and cultural variations), in working with and supporting members of potentially-affected communities (including refugees/asylum-seekers with insecure immigration status), and in specialist social work practice with girls who are FGM survivors.

At interviews held at early stages of the pilot, National FGM Centre SSWs, SWs and PWs reported that they expected to undertake the following work: provide advice to LA staff and referring professionals about FGM practice and about how to engage with FGM survivors; increase awareness of the different types and variations in attitudes to and practices around FGM; improve knowledge about the appropriate questions to ask women and other members of potentially-affected communities during the course of case management (including questions to ascertain how clients feel about FGM, whether or not they agree with the practice, and whether or not parents want their daughters to undergo it).

National FGM Centre staff in the pilot sites expected that part of their roles would be to make themselves known to social work managers and teams across the LAs in which they are embedded. Staff expected that they would attend Strategy meetings convened when there are reasonable grounds to believe that a child might be at risk of FGM, in which they would be able to highlight risk factors and ask questions about the family which other professionals might not know to ask. They also anticipated that they would undertake joint visits with allocated LA social workers. This was expected to offer an opportunity for less confident or knowledgeable LA social workers to gain a better understanding of FGM and how best to engage with affected families. These activities were seen as a necessary part of the process of working to embed sustainable change within pilot site LAs.

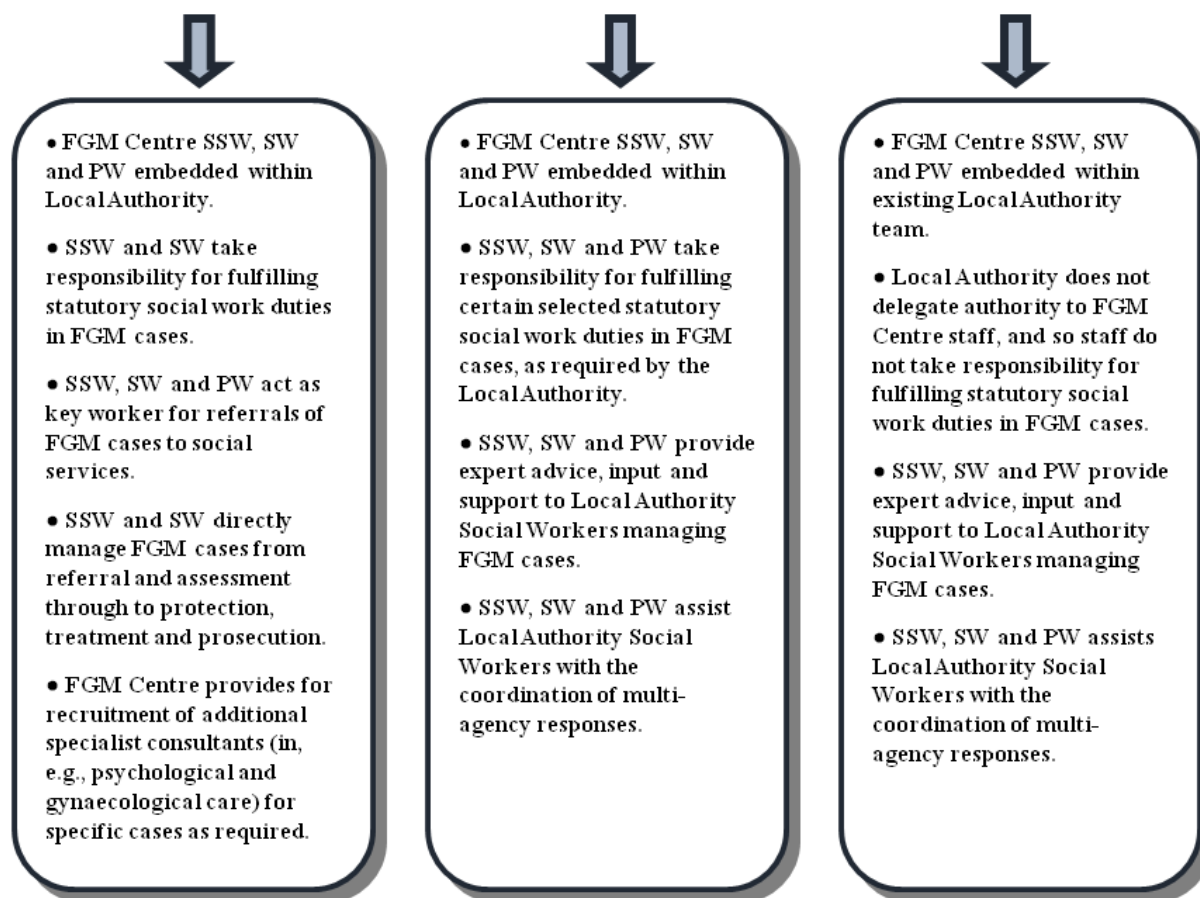
There was also an expectation that National FGM Centre staff would seek to build links with local community groups drawn from potentially-affected communities, to offer them advice and support, and to ensure that National FGM Centre staff can connect families who are isolated or facing particular issues to such groups to ensure that protective factors and support are in place. In this way, National FGM Centre staff hoped to engage and support families in a holistic manner. In particular, in working with mothers it was recognised that there will be diverse needs both related and un-related to FGM. It was felt that the diversity of experience and expertise within the team would mean that advice could be shared about where to signpost, and that working towards effective multi-agency partnership would help to ensure that women and girls could be signposted onwards to other services where necessary.

Staff reflected upon the high level of team working and believed that this was central to achieving the National FGM Centre's desired outcomes. PWs and SWs were embedded in LAs but employed by Barnardo's and part of a central National FGM Centre team. Individuals working on a case referred back to the National FGM Centre central team for support and guidance, and to explore possible risk factors which may not have previously been identified. Staff identified their intention to be flexible in their approach to cases, to allow for redistribution of support from the National FGM Centre if ever additional provision was needed for case management in particular LAs. The supervision process was seen as crucial to ensure that SSWs, SWs and PWs would be well supported in their case management work and to achieve positive outcomes for children and families.



**Figure 1: Continuum of Delegation**

**Full Delegation of Authority    Delegation of Selected Duties    Directly Embedded Support**



## **Development and sharing of knowledge**

To support the development of best practice within services and agencies in contact with cases of FGM, it was recognised that there was a need for a central location at which relevant data and information (including data captured by embedded National FGM Centre PWs, SWs and SSWs) could be collated and analysed, and from which knowledge and tools based on this data that support best practice could be disseminated to relevant professionals. This is different from case recording which is done directly by the SSW or SW into the local authority system.

The Knowledge Hub was a core facet of the strategy to achieve this knowledge-sharing objective. The Hub was a free-to-use, online resource which brings together existing information and tools in ways that are tailored to the needs of different professionals. The intention at the early stages of development was to link aspects of the Knowledge Hub to income generation efforts, such as accessing training and Barnardo’s-generated information, although this was not implemented.

Users could submit questions directly to National FGM Centre staff through the Knowledge Hub, or make selections on the website to generate a range of resources that have particular relevance to their area of interest or professional practice.

There was also an intention to capture and share the high level of knowledge and experience of National FGM Centre staff workers by developing new sets of practical resources made available for use by social workers and other professionals through the Knowledge Hub. For example, an FGM risk assessment tool for social workers is currently in development.

## **Outreach events and stakeholder engagement**

In interviews, staff expressed the belief that the National FGM Centre model could be effective in achieving its desired outcomes if and because it combines specialist social work provision and system change with efforts to address and change community attitudes towards the practice. It was recognised that effective community engagement and strategic partnerships with other organisations in the FGM sector would be crucial to achieving this.

National FGM Centre staff expressed awareness of the risk that the National FGM Centre may be perceived as a threat by others in the sector. They also noted that there have been discussions about how to mitigate this risk. They communicated that there was a need to stress the particular expertise of Barnardo's in social work, which smaller grassroots organisations do not generally possess.

It was also recognised that in areas where there was both low and higher prevalence of potentially-affected communities, there were groups working and training locally around FGM while facing funding challenges. It was felt that the process of engaging with these stakeholders and providing additional community outreach programmes required sensitive management. Staff emphasised that the National FGM Centre did not wish to undermine the activity of other groups or create less demand for their services, not least because the National FGM Centre did not plan to provide local community outreach programmes in the long-term. Staff were therefore conscious of and wished to support the health of the FGM sector as a whole. The stated intention of National FGM Centre staff was to work with a range of organisations and provide support for capacity building, to help foster a robust sector.

As such, staff believed that productive, strategic partnerships with stakeholders should be fostered to bring together experience and learning on what works in tackling FGM, and to develop and share effective and sustainable solutions. A stakeholder event strategy was put in place to frame the process of holding events in London, Birmingham and Sheffield, which was run in partnership with voluntary organisations. The stated intention was to hold events that would be free to attend and which would serve as an opportunity for community organisations and statutory agencies to share knowledge and understanding around FGM.

During the evaluation period, the National FGM Centre held 2 stakeholder events. The first was held in London and run in partnership with the Manor Gardens Health Advocacy Project, an organisation that works to promote the health and wellbeing of refugee and migrant communities in North London and which has been running community-led activities to tackle FGM since 2010. The second was held in Birmingham and run in partnership with Birmingham and Solihull Women's Aid, a local refuge supporting women and children affected by domestic violence, rape and sexual assault that has been providing an FGM prevention programme for the past 6 years.

## **Existing research relating to the pilot**

### **Main findings from the evaluation literature review**

A literature review (Appendix 5) conducted as part of the evaluation identified a number of promising practices as well as challenges and gaps which the project may help to address.

Social care, health, education and other relevant professionals are central to identifying girls and women affected by FGM, reporting concerns, initiating protective measures for girls at risk of FGM, and ensuring appropriate care and support is provided if FGM has already been undertaken. In particular, social services are a point of contact and disclosure for women and girls from potentially-affected communities. Therefore, practitioners should have a strong knowledge of FGM best practice, including understanding of prevention tools, and a culturally informed and sensitive approach to engagement.

Multi-agency working and collaboration is crucial to help identify local needs and suitable prevention strategies. This requires effective information sharing and trust between agencies.

Effective and meaningful engagement with stakeholders is vital to prevention efforts. These stakeholders include community and grassroots groups, men from FGM-affected communities, religious leaders, and other relevant professionals such as teachers who have regular and ongoing contact with young people.

Specialised services which implement a gender-sensitive, victim-centred approach are well-placed to meet the specific needs of women and girls who have undergone, are at risk of, or are affected by FGM.

Sensitivity, including cultural sensitivity, should be at the forefront of engagement with women and girls. Significant regional, cultural and other diversity in FGM practice means that approaches should be tailored to particular individuals and communities in a culturally informed way. Professionals in contact with cases of FGM should be alert to the need for sensitivity in their use of language and to reactions to it.

## Use of terminology and cultural sensitivity

There is debate in the literature about the most appropriate or culturally competent terminology to use in relation to the practice (Options UK, 2011). Dustin and Davies (2007: 4), for example, advocate the use of the term ‘female genital cutting’ (FGC). They note that ‘female genital mutilation’ came to replace ‘female circumcision’ as a term which could convey the damage done to women, but argue that FGM ‘was intended to be a pejorative to convey the meaning that girls are physically mutilated in the practice. This can cause offence in the cultures where it is practiced [sic].’ The authors believe that the term FGC is a more neutral, non-blaming term, ‘which still graphically represents the injuries that girls suffer’ (*ibid*). Similarly, Boyle (2005) notes that while the term FGM is widely used by international actors such as the World Health Organisation, some African feminists and scholars have criticised the term for its ethnocentricity: the author therefore favours FGC as a supposedly non-politicised description of the practice.

This debate raises some important considerations around sensitive and culturally competent interaction with girls and women who are affected by the practice, which are explored in greater detail below. This evaluation report refers to FGM in acknowledgment of the severity of the harm caused to girls and women who undergo it, and in accordance with the approach of the National FGM Centre, statutory services and agencies, intergovernmental institutions, and other specialist UK organisations such as FORWARD UK, the Iranian and Kurdish Women’s Rights Organisation (IKWRO), and Asylum Aid.

## Changes to the project’s intended outcomes or activities

There was a re-conceptualisation of the intended consultancy package, particularly as it relates to income generation. In the early developmental stages of the pilot, the intention was to develop a bank of consultants available to offer bespoke consultancy services to professionals working within a range of services and agencies. The National FGM Centre had links to social workers, gynaecologists and midwives, education professionals, and the police. It therefore envisaged that its consultancy offer would be professional-to-professional. When asked, during interviews, about the development of consultancy, staff noted some of the potential difficulties with establishing this system. For example, while gynaecologists with concerns about FGM would have guidance to follow within their internal system, there was a question about whether and how different professionals would be free to follow external advice. Consultancy work was subsequently undertaken on an ad hoc basis in response to demand from partners or agencies. This was varied in nature and predominantly unpaid. The original intention for this element of the National FGM Centre was to charge for this service: however, demand was felt to be insufficient for a paying service. Moreover, as the National FGM Centre was setting up in the early phase of the work, it was felt that the priority should be on developing expertise within the Centre and promoting the service amongst professional networks. Sustainability for the consultancy element will be examined in the next phase of the evaluation.

## Reconceptualising the continuum of intervention

The original proposal for the pilot expected to offer LAs 2 different variations of the delegated authority model. First, full delegation of authority in which a National FGM Centre SSW, or SW acts as the key worker for referrals and provides direct case management from referral and assessment to protection, treatment and, ultimately, prosecution. Alternatively, directly embedded support, in which a National FGM Centre SSW, SW or PW is situated within the existing LA team to provide expert input, advice and support to inform case management. With the second option, the LA does not in the first instance fully delegate authority, but delegates some support functions and gains support on the coordination of responses provided to them by expert National FGM Centre staff.

In general, participating LAs initially took up the offer of delegated embedded support rather than full delegated authority. This did not result in the system change in social work which is one of the pilot's intended outcomes. However, there is evidence from the experience in some of the pilots that LAs can work towards delegated authority as an alternative to granting it initially, and this occurred in at least 2 of the LAs which did not provide delegated authority from the outset. The use and effectiveness of delegated authority and delegated support will be explored further in the year 2 evaluation, when there will be more evidence available, as it is not possible to draw definitive conclusions from less than 6 month's experience of direct social work provision.

In response to this pattern of uptake, there was discussion about including the representation of 'delegated duties' in the continuum of social work duties which also includes 'delegated authority', to better reflect that delegation of particular responsibilities can and is taking place along the continuum. This continuum encompassed the range of responsibilities that social workers and project workers took on in the pilot sites, from recording on Care First, undertaking preventative work with families who are low risk cases, or being the main presenter at a case conference, through to full delegated authority in which the social worker is the complete case holder working within LA systems and processes.

This approach to conceptualising the continuum more fully and accurately reflected the National FGM Centre's work in LAs, including their fulfilment of duties that would not otherwise be delegated to the voluntary sector. This work therefore points to how the system of child protection could change more systematically; by offering a package of delegation along a continuum, which can be tailored to LA needs and levels of comfort with delegation, it is possible to develop a system which allows greater responsiveness to need and flexibility with case management. This offer was an interesting development for Barnardo's, which has not previously managed fully embedded social workers offering a full range of social work duties. Whilst the organisation employs qualified social workers, their work has not been to directly discharge statutory duties in this way to date.

As full delegated authority was formally granted in only 1 pilot site and only 3 cases were delegated during the evaluation period, it was not possible to evaluate this aspect of the model. However, the model of full delegated authority will be tested further during the coming year. It is expected that, where full delegated authority is granted, National FGM Centre staff will maintain flexibility in their working practices to fit into and complement existing LA social care systems. Future research will test the delegated authority model further.

## **The context within which this innovation took place**

With regard to the delegation of social work duties, this innovation took place in LAs with low prevalence of FGM and with smaller, more isolated and geographically disparate populations from potentially-affected communities. Appendix 1 provides a summary of different sites' engagement with the pilot. In addition to the pilot sites, the National FGM Centre operated in the national context, contributing to the national discussion about FGM. It did this by hosting or participating in conferences, coordinating national policy responses, engaging the media, and building stakeholder networks, including offering training packages to relevant agencies, and developing and promoting the intelligence-sharing and network-building work of the Knowledge Hub.

## Section 2. Overview of the evaluation

### Evaluation questions

The main evaluation questions related to the model of the Barnardo's and Local Government Association National FGM Centre and how effective was, both in terms of its constituent parts and as a whole. The following evaluation questions were considered:

Q. 1: Has the continuum of delegated social work intervention improved the social care response for children affected by FGM?

Q. 2: To what extent are professional staff working in social work, health, education and the police better informed about FGM in both the pilot LAs and in England, as a result of the project?

Q. 3: Was the intervention effective in working with community groups to change attitudes and behaviour towards FGM?

### Methodology used to address these questions

In-depth interviews were conducted with staff involved in the development of the project. This included the 2 existing SSWs, 2 SWs and 2 PWs embedded in the different pilot sites, 6 project leads and managers from Barnardo's, 2 business support staff from Barnardo's, and 9 leads from LAs including Directors, managers, commissioners of adult and children's services, and safeguarding leads. The purpose of these interviews was to refine the theory of change underpinning the National FGM Centre's model to assist the early development of the project and to understand how, and how effectively, the continuum of intervention has been implemented in the different pilot sites. The embedded 2 SSWs, 2 SWs and 2 PWs were each interviewed at 2 time points to understand developments in case management and community engagement in the pilot sites. Interviews were also conducted with FORWARD, the organisation commissioned to do community outreach events and undertake a PEER research project.

In-depth case studies of FGM case management were conducted in 3 of the pilot sites. This involved conducting in-depth interviews with professionals involved in 3 cases, including LA social workers, Barnardo's SSWs, SWs and PWs, and professionals from other agencies involved with supporting cases. In each case study, staff were identified, and detailed and anonymised interviews were conducted to understand the approach to case management, the relationship with the family, and the multi-agency response.

The use of different stages of the continuum was reviewed to identify why LAs have opted for different levels of intervention, and the outcomes of their engagement with the FGM Centre for service users, embedded project staff, and LA senior managers. This



review was developed through the case studies of FGM case management, interviews with National FGM Centre staff, and discussions with LA managers.

Conferences and smaller-scale stakeholder and community events were observed to assess the National FGM Centre's engagement with stakeholders, including LAs, social care practitioners, schools and charities.

## **Changes to evaluation methodology from the original design**

The evaluation originally intended to provide 3-5 case studies of FGM case management per pilot site. It was not possible to undertake this number of case studies, largely due to delays in recruitment of SSWs, SWs and PWs in the pilot sites, which meant that case management began later than anticipated.

It was also not possible to interview families involved in the cases selected. The reasons for this included the nature and level of the cases, uncertainty about some families' UK residency status, and the reluctance of some families to speak about their experiences with a researcher, which was often related to sensitivity around the subject of FGM and/or high levels of professional involvement in their lives because of safeguarding concerns.

The evaluation plan stated that telephone interviews would be conducted with a sample of professionals who have accessed consultancy support. Because the National FGM Centre's consultancy offer was revised, it was not possible to evaluate the consultancy work in this way. The consultancy work which was undertaken has been noted above (page 9).



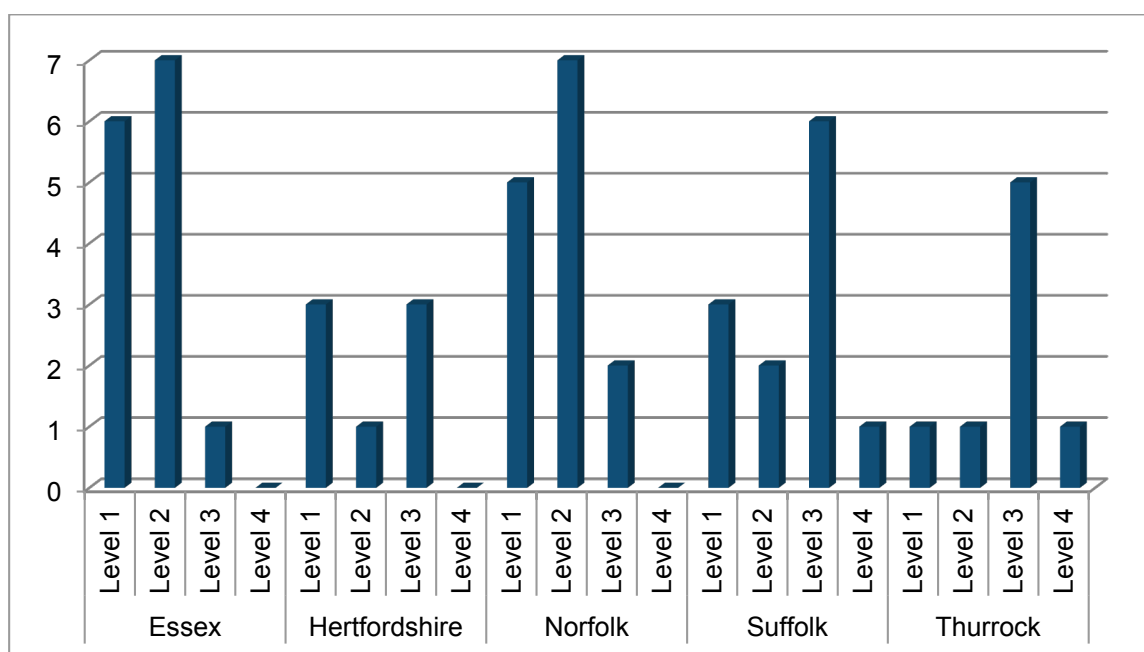
## Section 3. Main Findings

### Q.1: Has the continuum of delegated social work intervention improved the social care response for children affected by FGM?

#### Main findings related to social work provision and case management

Embedded FGM Centre staff were involved, to varying degrees, in the social work response to 55 separate cases of FGM, through which they contributed to the protection and education of 123 children across the pilot sites. In terms of direct involvement with case management, the outcomes achieved vary with the level of risk and individual/family need. However, analysis of case management data has shown some evidence for outcomes which correlate with the Theory of Change (Appendix 3). For interventions at levels 1-3, these included signposting families to health or community services, to enable longer-term medical or psychological care and to improve general well-being through holistic support services. Level 4 interventions resulted in formal child protection measures, including an FGM Protection Order in one case. Further details are provided below in Case Study boxes 1, 2 and 3.

**Table 1: Number of FGM Cases Per Pilot Site, by Level of Intervention**



Source: National FGM Centre  
Base: all cases opened by May 2016 (55)

See Appendix 2 for key of levels

Theory of change interviews with senior LA staff and case study interviews with LA social workers highlighted that existing frontline staff in the pilot sites reported generally low levels of knowledge and confidence in managing FGM cases. One LA senior manager

stressed the importance of improving social work practice around FGM in areas of low prevalence:

‘Just because we don’t have a high population [from potentially-affected communities] doesn’t mean that we don’t need to engage people from that community. In fact, it’s more likely to be overlooked here because the numbers are so small, and it’s hard to develop good practice in areas where the numbers are relatively small.’

## **Headline Finding**

Embedded staff from the Barnardo’s and Local Government Association National FGM Centre who provided LAs with support in case management and engagement with families were generally highly valued by pilot site staff for their specialist knowledge, experience and confidence in engaging with families.

The bespoke nature of delegation within each pilot site was found generally to work well and had a positive effect on the social care response for children.

In pilot sites where National FGM Centre SSWs, SWs or PWs undertook joint home visits with the LA social worker or took the lead on home visits to families, recorded observations, made case notes, and otherwise exercised a degree of professional autonomy within the LA team, the effect of access to the expertise of the National FGM Centre workers appeared to have a positive effect on service provision.

Initially, the levels of professional knowledge and confidence among LA staff appeared to have been raised by joint working, through which LA staff observed and learnt from how FGM Centre experts interacted with children and family members. As one social worker explained, ‘I feel like I’ll definitely know what to do you know next time... I will be praying to have someone who is like [x] because... we are working as a team and I never had any problems.’ However, as another LA senior manager commented, it is not a good use of resources in the longer term, to always have 2 qualified social workers working together if this is not necessary. This may motivate further exploration of full delegated authority. Whilst training of existing children’s Social Care staff may be an alternative option for improving knowledge and responses to FGM, for this to be effective, it would require continuous refreshing and practice experience to maintain a good standard. Furthermore, the presence of FGM specialist staff adds not only expertise but also challenge to internal practices.

There were also instances in which National FGM Centre staff undertook joint visits with LA social workers, and did FGM-specific assessments with mothers whilst the allocated social workers conducted general assessments with the children. This worked well in

situations where a full parenting assessment is not needed (that is, when the referral relates to FGM only and parenting capacity is otherwise not in question) and National FGM Centre staff could judge whether a Section 47 was needed. This may not be a resource-efficient process in the longer term if the National FGM Centre has an allocated social worker in the LA who can undertake the full assessment.

Interviews with National FGM Centre staff established that the SSWs, SWs and PWs were recruited from a variety of backgrounds and had a high level of wide-ranging professional expertise. They brought knowledge about the different types and national, regional and cultural practices of FGM, as well as expertise in working with refugees and asylum-seekers, immigration and nationality rules, allied issues such as forced marriage and 'honour'-based abuse, and the role of family networks in safeguarding or putting children at risk.

Embedding this expertise in multi-agency social care settings at all points of the delegated social work continuum resulted in a better quality of social care response for families. This response can go beyond formalised statutory requirements and contribute to improvements in LA engagement with members of potentially-affected communities that are geographically dispersed and/or isolated, and who may not otherwise come to the attention of statutory or community services.

A recent positive Ofsted inspection in 1 pilot site highlighted the role of the Barnardo's worker in partnership with the LA:

'Early identification of risk with regards to female genital mutilation, forced marriage and radicalisation leads to proactive and immediate safeguarding of young people, underpinned by comprehensive multi-agency support. A particular strength is the active partnership working between social care and early help family support practitioners... This provides continuity of relationships and sensitive specialised support for children and families. Impressive protective work was demonstrated by workers in a case of female genital mutilation.'<sup>2</sup>

The report pointed to evidence of good practice and effective interventions involving FGM. This suggests the potential success of joint working between the National FGM Centre project workers and allocated social workers.

Case study interviews undertaken with National FGM Centre staff and LA social workers provided further detail about how the continuum of delegated social work operates in practice. These are summarised in pages 28-30.

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<sup>2</sup> *Suffolk County Council Inspection of services for children in need of help and protection, children looked after and care leavers and Review of the effectiveness of the Local Safeguarding Children Board.* Inspection date: 23 November 2015 – 17 December 2015. Ofsted: 2016

## Case study 1

Case study 1 was in a pilot LA in which the FGM Centre PW had a range of delegated duties, including both joint home visiting and sole visits where appropriate, as well as participation in core group, strategy and other case-related meetings. The professionals involved reported finding the joint working model highly effective. The allocated LA social worker reported that whilst this was considered to be a high risk case, with tense relationships between the family and professionals, the family responded more favourably to the PW, compared to the LA social worker and police. The PW in this case was able to conduct a number of home visits on her own to break down barriers to the family's engagement with the LA.

The LA social worker reported that she approached engagement with the family in a more effective manner following guidance from the National FGM Centre PW: seeking advice on which questions to ask in relation to protective factors and travel intentions. She felt better able to assess risk and protective factors as a result. The PW briefed and de-briefed the interpreter involved to ensure that their role and understanding of the case was clear, that they did not take short cuts in language and avoided making assumptions in their translation. This was noted by several other agencies involved in the case to be good practice and they subsequently committed to adopting similar approaches in their own work.

The role of other agencies at the assessment stage was a critical aspect: a different social care team undertook an initial assessment which had not been made available to the National FGM Centre PW and LA social worker at the time of reporting. This left uncertainty about which questions had been put to the family and about the quality of the assessment. The PW therefore explored other methods to understand the family's position about FGM and the safety of the child, including talking to the older siblings about being in the UK, their country of birth, their school, and their grandparents.

This case remained open at the time of writing, and met the National FGM Centre's highest level of risk to the child, Level 4. The family had sought asylum in the UK. The case raised important considerations about the interaction between the asylum system and FGM prevention, as failed asylum seekers or refugees who return to their country of origin may have children at risk of FGM. The PW and allocated social worker communicated their concerns about risk to the children to the Home Office.

Joint work between the social worker and FGM Centre PW established improved engagement with the family and more effective processes of communication between agencies, and ensured specialist assessment of risk when safeguarding concerns escalated further.

## Case study 2

National FGM Centre staff and senior managers described the need to mitigate 'unnecessary escalation' of cases, and encourage caution and care amongst LA staff. They noted a sense of uncertainty among staff around the requirements of Mandatory Reporting and the circumstances in which they should be referring. On the other hand, work was also undertaken by National FGM Centre staff to ensure that cases were escalated upwards when necessary to implement safeguarding measures.

Case study 2 illustrated this challenge. It involved a case from a pilot site without full delegated authority to the National FGM Centre, with a family with a large number of children. The elder sisters had all undergone FGM and the case centred on the family's intentions towards the youngest.

The National FGM Centre SW conducted an urgent joint visit with the allocated social worker and acted as interpreter when one could not be secured at short notice. The National FGM Centre SW reported that during a candid conversation with a family member, information was revealed suggesting that the youngest girl was at risk of FGM. This was later denied by the family member who subsequently appeared to adopt a different attitude towards FGM.

Interviews highlighted that the relationship of the family to the LA and the National FGM Centre SW grew increasingly tense, although work continued to be undertaken with the older children as potential protective factors for the youngest daughter. Effective engagement with the family also seemed to have been impeded by difficulties in communication due to a lack of high quality and timely interpreting services. The National FGM Centre SW participated in core group meetings and child protection conferences. The LA sought an FGM protection order and court proceedings will take place in the coming months, during which the SW will present evidence.

This case highlighted the high level of engagement by National FGM Centre staff in case management and inquiry, from initial referral through to the implementation of formal safeguarding measures. The relationship breakdown with the family seemed to have created difficulties in engaging the family, but it was clear that the specialist knowledge of the National FGM Centre SW was of significant benefit in the management of a complex case that escalated quickly.

This case highlighted the critical importance of well-resourced and high quality interpreting and translation services over the 'life' of a case, to ensure a robust social work response.

### Case study 3

The position of embedded National FGM Centre staff as external expert professionals was understood to work effectively because their work was ring-fenced and protected from being absorbed into other work or cases.

They also demonstrated expert capacity for preventative work, including, in some pilot sites, engaging with cases which were designated as requiring no further action. In these cases, National FGM Centre staff provided support to girls and women when the statutory involvement of the LA ended.

In one such case, a referral was made by a health service for a pregnant woman with 2 daughters. The case was judged by an LA social worker to be low risk, and the woman chose to engage voluntarily with National FGM Centre staff when asked if she was happy to receive a visit. Engagement with the LA ceased at this point, and no other services would have been made available to the family.

National FGM Centre staff undertook scenario work with the woman about potential family involvement and who she would turn to if pressure to allow FGM were applied. They worked to link her in to local community groups and religious organisations to help her integrate into the community, connect her with health services to answer her questions about her FGM, and provide some practical and emotional support. This remained in the context of safeguarding children from FGM. The Barnardo's workers were clear with both the woman involved and in their responses to the evaluation team that this was within their remit and that the work would end when they were satisfied that a support system was in place, and the father and extended family were not a risk.

In this and other similar cases, the position of National FGM Centre staff outside of statutory social work was felt by a range of respondents to ease families' concerns about engagement even once their cases had closed. National FGM Centre staff were able to prioritise home visits and full FGM assessments with families. Respondents reported that, if National FGM Centre staff had not been in place, the usual process would have been followed, and a 15-minute phone call from a social worker would have taken place instead of this preventative work. Thus, Barnardo's workers were able to provide a unique offer.

Preventative engagement by specialist workers filled a gap in engaging with families who fall beneath the threshold for statutory involvement, producing improved social care responses for children not at immediate risk of harm and for families in the community.

## **Q.2: To what extent are professional staff working in social work, health, education and the police better informed about FGM in both the pilot local authorities and in England as a result of the project?**

An important element of the National FGM Centre logic model was that the embedded Social Workers and Project Workers spend time networking across teams to raise awareness about the issue of FGM, and about their own role and what they can offer. Moreover, it was hoped that existing social care professionals would improve their practice, by interacting and joint working with the National FGM Centre staff. SSWs, SWs and PWs dedicated a substantial amount of effort to this work in the pilot sites. SSWs, SWs and PWs' networking efforts involved presenting to health visiting and midwifery health service managers at local Service Manager team management meetings, with the aim of spreading knowledge of their service.

A wide range of respondents from both the National FGM Centre, LA and partner agencies reported that poor quality referrals were a significant challenge and one that the SSWs and PWs sought to improve in their work. Referrals, LA senior managers reported, were frequently made with scant information about the child or the reasons for concern, and often made without the referrer first speaking with the child or mother to explore the issue to gain better information. FGM Centre staff therefore worked with LA colleagues to determine best practice and advise professionals working across agencies on how to make referrals, including what constitutes sufficient grounds for referral. Managers and National FGM Centre staff cited lack of professional knowledge about FGM alongside anxiety about mandatory reporting as reasons for inappropriate referral practice. This work culminated in the development of the FGM Multi Agency Risk Assessment tool, which is being piloted in 8 different LA areas (6 in London). The tool is currently being independently evaluated. However, this tool, along with the continued information dissemination work through the Knowledge Hub, was intended to address this deficit in professional knowledge and confidence.

An important challenge faced at the pilot site level was the large geographical size of the areas in which they operated, particularly where the population was relatively widely dispersed. Further, there were a large number of social work and other teams in each area that the SSWs and PWs needed to connect and work with, meaning that their awareness raising and engagement work required significant mobility and time. Given this challenge the SSW and PWs' work relied on the cooperation and enthusiasm of senior management in championing their work and the issue of FGM. Such leadership made a difference in terms of ensuring that, for example, multi-agency training was taken up by staff at different levels of seniority. When buy-in from LA senior management staff was lacking, this appeared to represent a barrier.

According to our observations and comments from LA respondents, where SSWs, SWs and PWs were present, they reportedly were knowledgeable about presenting factors



and risks of FGM, were able to answer colleagues' questions, were approachable and non-judgemental, provided effective advice on working with families, reassured professionals about what to do in cases of FGM, and raised awareness about risk and presenting factors. However, this effectiveness relied on there being direct interaction between local staff and FGM Centre SSWs and PWs. Given that the latter are few in number, the national impact will be limited. National awareness-raising is therefore an important component of the National FGM Centre's work.

To raise awareness nationally, the National FGM Centre arranged a conference which was held in October 2015 and well attended by delegates from a range of LAs and other agencies. This was an opportunity for participants to learn about FGM risks, presenting factors, the implications of mandatory reporting and how to work with different agencies.

In addition, the National FGM Centre staff developed control room instructions for national ambulance crews called to assist with pregnancies. The intention of this tool was to help ambulance crews make correct decisions about health care as well as to build intelligence to inform the safeguarding of girls. The tool is still in the final stages of development and is not, therefore, evaluated as part of this report. However, it is an example of how front line learning from the SWs, SSWs and PWs was translated into practice advice for another agency.

Additionally, at the national level, National FGM Centre staff dedicated time to raising awareness of the National FGM Centre and the issues and challenges involved in working with FGM in social work settings, and making links with potential new client LAs. FGM Centre staff reported speaking at head teachers' forums, barrister networks, midwives' meetings and to partners in health and in Local Safeguarding Children's Boards, with the expectation that knowledge will trickle down to all levels.

### **Q.3: Is the intervention effective in working with community groups to change attitudes and behaviour towards FGM?**

The intention of the National FGM Centre pilot was to develop an integrated, whole sector approach that works with all stakeholders who are able to contribute to positive outcomes and creates strong links between community engagement and social care and other statutory services, to help align all efforts for prevention, protection and treatment nationally and even more strongly in local areas with delegated authorities. It was believed that this integration would result in improved and timelier referrals, more lasting and sustainable prevention efforts, and rapid learning to inform future strategies. While it is too early to say whether referrals to social care for FGM have changed as a result of the pilot, it is possible to comment on the apparent effectiveness of community engagement events, through the team's observations and conversations with participants.



Community engagement and outreach events were undertaken in pilot sites with a local community group partner. This collaborative outreach model appeared to be successful in engaging local women from potentially-affected communities by combining the National FGM Centre's specialist knowledge with local community partners who were drawn from or had long-standing relationships with potentially-affected communities. One such event in a pilot LA was run in conjunction with the Dahlia Project and a local community project which promotes social inclusion and capacity building, thereby bringing together specialist therapeutic and community expertise.

The event was advertised as an opportunity to discuss different cultural practices, rather than as an FGM outreach workshop *per se*, and the facilitators opened discussion between participants on the topics of culture and healthy relationships before introducing discussion of FGM. This echoed comments made by FGM Centre staff in interviews that in working with women, there were diverse needs both related and un-related to their FGM, and that for families who may be recent arrivals, have needs related to their immigration status, or face social isolation, FGM may not be the only or even the primary concern. The National FGM Centre therefore modelled an approach which recognised that outreach and engagement to change community beliefs and behaviour also required listening to the needs of members of potentially-affected communities and understanding FGM in its wider context within communities.

The organisers' flexibility in allowing conversation between participants to develop organically enabled positive, open discussion between the diverse women participating in the group. This seemed to bring a number of benefits: by talking about FGM with others who had undergone the practice in different circumstances, there were opportunities to foster solidarity through discussion of similar experiences, and to learn from different experiences and practices. There seemed to emerge from the discussions a feeling of mutual understanding among at least some of the participants. It seems possible that, having discussed these issues at the workshop, some participants may have more confidence discussing them in other circumstances.

The National FGM Centre commissioned FORWARD to hold events and community engagement training with community organisation staff, and to conduct a rapid Participatory Ethnographic Evaluation and Research (PEER) study in Essex and Norfolk among UK-based migrants who originated from communities potentially-affected by FGM. Eighteen individuals (15 women and 3 men) were recruited through local community organisations as peer researchers and change agents, and trained and supported by FORWARD and the National FGM Centre to design and conduct conversational interviews with their peers, focusing on life in the UK and FGM.

The research aimed to shed light on the lived realities of these people and gain insights into views on FGM in the UK and their countries of origin, to use the findings to inform and improve FGM programmes, and to encourage those involved in the research to ensure that they are central to the research projects and programmes that concern them.

The information from PEER interviews provided valuable insight into the perceptions of communities in low prevalence areas about FGM (about which there is little data), including why it is practised, whether attitudes towards the practice are changing among members of potentially-affected communities in England, and attitudes towards service provision for those affected by FGM. PEER participants also made a number of recommendations. These included placing a greater focus on support for migrant women and men to learn English to support their ability to integrate, access services and find employment; increasing support and funding for community-based organisations working closely with migrant families; increasing awareness-raising and education on FGM; targeting the older generation within potentially-affected communities and encouraging religious leaders to enter or lead the conversation; engaging young people to raise awareness about their rights; and providing better signposting to services.

The PEER research, commissioned through the National FGM Centre, should serve as an important contribution to both LAs' and community or voluntary organisations' understanding of the needs and attitudes of potentially-affected communities in areas of low prevalence, and how they can be engaged to effect change and promote community inclusion.

## **Lessons learned about the barriers to this innovation**

A notable barrier was the length of time required to negotiate the relationships with the first 3 pilot LAs. Agreeing memoranda of understanding and other conditions of partnership set back the start date for SSWs, SWs and PWs to begin work on the ground in LAs. The learning from these negotiations with the initial 3 LAs meant that agreement was secured in a more timely way with the LAs that joined later.

Staff reported some challenges in establishing themselves within Barnardo's as the specialist FGM team. They faced some difficulties both in terms of clarifying responsibilities around policy work and responses, and with regard to having their specialist IT needs met. Beyond the early developmental stages of the pilot, this does not seem to have been a barrier to working towards the National FGM Centre's objectives.

There were particular problems with the recruitment of specialist staff for posts in the pilot sites. Given the large geographical areas of the pilot LAs, a smaller than expected staff team had to cover, at times, both their LA and neighbouring LAs in terms of case management and community engagement. Whilst there appeared to be no negative outcomes on case management and support to children and families, as caseloads did not suffer as a result of this, it seemed to have affected engagement with community groups and professional networks, according to a number of respondents in interviews. As noted above, SSWs, SWs and PWs met with many partner agency teams to highlight their role, what they could offer in terms of best practice guidance and support, and to discuss referral practice. However, there were limits to what could be achieved by 1 or 2

specialist workers operating across geographically-large LAs and this highlights the need to adopt an efficient model of provision.

The systems in place with regard to data protection and security in some LAs meant that there were delays in granting access to embedded National FGM Centre staff to IT and case recording systems. This created some logistical difficulties for staff in their case work. National FGM Centre workers also expressed a level of discomfort about the process of gathering information for, and then recording, assessments. In some pilot LAs, when a joint visit was made to a family, all the information recorded was held by the allocated LA social worker. This raised questions about whether the LA social worker's record was an accurate reflection of the work undertaken by both parties to the visit, as the SSWs were unable to access the records to verify this. National FGM Centre staff did not have full access to social care recording systems, and therefore could not track information or check its validity. There seemed to be a strong ethos of joint-working with LA social workers in the pilot sites, which enabled National FGM Centre workers to request and receive information in a timely way. However, this may have affected day-to-day efficiency for National FGM Centre workers, who relied upon the willingness of LA colleagues to allow access to case information.

The community events and training run by FORWARD appeared to have been managed successfully. For example, according to our observations there was generally good attendance and high engagement from participants. Participants were open and comfortable with discussing personal issues and there was a substantial amount of challenge and discussion between participants and facilitators. However, logistical difficulties were encountered in spanning 2 large LAs in terms of the financial and time costs. The community partners were facing funding restrictions and were therefore reliant upon a small staff team, which created challenges in terms of attending training events. With this in mind, these organisations also questioned what the next steps would be and how the work would affect them as organisations and their ability, under difficult financial circumstances, to support their communities. It was emphasised that this was a new journey and that they were contributing to the creation of bespoke responses for the area. However, it is important to remain vigilant to the barriers to participation for small community groups in terms of resources, logistics and administration, and also to design methods of engagement, which suit their needs.

Case studies and staff interviews highlighted the difficulties encountered in relation to interpreting and translation. These services were not always readily available, which presented significant challenges when high risk referrals were made and home visits had to be undertaken as soon as possible. Visits or meetings with non-English speaking families could be significantly hampered by inadequate translation, and families were negatively affected by the failure of LAs to have documents translated in a timely manner and to communicate safeguarding or legal processes effectively, as reported both by families and professionals involved.

## Lessons learned about the facilitators to this innovation

The offer of embedded expert SSWs, SWs and PWs seemed to be enthusiastically received and worked well. National FGM Centre SSWs, SWs and PWs were considered by a number of LA respondents to be an asset for their high level of expertise, which also lent itself to mitigating 'unnecessary escalation' of cases and encouraging caution and care amongst pilot site staff.

Having external professionals was seen to work effectively because their work was ring-fenced and they were not absorbed into other work or cases. As such, both managers and LA social workers responded well to the input of National FGM Centre staff in cases, particularly in engaging with families and providing expert country-specific or type-specific information about FGM. However, there may be a challenge for the future sustainability of the model if LAs are required to pay for the service directly. The extent to which their services may be taken up and, where taken up, the extent to which their resources may be protected from generalist case work, is uncertain.

The openness of the pilot LAs to innovation was an important facilitator to the level of success achieved in the pilot sites. Some pilot LAs enabled much greater involvement of National FGM Centre workers in case management, and particularly in undertaking preventative work with families who do not meet thresholds for statutory involvement. This seemed to have a number of benefits: recognising that levels of risk to a child can change over time and undertaking scenario work with families to mitigate this, and giving greater time to support families in areas of low prevalence, who may feel isolated and unsupported by services, to feel settled and integrated into their local community. When a referral was assessed as low risk, pilot sites were encouraged by the National FGM Centre to ask families whether they were willing to meet with a specialist worker to explore their needs further. The LAs which adopted this practice more enthusiastically saw positive results. One pilot LA seemed to be more resistant to trialling new practices around preventative work; the suggestion from respondents was that there might be concern about the LA being seen to over-react or behave differently to FGM cases. This reported caution went alongside a lack of policies and procedures in the LA. The National FGM Centre helped the LA to develop these and respondents felt that this might create a more confident response.

The specialist knowledge of the National FGM Centre team, both as it was embedded at the LA level and in terms of national operation, enabled the dissemination of best practice guidance and policy. This was evident in the practical application of the consultancy work, and in the development of an innovative FGM risk assessment tool for professionals.

Engagement, collaboration and consultation with the voluntary sector and partner agencies appeared to be strong and effective; including efforts not to replicate work already being undertaken and provide practical resources. Staff reported that they were conscious of sensitivities in the sector about a large charity entering the FGM field and

endeavoured to work in partnership and offer support and capacity-building where possible.

## Section 4. Limitations of the evaluation and future evaluation

This evaluation mainly drew upon qualitative data gathered from observations, case study interviews, and interviews with professionals. This qualitative data was also triangulated with monitoring data on case management to understand the scale of casework and whether intended outputs were achieved. However, it was beyond the scope of this evaluation to assess the final impact in terms of reducing the number of cases of FGM. There were a number of reasons for this. Primarily, to demonstrate that the intervention avoided cases of FGM, it would be necessary to compare National FGM Centre clients and beneficiaries to a comparison group that received no intervention (or received 'business as usual' – that is, usual practice in managing FGM referrals). This presents many problems. First, there is no routine screening or assessment for FGM and prevalence figures of FGM in the UK are estimates only. Therefore, any assessment of whether FGM was avoided would depend on the self-reported data of the intervention and comparison group, much of which may be unreliable given the controversial and difficult nature of the practice. Moreover, any such data collection would have to be done longitudinally, over a great many years, to ensure that enough of the period during which a girl or woman would be at risk is covered. Whilst a limited time period over which to obtain data could be used (for example one year): however, the outcome of interest – FGM taking place or not - is a binary measure and its harm no less diminished for being delayed. Thus, a longer time frame to collect data would be needed.

Despite the limitations for an impact assessment, phase 2 of the evaluation (due to report in March 2017) will be an opportunity to obtain more comparative data to demonstrate impact. However, this is likely to focus on process efficacy such as the relative number of referrals to social care from health agencies, compared to a site where there is business as usual. This would be a proxy measure for harm avoided but, given the theories of change evaluation already undertaken, would be able to plausibly model potential impacts. Similarly, a cost benefit analysis is not possible at this stage of the evaluation because impacts or benefits have not been quantified robustly due to the absence of a comparison group, but will be undertaken in the second phase.

This evaluation was designed to support the process of change and help spread good practice. However, the detailed narratives provided by the evaluation are drawn from in-depth research methods involving a wide range of respondents who repeatedly reinforced the importance of core themes. The evaluation therefore provides an understanding of how the project works and what it achieves, including some projections of the impact it is likely to have in future.

## Section 5. Plans for sustainability of the evaluation

The Barnardo's and Local Government Association National FGM Centre has received further funding from the Department for Education and Opcit Research will conduct an evaluation of its new programme of work. Beyond that, if external evaluation is not maintained, continuous monitoring of impact will still be required. Opcit Research has developed Learning Logs for use by SSWs, SWs and PWs that may be implemented on an ongoing basis. This would provide high quality qualitative data for continuous evaluation. Further, the systems that are currently in place for monitoring the number and nature of cases were found to work effectively. This finding is, however, based on a relatively small number of cases: if the caseloads of SSWs, SWs and PWs continue to grow, the central team may require extra capacity to continue effective monitoring. In addition, working relationships between the central team staff and LA senior contacts were found to be effective. This provides a good foundation from which to maintain and strengthen the links between LAs and the National FGM Centre that are so crucial to ensuring that relevant information, including analyses of the project's impact and learning on best practice, are shared widely.

Phase 2 of the evaluation will provide an opportunity to model the impacts on risk of FGM and will attempt to create a useful comparison between National FGM Centre sites and other sites in which practice is business as usual, by looking at referral outcomes of cases identified as being at risk of FGM.

## Section 6. Implications and Recommendations for Policy and Practice

The National FGM Centre pilot, provided by Barnardo's and the LGA, was well received in the LA pilot sites. The strongest evidence came from field work in these pilot sites, through interviews with SSWs, SWs and PWs, and the local Social Care staff who worked with them. The evidence was supported through in-depth case studies. While there was less direct evidence on the influence of the Knowledge Hub, as end-users are more dispersed and diverse, an apparent strength of the Knowledge Hub was that it supplemented the work undertaken within pilot sites. The Knowledge Hub's role was to collate and distribute learning that came from practice in the pilot sites and it therefore represented a valuable tool for improving practice nationally. In our view, it should continue to be viewed as an important part of the entire National FGM Centre offer.

Feedback from LA partners within the pilot sites was extremely positive. National FGM Centre SSWs, SWs and PWs provided challenge, insight, and support, which were not previously available within their local social work teams. Moreover, the position of National FGM Centre staff as an additional (and new) resource meant that their time was largely protected to pursue preventative and early help work. This meant that SSWs, SWs and PWs were not only able to work on FGM prevention, they were also able, at least potentially, to help model good practice in social work more generally. In particular, the SSWs, SWs and PWs worked to recognise protective factors, and build alliances and trust with the families with which they engaged. These philosophies of practice were encouraged nationally, in particular through the Signs of Safety framework.

SSWs and SWs were able to maintain a distinct identity from mainstream social workers. It may be due to this distance that SSWs and SWs were able to build trust with families with whom mainstream social workers had hitherto been unable to develop trusting relationships. An inherent risk to the National FGM Centre pilot is, therefore, that SSWs and SWs may lose this perceived status in the eyes of the families they support if they are given more delegated powers and especially if they become involved in more child protection proceedings. Further research during the next phase of the pilot, particularly in Hertfordshire which has opted for the full delegated model, will be valuable for understanding these risks and benefits. However, we note from the development of practice elsewhere in the country, notably the London-based FGM early intervention pilot in which Specialist Social Workers are fully embedded in social work departments, that this has not yet proven to be a problem. Moreover, senior managers in Hertfordshire reported that the decision in favour of full delegated authority suited their needs: the National FGM social worker was placed in their Joint Child Protection Team, a specialist Police-social work partnership co-located at Police headquarters. It was felt that locating a specialist worker here with delegated authority would help to reduce a perceived tendency by social workers in joint teams to start behaving like police officers by embedding FGM-specific social care expertise in the team, and to develop social care practice further within this team.



One of the main elements of interest in the National FGM Centre pilot, and a leading hypothesis, was that by delegating social work powers to a specialist social work provider, with skilled and knowledgeable staff, a better quality of service would be provided.

An important finding from this evaluation is that social work provision to girls and families affected by FGM was quickly and significantly improved through the intervention of the National FGM Centre social workers, embedded in the local authority safeguarding team.

Within 3 months Ofsted made a positive assessment of the National FGM Centre work: “impressive protective work demonstrated by workers in a case of female genital mutilation” and in another LA, Ofsted specifically linked, “developments to safeguard children at risk of female genital mutilation, as part of a Department for Education – funded innovation project” to “improve(d) awareness of this safeguarding issue across agencies” (Ofsted, 2016: 15).

It has not yet been possible to evaluate the relative outcomes achieved in full delegated authority settings compared to those with only some delegated powers, but this will be tested in the next phase of the work.

In some areas where the SSW was not given full delegated duties, they were able to engage meaningfully with case work, discuss cases and conduct joint assessments with allocated social workers. In some areas where fully-delegated duties were granted, workers did not enjoy as much access to case files and other necessary resources as their colleagues in other areas. This demonstrates that the implementation of any form of delegated authority depends very much on the area, the level of leadership and involvement from senior management, and the extent to which personal professional relationships are negotiated and developed in local teams.

It is important to consider that the National FGM Centre pilot is a means for testing out what works in developing these relationships. It would appear that there is no single solution for establishing joint working at whatever level of delegated authority, for all areas. Further, we can see that where SSWs, SWs and PWs were in place, trust developed in a positive direction, even if at different paces, so that gradually, in some cases, LAs agreed to delegate further responsibilities. Our view is that LAs should be given time to adopt the National FGM Centre model at different paces. However, as the project matures, as new sites adopt the model, and as learning from the national pilot is better understood, this process may become faster and more efficient. This is the next phase of the National FGM Centre, which Opcit Research will continue to evaluate.

## References

- Antonazzo, M. (2003). "Problems with Criminalizing Female Genital Cutting", *Peace Review: A Journal of Social Justice*, 15:4, 471-477
- Baillot, H., Murray, N., Connelly, E. and Howard, N. (2014). *Tackling Female Genital Mutilation in Scotland*. London School of Hygiene and Tropical Medicine, and Scottish Refugee Council: Glasgow
- Berg, R. and Denison, E. (2013). "A Tradition in Transition: Factors Perpetuating and Hindering the Continuance of Female Genital Mutilation/Cutting (FGM/C) Summarized in a Systematic Review", *Health Care for Women International*, 34:10, 837–859
- Bindel, J. (2014). 'An Unpunished Crime: The lack of prosecutions for female genital mutilation in the UK', *New Culture Forum*, 1-58
- Boyle, E.H. (2005). *Female Genital Cutting: Cultural Conflict in the Global Community*. John's Hopkins University Press
- Bulman, K., McCourt, C. (2002). "Somali refugee women's experiences of maternity care in west London: A case study", *Critical Public Health*, 12:4, 365-380
- City University London, Trust for London, Equality Now, Rosa – The UK fund for women and girls, and The Royal College of Midwives (2015). *Taking Local Action on FGM: An Essential Guide for Local Authorities*. London
- Costello, S., Quinn, M., Tatchell, A., Jordan, L., and Neophytou, K. (2015). "In the Best Interests of the Child: Preventing Female Genital Cutting (FGC)", *British Journal of Social Work*, 45:4, 1–18
- Dawson, A., Turkmani, S., Varol, N., Nanayakkara, S., Sullivan, E., and Homer, C.S.E. (2015). "Midwives' experiences of caring for women with female genital mutilation: Insights and ways forward for practice in Australia", *Women and Birth*, 28:3, 207-214
- Department of Health (2015). *Commissioning services to support women and girls with female genital mutilation*. Department of Health: London
- Dorkenoo, E., Morison, L. and Macfarlane, A. (2007). *A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales: Summary Report*. FORWARD: London
- Dustin, D., Davies, L. (2007). "Female Genital Cutting and Children's Rights: Implications for Social Work Practice", *Child Care in Practice*, 13:1, 3-16

- Dustin, M. (2010). "Female Genital Mutilation/Cutting in the UK: Challenging the Inconsistencies", *European Journal of Women's Studies*, 17:7, 7-23
- European Institute for Gender Equality (EIGE) (2013). *Female genital mutilation in the European Union and Croatia*, EIGE: Vilnius
- Goodey, J. (2004). "Sex Trafficking in Women from Central and East European Countries: Promoting a 'Victim-Centred' and 'Woman-Centred' Approach to Criminal Justice Intervention", *Feminist Review*, 76, 26-45
- Kelly, L. (2002). "From commonality to difference and back again?: reflections on international efforts to challenge violence against women", Keynote speech: Expanding Our Horizons: Understanding the Complexities of Violence Against Women. Meaning • Cultures • Difference Conference, 18-22 February 2002, Sydney, Australia
- Kwateng-Kluytse A. (2004). *Legislation in Europe regarding female genital mutilation and the implementation of the law in Belgium, France, Spain, Sweden and the UK*, International Centre for Reproductive Health: Ghent
- Johnsdotter, S. (2009). *The FGM Legislation Implemented: Experiences from Sweden*, Malmö University: Malmö
- Macfarlane, A. and Dorkenoo, E. (2014). *Female Genital Mutilation in England and Wales: Updated statistical estimates of the numbers of affected women living in England and Wales and girls at risk. Interim report on provisional estimates*. City University London and Equality Now: London
- Monahan, K. (2007). "Cultural Beliefs, Human Rights Violations, and Female Genital Cutting", *Journal of Immigrant & Refugee Studies*, 5:3, 21-35
- Norman, K., Gegzabher, S.B., and Otoo-Oyortey, N. (2016). "*Between Two Cultures*": A Rapid PEER Study Exploring Migrant Communities'. *Views on Female Genital Mutilation in Essex and Norfolk, UK*. Published online: Peer Research: National FGM Centre
- The Office for Standards in Education, Children's Services and Skills (Ofsted) (2016). *Thurrock Council Inspection of services for children in need of help and protection, children looked after and care leavers and Review of the effectiveness of the Local Safeguarding Children Board*. Ofsted: Manchester
- Options UK (2011). *Tackling FGM Special Initiative: PEER Research, full report*. Esmee Fairbairn Foundation, Trust for London and Rosa: London
- UNHCR (2013). *Too Much Pain. Female Genital Mutilation and Asylum in the European Union: A Statistical Overview*, UNHCR: Geneva
- World Health Organisation (WHO) (2014). *Female Genital Mutilation*. Fact sheet No. 241

## Appendix 1: Summary of Local Authority Engagement with the National FGM Centre

Local Authority	Degree of delegation	Notes on delegation and local context/structure	Issues of concern identified by LAs
Hertfordshire  Work began:  January 2016	Full delegated authority	<ul style="list-style-type: none"> <li>▪ 4 cases from Jan-March</li> <li>▪ Joint Child Protection Investigation Team (JCPIT) receives all incoming referrals; SSW sits in this team</li> <li>▪ LA is open to innovation and holds a large innovation grant itself. Pilot therefore seen as an opportunity to develop practice in Children's Services and across other agencies, and to build on LA's very strong partnership ethos</li> <li>▪ fourth or fifth largest child population in the country, and around 25% of total population is black or minority ethnic (BME) (reported in interview)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Appropriate FGM recognition and reporting, and child safeguarding, particularly with regard to improving the quality of referrals (especially with midwives at the ante-natal point)</li> <li>▪ Positively encourage social workers to avoid emulating police behaviour (identified as a risk in joint teams) and retain focus on children's social work practice rather than punishing the perpetrator</li> <li>▪ National FGM Centre to support better engagement with faith communities and communities that are potentially-affected by FGM</li> </ul>
Thurrock  Work began:  January 2016	High level of delegated duties	<ul style="list-style-type: none"> <li>▪ Recent decision to send referrals directly to the National FGM Centre social worker from the MASH, suggesting confidence in the work being undertaken</li> <li>▪ SSW sits in the MASH alongside police officers, health visitors, housing professionals, Independent Domestic Violence Advocates, and practice managers from social care, troubled families and early help.</li> <li>▪ Smaller geographically than neighbouring LAs; expected that SSW would be able to move around the area more easily to raise awareness and conduct home visits</li> <li>▪ 19.1% of population is BME (2011 census data)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Need to engage families from affected communities more effectively and at an earlier point in the process to aid prevention efforts (for instance, through Children's centres)</li> <li>▪ Developing effective pathways with partner agencies</li> <li>•</li> </ul>

<p>Suffolk</p> <p>Work began: October 2015</p>	<p>High level of delegated duties</p>	<ul style="list-style-type: none"> <li>▪ Joint-working model between National FGM Centre PW and allocated social workers</li> <li>▪ PW sits in the Make A Change team, which also manages the LA's response to trafficking, gangs and related issues in terms of factors in child exploitation. PW is now on the MASH pathway for FGM referrals</li> <li>▪ 4.8% of population is BME (suffolk.gov.uk, 2015 figure); larger ethnic minority population in Ipswich in particular (11.1%), and this location is a dispersal area for asylum seekers</li> <li>▪ Higher numbers of patients coming through hospitals who have undergone FGM than in neighbouring LAs. Public health in particular has therefore been dealing with the issue of FGM and has developed specialist knowledge.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Understanding whether the low reporting rate reflects low prevalence</li> <li>▪ Understanding whether referrals are being made correctly</li> <li>▪ Ensuring effective pathways and suitable responses</li> <li>▪ Understanding why a number of cases have been designated as 'no further action' and whether this was the appropriate response.</li> </ul>
<p>Norfolk</p> <p>Work began: October 2015</p>	<p>Intermediate level of delegated duties</p>	<ul style="list-style-type: none"> <li>▪ Duties delegated to SSW include data recording, conducting joint home visits, recording case notes</li> <li>▪ SSW sits in the MASH</li> <li>▪ Very few cases referred before the pilot and since its implementation; SSW also therefore assessing cases deemed no further action or closed</li> <li>▪ 2011 census data puts the BME population at 7.6%</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ensuring that existing policies and procedure relating to FGM are matched by professional knowledge and confidence</li> <li>▪ Need to de-escalate the response where necessary in case management when police colleagues in the MASH push for a criminal justice response</li> </ul>
<p>Essex</p> <p>Work began: January 2016</p>	<p>Intermediate level of delegated duties</p>	<ul style="list-style-type: none"> <li>▪ Delegated duties include giving advice to professionals within social care and referring agencies and some joint home visiting</li> <li>▪ Anecdotally, opportunities for early help seem to be constrained by high intervention thresholds</li> <li>▪ PW sits in the Hub</li> <li>▪ The BME population of Essex is 5.6%, according to 2011 census data; Essex has seen the placing of refugees and asylum seekers within the county and the demographics</li> </ul>	<ul style="list-style-type: none"> <li>▪ Relatively high numbers of 'inappropriate' referrals</li> <li>▪ Generally low levels of professional knowledge about FGM</li> <li>▪ Limited engagement with potentially-affected communities</li> <li>▪ Lack of LA policies and procedures</li> </ul>

		are therefore changing	
Southend  Work began:  April 2016	Intermediate level of delegated duties	<ul style="list-style-type: none"> <li>▪ Work in Southend has only recently begun: duties delegated include the provision of advice to professionals and performing joint home visits</li> <li>▪ 2011 census data puts Southend's BME population at 8.3%</li> </ul>	<ul style="list-style-type: none"> <li>▪ Awareness raising, building community links, and joint visits to ensure both good outcomes for families and greater confidence and knowledge for LA social workers</li> <li>▪ Particular focus on Public Health as the frontline in FGM risk identification and raising awareness in schools</li> </ul>

## Appendix 2: National FGM Centre Levels of Intervention

<p><b>Level 1</b></p> <p>Cases are referrals where National FGM Centre staff advise more investigation or no further action at arrival due to lack of evidence of risk</p>
<p><b>Level 2</b></p> <p>National FGM Centre staff indirectly work with the family, often by advising the referrer (e.g. school) on work to do with the girl, and conversations to have with the parents. There are indications that without the provision of services, needs may escalate or circumstances deteriorate to the detriment of the children or families concerned.</p>
<p><b>Level 3</b></p> <p>Cases which require more targeted and enhanced support that will on occasions include specialist provision. As far as possible, all engagement with services will be sought on a voluntary basis; however, it is likely that some children and families within the upper end of this level of need will be at risk of harm and statutory powers may be required to ensure participation.</p>
<p><b>Level 4</b></p> <p>Needs that can be described as acute, either in terms of urgency, complexity or in terms of the degree of risk to which a child or young person is exposed. While relatively speaking, very few children and young people fall into this category of need, services provided tend to be resource intensive, very costly and children with these needs are often at risk of having the poorest outcomes.</p>

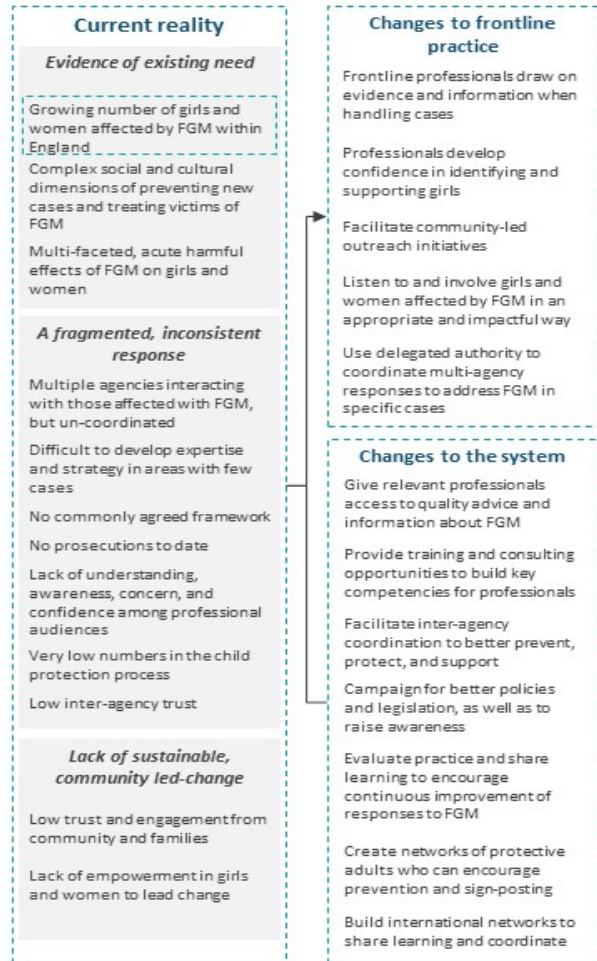
## Appendix 3: Theory of Change Interview Script

<p>Problems and Solutions</p> <ul style="list-style-type: none"><li>- What problems is the FGM National Centre project trying to address (for which groups)?</li><li>- Why is it trying to address them? (for whom)?</li><li>- Is it, and how is it, different from what was happening previously?</li></ul> <ul style="list-style-type: none"><li>- What assumptions do you have about how the project is likely to bring about change? (e.g. of assumptions: the community supports the project? There is diverse commitment from professionals and women and girls affected. There is an economic case for change)?</li></ul> <ul style="list-style-type: none"><li>- What are the main ways that the project will work? (be specific about processes e.g. routine recording and referral, training for professionals, codifying risk for recording, what are the things the project does?)</li></ul> <ul style="list-style-type: none"><li>- What outcomes do you expect to observe in the short and medium term?</li><li>- What outcomes in the longer term?</li></ul>
<p>Inputs</p> <p>What are the main inputs into the project? (e.g. money, staff time, accommodation)</p>
<p>Processes</p> <p>What are the key processes involved in the project? (e.g. of a process: specialist social workers within social work settings, delegated social work, intelligence hub)</p>
<p>Outputs</p> <p>What are the main outputs? (e.g. social workers recruited)</p>
<p>Outcomes</p> <p>What are the main outcomes and how do these relate to the processes and outputs?</p> <p>What challenges do you expect the project to encounter, in terms of achieving its desired outcomes?</p>

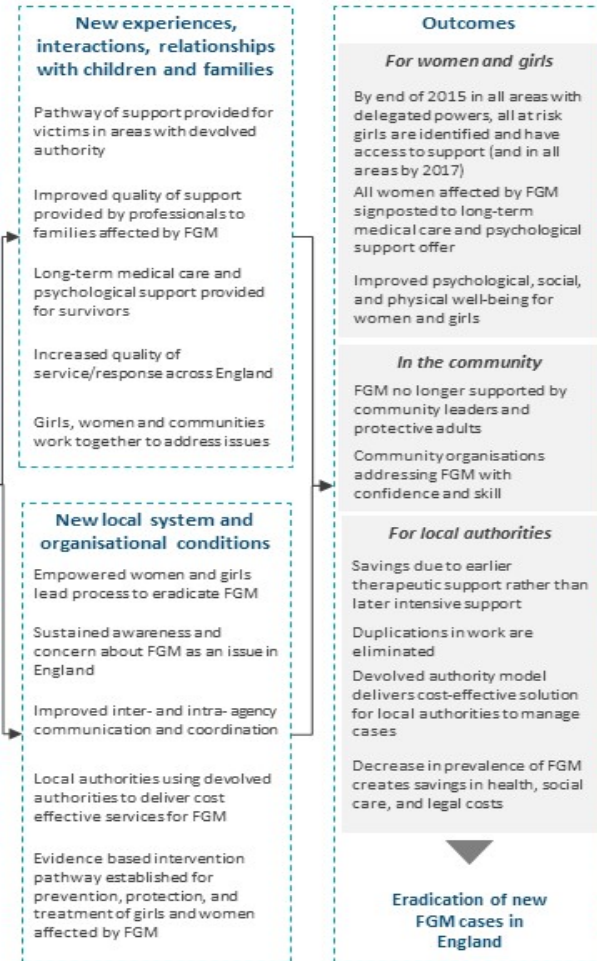


# Appendix 4: National FGM Centre Theory of Change

## Centre of Excellence



## Theory of Change



## Appendix 5: Literature review

This literature review serves to identify promising practices as well as challenges and gaps that the project may help to address. In summary, a number of leading findings are highlighted:

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

### Terminology and national context

The definition set by the World Health Organisation (WHO) (2014: no page number) is used widely in peer-reviewed literature, grey literature and by specialist organisations. It defines FGM as ‘all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons’, and sets out four classifications:

- Clitoridectomy (Type I): partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris);
- Excision (Type II): partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are “the lips” that surround the vagina);
- Infibulation (Type III): narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris;
- Other (Type IV): all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area (WHO, 2014: no page number).

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

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

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

## **Engagement with girls and women from FGM-practising countries**

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

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

### **Cultural sensitivity**

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

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

Similarly, scholars point to the risk of inducing feelings of shame if health care providers react with shock in an initial examination: another risk which could be mitigated with training (Monahan, 2007). An awareness to how language is used which may include

careful use of terminology, including a consideration of the use of 'mutilation' and effective, sensitive communication that recognises the trauma endured and engages cultural sensitivity is advocated in the literature.

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

### **A victim-centred approach**

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

Trafficked women are not prioritised as 'innocent' and 'deserving' victims by criminal justice agencies in comparison to other victim categories that fulfil such stereotypes, and are often seen as complicit in their exploitation (Goodey, 2004). This may be a factor to consider in interactions with women who have undergone FGM in relation to discussing the potential for risk to their daughters: whilst the literature emphasises the need for a child protection context to safeguard girls, a gendered approach to tackling and responding to FGM will support affected communities and professionals to identify and address the root causes of the practice (Baillot et al, 2014), without creating an environment which stigmatises, much less criminalises, women who have undergone FGM and risks driving the practice underground (Antonazzo, 2013, Monahan, 2007).

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

'victim'; highlighting the ways in which women and children resisted abuse and endeavoured to cope with its many consequences.

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

Rather, feminist scholars of GBV advocate for a more complex understanding of identity and the lived experiences of women who have experienced trauma or abuse, encompassing a recognition of their status as victims, but allowing them agency in managing the consequences and coping mechanisms; in the context of FGM, encouraging women in the communities concerned to engage in debate, change attitudes and create alternative ways of affirming their cultural identity (Dustin, 2010). This call in the literature for a victim-centred approach that is situated within a violence-against-women agenda, should therefore be read alongside scholarship which advocates for a nuanced understanding of victimhood, in which individual agency and strength should be recognised.

### **Engagement with women from FGM-practising countries: prevention and protection**

There is a dearth of adequate data collection practice from which to accurately map FGM practice, and with which to inform prevention and protection. In literature addressing engagement with women and girls in a health and social care context, it is widely emphasised that these environments are crucial in terms both of prevention and protection; in ensuring effective clinical outcomes for women and in terms of supporting an appropriate child protection response.

FGM has been identified as a blind spot for social services and child protection workers (Costello et al, 2015). Nevertheless, the social work context is highlighted in the literature as an important point of contact and disclosure for women who have undergone FGM, and therefore as a point at which prevention and protection work can be undertaken. Costello (2013) argues strongly for this multi-faceted social work role '[they] have responsibilities...to protect girls from being cut; to advocate for services for affected women...and to engage with practising communities in processes to stop the practice'. Dustin and Davies (2007) make the case for a strong grounding in cultural understanding of the practice for social workers, recognising that an understanding that there may be anxiety or resistance about what will happen if FGM is abandoned (for instance, what the

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

Maternity services are judged to be of particular importance; as Baillot et al (2014) observe, women who have undergone FGM often only come into contact with services when pregnant, and therefore maternity services play a pivotal role in asking about and recording cases of FGM, counselling and providing information about the law and support available to women, and in protecting girls from and preventing FGM. As the authors explain, 'pregnancy was seen as a point at which professionals can sensitively initiate a discussion about a mother's future intentions for her daughter(s) and critically, provide support to enable and empower parents to protect their daughter(s) from the practice'. Dawson et al (2015) note that midwives are critical to the provision of high quality care for women who have undergone FGM, and that an informed and culturally sensitive approach in a midwifery setting is important to ensuring continuity of care. Nevertheless, fear and a lack of experience in caring for women with FGM, barriers to the development of rapport with women, working with interpreters, cultural misunderstandings, inexperience with associated clinical procedures and a lack of knowledge about FGM types all hinder positive outcomes.

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

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

As the authors note, 'a lack of clarity was also apparent as to the appropriate child protection response, if any. A police respondent described a 'blockage' where girls born to mothers with FGM are concerned' (Baillot et al, 2014). As evidence from scholars at the beginning of this section highlighted the importance of the maternity setting as often the first point at which FGM is disclosed, effective multi-agency working in this environment, including specific training and guidelines regarding how best to undertake

protection and prevention in relation to a child whose mother has been discovered to have undergone FGM, would seem to be of paramount importance, enabling both a clinical assessment for the mother and a risk assessment (or form of engagement with the parents about potential harm) for girls in the family. Responses from different agencies pointed variously to an overly-guarded approach from medical professionals, to slow responses from social services and an, at times, either under- or over-reaction from police. The authors note that training and guidance is particularly lacking on reporting and, specifically, how to respond to adult women survivors of FGM in maternity services.

Baillot et al (2014) also recommend that FGM be embedded within child protection and safeguarding training for professionals, with the specific causes and consequences of FGM highlighted in a child protection context. The authors (reporting on the Scottish example) argue that in the context of an increasingly diverse population with growth in communities potentially-affected by FGM, there should be sustainability in mainstreaming an FGM approach to community development and the establishment of guidance and services on the one hand, but also in ensuring sustainability of specialist knowledge; ensuring that expertise is not concentrated in individuals who may leave, as a substitute for a long-term, sustainable and multi-agency approach. Similarly, in their evaluation of the FGM Initiative which supported community-based organisations in the UK to carry out FGM prevention work, Options UK (2011) stress that multiple agencies, including statutory organisations and community groups, should work together to identify local needs and suitable prevention strategies, alongside a focal individual to act as coordinator and champion.

Evidence from literature surveyed for this review, therefore, emphasises the importance of informed, and culturally competent, engagement in clinical and social care settings with women who have undergone, or are potentially-affected by, FGM. It also stresses that effective multi-agency working and a holistic approach to service provision is essential to protection and prevention efforts. However, this literature points to existing barriers (cultural, linguistic, stigma-related or service provision-related barriers) to establishing such best practice outcomes and highlights a lack of best practice seeking to overcome such barriers.

### **Engagement with communities**

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

The authors observe that men are becoming increasingly involved in discussions about FGM and stress that this is of paramount importance to ensure community-wide and –led



solutions that reflect lived experiences; engagement with men and women should be carried out separately initially, but men and women can also work effectively together. Dawson et al (2015) note that the involvement of men is important both because men can also experience FGM-related complications both personally and in relation to their partners' suffering, and because they may be central to a decision about FGM for their daughters or re-infibulation for their partners.

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

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

Evidence from surveyed literature demonstrates that this work with potentially-affected communities can be bolstered by engagement with schools and with community or campaigning groups, all of which can play a role in prevention and protection. Baillot et al (2014) quote an NGO worker reflecting that, 'I know myself of children who have been identified by nursery or classroom assistants...Schools can play a role in identifying girls', although the authors report that evidence suggests that teachers are a group who have received very little training on FGM. The Options UK (2011) evaluation notes that most projects faced resistance when trying to work in schools, as many said that they did not want to address the issue for fear of stigmatising certain groups. However, Dustin and

Davies (2007) assert the importance of prevention programmes in schools, arguing that teachers need to become familiar with the language used to describe FGM and behaviour indicative of FGM, such as long periods in the toilet and school absences.

### **Availability of evidence: a note on methodology**

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

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



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