

FGM

SCOPING STUDY

Northern Ireland



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Introduction

This research was commissioned by the African and Caribbean Support Organisation Northern Ireland¹ (ACSONI) and undertaken by a team of researchers from the Ulster University led by Dr Fiona Bloomer. This project was carried out with funding from Rosa Foundation UK. ACSONI thanks Rosa Foundation for this support.

This scoping study seeks to provide an estimate of the number of women and girls affected or potentially affected by FGM in Northern Ireland. ACSONI conducted community engagement focus groups. The sessions were facilitated by Saria Khalifa and supported by Nattassa Latcham of ACSONI, Asma Aljunaid, Sahra Mahamuud and Saba Hasaballah of the local African Community.

It further seeks to identify service provision in Northern Ireland and to identify gaps in both service provision and knowledge. The research team – Dr. Fiona Bloomer, Dr. Noirin MacNamara, Danielle Mackle, Dr. Claire Pierson, completed this section of the study.

We would like to emphasise that the research was a scoping study to identify issues and preliminary findings on FGM in Northern Ireland. It is not a comprehensive study but instead provides a foundation for future research and engagement with stakeholders who took part in the study and also those who due to time constraints did not take part in the scoping study.

ACSONI thanks all the participants, researchers, sponsors and partners in this project. This scoping study has identified key gaps in service provision and knowledge and highlighted areas for further development for a range of stakeholders.

¹ African and Caribbean Support Organisation Northern Ireland (ACSONI) is an autonomous community-based Organisation formed in 2003 with a proactive approach towards targeting needs and facilitating belonging among individuals from the continent of Africa, the Caribbean (West Indies) and other families in Northern Ireland with these linkages. ACSONI is the central body representing the various African and Caribbean groups here in Northern Ireland. In this context, ACSONI provides advocacy by awareness raising around harmful practices or health concerns, signposting and safeguarding vulnerable women and children against FGM.

Background

Female Genital Mutilation (FGM) is the act of removing all or part of the external female genitalia for non-medical reasons (WHO, 2016). FGM is also referred to as female genital cutting or female circumcision. There are no health benefits to the cutting or removal of female genitalia and it is recognised internationally as a human rights violation (Forward, 2016). The World Health Organisation (WHO) estimates that approximately 140 million women and girls globally have experienced it. It has been documented in 30 countries in Africa and around the globe including the Middle East, Asia, Europe, North America, South America and Australia (WHO, 2016). Whilst FGM is reportedly carried out within the UK, it is also likely that girls will be taken from the UK to another country to have the FGM procedure, often during “a long holiday abroad or going ‘home’ to visit family” (O’Hagan, 2015).

Within the UK, the NHS estimates that approximately 137,000 women and girls are affected by FGM and within Ireland, AkiDwA have calculated that roughly 3,780 have undergone FGM (AkiDwA, 2016). However, to date no specific data or estimates have been published on the number of women and girls affected within Northern Ireland.

Methodology

There is a dearth of literature and statistics available that relates to the prevalence of FGM in Northern Ireland. This scoping study has sought to outline the definition and prevalence of FGM in the UK and Ireland and to highlight the physical and mental effects of FGM on women and girls. The study also considers the literature highlighting FGM as a Human Rights issue in the UK and Ireland. The research report has also reviewed any policies that may be relevant to FGM in Northern Ireland.

The study sought to estimate the number of women who may have been affected by FGM, however as discussed in section 3, this was not achieved.

The views of the stakeholder organisations have been obtained through a series of semi-structured interviews with representatives of statutory and voluntary organisations and NGOs (15 in total). The findings of the engagement with stakeholders are discussed in



further detail in section 4 of this report. (Participating organisations are listed in appendix 1). The views of communities affected by FGM were explored in a focus group facilitated by Saria Khalifa in partnership with Nattassa Latcham, ACSONI. This is reported on in section 5 of the report.

Section 6 reflects on key findings and makes a series of recommendations.

Health Risks of FGM

Female genital mutilation is medically unnecessary as it interferes with the normal functioning of female genitalia and can give rise to a range of physical health complications (WHO, 2016). There are several serious physical and mental health effects of FGM. The WHO has classified FGM into four types which vary in severity and which are outlined in the table below.

FGM is mainly practiced on girls under 18 years old. The practice has short-term effects such as extreme pain, bleeding and possible infection and longer-term effects on urination,

menstruation and childbirth (WHO, 2016). Alongside physical effects, the trauma of such an experience has a potential impact on mental health; in fact, there is strong evidence of a correlation between FGM and psychiatric disorders with young girls and women presenting with psychological distress and post-traumatic stress disorder (Kizilhan, 2011; Mulongo, et al., 2014).

Reasons why FGM is performed

The World Health Organization state that the reasons why FGM is performed are subject to variation between regions as well as over time. Typically, a mix of sociocultural factors within families and communities are at play:

- Where FGM is a social convention (social norm), the social pressure to conform to what others do and have been doing, as well as the need to be accepted socially and the fear of being rejected by the community, are strong motivations to perpetuate the practice. In some communities, FGM is almost universally performed and unquestioned.
- FGM is often considered a necessary part of raising a girl, and a way to prepare her for adulthood and marriage.
- FGM is often motivated by beliefs about what is considered acceptable sexual behaviour. It aims to ensure premarital virginity and marital fidelity. FGM is in many communities believed to reduce a woman's libido and therefore believed to help her resist extramarital sexual acts. When a vaginal opening is covered, or narrowed (type 3), the fear of the pain of opening it, and the fear that this will be found out, is expected to further discourage extramarital sexual intercourse among women with this type of FGM.
- Where it is believed that being cut increases marriageability, FGM is more likely to be carried out.
- FGM is associated with cultural ideals of femininity and modesty, which include the notion that girls are clean and beautiful after removal of body parts that are considered unclean, unfeminine or male.
- Though no religious scripts prescribe the practice, practitioners often believe the practice has religious support.

Type 1	Type 2	Type 3	Type 4
Clitoridectomy: 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: 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: 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: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.



- Religious leaders take varying positions with regard to FGM: some promote it, some consider it irrelevant to religion, and others contribute to its elimination.
- Local structures of power and authority, such as community leaders, religious leaders, circumcisers, and even some medical personnel can contribute to upholding the practice. In most societies where FGM is practised, it is considered a cultural tradition, which is often used as an argument for its continuation.
- In some societies, recent adoption of the practice is linked to copying the traditions of neighbouring groups. Sometimes it has started as part of a wider religious or traditional revival movement. (WHO, 2016:1)

FGM is considered a 'hidden practice' (Forward, 2007) due to the strong taboo associated with the practice and the cultural sensitivities involved in speaking out against it. FGM is often referred to as a religious practice (O'Hagan, 2015) yet it has been highlighted there is no basis within religious scripture. As such, it is related to the control of women's sexuality and gender-based social norms relating to 'marriageability' (WHO, 2016). FGM is culturally-embedded, as it is viewed as a form of cultural expression among those who support it. FGM may be upheld as a religious obligation by some Muslim populations, even though the practice predates Islam and it is practiced by Muslims, Christians and followers of traditional African religions (UNFPA/ UNICEF 2016).

Service Provision and Practitioner Knowledge

Within the confines of the scoping study it was not possible to complete a detailed literature review of FGM related to service provision and practitioner knowledge. The following are exemplars of studies which are of interest as they focus on either recent UK studies (1) or are systematic reviews of previous studies, highlighting common findings (2, 3, 4, 5). The majority of studies centre on the roles of health professionals.

(1) A study conducted in London concluded that professionals such as teachers, doctors, midwives and nurses, who are well placed to safeguard girls, were often unaware that girls are at risk of FGM. For those under-18 years of age, FGM is often not viewed as a safeguarding issue, and is therefore not aligned with professionals' current duties to identify, report and refer child maltreatment (Roy et al, 2011).

(2) A systematic review of research conducted around the globe during the period 2000-2014 found that healthcare practitioners are often under-informed about FGM (Zurynski et al, 2015), although the authors note that many studies suffered from methodological problems. They did identify that whilst most health professionals were aware of the practice of FGM, few correctly identified the four FGM categories defined by WHO. The authors further noted that knowledge about FGM legislation was high in the UK (94% of health professionals from the UK knew that FGM was illegal) though knowledge varied elsewhere: 25 % of professionals in a Sudanese study, and 46 % of Belgian labour ward staff knew that FGM was illegal in their country.

(3) A systematic review of research of doctors' experiences around the globe during the period 2000-2014 recommended "improved education and training opportunities for medical students and doctors to build knowledge and skills and to change attitudes concerning the medicalization of FGM and reinfibulation" (Dawson et al, 2015:40).

(4) A systematic review of research from 15 countries explored the role of men in abandonment of FGM (Varol et al., 2015). The authors found that there was ambiguity in men's position on FGM, though many wanted to abandon this practice. The authors identified that a combination of barriers to halting FGM were at play; they conclude that "the level of education of men was one of the most important indicators for men's support for abandonment of FGM. Advocacy by men and collaboration between men and women's health and community programs may be important steps forward in the abandonment process." (ibid:1).

(5) Cappa et al (2013) reflect on a UNICEF study of the data on FGM and exploration of the dynamics of change. The authors note that interventions to achieve the abandonment of FGM must be comprehensive, culturally sensitive, incorporating a social perspective based on human rights and gender-equality principles. It is argued that whilst attitudes to FGM are changing and the overall trends are decreasing, progress on halting FGM varies between countries. "As many as 30 million girls are still at risk of genital mutilation/cutting in the next decade if present trends persist" (ibid; 1081).



HUMAN RIGHTS, LEGISLATION & POLICY

FGM as a Human Rights issue in the UK and Ireland

FGM is internationally recognised as a form of gender based violence and a form of child abuse. One of the key European human rights documents establishing standards with regards to FGM is the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (known as the Istanbul Convention). The Convention entered into force in 2014 and represents the first convention to recognise that FGM exists in Europe and needs to be systematically addressed. Article 38 offers a comprehensive framework to prevent and combat this violence. The UK has been a signatory to the convention since 2012.

Within the UK FGM has been illegal since 1985 under the Prohibition of Female Circumcision Act (1985) replaced in England, Wales and Northern Ireland by the Female Genital Mutilation Act 2003. The maximum criminal penalty under this Act is 14 years imprisonment. Under the terms of these acts, it is criminal to:

- Excise, infibulate or otherwise mutilate the whole or any part of the labia majora or labia minora or clitoris of another person.
- Aid, abet, counsel or procure a girl to mutilate her own genitalia.
- Aid, abet, counsel or procure another person who is not a UK national to mutilate a girl's genitalia outside the UK.

The FGM Act (2003) extended the offence to enable prosecution of those who assist a non-UK person to mutilate a girl's genitalia overseas. For instance, parents who procured FGM for their daughters outside of the UK would be committing a criminal offence, even if they have not carried out the procedure themselves, but have made the relevant arrangements.

The Serious Crime Act 2015 amends the 2003 Act. These amendments mean that it is illegal to:

- Perform FGM by a UK national or a person who is resident in the UK.
- Assist a non-UK person to perform FGM to a UK national or a person who is resident in the UK.

The changes mean that the 2003 Act can capture offences by people who are habitually resident in the UK even if they are not permanent UK residents as defined by the 2003 Act (Home Office, 2015).

The 2015 Act also prohibits the publication of information that would be likely to lead to the identification of a person against whom an FGM offence is alleged to have been committed. Anonymity commences once an allegation has been made and will last for the duration of the victim's lifetime. This prohibition may be lifted if:

- A person being tried for an FGM offence could have their defence substantially prejudiced if the restriction to prevent identification of the person against whom the allegation of FGM was committed is not lifted.

Or

- Preventing identification of the person against whom the allegation of FGM was committed could be seen as substantial and unreasonable restriction on the reporting of the proceedings and it is considered in the public interest to remove the restriction (Home Office, 2015).

The 2015 Act also creates a new offence of: Failing to protect a girl from FGM. If an offence of FGM is committed against a girl under the age of 16, each person who has parental responsibility and has frequent contact with the girl at the time the FGM occurred will be liable. The maximum penalty for the new offence is 7 years imprisonment or a fine or both.

The 2015 Act also provides for a Female Genital Mutilation Protection Order (FGMPO).

The court may make a FGMPO for the purposes of protecting a girl against the commission of a genital mutilation offence or protecting a girl against whom such an offence has been committed. Breach of a FGMPO carries a maximum penalty of 5 years imprisonment in the case of a criminal breach or as a civil breach is punishable by up to 2 years imprisonment.

The 2015 Act also creates a new mandatory reporting duty for specified regulated professionals in England and Wales. It does not apply in Northern Ireland (Home Office, 2015). However, Section 5 of the Criminal Law Act (Northern Ireland) 1967 could be applied, under the section "Penalties for concealing offences etc.", this could be read as a general duty to report offences. However, the person who has acquired the relevant information must know or believe that:

- an offence has been committed; and
- that they have information which is "likely to secure, or to be of material assistance in securing, the apprehension, prosecution or conviction of any person for that offence".



These conditions need to be met in order for duty to report to apply. If a person became aware of a FGM case but did not know it was illegal, or did not possess the required information the condition would clearly not apply. In essence there is only an offence where someone does not disclose an offence and material information to the apprehension of a suspect where they accept or agree to accept any consideration.

Ireland

In Ireland, the Criminal Justice (Female Genital Mutilation) Act 2012 makes it a criminal offence for someone resident in Ireland to perform FGM or to remove a girl from the State for the purpose of FGM. The maximum penalty under all sections is imprisonment for up to 14 years or a fine or both.

Policy Overview in the Republic of Ireland and Northern Ireland

Republic of Ireland

Ireland's first National Action Plan to address FGM (2008-2011) resulted in some progress particularly with regard to legislation and support:

- A specialised clinic on FGM was established and the National Maternity Healthcare Record (NMHCR) incorporated FGM as a risk factor.
- AkiDwA (the national network of migrant women living in Ireland) delivered awareness-raising and training to over 3000 healthcare professionals.
- The FGM Act 2012 was enacted.

However, key issues remain to be progressed. The NAP was not adopted by any government department or agency and no coordinated strategy or inter-agency working group addressing FGM was established (AkiDwA, 2016).

AkiDwA produced a report Towards a National Action Plan to Combat Female Genital Mutilation 2016-2019 in order to address these concerns. The plan focuses on five strategic themes:

1. Prevention (engaging the community).
2. Protection (safeguard women and girls at risk of FGM).
3. Provision, Support and Care (for women and girls who have undergone FGM).
4. Prosecution.
5. Promote the Eradication of FGM Globally.

The report proposes key actions within each strategic theme. It clearly identifies the target group, actors and indicators which would relate to each proposed action. To date no such monitoring and evaluative framework has been proposed in Northern Ireland.

There are overlapping concerns identified in the report, which are also evident in Northern Ireland. The report maintains that in Ireland:

- Professionals working with children should be informed and trained to identify girls at risk and recognise signs that a girl may have been previously subjected to FGM.
- Healthcare professionals need an awareness of FGM and preparedness to respond to it in a culturally appropriate manner. Training needs to equip professionals with the knowledge and confidence to recognise and comprehensively treat FGM-related problems.
- FGM-related issues must be integrated into health policy, strategy and training.
- Evidence-based guidelines must be produced which provide clear direction for healthcare professionals, including protocols for cross-sector cooperation and referral.
- Although legislation is in place which makes it a criminal offence to perform FGM in Ireland, FGM does not have an Irish Crime Classification System (ICCS) code which makes it difficult to record FGM as a specific crime and has a negative impact on wider reporting and data collection mechanisms.
- The report stresses that communities are experts in their own lives and their engagement is essential to enable them to end FGM. (AkiDwA, 2016: 10-15).

Northern Ireland

Co-operating to Safeguard Children and Young People in Northern Ireland provides the overarching policy framework and core statutory guidance for safeguarding children and young people in the statutory, private, independent voluntary, community and faith sectors. This policy provides for the following key responsibilities with regard to FGM in Northern Ireland:

- Where any individual or organisation has a concern that a child may be at immediate risk of FGM they must report it to the PSNI without delay.
- Where there is a concern that a child is at risk of FGM, a referral to the relevant Health and Social Care Trust should be made in line with section 6 of the policy. This enables a response which is compliant with a family supportive approach in the first instance, or if there is judged to be a significant risk to the child of FGM, it enables a response compliant with Child Protection Policy and Procedures and includes the involvement of the PSNI.



- Consideration must always be given to the needs of any female child of the family or any female child resident in the same household.
- Practitioners must comply with the Multi Agency Practice Guidelines on Female Genital Mutilation, any Professional Guidance on FGM issued by their professional body, and their internal organisational policies, procedures and guidance.
- Where it is established that a child has been a victim of FGM that child should be provided with the full range of necessary health, social care and counselling supports. (DHSSPS, 2016).

The Multi Agency Practice Guidelines on Female Genital Mutilation provide practice guidelines to frontline professionals who are responsible for safeguarding children. They set out:

- How to identify a girl or young woman who may be at risk of being subjected to FGM and how to respond appropriately to protect her.
- How to identify when a girl or young woman has been subjected to FGM and how to respond appropriately to support her.
- Measures that can be implemented to prevent and ultimately eradicate FGM.

The Multi Agency Practice Guidelines outline specific factors which may heighten a girl's or woman's risk of being affected by FGM, indications that FGM may take place soon, and indications that FGM may already have taken place. They detail good practice to follow in all cases and the available legal interventions. They further outline specific guidelines for health professionals, the police service, health and social care children's services, and for schools, colleges and universities.

The guidelines identify that the abandonment of FGM must be a 'bottom-up', community-led approach. The guidelines highlight the role of the Safeguarding Board for Northern Ireland in the drive to eliminate the practice and the importance of educating professionals so that they are up to date with child protection procedures in relation to FGM and are confident working with preventative programmes which relate to FGM (DoF, 2014: 46-47).

United Kingdom

Tackling FGM in the UK - Intercollegiate Recommendations for identifying, recording, and reporting was published in 2013. The report makes nine key recommendations for tackling FGM in the UK. It further details key policy recommendations and expected actions to operationalise the nine key recommendations (RCM et al., 2013: 18-23).

The nine key recommendations on tackling FGM in the UK are as follows:

1. Treat it as child abuse.
2. Document and collect information.
3. Share that information systematically.
4. Empower frontline professionals.
5. Identify girls at risk and refer them as part of child safeguarding obligation.
6. Report cases of FGM to police and support services.
7. Hold frontline professionals accountable.
8. Empower and support affected girls and young women (both those at risk and survivors).
9. Implement awareness campaign.

Drawing on small-scale qualitative studies across the UK this report outlines some views of people from affected communities on the prevention of FGM:

- Strong support for a more interventionist stance by the UK government particularly among young women.
- Women and mothers may come under pressure to practice FGM either in the UK or abroad.
- Those who want to end FGM state that while community based education initiatives are important they are not enough.
- There is mixed evidence with regard to the effectiveness of the law against FGM and its deterrent impact.
- Access to specialist FGM services such as de-infibulation is vital for counteracting continuing support for FGM.
- Survivors of FGM may not always recognise that subsequent health problems are caused by FGM and this realisation often lessens their support for this practice. (RCM et al., 2013: 11)

The report also identifies barriers to preventing FGM including:

- Professionals' lack of awareness of FGM with regard to when to consider a child at risk.
- Concerns about the risk of offending or stigmatising people from affected communities.
- Concerns that referral of at-risk girls will overwhelm services.
- Unclear referral thresholds particularly within health, education and children's social services. A failure of professionals to respond when presented with a child who may be at risk of FGM.
- Lack of robust monitoring and surveillance systems.
- Lack of accountability in relation to local performance. (RCM et al., 2013: 14)



Recent policy recommendations

The NSPCC produced a briefing paper on addressing FGM in Northern Ireland in March 2015. This paper notes several suggestions for consideration within Northern Ireland:

- The establishment of an FGM Strategic Group to coordinate and operationalise the Multi-Agency Practice Guidelines, the responsibilities in the Serious Crime Act 2015 and the development of a Northern Ireland wide FGM strategy.
- Collation of information on the prevalence and incidence of FGM in Northern Ireland.
- Implementation of a regionally organised public health awareness raising campaign on FGM.
- Targeted awareness-raising with communities affected.
- Training to develop competence knowledge and awareness of multi-disciplinary frontline staff.
- Development of prosecution guidance for Northern Ireland on the issue of FGM (O'Hagan, 2015).

The Tackling Female Genital Mutilation Initiative (TFGMI) have also produced a best practice guide on Communities Tackling FGM in the UK. The guide stresses that ending FGM in the UK requires multi-agency working and that “working with FGM-affected communities is essential to a comprehensive and effective response to FGM” (Khalifa & Brown, 2016: 7).

The TFGMI defines FGM-affected communities as:

“not only women and girls directly affected by or at risk of FGM, but also other people within their social sphere: spouses, children and young people, religious and community leaders, who have all been essential in supporting women affected by FGM” (Khalifa & Brown, 2016: 9)

The guide identifies key principles of approach used in best practice projects to end FGM which work within “holistic frameworks that consider prevention, protection, support and access to care” (Khalifa & Brown, 2016: 14).

Key principles of approach:

- Use a Human Rights Approach – FGM should be placed within a wider context of ‘Violence against Women and Girls’ (VAWG) and the root causes of gender inequality should be addressed.
- Do no harm – Types of harm include presenting FGM and affected communities in negative and judgemental terms, relying on FGM survivors to publicly campaign without providing adequate support for them, the use of graphic images, presenting FGM as practiced by only

one ethnic group or religion, and a poor understanding of safeguarding processes. Non-stigmatising and culturally affirmative approaches which have a good understanding of safeguarding, have a total commitment to reporting identified cases, celebrate change and take the needs of FGM survivors into full account mitigate potential harms.

- Place women and girls at the centre of projects.
- Involve wider stakeholders. (Khalifa & Brown, 2016: 14-17)

The TFGMI outline best practice in engaging women affected by FGM, men, young people, religious leaders in religious settings, schools and newly arrived communities.

House of Commons Home Affairs Committee, Female genital mutilation: abuse unchecked, Ninth Report of Session 2016–17, September 2016

This is the third report (following one in 2014 and one in 2015) on FGM produced by the Home Affairs Committee. It is the result of a roundtable discussion on FGM, held in July 2016, that brought together survivors, grassroots organisations, clinicians, representatives from the criminal justice system and educationalists. It documents positive developments on the issue and areas in need of consideration:

- The report reiterates the difficulty with estimating the numbers of women and girls affected by FGM and advocates for a more reliable methodology to be developed to adequately measure how many are affected in the UK. It also highlights the lack of information on attitudes to FGM and a lack of data on where the procedure is being carried out.
- Since April 2015, clinicians across NHS healthcare settings have been required to record when a patient with FGM is identified as part of clinical examination. This data is sent to the Health and Social Care Information Centre (HSCIC), where the information is anonymised, analysed and published in aggregate form. Despite providing more data on FGM the process has raised concerns from clinicians as the data is gathered without the patients consent and in many cases the data gathered is incomplete.
- In terms of safeguarding bodies, it was noted that there is a lack of joined up work across sectors and in some cases duplication of work. This is compounded by the absence of a central authority to co-ordinate expertise, manage resources and adjust strategy.
- The report advocates (with caution) the implementation of mandatory examinations on children in high-risk cases. This is in place in France and has resulted in a number of prosecutions.

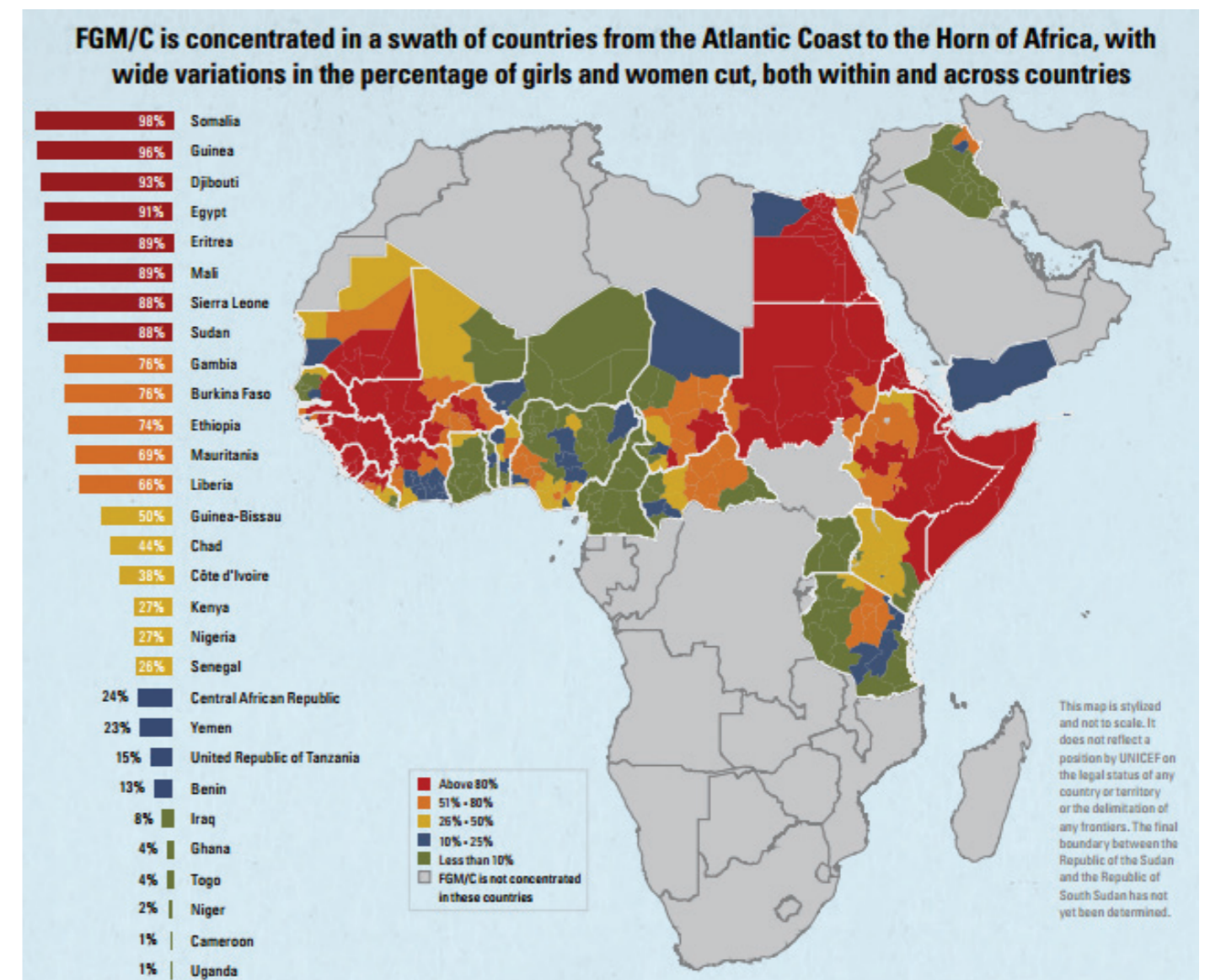


- It is noted that police and border agencies can do more to increase their knowledge of FGM practices and guidance for dealing with potential cases of FGM.
- Personal, Social, Health and Economic (PSHE) education has a key role to play in helping pupils to understand FGM and to keep themselves and others safe. The report recommends compulsory PSHE classes.
- The importance of communities in tackling FGM is noted, but the lack of funding given to community groups was highlighted as a barrier to continuing ongoing work on the issue.
- The report praises mandatory reporting procedures but believes that disciplinary procedures against those who choose not to report are weak and unsatisfactory. In addition, a central Government office to collate data on the mandatory reporting of FGM is needed.
- The lack of successful prosecutions for FGM is a barrier to eradicating FGM. France is cited as a positive example of securing prosecutions. However, we note that the mandatory examinations in France and the number of prosecutions resulted in families waiting until the children were older (past the age of mandatory exams) before taking them abroad so it drove it further underground and thus is not a successful model for long term solutions.
- The report recommends an FGM summit which would convene European leaders and those from 'home' countries practicing FGM. This took place for the first time in 2014.

ESTIMATING DATA

This report sought to provide an estimate of the numbers of women and girls who may have been affected by female genital mutilation (FGM) living in Northern Ireland. However as outlined below, this was not possible. We have however provided information about the prevalence of FGM globally, drawing on reports by the World Health Organisation (WHO) and data published by UNICEF (2013).

Figure 1 - Percentage of girls and women who have undergone FGM in countries of high incidence (UNICEF, 2013).



STOP FGM

A global change movement is gathering pace and a world without FGM seems more realistic than ever - however continued financial support, along with inspired and determined leadership, is needed to achieve long term change - Leyla Hussein, FGM Initiative Advisory Board Member, (Khalifa & Brown 2016).





STAKEHOLDER VIEWS

The most recent data highlighting the percentage of girls and women aged 15-49 years who have undergone FGM/C (by place of residence) has been published by UNICEF (2016). The research team sought to obtain data from the Northern Ireland Census (2011) detailing the number of residents by country of birth resident in Northern Ireland in 2011 alongside the percentages of girls and women aged 15-49 who have undergone FGM from those countries to date. However, we determined that in all but five of the countries concerned the number of people living in Northern Ireland from these countries was less than 100. In addition, we were unable to obtain detailed robust data on immigration since 2011 during the period of our study. Ethically we believe it would be inappropriate to publish data estimating the numbers affected by FGM, particularly as this might lead to individual members of communities affected being identified. We recommend this matter of prevalence await further consideration by the Safeguarding Board² subgroup .

During the timespan of the scoping study (September to December 2016) 15 semi-structured interviews took place with a range of statutory and non-government organisations. (Appendix 1 lists organisations who participated). The study participants were identified in collaboration with ACSONI and referral by stakeholders. Each stakeholder participated in a semi-structured interview which focused on: their organisations experience of working in the area of FGM; services offered; staff training; awareness of good practice; gaps in knowledge or support in relation to FGM.

The findings are presented below under a series of thematic headings.

Prevalence of FGM

None of the interviewees could identify a source for data on the prevalence of FGM in Northern Ireland. Some interviewees suggested a member of medical staff at a hospital in Belfast with a specialist interest in FGM may hold data but this could not be confirmed by the research team.

There were anecdotal reports that midwives have encountered several cases in Northern Ireland.

Of the five refugee support services interviewed all stated that they had not encountered any disclosures relating to FGM.

The NSPCC have a dedicated helpline for FGM. They have received 6-7 calls about FGM in Northern Ireland.

Two interviewees stated that there is suspicion that a “cutter” may operate in Ireland and that FGM is being performed in the north west of Northern Ireland. Another interviewee also stated that there had been “chatter” of there being a “cutter” who moves between Dublin and Belfast. **We stress that both of these are unconfirmed.**

Three voluntary organisations stated that they believe that women and girls are coming into Northern Ireland who have already undergone FGM. These organisations also highlighted that young children are at risk of being taken out of the country to have FGM performed in the families’ home country (two highlighted that this could be taking place during school holidays). One stakeholder representative stated that “Mothers are usually more sympathetic

² The Safeguarding Board for Northern Ireland (SBNI) was established by the Department of Health, Social Services and Public Safety (DHSSPS) in 2012 in recognition of the fact that children are more likely to be protected when agencies work in an all-inclusive, coordinated and consistent way. A subgroup is currently considering FGM matters.



than fathers, the mothers often say ‘because I am suffering I do not want my daughter to suffer’ but the fathers are in the background pushing for FGM”.

Stakeholders expressed serious concern about the lack of data on the prevalence of FGM. This led to assumptions being made that this issue was not being taken seriously by government. The absence of data also contributed to an absence of the development of specific services for those at risk and victims.

Implementation of Guidelines

Stakeholders who were aware of the multi-agency guidelines issued by the Department of Finance in 2014 stated that that had been well received, though one issue identified was whilst the document is very clear in terms of information on cases for girls and young women who are under 18 that there is insufficient information on the options available to women over 18 years of age. Whilst it was evident that the document was warmly welcomed, serious concern was expressed that the guidelines had not been fully distilled down to practice. One interviewee stated that further guidance was needed from the Chief Medical Officer on how the guidelines should be implemented on a day to day basis. Stakeholders were critical of the lack of ownership of the guidelines within central government. It was argued that there was a need for one departmental body to implement the guidelines, audit and monitor incidences of FGM in Northern Ireland. The absence of this was identified as a key barrier to the detection and prevention of FGM in Northern Ireland. As identified by one interviewee “There is no baseline to measure how well the guidelines are being implemented. A robust implementation plan, key actions and performance indicators are needed in order to distil the multi-agency guidelines into practice.”

One statutory organisation considered the risk of failing to adequately implement the guidelines was that government would remain underinformed about FGM. This could also lead to Northern Ireland being viewed as “a soft touch” and as a result Northern Ireland would stand out at international committees such as CEDAW and Children’s Rights as not as advanced as rest of UK.

In summary stakeholders expressed serious concern about the lack of an implementation plan for the multi-agency guidelines and the absence of a departmental body to lead on this. Again, this led to assumptions being made that this issue was not being taken seriously by government.

Reporting FGM Cases / Suspected Cases

In terms of current practice four key points were noted by stakeholders:

1. If a midwife comes across a case of FGM it is noted in the patient’s file and the case is referred to a doctor. No diagrammatic drawing is completed to note the severity or extent. Furthermore, there is nowhere to report the case for monitoring purposes. It was assumed similar procedures of referral existed across the health sector.
2. If a teacher suspects a child is at risk of FGM they have been instructed to make a report to child protection services and then to the education authority.
3. The NSPCC host a helpline for FGM cases. They have an established set of procedures for such calls - if there is an immediate concern the relevant services are alerted, alternately if advice is needed staff are fully trained to provide it. Typically, the calls are from health or education professionals who are unsure of the issues and need confirmation that they have acted appropriately.
4. Refugee support service staff generally reported that they would follow their organisational policy for safeguarding by referring the case to the local safeguarding team in the first instance. Some refugee support services were not aware of the multi-agency guidelines and have not received appropriate training with regard to FGM.

One interviewee argued that the school nurse system could offer screening if properly resourced. The school nurse service is confidential and non-stigmatising. Health visitors have also been identified as having a key role to play as they built relationships with families.

Although social workers have a role to play one interviewee expressed concern about how they are perceived within communities. One interviewee gave the example of a school in England which had had adopted an interventionist approach whereby all girls from affected communities were automatically put on the at-risk register if their mother was a survivor of FGM. This drove the issue underground and resulted in increased barriers between the affected communities and the school.

There is no mandatory reporting procedure to police in Northern Ireland (or in Scotland). One interviewee noted that the emphasis on mandatory reporting and reporting mechanisms in England and Wales was good as it emphasized the need to document all cases. Another interviewee stated that mandatory recording is “imperative so that we have accurate data of the numbers of women affected so that there is some idea of service need”. Whilst there is no positive obligation to report a crime elsewhere in UK, the same interviewee queried if the Northern Ireland Criminal Law Act of 1967 places an obligation on healthcare professionals in



Northern Ireland to report FGM to the police. “This is obviously a crime that would entail a prison sentence for the perpetrator and even though the woman is the victim of the crime, does this piece of legislation override her right to privacy as a crime has obviously been committed? If she says that the crime was committed outside the UK does the same proviso apply?”. However, as discussed in section 2 there are limitations to relying on the Northern Ireland Criminal Law Act of 1967.

One voluntary sector interviewee stated that they do not ask people about FGM because it is such a sensitive topic and they do not wish to further traumatise anyone. They emphasised the need for trust which has been built up over time and for a safe space before FGM could be raised and discussed.

In summary stakeholders identified that recording mechanisms were in place for FGM. However, it is unclear what the outcomes of recording cases was in the health service. In addition, it was noted that not all non-government organisations were aware of guidelines or had access to training. It is important to address this gap in professional knowledge, statutory obligations and processes, and culturally appropriate responses for affected communities.

Training

Interviewees were unclear as to the levels and types of training available for service providers on FGM. It was noted that FGM is part of the undergraduate nursing and midwifery curriculum and it is incorporated as part of safeguarding in pre-registration training. Further awareness training is available from the Clinical Education Centre but this is not mandatory. Whilst midwives are more likely to have specific training it was unclear how many knew how to document cases and what the referral pathway was when cases were detected.

The Royal College of Nursing and the Royal College of Midwives also provide training to the PSNI, the early year’s sector and to the Health Trusts. The NSPCC also participate training sessions with stakeholders such as professional bodies. One stakeholder noted that whilst various opportunities for training were on offer, it was unclear if the training was mandatory, or if the training was only reaching those who were interested in the issue. The Department of Education offer training to the board of governors for schools and the teacher within each school designated for safeguarding. The Border Agency officers have specific training in how to deal with suspected cases of FGM.³

³Border staff are ‘expected to undertake an e-learning course on how to identify women and girls at risk of FGM leaving or returning to the UK and that 2,311 Border Force staff have completed that training. New e-learning for Border Force staff on Modern Slavery also includes a module about FGM’ (HC 390, 2016: 14). This recent report from the House of Commons noted that a more sophisticated understanding of the regional nature of FGM within countries would help police and Border Force officers to better target and engage with at-risk individuals and families. Such an understanding would ‘prevent an overly narrow targeting of flights between the UK and high-prevalence countries which serves to mask the full extent of locations where FGM is practised’ (HC 390, 2016: 15).

A small minority of the organisations interviewed stated that they felt confident that they are well trained and briefed on the subject/issue of FGM in Northern Ireland.

In summary with regards to training, stakeholders identified that specific training was needed in the health sector including equipping staff with the skills to complete accurate diagnostic drawings of FGM. Additionally, training was needed on how to discuss FGM and how to respond to it in a culturally appropriate manner⁴. Training needs to equip professionals with the knowledge and confidence to recognise and comprehensively treat FGM-related problems including how to respond to psychological trauma and complications which may arise during pregnancy or childbirth.

Current Gaps In Service Provision

Several interviewees identified the lack of specialist services for physical or psychological support for survivors of FGM in Northern Ireland as a key problem. Healthcare professionals have no information on the specialist services that they can signpost patients to and one interviewee emphasised that frontline professionals do not know what girls and women need in terms of care and support⁵. Two interviewees stated that they were aware of one or two medical staff who had a special interest in FGM but were unsure what services were offered or the referral pathway. Two interviewees stated that they had been informed that there was a clinic in Germany which offered free treatment regarding de-infibulation.

Several of the interviewees stated that there needs to be more information made available to the communities where FGM is prevalent, to make them aware of the impact and effects on girls and women, as well as the illegalities of the practice in the UK. One organisation suggested that this information should be made widely available when first entering the country. Several interviewees noted that information on FGM needed to be added to the welcome packs for new arrivals to Northern Ireland provided by the NGO Bryson House.

⁴It is important to note that survivors have recounted feelings of distress and further traumatization as a result of the reactions they receive from professionals when they share that they have been subjected to FGM “inappropriate and insulting questions and feelings of shame from being made to feel abnormal” (DoF, 2014: 17)

⁵Examples of organisations that provide holistic women’s mental health and wellbeing services include Holistic Services in Scotland, NESTAC, and the Dahlia Project (Khalifa & Brown, 2016: 59-61).



In summary it is evident from the interviewees that there are significant gaps in terms of service provision for survivors of FGM. Health professionals are unclear what services exist and what is needed by girls and women affected by FGM. The impact of the absence of specialist care could lead to further physical and mental health problems.

In addition, there is a gap in services for communities in terms of raising awareness. Advice from the TFGMI provides clear information on sharing information with newly arrived families and engaging with communities in an effective manner (outlined below) (Khalifa & Brown, 2016: 42).

Culturally appropriate responses

It has been highlighted in the literature (DoF, 2014:7) that FGM is often seen as a “natural and beneficial practice by a loving family who believe that it is in the girl or woman’s best interest” - this has the potential to hinder a girl’s incentive to disclose or raise concerns about it. Some interviewees suspected that there was a lack of knowledge on the ground within affected communities and among some professionals that FGM is illegal in the UK and Ireland and that it is child abuse.

There was a varied response regarding how best to broach and discuss FGM with affected communities and with the wider population. One interviewee stressed that FGM must be presented as a cultural issue, it is not about religion and that such views can be tackled through education. Another interviewee argued that children need to be educated about FGM in creative ways, noting that examples of good practice were identifiable elsewhere in the UK. The Department of Education stated that they regard this matter as highly sensitive and were reluctant to provide cultural education on FGM as it could alienate affected communities.

It was also noted by another interviewee, that whilst FGM is a human rights violation and must be addressed and prevented, they felt that existing public campaigns in the UK unfairly targeted Muslims. They also perceived that work with affected communities would be more effective than a public campaign which has the potential for driving the issue underground. Another interviewee argued that we are oversensitive to cultural issues in Northern Ireland and are more willing to be accepting of different practices because of the contentious history of culture and tradition in Northern Ireland.

Stakeholders identified that whilst community groups are trying to lead on this issue, an absence of resources restricted their efforts. It was argued that it is vital that statutory agencies support initiatives to enable these communities to raise awareness of FGM.

The TFGMI provides a clear approach in engaging with communities on FGM. It defines prevention as ‘a shift in the attitudes and behaviours that continue to allow the practice of FGM to continue’ (Khalifa & Brown, 2016: 18). Several proxy indicators are identified to assess if such shifts are taking place, including if communities:

- Are more aware of reasons to end FGM;
- Demonstrate declining support for any form of FGM;
- Are skilled and confident to speak out against FGM; and
- Reject FGM on the basis that it is a violation of children and women’s rights (Khalifa & Brown, 2016:18).

The TFGMI identify several general prevention considerations including:

- The need to explore and understand the rationales for FGM at the start of any intervention as support can take many forms with different and evolving justifications
- Rights based arguments work best as they address underlying justifications and enable wider conversations on safety, protection and rights for girls and women.
- Coordinated and comprehensive interventions where ‘community-based prevention, statutory responses for safeguarding and detecting cases of risk, and linking women into care, have worked best (Khalifa & Brown, 2016: 19).

The TFGMI identify the voices of community champions as the driver of change in FGM campaigns. Stakeholders noted that this was happening on an ad-hoc basis within communities, by volunteers. Women’s group attached to NICRAS, NICEM and other NGOs as well as stand-alone groups could provide a vehicle for a community based preventative approach⁶.

The recent House of Commons report notes that within the UK NGOs rely heavily on their own resources, with little support from government and are thus hampered in terms of impact. The report states that ‘there is no doubt about the Government’s willingness to confront this abuse but unless sufficient resources are provided to those groups who work and campaign within the communities where FGM is practised, efforts to prevent it will be in vain’ (HC 390, 2016: 17). From the analysis of stakeholder responses, it appears that this situation also applies to Northern Ireland at present.

⁶Examples of CBOs that work with newly arrived communities include:

- Bolton Solidarity Community Association – deliver FGM workshops to newly arrived in partnership with their local Refugee Resettlement Team
- BAWSO (Wales) – embed questions around migration history in assessments of new clients and run coffee mornings during which project workers will slowly bring up FGM
- BWHFS – developed a welcome pack for new arrived migrants which provides information about FGM, provide the welcome pack in several languages, undertake extensive outreach and offer one-to-one support for individual women (Khalifa & Brown, 2016: 41-42)



In summary it is evident from the interviews that there was consensus that engagement with communities was needed and that it must be done in a culturally sensitive manner. The key determinant of this engagement was resources for the affected communities. The TFGMI have provided clear guidelines on initiatives which could be adopted in Northern Ireland. The role of community champions is key – this should be persons from the affected communities who should be provided with resources and support to engage with communities directly.



COMMUNITY VIEWS

The first part of this research focused on the services and resources that exist for those who have experienced or are at risk of FGM. Whilst this provides a basis for evaluating progress made on the issue in Northern Ireland, core to our understanding is the experiences and perspectives of those women.

The second stage of the research involved a focus group with 19 women whose countries of origin included Somalia, Sudan, and Iran. The women who attended the focus group are involved in community development and some have campaigned on the issue of FGM. This focus group was led by an expert facilitator, Saria Khalifa, who works with the ROSA foundation in Britain on FGM issues.

This part of the study reports on the findings from this focus group. Due to the short nature of the scoping study, the sample size is not large enough to provide comprehensive findings but rather provides a flavour of the issues surrounding FGM for women in Northern Ireland. Many of the issues reported in the focus group are reflective of issues presented in current literature and policy papers.

The culture of FGM

“They see it as a cultural practice. They see it as a favour for their daughters and if they don’t do it they won’t marry their daughters. That’s how they see it. They see it as a good thing for the community and a good thing for the children. That’s how our community sees it.”

Women participating in the focus group noted that they all knew FGM was part of their culture even though they rarely spoke about it within their families. Reasons for FGM were stated as ‘protecting honour’, ‘ensuring a daughter would get married’ and ‘control of sexuality’. Many women only realise when they are older that this creates physical and mental health complications. Whilst the women participating in the group stated they would not have FGM performed on their own daughters, they knew of others who did so despite knowing the dangers, indicating the strength of cultural norms.

Participants stated that men are often in favour of FGM as they have little awareness of the damage that it brings to women. They believed that a combination of awareness education and enforcement of the law were needed to change cultural practices surrounding FGM.



Safe space to speak

“There is nothing. I can speak for my community, me and [Participant #1] has been campaigning for the last 2 years. I’ve been living [the] last 3 years in Belfast and she’s been living [here] last 6 years and we feel like there’s nothing here for us. There is no place that we can meet and talk about our experience.”

Part of the cultural shift needed to eradicate FGM needs to take place from the bottom up, from women themselves who have been affected by FGM. Providing spaces for women to share experiences, perspectives, knowledge and strategies is crucial to break down societal stigma around the open discussion of sensitive bodily issues such as FGM. Such discussion can also empower women to challenge practices within their own communities and become agents for change. Also education and awareness raising will be most successful coming from within communities themselves rather than seen as being ‘imposed’ by outsiders. However, to be agents for change women need support and opportunities to articulate their own experience.

Support from statutory agencies

“Now as an interpreter I work for the Trust. Now they are aware. The woman, let’s say she’s pregnant and going to have a girl, they’ll tell her about FGM and that it’s illegal, things like that and whenever she has a baby, let’s say a girl; they will tell her before they discharge her from the hospital. The midwife or the nurse will tell her about FGM; the rules, the regulations here. So you can see now they are practising...even better, it’s getting better, it’s just that they could do more.”

Whilst participants highlighted that practitioner knowledge and safe-guarding is improving, they also felt that there are gaps in awareness of FGM and in service provision for women who have experienced FGM. Participants perceived that often health professionals wanted to help women but there was a limit to how much help they could provide or that initiatives began with good intentions and then peter out.

Language and cultural barriers were mentioned several times as impediments to open discussions and that trust and empathy (along with the practical issue of translation) are key to engaging with women on the topic of FGM.

Response of statutory agencies

“Other families who live outside Belfast...the lady had a baby and she came from Europe as well. She moved from Holland; she was not from Africa and the children [were] born in Holland, Netherlands and what they did, when they saw the mum had FGM they referred her to Social Services, next day she had Social Services at her door. That’s why people make them afraid and they forced that woman to show her children’s...to see if they had FGM or not; Although she had a certificate, she attended FGM awareness from the Netherlands and she told them, it’s only me; my children never been outside the country, they never been cut but they force that woman to the point where she was so afraid to give them permission to check the children. You know there’s a limit to awareness as well.”

Whilst response to suspected FGM is to be welcomed, and is necessary in terms of safeguarding children and young people, participants did note that over-response on occasion could risk alienating communities. Two experiences in particular were articulated as creating fear in women that if they spoke out on FGM they would put their own family at risk of being investigated. This in particular creates issues around building trust between communities and statutory agencies to tackle FGM before it takes place.

In summary the focus group participants noted that FGM needs to be challenged through cultural and legal ends. Communities need support and safe spaces to challenge cultural norms. It was noted that statutory services were improving in how they responded to FGM but that this was not comprehensive and more needed to be done.



CONCLUSIONS AND RECOMMENDATIONS

The purpose of this scoping study was to provide an evidence based review into FGM within the context of Northern Ireland. It further sought to identify key issues which would inform the design of a wider research project. The research team sought to identify data relating to the numbers of women and girls affected by FGM, to identify service provision and to provide an overview of the awareness and knowledge of FGM by statutory bodies in Northern Ireland.

The study has identified a series of key issues:

1. Stakeholders expressed serious concern about the **lack of data on the prevalence of FGM**. This led to assumptions being made that this issue was not being taken seriously by government. The absence of data also led to a lack of development of specific services for those at risk and victims.
2. Stakeholders expressed serious concern about the **lack of an implementation plan for the multi-agency guidelines** and the absence of a departmental body to lead on this. Again, this led to assumptions being made that this issue was not being taken seriously by government.
3. Stakeholders identified that **reporting mechanisms** were in place for FGM in some statutory bodies. However, it is unclear what the outcomes of recording cases were in the health service. In addition, it was noted that not all non-government organisations were aware of guidelines or had access to training. It is important to address this gap in professional knowledge, statutory obligations and processes, and culturally appropriate responses for affected communities.
4. With regards to training, stakeholders identified that **specific training was needed in the health sector** including equipping staff with the skills to complete accurate diagnostic drawings. Additionally, **training was needed on how to discuss FGM and how to respond to it in a culturally appropriate manner**. Training needs to equip professionals with the knowledge and confidence to recognise and comprehensively treat FGM-related problems including how to respond to psychological trauma and complications which may arise during pregnancy or childbirth.
5. It is evident from the interviews that there **are significant gaps in terms of service provision** for survivors of FGM. Health professionals are unclear what services exist and what is needed by girls and women affected by FGM. The impact of the absence of specialist care could lead to further physical and mental health problems.

6. In addition, there is **a gap in services for communities in terms of raising awareness**. Advice from the TFGMI provides clear information on how sharing information with newly arrived families and engaging with communities in an effective manner (Khalifa & Brown, 2016:42).
7. It is evident from the interviews that there was consensus that **engagement with communities was needed and that it must be done in a culturally sensitive manner**. The key determinant of this engagement was resources for the affected communities. The TFGMI have provided clear guidelines on initiatives which could be adopted in Northern Ireland. The role of community champions is key – this should be persons from the affected communities who should be provided with resources and support to engage with communities directly.
8. In relation to the communities affected, focus group participants noted that both cultural and legal approaches to challenging FGM were needed.
9. Focus group participants also stated that those engaging with communities needed adequate resources, concurring with the views of stakeholders.
10. The focus group participants also noted that statutory services were improving in their response to FGM but that this was not comprehensive. Again this concurs with the views of stakeholder interviews.

The issues above highlight a number of concerns regarding FGM in Northern Ireland. Of note is the work of the Safeguarding Board's FGM subgroup, which is currently focusing its efforts on three areas of work:

- Pathways – this focuses on referral pathways for victims/ survivors in relation to post trauma issues and children / those at risk.
- Community development – this focuses on how to engage with communities.
- Data collection – this considers how existing systems can gather data and what other models exist.

It is expected that the findings of the subgroup will be reported on later in 2017. It is not yet clear to what extent these will address the concerns raised by stakeholders. As outlined in this report it is evident that much remains to be done to address FGM and service provision issues in Northern Ireland.



Recommendations

To complement the issues raised above, the research team has identified a set of over-arching recommendations:

1. The need for a human rights based, 'do no harm' approach with affected communities at the centre of all emerging policy and practice guidelines. A clear commitment is needed that all communities in Northern Ireland need equal protection including those affected by FGM.
2. An implementation plan for the multi-agency guidelines is required.
3. The need for a more cohesive and comprehensive data collection strategy among all statutory and voluntary sector organisations. We await the data collection subgroup plan on how best to ascertain the prevalence of FGM in Northern Ireland, incorporating both survivors and those at risk.
4. The need to develop a regional multi-agency awareness raising and training strategy. It would seem appropriate that all statutory and non-statutory professionals with safeguarding and child protection duties should undergo a uniform training programme. This does not need to be resource intensive – existing DVD and e-learning materials can be used. Additional training must be provided to those with a medical remit. (We note that since fieldwork was undertaken the SBNI facilitated a 2-day training course, attended by a number of different agencies, regarding the roll out of multi-agency training on FGM. As part of the course, there is an undertaking to deliver multi agency training within each respective organisation over the next 18 months).
5. A more detailed understanding of professionals' awareness and views around the issue of FGM is required.
6. The focus of protection, support and care needs to include not only those girls and young women at risk of undergoing of FGM but also survivors of FGM. While the estimated number of FGM survivors in Northern Ireland is at this stage unknown and may not warrant a specialised clinic, it is essential that health care and support professionals have clear referral pathways which look after the persons physical and psychological needs.
7. Engagement with communities should be conducted in a culturally sensitive manner and community champions are central to this. Community champions should be from the affected communities and should be provided with appropriate resources and support to enable effective programme delivery.

END FGM





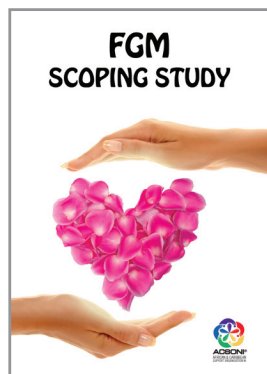
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APPENDIX

LIST OF PARTICIPATING ORGANISATIONS

- ACSONI (African and Caribbean Support Organisation Northern Ireland)
- Barnardo's N.I.
- UK Border Agency
- British Red Cross
- Department of Education
- Department of Finance
- Extern
- NICEM (Northern Ireland Council for Ethnic Minorities)
- NICRAS (Northern Ireland Community for Refugees and Asylum Seekers)
- NSPCC (National Society for the Prevention of Cruelty to Children)
- PSNI (Policing Service of Northern Ireland)
- Royal College of Midwives (Northern Ireland)
- Royal College of Nursing (Northern Ireland)
- Royal College of Nursing (UK)
- Safeguarding Board
- Rosa Foundation United Kingdom



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