*Opcit Research

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MOPAC FGM Pilot Project

Literature Review of existing research on FGM and effective preventative practice

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

Terminology and national context

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

There is debate in the literature about the most appropriate or culturally competent (Baillot *et al*, 2014: 37) terminology to use in relation to the practice. Dustin and Davies (2007: 4) note that female genital mutilation came to replace 'female circumcision' as a term which could convey the damage done to women. The authors, however, advocate for 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: 25) 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; the author favours FGC as a so-called non-politicised description of the practice.

Whilst 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 2410 women seeking asylum in the UK in 2011. More than 20% of women seeking asylum in the UK from 2008-2011 were from FGM-practising countries (UNHCR, 2013).

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

- **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: 33). Regional and cultural diversity in the practice of FGM means that approaches should be tailored to particular communities in a culturally informed way, and use appropriate tools, including from the country of origin where possible and suitable (Baillot *et al*, 2014: 42). This includes developing an understanding of any culturally-specific reasoning for the FGM performed and its importance from the perspective of those who

practise it, so that agencies are able to better help families resist the practice (Dustin and Davies, 2007: 6).

This requires 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) reflect that, 'women who are unable to communicate with professionals find the service remote, confusing and, at times of stress such as birth, quite frightening, while midwives who are unable to communicate effectively with them fall back on the use of cultural stereotypes and distancing behaviour'. The authors note that many Somali women perceived that Westerners had both a lack of understanding and negative attitudes towards women who had undergone FGM, creating the potential for misunderstanding and poor clinical outcomes for these women. This perception of a lack of support served to reinforce a sense of isolation and fear amongst these women, particularly for those suffering other forms of trauma, such as forced migration (ibid).

Similarly, scholars point to the risk of inducing feelings of shame if health care providers react with shock in an initial examination; again, a risk which could be mitigated with training (Monahan, 2007: 31). An awareness to how language is used (this 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: 26). Therefore, practitioners should recognise and manage their reactions to unfamiliar cultural practices and minimise discomfort to create a safe and confidential environment for women and girls (Costello *et al*, 2015: 1269). The importance of finding ways to build rapport with women and girls has been stressed (Dawson *et al*, 2015: 210).

- **A victim-centred approach**

A clear advocacy can be found 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: 40) argue, adopting this approach – in contrast to, for example, one which treats affected women as complicit offenders (Goodey, 2004: 32) - can help to ensure a gender-sensitive and victim-centred approach to reporting, investigating, and prosecuting FGM (see also, Options UK, 2011). This is similar to the evolution in approach adopted in relation to victims of sex trafficking, who may face a similar range of barriers to accessing help, prejudice as members of immigrant communities, and practical problems such as a language barrier.

Trafficked women are not prioritised as 'innocent' and 'deserving' victims by criminal justice agencies in comparison to other victim categories that fulfil such stereotypes, and are often seen as complicit in their exploitation (Goodey, 2004: 33). This may be a factor to consider in interactions with women who have undergone FGM in relation to discussing the potential for risk to their daughters: 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: 40), without creating an environment which stigmatises, much less criminalises, women who have undergone FGM and risks driving the practice underground (Antonazzo, 2013: 477, Monahan, 2007: 28).

It should be noted here, as Goodey argues in relation to trafficking for sexual exploitation, that recognising 'victimhood' is not to construct a one-dimensional and powerless victim, but rather, 'recognition of the individual's status as a victim, as a result of a criminal offence, is desirable as long as it affords certain rights and other practical provisions' (Goodey, 2004: 34). This is supported by Kelly, 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: 11). This ties back into 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, empowering 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.

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

Hospital and/or medical records contain information about FGM and can contribute to the development of a comprehensive picture of FGM prevalence in the UK. However, limitations exist in relation to data collection and evaluation of this information, notably with potential under-recording due to the lack of knowledge of FGM among health professionals to

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

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

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

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

Moreover, Costello e*t al* (2015: 1261) advocate for four key areas of competence towards which social workers should work: FGM practices, prevalence and harms; the cultural

complexities and social bases of cutting girl children; effective international prevention strategies and programmes; and culturally respectful strategies to engage sensitively with children considered at risk of being cut, women who have been cut and their communities. Scholars therefore set out a role for social workers, which encompasses a strong working knowledge of FGM and prevention tools, alongside a culturally informed and sensitive engagement approach.

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

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

Baillot *et al* (2014: 40) also advocate for FGM to 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 key 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; stressing also that effective multi-agency working and a holistic approach to service provision is essential to protection and prevention efforts. However, this literature points to existing barriers (cultural, linguistic, stigma-related or service provision-related barriers) to establishing such best practice outcomes and highlights a lack of best practice seeking to overcome such barriers. As such, the MOPAC FGM pilot will contribute to a greater understanding about the impact of proactive information sharing between different agencies, such as maternity services and social care; about how social work responses can be made more effective and proportionate in terms of identification and action taken; and about more effective and informed heath and social care practice with victims or potentially affected individuals.

Engagement beyond the clinical setting

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

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: 212) note that the involvement of men is important both because men can also experience FGM-related complications both personally and in relation to their partners' suffering, and because they may be central to a decision about FGM for their daughters or 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: 3) argue, women aged over 50 who have had FGM themselves are also likely to exert pressure to continue the practice among their younger family members; three fifths 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: 9), who cite evidence that in 16% of cases where FGM has taken place, either one of the parents may have opposed FGM but the decision is overridden by family elders or community leaders. Monaghan (2007: 33)

advocates 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: 1270) 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: 45) assert, 'without a genuine and effective commitment to the participation of affected communities in work on this issue, not only will we fail to understand the true levels of potential risk faced by women and girls... we will run the risk of further marginalising the community voices that are the most effective advocates for change'. Work with community groups is therefore of central importance in identifying local needs, tailoring solutions and helping to deliver safeguarding efforts, although progress needs to be made on better resourcing and meaningful inclusion (ibid).

Evidence from surveyed literature demonstrates that this work with potentially-affected communities can be bolstered by engagement with schools and with community/campaigning groups, all of which can play a role in prevention and protection. Baillot *et al* (2014: 29) quote an NGO worker reflecting that, 'I know myself of children who have been identified by nursery or classroom assistants...Schools can play a role in identifying girls', although 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: 12) assert the importance of prevention programmes in schools, arguing that teachers need to become familiar with the language used to describe FGM and behaviour indicative of FGM, such as long periods in the toilet and school absences.

Availability of evidence and link to the MOPAC FGM Pilot

A wide-ranging online search was conducted to draw together existing peer-reviewed literature related to work with FGM victims. This was conducted using Google Scholar and university library databases, with a focus on academic publications focused on, for instance, social care, women's health 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 in order 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 impact of legislation/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 context (for instance, Australia), 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 (see 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.

As such, the MOPAC project addresses a gap in knowledge and practice; working with mothers and with communities more widely, in a multi-agency and collaborative manner to both support women who have been cut (a victim-centred approach) and prevent girls from undergoing the practice.

SUMMARY

To summarise, the literature surveyed highlighted the following *must haves* and *should haves* which may be considered in relation to the MOPAC project:

- **Health, social care and other relevant professionals** are key in 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 pivotal role of maternity services in recording FGM cases, prevention and protection.
    - **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 reactions.
- Effective and meaningful **engagement with key 'stakeholders'** is vital to prevention efforts; including community/grassroots groups, men from FGM-affected communities, religious leaders, other relevant professionals such as teachers who have regular and ongoing contact with young people.

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