People who tackle FGM need support; how can we reduce burden and support them?

'We carry this trauma'

Churchill Fellowship Report

Astrid Fairclough
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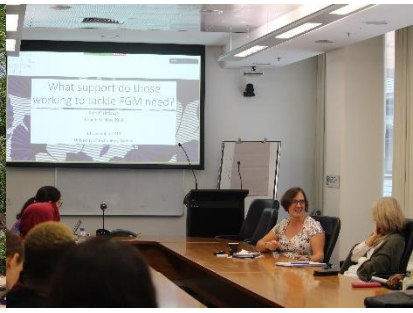

What is FGM?

FGM refers to all procedures involving partial or total removal of the external female genitalia or other injury the female genital organs for non-medical reasons. It is a deeply entrenched social and cultural norm in many places.

The practice can cause short- and long-term health complications, including chronic pain, infections, increased risk of HIV transmission, anxiety and depression, birth complications, infertility and, in the worst cases, death. It is internationally recognized as an extreme violation of the rights of women and girls.

FGM violates human rights principles and standards – including the principles of equality and non-discrimination on the basis of sex, the right to freedom from torture or cruel, inhuman or degrading punishment, the right to the highest attainable standard of health, the rights of the child, and the right to physical and mental integrity, and even the right to life.

Medical Classification of Types of FGM

Female genital mutilation is classified into 4 major types.

- Type 1: this is the partial or total removal of the clitoral glans (the external and visible part of the clitoris, which is a sensitive part of the female genitals), and/or the prepuce/ clitoral hood (the fold of skin surrounding the clitoral glans).
- Type 2: this is the partial or total removal of the clitoral glans and the labia minora (the inner folds of the vulva), with or without removal of the labia majora (the outer folds of skin of the vulva).
- Type 3: Also known as infibulation, this is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoral prepuce/clitoral hood and glans (Type I FGM).
- Type 4: This includes all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

Deinfibulation refers to the practice of cutting open the sealed vaginal opening of a woman who has been infibulated, which is often necessary for improving health and well-being as well as to allow intercourse or to facilitate childbirth.

Definitions taken from United Nations Population Fund and World Health Organisation

https://www.unfpa.org/female-genital-mutilation
https://www.who.int/en/news-room/fact-sheets/detail/female-genital-mutilation

Photos on front page; meeting women in Ortum maternity home, at Giza pyramids, looking towards Aberdeen Bay in Freetown, Sierra Leone, and at the University of Technology Sydney, talking about my research.

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Annexes

Summary report

A summary of my Fellowship report is also available at:

https://www.wcmt.org.uk/fellows/reports/fgm-how-healthcare-professionals-affected-communities-are-supported

Table of Additional Contents

Within the report are included stories, case studies and in-depth analysis relating to topics associated with the research, but additional to it.

Several of these reflections are adapted from the blogs I posted as I was abroad, about research and experiences travelling. They provide a more personal account of my Fellowship, and more stories can be seen online.

Acknowledgements

In mid-2018, I got a phone call on a workday a little after 10am from my brother, Julian. This was unexpected, but he said:

'Astrid, I think you should listen again to Women's Hour, there's summat on it which is your kind of thing'.

Rarely have I received an unexpected phone call which led to a more profound impact on my life.

So, my very first thanks go to Julian, to BBC Radio 4's Women's Hour and the absolutely amazing Winston Churchill Memorial Trust who entrusted me with a Fellowship. I hope I can continue to cherish and enjoy it for many years to come. I am in awe at how Fellowships enrich UK life.

The way my journey to a Fellowship started set the tone to come. Unexpected became the norm, profound became almost expected. Across the globe I met so many incredible people who are part of the movement to End FGM. Thank you to everyone who gave their time, insight and honesty. My ideas would be nothing without you.

There was a long period of preparation, and I received so much help before the plane took off, whilst I was travelling, and since. Thank you to just a few colleagues and friends, the brilliant Janet Fyle Royal College of Midwives, Janice Rymer Royal College of Obstetrics and Gynaecology, Lorren Stainton and Deqa Dirie NHS England, Dorian Kennedy, Mark Davies and Helen Steele at Department of Health and Social Care for encouraging me through the early stages, Jane Miller DfID helping from afar in Tanzania, Leyla Hussein, Lisa Zimmerman, Gill Squires, Cath Holland, Jennifer Bourne, Juliet Albert and Trish Dyter, Yana Richens, Jacqui Hunt for saying exactly what I didn't realise I needed to hear at just the right moment, and Joey Buckley, 'officially' NHSE but also with a wider remit covering caffeine and other refreshments.

My friends, new and old, south east and south west, and further afield. Those of you who understood what I was doing, and those who I think may have been baffled, but supported me nonetheless. Your collective support has been absolutely incredible. I can name but a few, Jenny, Johanna, Jess and Laura, Ian and Richard, Catherine, Isabel and the Sevenoaks band, the SSRC rowing crew, then since returning Renee, Audrey and Ben, I really could carry on.

To the Wessex Care Records programme and partners, thank you so much for accepting me with my wider passion in tow. I still think it was too much to expect you to support me in this, yet you have in spades. Thank you so much to NHS Dorset, my employer, for the extra time I was given to travel, and for the recognition that we are part of a wider NHS family.

Last but not least, thank you to my glorious and numerous family, my cousins, aunts and uncles, Ruby and George, the ever-kind Johns' Swanage contingent who unexpectedly dealt with all manner of wobbles, my sister-in-law Lizzie, my darling brother Julian and my long-suffering parents, John and Bobbie, at which point words fail me.

It takes a village to raise a child. It took nearly half the UK to support this Churchill Fellow.

Thank you.

Executive Summary

The challenge: Ending female genital mutilation (FGM) is a global and ferocious challenge. It is so important that we succeed, but the work is difficult and complex.

If FGM stops tomorrow, millions of survivors will still need care and support to address either physical or emotional consequences. The NHS is likely to need healthcare professionals to care for women living with the mental and physical consequences for the next 50 years and more. And FGM is not going to stop tomorrow. With a huge increase in effort, we can hope to End FGM globally by 2030.

In the UK, the efforts to safeguard girls and provide high quality healthcare services greatly increased in scale and ambition in 2014 following The Girl Summit, an international conference dedicated to eradicating FGM and child and early marriage. The awareness and understanding of matters relating to FGM by healthcare professionals has transformed, but this has not resulted in consistent services across the NHS. In 2019, the work was moving into 'business as usual', but the challenge was if this was happening in a sustainable way, which would truly lead to us ending FGM.

Five years on from the Girl Summit, difficult and often uninformed questions were starting to emerge; the undertone was 'hasn't this been sorted out yet?'. Bias, unconscious perhaps, has always challenged services supporting black and minority ethnic (BME) women.

At the same time, survivors and professionals were struggling to continue with the work and finding it difficult to cope. Experts were leaving the End FGM movement, and their experience was missed. There are more than 17,000 employees working in the NHS, who come from FGM affected communities. There may be between 3,700-4,100 survivors also employed by the NHS. There is no reason to believe that only these people are affected, though there is an argument to consider if they are affected differently.

The research: The aim was to develop recommendations to help to transition to the long term service provision needed to help the NHS to better support the efforts to End FGM, and to support those who will deliver this work. It became clear early on that due to the interdependencies between the work in the NHS and with the wider End FGM movement, the recommendations would have a wider scope than applying to just the health service.

I visited 4 countries, interviewing a diverse group, including healthcare professionals, charity and non-governmental organisation (NGO) employees, activists and campaigners, those representing international aid agencies within the United National (UN) System, government bodies and partners.

Kenya: With a whole system approach in place, I saw how projects are gradually changing the views of those who support FGM, but also heard about the toll that this work takes on those involved.

Egypt: The complexity of medicalisation (FGM happening in a healthcare setting and by a healthcare worker) and an inconsistent/partial effort to End FGM was evidenced, as well as the strain that this creates.

Sierra Leone: In an environment where there is still vocal support for FGM, I learnt about how difficult it is to make progress when there is no clear Government support to End FGM, and how confusing this can be for the people involved.

Australia: Facing a similar challenge to the UK in terms of prevalence of FGM, and with a similar health service, this visit gave an insight into how different strategic directions lead to a very different feel to the End FGM work.

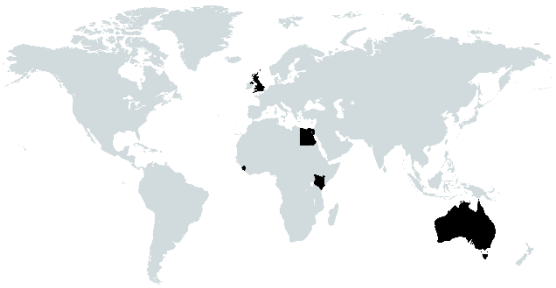

Figure 1: Map with countries visited and UK highlighted.

Returning to the NHS: The report provides sample NHS Action Plans for both national and local teams with practical ideas of how to adopt the learning from this research.

Conclusion: Healthcare professionals and other people involved in the work to End FGM find that they face professional and personal burdens as a result of their involvement.

End FGM programmes and employers have to provide support to address these burdens. There is also evidence to suggest that if support is provided, people will be more likely to continue with the work, keeping experience and expertise within the movement, therefore strengthening it.

There is also evidence that the burden is exacerbated by issues within the movement itself. Some of the burden is caused because supporting women with FGM and working to protect girls is difficult; this is largely unavoidable but can be addressed.

The other elements of the burden are caused by avoidable factors. With improvements in strategy and delivery, this load can be significantly reduced or removed.

Many contributors recognised how the support they received from their peers was the thing which made the most practical difference to them. Without fail, when asked what motivates them, they said that they think about the girls who are saved from this violent and meaningless abuse. By strengthening and facilitating the network and peer support mechanisms; the vibrant, diverse and resilient End FGM movement can learn to support and sustain itself. By making sure that we can see progress and talk about it, the movement will also provide motivation to carry on, remained centred and focused on the young girls who rely on us for protection.

The 10 findings and recommendations

1 People who work to End FGM face personal and professional burdens as a result.
……so we need to provide help and support and reduce this burden as much as possible.

2 An End FGM change programme works better when all aspects of society and Government are involved, using a whole system approach.
……so we need to make sure all stakeholders are involved and active.

3 FGM is a persistent gender inequality as much as gender-based violence and needs to be tackled as such.
And 4 The message must stay 'End FGM'; anything else will slow us down.
…… so we should carry this message and work with everyone to support the End FGM message, not alternatives.

5 To change the view of someone who supports FGM is difficult.
……so we need adopt an approach which targets the specific views they hold, whilst recognising that those involved in the work need to understand how difficult this can be.

6 End FGM networks often face difficulties in being sustainable and effective.
……but we need to overcome this, as they are essential support networks.

7 The End FGM movement has previously struggled to bring new people on board and to maintain momentum.
……but we need to find ways to do this, because the movement needs more people involved to spread the burden.

8 Where the 'third sector' is recognised as a profession, whose skills and capabilities receive investment, the outcomes are greater.
……so we need to find this investment and provide this support.

9 Projects often face financial instability; this leads to many consequences and distracts from the purpose to End FGM.
……so we need to introduce measures to reduce the instabilities.

10 Evaluation and evidence of what works is still lacking; this hinders working together and much more.
……so we have to work together to overcome this and can try different ideas to work together.

Acronyms

AIM	Amazonian Initiative Movement
ARC	Alexandria Regional Centre
ARP	Alternative Rites of Passage
BPSU	British Paediatric Surveillance Unit
CBO	Community Based Organisations
CCG	Clinical Commissioning Group
CICR	Centre of Indigenous Child Rights
CPS	Crown Prosecution Service
CSO	Civil Society Organisation
DHSC	Department of Health and Social Care
FARREP	Family and Reproductive Rights Education Program
FGM	Female genital mutilation
FIGO	The International Federation of Gynaecology and Obstetrics
GE-SL	Girlz Empowered-SL
HCP	Healthcare professional
LGA	Local Government Association
MoH	Ministry of Health
NEFTA	National Educational Toolkit for Female Genital Mutilation / Cutting Awareness
NSW	New South Wales
NGO	Non-Governmental Organisation
PPH	Post-Partum Haemorrhage
RCM	Royal College of Midwives
RCPCH	Royal College of Paediatrics and Child Health
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UTS	University of Technology Sydney
WCMT	Winston Churchill Memorial Trust
WHO	World Health Organisation

How did this project come to be?

In 2013, I was asked by the Department of Health and Social Care (DHSC) to carry out a study to consider what the NHS could do in terms of collecting and sharing information, to better support the work to End FGM. From then until early 2019, I led the FGM Prevention programme on behalf of the DHSC and delivered a national change programme across the NHS.

In the Prevention programme, we introduced many changes. This included making all NHS services collect and submit data about patients who had FGM, introducing systems to safeguard girls against FGM and kick starting a national awareness drive so healthcare professionals working across England would know about FGM.

There were many areas we knew we did not have the capacity or resource to take forward, and one of these which stood out for me. What about the midwives, nurses, and doctors who themselves have had FGM, or for whom their families or friends were personally affected; were they affected by treating women with FGM?

The NHS Long Term Plan states 'The performance of any healthcare system ultimately depends on its people – the NHS is no exception.'[1]. Our people are central to the NHS, yet to my knowledge, I believe that this is the first report to consider the needs of the workforce supporting women and girls with FGM.

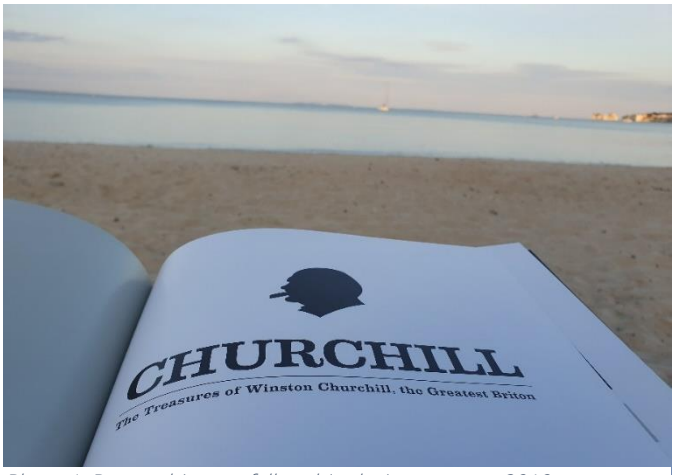

Photo 1: Researching my fellowship during summer 2019.

Working in England, I saw many professionals telling us their own stories, and I could see the toll this had on them. I would hear rumours, followed up but never substantiated, about families wanting to be treated by a midwife from the same community as them, with an expectation that they could pressurise her to keep secrets for them. The NHS workforce is made up of the UK population. The logic follows, if in the London Borough of Southwark, approximately 5% of women have had FGM, then of the healthcare professionals living in the borough, a similar proportion may have had FGM themselves.

Should a healthcare professional who has had FGM have to disclose this to her employer? No. Should they face additional pressure from patients and families because they have a shared cultural identity? No. More importantly, if they themselves are a survivor, are they OK to treat and support others? We know that flashbacks can be a long term consequence of FGM. We also know the emotional consequences on relationships with a survivor's parents and other family members may be very complex.

[1] NHS England, (2019). The NHS Long Term Plan, (*Section 4.1)* https://www.longtermplan.nhs.uk/online-version/chapter-4-nhs-staff-will-get-the-backing-they-need/

We tried to talk to people, professionals and community members about all these things. It was difficult and was a conversation without any precedent, as far as we knew.

Photo 2: A short break in Kenya in the Eldoret hills on the way back to Nairobi gave chance for a rest.

There are other difficult questions I think we should explore. I saw colleagues, both from FGM affected communities and those who were not, who had to step away from the work, because they found it too difficult to carry on. With support, could we keep them involved? But does everyone in the workforce agree that FGM should end? Do we assume that, if practising in the UK, professionals will agree with the policies adopted nationally? What about men?

I also worked in the policy team in relation to domestic abuse, and would often discuss how to support healthcare professionals who experienced domestic abuse, recognising not only the duty of care as an employer but the link to the professional's ability to then also give the best quality care he/she can offer. There is a recognised link here; why not in relation to FGM?

In wanting to explore this issue, I think that because there are only a small number of patients with FGM in the UK, therefore relatively few healthcare professionals deliver this. It is difficult to gain traction. In 2018-19, 118 NHS Trusts submitted information about patients with FGM that they had treated. But of these organisations, 77 had treated a total of 20 women or fewer in the year[2]. But my experience is that often people underestimate the numbers and scale of FGM in the UK. The population of women with FGM is small, but that does not mean insignificant or unimportant, as are the healthcare professionals supporting them. Analysis presented in the introduction goes some way to demonstrating the need to support the NHS workforce.

When I heard about the opportunity to travel as part of a Churchill Fellowship, I wanted to apply to consider this topic. I already knew that it was difficult to discuss this issue in the UK, but I hoped that by travelling overseas, I could learn from healthcare professionals treating many more women with FGM. If so, I wanted to bring lessons back to the NHS.

[2] NHS Digital (2019). Female Genital Mutilation (FGM) - April 2018 to March 2019, Annual Report, Experimental Statistics Report https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/april-2018---march-2019

Fellowship objectives

My objectives developed over the course of my research. Initially, I focused on making recommendations to change the work of the NHS to better support healthcare professionals involved in the work to tackle FGM, and therefore the End FGM movement itself. However, I identified early in my research that there was opportunity to consider a wider scope, and that there was also logical reason to do so.

It became clear early on that the efforts across many sectors all interact to create the wider movement to End FGM. If there is a focus on making sure that the NHS contribution is as strong as it can be, there equally needs to be a strong and consistent approach across all sectors.

It was also apparent that some ideas are not specific to one sector; support mechanisms for people may be helpful and applicable whether you are a midwife, teacher, police officer or charity worker. In adjusting the scope, I hope also to have protected against lost opportunities to learn.

Objectives around NHS service provision

1 To understand what motivates healthcare professionals to work to tackle FGM,
2 To understand if a healthcare professional faces a burden as a result of their work,
3 To understand what helps a healthcare professional to carry on when they face either difficulties or challenges when treating their patients,
4 To understand what relationships have made a difference to healthcare professionals when working to End FGM,
5 To understand if healthcare professionals who are themselves from affected communities (including if they are survivors) need additional or different support from that needed by healthcare professionals for whom FGM is not part of their family/community background,
6 To identify recommendations to improve how the NHS supports women and girls with FGM,
7 To identify recommendations to sustain the work within and by the NHS to tackle FGM.

Objectives around the wider efforts to tackle FGM

8 To understand what motivates other individuals working to tackle FGM,
9 To understand if other individuals working to tackle FGM face a burden as a result of their work,
10 To understand the relationship between the wider global movement and the work done by the NHS, and consider the interactions between these,
11 To identify recommendations to improve support to people involved in the work to End FGM,
12 To understand what challenges and difficulties are faced by the global movement (or national movements), and to identify recommendations to address these.

Context

FGM in the UK

FGM is illegal in the UK, in all forms, at all ages, and regardless of whether the individual agrees to being cut (i.e. if she consents). There are conditions which make it illegal to perform or arrange FGM in the UK and to take a girl overseas for her to be cut, and parents and guardians can be prosecuted for failing to protect their daughter. The first legislation was introduced in 1985, and has been strengthened several times since, in 2003, 2012, 2015 and 2018[3].

There has been a campaign for greater efforts to tackle FGM since the 1980s. In the 1990s, several NHS clinics started to offer specialised support to patients with FGM, mostly during pregnancy. However, there was little public or national momentum until around 2010, after which there was a gradual increase in activity and coverage. This led to the UK Government hosting the global 'GIRL Summit' in 2014, calling to End FGM and child, early and forced marriage. At the summit, the UK announced a range of domestic measures, and have since introduced legislation, and projects across the public sectors.

Over the last 5 or so years, the opening line to nearly all statements, press releases and publications was 'FGM is child abuse', and often followed up with the intention to prosecute where appropriate. This was whilst the media focus was on the lack of a successful prosecution, even though FGM has been illegal in the UK since 1985.

In the last two years, the national efforts around FGM have reduced in pace and tempo. Major policy announcements were focused around 2014 – 2016. There continues to be a trickle of updates refreshing the guidance, but the investment to support national and local implementation has substantially reduced, particularly funding to support community work.

Networks in the UK

In the UK, there are a mix of Government supported and self-governed networks, for campaigners and charities, for healthcare professionals and for other professional groups.

Colleagues often report issues with these networks. Frequently mentioned are:

- Stop/start and sporadic nature of Government/NHS organised networks, suggesting that these are run according to the agenda of the host organisation rather than the network members.
- Meetings turn into opportunities for attendees/organisations to grandstand rather than focus on the group agenda of the network.
- Claims that network discussions become echo-chambers, disconnected from communities affected by FGM.

[3] HM Government (Update 2020). Female genital mutilation: resource pack https://www.gov.uk/government/publications/female-genital-mutilation-resource-pack/female-genital-mutilation-resource-pack#legislation

- Little recognition of the time or cost to attend. Most Government/NHS networks are hosted during core business hours and often in London, which is difficult if network members either attend in a personal capacity or are not supported by employers to attend in work hours.

FGM survivors living in the UK

We know that many women live in the UK who have had FGM. The exact number is not known, so we use other information to help to estimate this.

NHS Digital publish statistics about the patients treated who have had FGM, but someone will only be counted within these figures if they have accessed the NHS since 2015, for a health condition which meant that their FGM may have been identified. Not all of the population will have received treatment of this kind over this period, so these numbers are a proxy which helps us to consider the prevalence of FGM across the general population.

Between July 2015 and the end of March 2020, at least 24,375 women have been treated in the NHS in England who have had FGM[4]. These are recorded when the patient discloses or a healthcare professional identifies that she has had FGM, when the hospital or GP practice have the right processes in place to allow for the data to be collected, and when the patient has not asked for her information to be removed from the collection, which is within their rights to do.

I am confident that the real figure is higher. There are some well publicised NHS FGM services which do not submit information to the statistics. There are patients who are treated who are not asked about FGM, despite circumstances meaning this would be appropriate. They may not therefore disclose.

Figure 2: Statistics relating to NHS patients with FGM.

Another source of information is the population level research commissioned by the Home Office and completed by City University[5]. This report contains estimates of the number of women living with FGM in England and Wales, as well as estimates of the number of women with FGM giving birth.

The report estimates that 137,000 women and girls with FGM who were born in FGM practising countries were living in England and Wales in 2011.

It estimated that, since 2008, women with FGM have made up about 1.5% of all women who give birth in England and Wales each year.

Figure 3: Statistics relating to estimate of number of women and girls with FGM in England and Wales.

[4] NHS Digital (2020). Female Genital Mutilation (FGM) – January 2020 to March 2020, experimental statistics https://files.digital.nhs.uk/C5/340282/Female%20Genital%20Mutilation%20%28FGM%29%20-%20January%202020%20to%20March%202020%20-%20Report.pdf

[5] Macfarlane, A. J. and Dorkenoo, E. (2015). Prevalence of Female Genital Mutilation in England and Wales: National and local estimates. London: City University London in association with Equality Now. https://openaccess.city.ac.uk/id/eprint/12382

Published in 2015, the report was based on international estimates of rates of FGM in 29 countries. In 2016, UNICEF published updated estimates about global rates of FGM in 31 countries, which include two more countries. This research has estimated that 49% of women and girls in Indonesia have had FGM, so the numbers in Figure 3 may be higher if this were included.

FGM and the NHS

FGM in the NHS Workforce

As the largest employer in the UK, with a diverse and majority female workforce, the NHS employs women who are themselves survivors of FGM.

Below is an analysis based on the approach taken by the City University to produce FGM prevalence estimates. To give context, around 81% of NHS employees state their nationality to be from the UK, and a further 6% are from Europe.

There is no widescale research into whether the rate of prevalence in a country of origin is replicated at the same rate in a population living in the UK from these countries. There are likely to be many factors which influence the rate of FGM in the population now residing in the UK, who have migrated from a country where FGM was a social norm.

The analysis uses the workforce statistics published by NHS Digital[6], and the prevalence rates of FGM in 31 countries across the world published by UNICEF.

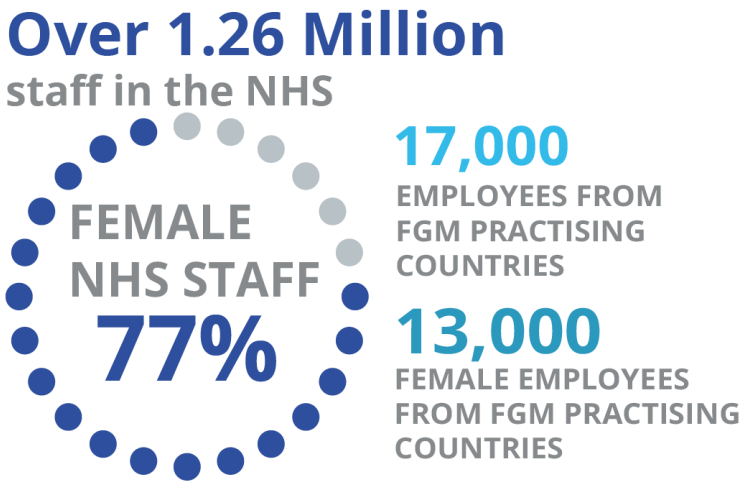

Figure 4. Statistics relating to the NHS workforce, and those from countries where FGM is practised.

Firstly, the analysis identifies the number of NHS employees who have stated their country of origin to be one of the 31 countries where UNICEF has a published FGM prevalence rate.

This estimated that 17,000 NHS employees are from the 31 countries. Of these around 13,000 are female, given that 77% of the NHS workforce is female.

UNICEF publishes prevalence rates for the whole country-level population. But they also publish rates according to wealth quintiles and the residence (urban/rural) status for the countries (where information is sufficient). Given this, it is possible to develop different estimates based on a range of assumptions.

Within this population of 13,000 female staff, when applying the different UNICEF prevalence rates to the group from each of

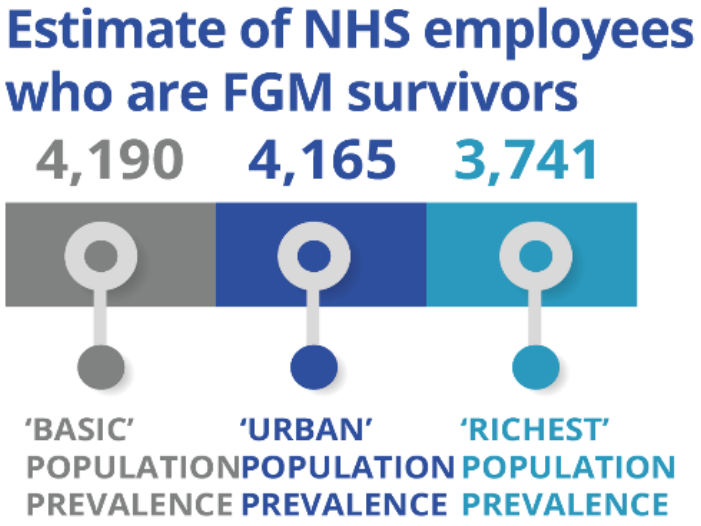

Figure 5: Statistics estimates number of NHS employees with FGM.

[6] NHS Digital (2019). NHS Workforce Statistics September 2019, https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/september-2019

the 31 countries, there are then estimates of the number of NHS employees who are survivors of FGM. There are three different calculations, each using a different type of prevalence rate.

One estimate of the number of survivors in the workforce uses the 'basic' prevalence rate of FGM across the whole population of the 31 countries.

The second estimate uses the prevalence rates for those living in urban areas. Whilst not a guaranteed relationship, there is narrative that those living in urban areas have better access to and chance of attending school, college and university. And the NHS workforce employs a high proportion of graduates. In the NHS Digital workforce analysis, 52% of people are in professional clinical roles, requiring a degree level education; many non-clinical roles also needing a degree. In 2017, the UK labour market consisted of 42% who were graduates[7].

Similarly, the third estimate uses the prevalence rates for the highest quintile of wealth. Again, using only a social narrative, there may be an association between the ability to migrate to the UK and coming from the highest wealth quintile, hence this final estimate.

This approach is very basic and should be used with great caution. The assumptions are too high level and do not have an evidence base to allow the estimates to be relied upon. There are many unknown factors, and significant limitation to the analysis. For many countries, the numbers are very low. Other considerations, which if reflected may increase or decrease the estimates, include:

- There is no evidence to verify if the rates of FGM prevalence in a country of origin are replicated in the group of people living in the UK who stated that they come from this country of origin.
- It is not possible to analyse what type of role held, for example doctors, nurses/midwives, therapists, administrative staff, estates and ancillary.
- From the published data, the gender split within a staff group from one country of origin is not known, therefore it is assumed that the overall proportional of 77% women is consistent.
- Nationality is a self-determined status, and there is no information about where the individual was born.
- The NHS workforce report excludes all GPs and employees of national bodies.

Detailed analysis is provided in Annex A.

Evidence of FGM prevalence in other countries

There is emerging evidence of prevalence in other countries around the world, which has not yet been included in research published by UNICEF. As such, these rates have not been used in the estimates in Figure 5: Statistics estimates number of NHS employees with FGM..

Malaysia is included in this category, with some research indicating there may be an FGM prevalence rate of 90% in the Islamic population in Malaysia. Around 60% of the population is Muslim, suggesting that the prevalence rate is significant, and potentially around half of Malay women have had FGM.

In the NHS, there is a large population of staff from Malaysia, with 2,440 employees as of 30 September 2019[8]. With this in mind, there may be somewhere around 900 female employees in the NHS who are also survivors of FGM with a Malay background.

[7] Office for National Statistics, (2017). Graduates in the UK labour market: 2017 https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/articles/graduatesintheuklabourmarket/2017

[8] NHS Digital (2019). NHS Workforce Statistics September 2019, https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/september-2019

Duty of care as an employer

The NHS Long Term Plan states *'The performance of any healthcare system ultimately depends on its people – the NHS is no exception.'*[9]. Our people are central to the NHS, and the NHS has a duty of care to support them.

Photo 3: Methods used in End FGM awareness campaigns in the NHS would vary

Background research has not identified any workforce policies which either account for the impact on healthcare professionals of working to End FGM or to meet the specific needs of members of the workforce for whom FGM may have a personal relevance, be that they are an FGM survivor, or they come from a community where FGM was prevalent.

Given that over 24,375 women with FGM have been treated by the NHS in the last five years and it is possible be that over 3,000 employees themselves are FGM survivors, it seems that there is sufficient evidence to suggest that we could usefully consider if guidance is needed to help employers understand how they can support this section of their workforce.

In 2018, the Royal College of Midwives (RCM) called for support for the midwives, nurses and other employees experiencing domestic abuse[10].

NHS Employers published guidance[11] in November 2017 about supporting NHS staff affected by domestic violence and abuse. This guidance recognises FGM as a type of domestic violence, therefore the guidance does by definition cover staff with FGM. On reviewing the guidance, it does not consider the aspects of FGM which differentiate it from other forms of domestic violence.

Finally, the DHSC published resource for healthcare professionals 'Responding to domestic abuse'[12] also mentions FGM. Again, specific consideration is not given to supporting FGM survivors.

The profiles of FGM and domestic abuse vary. Though not exclusively, the majority victims of domestic abuse are adult, and they are abused by an intimate partner. All genders may be victims. Domestic abuse may take many forms, including physical and sexual violence, coercive control, and economic abuse. FGM is carried out in the vast majority upon children and is a gender-based violence. It is very often arranged by a family member within a pattern of inter-generational abuse. These differences need to be carefully considered to understand if the support mechanisms to support survivors also need to have differences.

Both the DHSC and NHS Employers guidance is likely to include much which will address the needs of FGM survivors, but given that there are notable differences between FGM and many forms of domestic abuse, the guidance should be reviewed to consider if it meets all needs.

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[9] NHS England, (2019). The NHS Long Term Plan, (*Section 4.1)* https://www.longtermplan.nhs.uk/online-version/chapter-4-nhs-staff-will-get-the-backing-they-need/

[10] Pezaro,S, 2018. Safe places? Workplace support for those experiencing domestic abuse. https://www.rcm.org.uk/media/2472/safe-places-workplace-support-for-those-experiencing-domestic-abuse.pdf

[11] NHS Employers, 2017. Domestic violence and abuse: supporting NHS staff . https://www.nhsemployers.org/-/media/Employers/Publications/Health-and-wellbeing/HSWPG_DV_Policy-document.pdf

[12] Department of Health, 2017. Responding to domestic abuse A resource for health professionals. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/597435/DometicAbuseGuidance.pdf

Summary of the FGM Prevention Programme

The FGM Prevention programme was launched at the GIRL Summit in 2014, initially funded for three years and then extended. Hosted first by the Department of Health, and then transferred to NHS England, the programme delivered policy, guidance and introduced systems to improve the NHS' response to FGM.

The programme also worked with colleagues from across Government and other sectors on a wide range of matters, representing the views of the health service for example in the development of the multi-agency statutory guidance, and working as part of multi-agency projects for example with the LGA/Barnardo's project, the National FGM Centre.

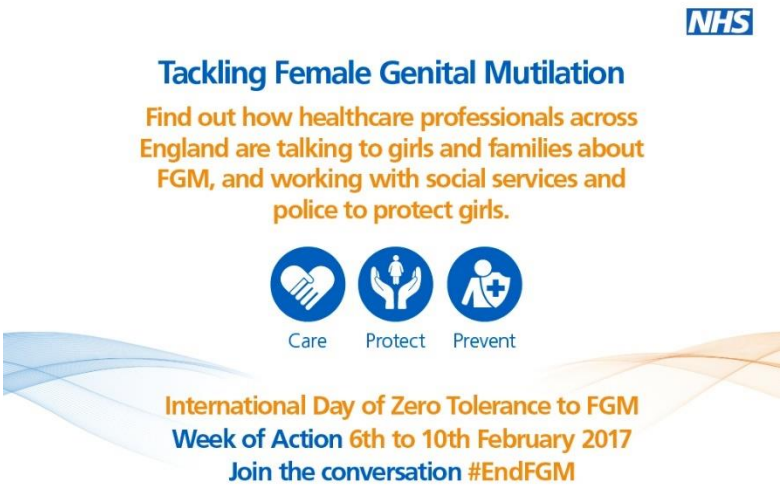


Figure 6: Example of NHS Prevention Programme communication materials.

Under the motto 'Care, Protect, Prevent', the outputs are described below.

FGM Prevention Programme

Information / records

- Standards and coding about how to record FGM in a medical record.
- Collecting and publishing the 'FGM Enhanced Dataset' from NHS organisations who provide treatment, about patients receiving care related to their FGM
- Funded the British Paediatric Surveillance Unit – Study of FGM in Children

Training and awareness – mostly professional audience

- Conferences, workshops, online sessions, and presenting at events hosted by others, reaching in excess of 5k people directly, to kickstart a national awareness drive across the NHS.
- Providing national FGM e-learning sessions within the National eLearning for Healthcare platform, fully accredited and provided free to NHS and local authority professionals.
- Published *FGM: Standards for training healthcare professionals*, aligned with the Intercollegiate safeguarding curriculum.
- Supported the Royal College of Paediatrics and Child Health (RCPCH) to deliver specialist training in identifying and caring for under 18s with FGM.

Communications – to the general public, to patients and as part of corporate NHS identity

- NHS.uk info / patient leaflets / 'Health' passport
- Contribution to Home Office online resource pack
- Funded the Royal College of Midwives (RCM) to produce and publish #EndFGM animations bringing to a wider audience the patient experience in relation to FGM.
- Supported RCM to offer online FGM Specialist Network.
- Running TV and online social media campaigns seen/heard by an audience of 1.7 million to raise awareness that the NHS can provide care and support to survivors and challenging some of the myths relating to FGM.

Safeguarding

- The FGM Information Sharing system, which means when a child has a family history of FGM, this information is shared with other professionals (including her GP) who will treat her as she grows up but who may not otherwise be aware of this family history.
- Issuing safeguarding guidance, including a one-page safeguarding pathway including how to meet the Mandatory Reporting duty
- Supporting development of the FGM Mandatory Reporting duty, and the 'Strengthening Safeguarding' communications campaign.

Service provision

- Commissioned independent health economics report, estimating cost of service provision for the physical and emotional support to survivors.
- Published *Commissioning services to meet the needs of women and girls with FGM* for commissioners to understand how to assess need and develop care pathways, including a service standard for provision of care for those under 18.
- Commissioning 8 NHS FGM Support Clinics across England which provide assessment and care to non-pregnant women, midwife-led, with on-site advocacy and language support and counselling. Evidence from these clinics is expected to inform the need for this kind of service.

Why choose the countries I visited?

I visited countries in Africa where there are many millions of women and girls living with FGM, and where there is much more work happening to End FGM. Health professionals working in countries across Africa with higher prevalence have treated many more survivors than most professionals working in the NHS. I wanted to learn from their extensive experience.

Kenya

Figure 7: Map of Kenya

The general consensus in the global arena is that in Kenya work to End FGM is making good progress. Part of this is a clear, loud and public discussion about FGM.

There is international evidence of the reduction in the prevalence rate. From 2014 The Girl Generation[13], a social change movement working in seven different countries in Africa, had a significant presence in Kenya. In 2013 the Anti-FGM Board was established as a national body to coordinate the work across the NGOs and Government Ministries, which is something that stakeholders have asked for in the UK.

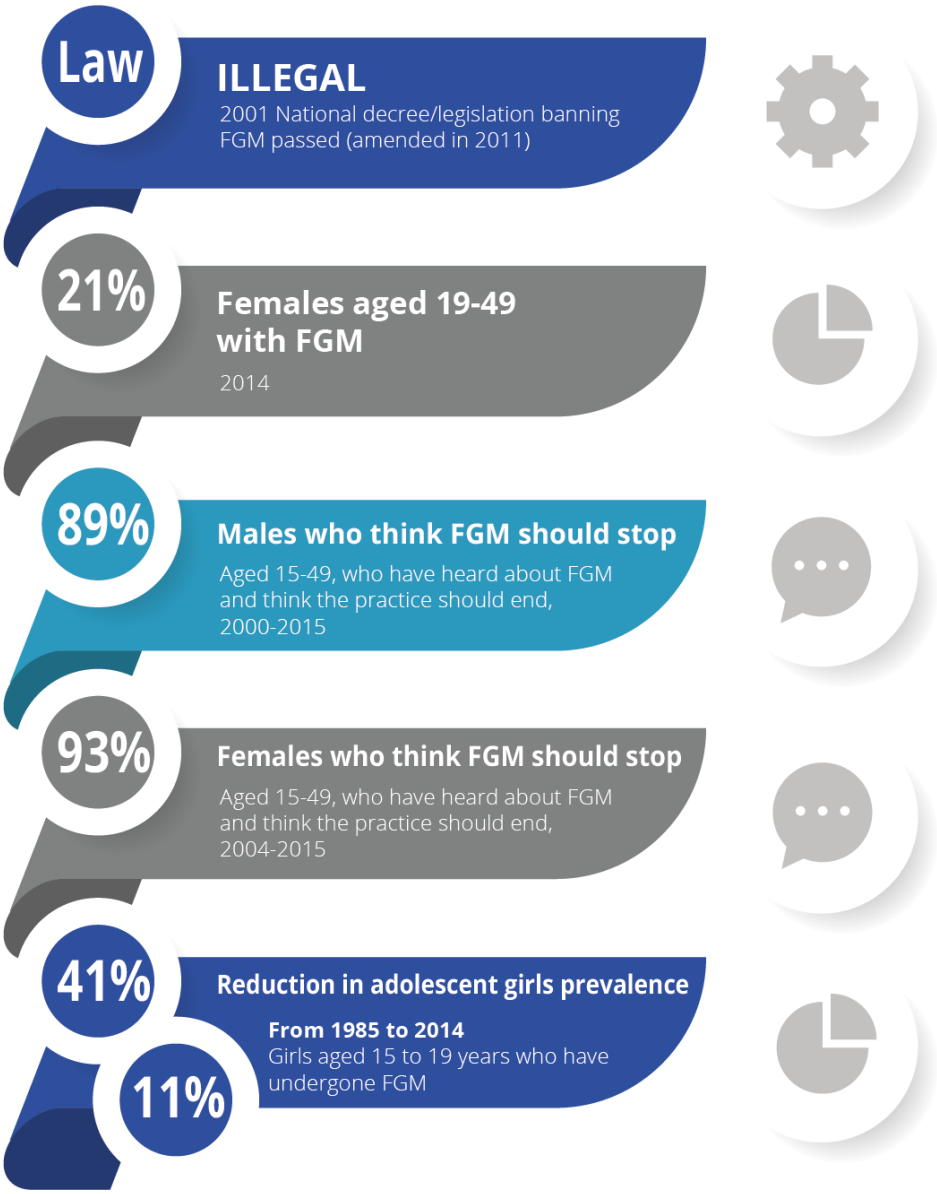


Figure 8: Headlines and statistics relating to FGM in Kenya.

[13] The Girl Generation, https://www.thegirlgeneration.org/

Sierra Leone

Figure 9: Map of Sierra Leone

In visiting Sierra Leone, I went to one of the few remaining countries where FGM is commonplace and there is no national legislation making it illegal. FGM is closely linked to the Secret / Bondo society, as it is part of the initiation ceremony into the society for women. There is a vocal movement calling to End FGM. My interest was in how they are making progress and surviving in this context.

In 2014 and 2015. I heard about a significant drop in FGM happening because of the restrictions placed upon society to control the spread of Ebola during the epidemic, though this turned out to be a temporary reduction. I was interested to hear about this change and whether there was opportunity to learn from what happened at the time and subsequently.

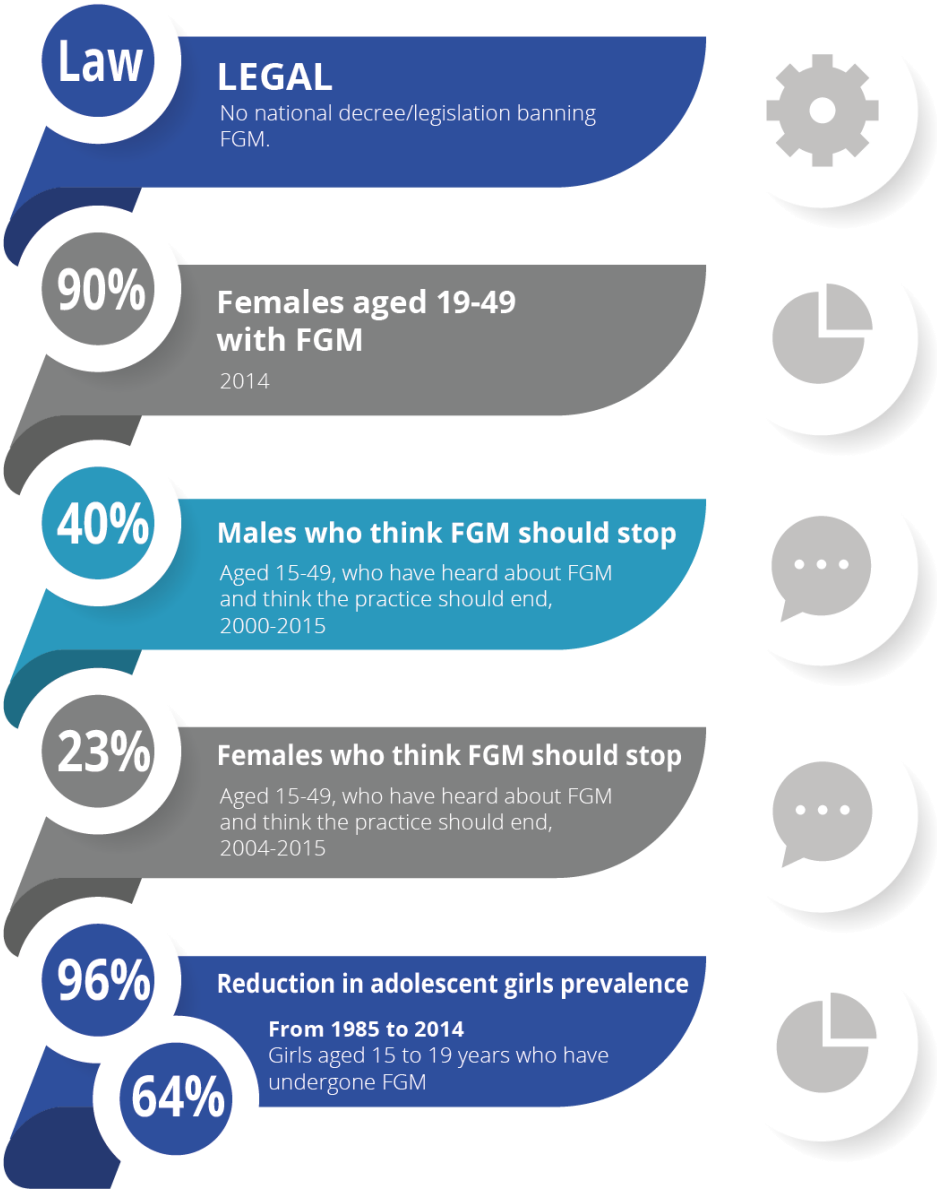


Figure 10: Headlines and statistics relating to FGM in Sierra Leone.

Egypt

Figure 11: Map of Egypt

The main reason to visit Egypt was because there has been a change in how FGM happens, known as medicalisation. FGM is commonly performed by health personnel, and girls under 15 years are four times more likely (80%) than women aged 45 to 49 years (17%) to have been cut by a healthcare professional.

I was also aware of the role that Egyptian doctors play in the NHS workforce. After doctors from the EU, this is the third largest cohort of doctors with non-UK nationality in the NHS. 95% of Egyptian staff are doctors, which makes up just over 1,800 people[14]. Though statistics are not available, there is also a strong profile of Egyptian doctors in the gynaecology and obstetrics field, as well as strong links between the Royal College of Obstetricians and Gynaecologists, and the Egyptian Society of Gynaecology and Obstetrics via FIGO, the International Federation of Gynaecology and Obstetrics.

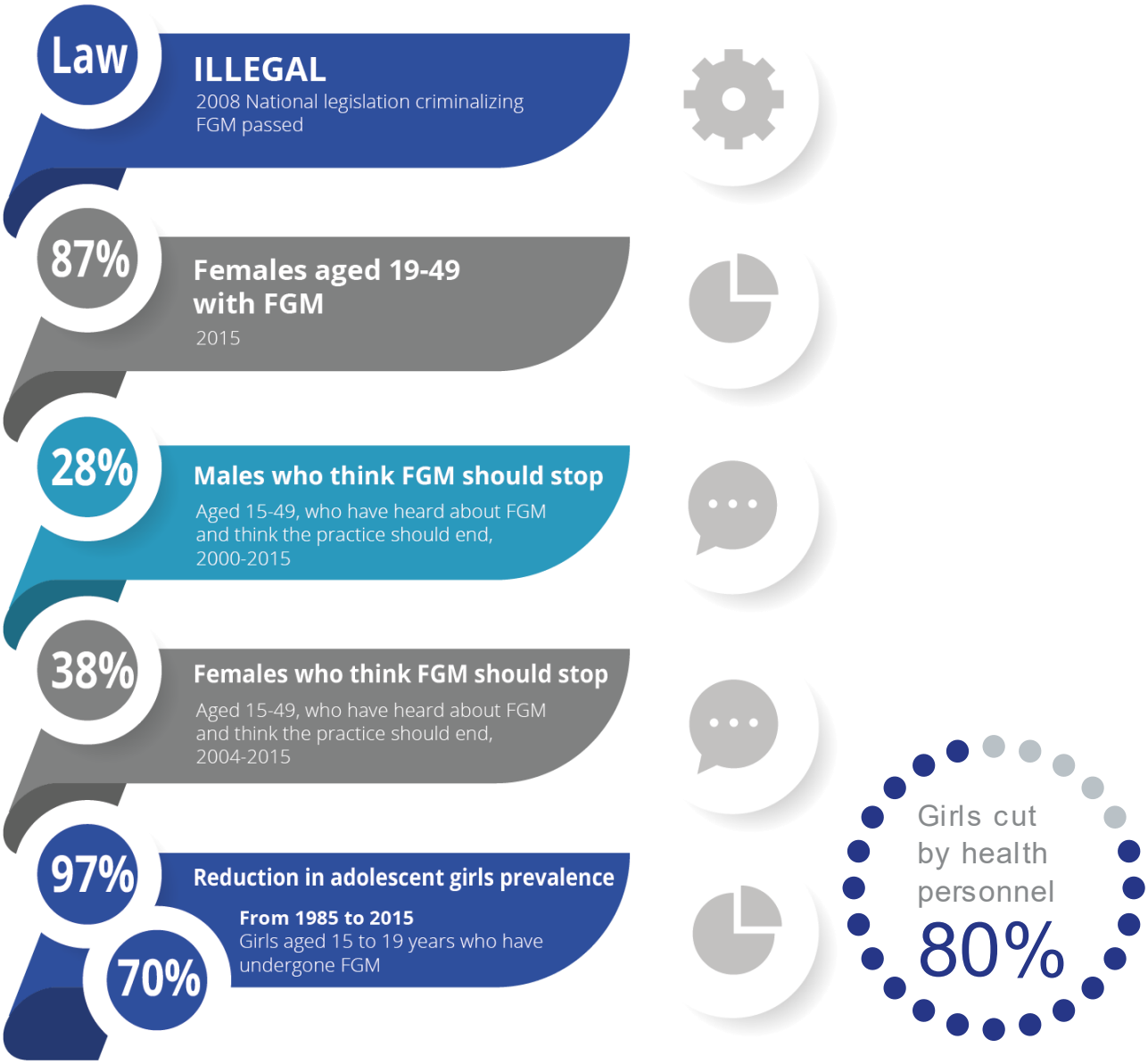


Figure 12: Headlines and statistics relating to FGM in Egypt.

[14] NHS Digital (2019). NHS Workforce Statistics September 2019, https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/september-2019

Australia

Figure 13: Map of Australia

I wanted the final stage of my research to be in Australia, a place which is facing a very similar challenge to the UK in terms of prevalence of FGM, and sharing a very similar perspective due to parallels in our health services.

I had also heard about subtle differences between their approach and ours. A colleague who visited from Australia had said she was interested to note that the message about criminality and prosecution appeared prominent to her.

As well as learning from Australian colleagues, I could also share what I had seen up to that point in the research and debate ideas.

Using a similar approach as the City University estimates of FGM prevalence in England and Wales, the Australian Institute of Health and Welfare published an estimate that 53,000 women and girls born elsewhere are now living in Australia who have undergone FGM[15].

Figure 14: Statistics relating to estimate of number of women and girls with FGM in Australia.

Figure 15: Information relating to FGM in Australia.

[15] Australian Institute of Health and Welfare 2019. Towards estimating the prevalence of female genital mutilation/cutting in Australia. Cat. no. PHE 230. Canberra: AIHW. https://www.aihw.gov.au/getmedia/f210a1d8-5a3a-4336-80c5-ca6bdc2906d5/aihw-phe-230.pdf.aspx?inline=true

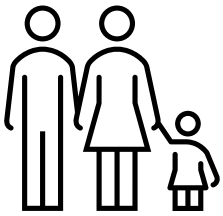
Background information

Medicalisation

When referring to the 'medicalisation' of FGM, this describes when a healthcare professional carries out the act of FGM. This is also usually associated with this either happening in a health setting such as a hospital or clinic room, or a location which is cleaner than the traditional locations. In doing so, the girl might be given anaesthetic, and it might be that sterile instruments are used. There is an expectation that being performed by a healthcare professional, the health consequences will be minimised, by the wound been purportedly cleaner, tidier, carried out by someone who knows what they are doing.

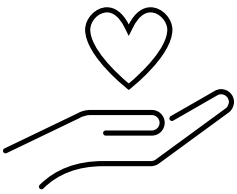
The move towards medicalisation of FGM does not mean that FGM is legal. A more detailed discussion around medicalisation is included.

Intergenerational patterns of abuse



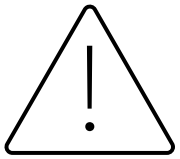
For thousands of years, FGM has been a form of inter-generational violence, meaning that it happened within family units. Someone from an adult part of the family arranges for the young girls in the family to undergo FGM.

Safeguarding



Safeguarding is the umbrella term for the activity taken to protect someone (child or adult) from abuse. The term is used across the public sector, including the NHS, social services, education, and with third sector, charity and community organisations. Safeguarding practice continues to develop and is complex. When training a professional to effectively safeguard someone from abuse, the intention is to be able to identify indicators of a growing risk of abuse, and to know how to take appropriate steps to help protect the person at risk of harm.

Being 'at risk' of FGM



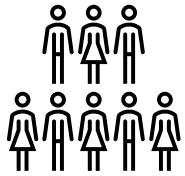
In recent years, I believe there has been misuse of the term 'at risk of FGM'.

In a community where the vast majority of girls have FGM, where anti-FGM legislation is ineffective, and evidence demonstrates a high ongoing level of support for the practice, simply being a girl is likely to be sufficient to say that she is at risk of having FGM before she is 14 years old. The movement to End FGM aims of course to change circumstances such as these, but this remains the case for millions of girls growing up today.

However, in somewhere like the UK, where we have very little evidence of whether FGM continues in second-generation or later immigrant families, and where FGM is not a social norm, I think that more information is needed before it can be decided whether a girl from a particular family/community is indeed likely to have FGM as she grows up.

It is important that if she has a family history of FGM, the NHS in partnership with others need to consider this whilst she grows up, to make sure that she is not at risk of FGM, but if the risk develops, then action is taken to protect her. This has to be balanced with the opportunity for families to escape from the cycle of abuse, and for the intergeneration pattern to be broken.

Third sector



A term often used in the research, the third sector is the part of the economy or society which is made up of non-governmental or non-profit making organisations. These include charities, campaign groups, community groups.

In Kenya and Sierra Leone, small groups working at a community level were often call community based organisations (CBOs). In Egypt, similar groups were called civil society organisations (CSOs).

A little more detail...

Men

The country were I spoke the fewest number of men was Australia, where I only spoke about FGM to those who attended the lecture at the University on my first day, and my family when I had finished working and was on holiday. In Kenya, I had some in depth conversations with several men.

In all countries, I spoke in depth about men, and their role in so many aspects relating to FGM. As with all other aspects of FGM, this varies according to context.

In Egypt, the role of men and fathers appeared to be a strong influence, yet I heard of no community-based projects working with men. I spoke to someone involved in counselling survivors of domestic violence, and was so sad to hear that she worked with women to help them understand how to adjust their behaviour to avoid violence; *'if the husband hits her because she is noisy, I help her understand she should be quiet'.*

If ever someone is in doubt as to why men need to be part of the End FGM work, this quote from a midwife in Kenya explains:

'Because when they don't understand, they do not know we are in the darkness'.

Being in Australia at the same time as the bush fires and heatwave

In December 2019, Australia was hitting the news because of the scale, severity and duration of the bush fires they were fighting. And I flew into the middle of it.

On Tuesday 17 December, the record for the hottest average day since records began in Australia was broken, and it was broken again the following day. I was in Melbourne, right in the hot bit.

I'd been in Canberra, where the smoke was much more intense. The roads looked hazy, and there was a strange burning smell just hanging in the air, which had crept into the train carriage from about an hour before I arrived at Canberra Station.

On my flight from Canberra to Melbourne, I could hardly stop staring out of the window. The smoke was bubbling along the ground like it had spilled from a cauldron. There were a few 'weather' clouds at the normal height, but also a layer of smoke covering the earth, giving an eerie view. We didn't fly anywhere near the fires of course, but this is just how far it spreads.

Photo 5: Smoke lying on the ground, just outside Canberra.

My seat was close to some volunteer firefighters. They were returning home after a couple of weeks, firefighting close to Canberra. So many passengers chatted to them, the flight attendants gave them free beers, and in the end of flight announcement, the cabin crew manager also thanked the firefighters for all they are doing. Cue spontaneous applause, and such warmth.

It felt that as a visitor, I was getting glimpses of something so serious, a concern shared by the whole community, causing a real threat to life and the way of life here. There are questions, not just about today and tomorrow, but deeper, about

Photo 4: As the smoke crept across Sydney harbour.

what is to come. The fires were very early in the season, as summer started officially on 1 December. I don't think I can understand the scale or depth, but I know it is big. Personally, I was very far from any kind of danger. But just being here for a short time, it feels like it's not only the smoke hanging in the air, it's the questions too.

Of course, a few months later, I have found myself living through a period of great uncertainty as the UK faced the coronavirus pandemic. Looking back, in Australia I was witness to something shaking the foundations of their life; but shortly after the world has faced a similar challenge.

Approach and methods

I contacted organisations in each country that I had worked with or met through work, found through internet research, or had learnt of through media coverage.

I wanted to meet diverse groups, including healthcare professionals, charity and NGO employees, activists and campaigners, those representing international aid agencies within the UN System, government bodies, and partners. I also contacted Government agencies in all countries I visited, with notably mixed success.

Photo 6: Meeting Dr Tammary Esho in Nairobi.

I asked for opportunity to meet and discuss their work, and for recommendations of who else to meet. I organised a series of meetings, at which I undertook semi-structured interviews. Within these I would explore:

- the work they (or their organisation) have done, and the profile of FGM in their communities,
- the impact FGM has on women and girls in terms of physical, mental health and society,
- the challenges they have faced, and whether they consider there to be a challenge in offering a sustained and sustainable effort to End FGM (locally or scaled to the national / global level),
- their views about what works in ending FGM, and what successes they have seen,
- how they feel about the work they have been involved in, and, if they themselves have faced difficulties, what they have been,
- what they have done to support themselves and/or their colleagues,
- when they think of these difficulties, what is it which motivates them to continue
- their views relating to partnership working and a whole system approach,
- their experience of multi-agency and partnership working,
- if they have experience of working with professionals who are themselves from communities where FGM is an issue and if that was different to the impact on the individual, and ideas to support further (as appropriate),
- their views on youth-led work,
- their ideas about what else was needed to End FGM, and what work they believe will lead most quickly to FGM not happening to anyone in their community.

Depending on the context and experience of the individual I was meeting, I would adapt the questions and I also asked about:

- data collection, evidence of outcomes and the international statistics,
- social media,
- medicalisation of FGM,
- the role of women and girls in society / community,
- links to removal from education, child marriage, teenage pregnancy, maternal mortality,
- 'reconstruction' surgery.

I would talk about my work and experience, explaining that I am not clinical. I would describe how WCMT are supporting my work, and I spoke to everyone I met about using our discussions to contribute to my report and recommendations. I often highlighted that this is social research, which I would describe as 'chatty' research, and was therefore different from academic research. I tried to take photographs with everyone I met, but on some occasions I either felt we were not in an appropriate location, or I sometimes forgot to ask.

I had canvas shopping bags printed with a design reflecting my project, which I often gave as tokens of gratitude to those I met.

I had opportunity to arrange additional meetings with contacts of those with whom I had met. I tried to follow up on all such opportunities. It was good to have some flexibility within my schedule to accommodate these meetings.

I found that I was often managing the expectations of those with whom I met about my role. In remote and rural locations, I found that almost universally, those I met hoped I could facilitate access to funding. This was not the purpose of my visit, which I had made clear when I asked to meet them, and so I would repeat this in the introductions.

Photo 7: Rachael in Sierra Leone with a gift bag

Although I did not intend to specifically set out to address issues relating to funding, I found that in the interviews, if I did not bring funding into the interview, the interviewees would. Rather than avoid the matter, these conversations have fed into the findings.

I did not ask any interviewees to tell me whether they have had FGM. There was no need for me to obtain personal disclosures to successfully learn about the work I was visiting. Of the women I met who I believe to have grown up in FGM-affected communities, fewer than 10 told me that they had FGM, just over 5 told me that they had not been cut, and over 20 met me and took part in the research without revealing if they themselves had been cut.

Willingness to contribute

By nature of agreeing to be interviewed, many contributors are likely to be personally committed to the global fight to End FGM. However, about half were working in a professional capacity, where their job had led to them being involved in the work to End FGM, and they were still primarily doing this within the context of their paid employment. The other half were those who were in a campaigning / advocacy role, sometimes paid, but not in the kind of role which would be advertised as a vacancy if they stopped. I am confident therefore that the findings will be balanced to consider the needs of all involved campaigners.

The recommendations have been designed to support all healthcare professionals, assuming that they will not /do not necessarily have to take part in the End FGM movement in personal capacity.

Record of meetings

A record of the people I met and the themes discussed within the interviews is included in Annex B.

Terminology – female genital mutilation / cutting

In this report, I use the term 'female genital mutilation' or FGM. This is the dominant term in the UK. When overseas, I used a variety of phrases, often adopting the phrase most in use in the community or context in which I found myself.

The UK Government choose to always use the term female genital mutilation, and in doing so, to recognise the serious harm caused. The majority of stakeholders also use the same term, with some using female genital mutilation / cutting (FGM/C). The NHS will use the phrase FGM in training and policy materials but supports clinicians to be led by their patient as to what or how to describe what has happened to them.

Cutting, or female genital cutting, is often perceived to be less judgemental or confrontational, as using the word mutilation can bring up more emotions and more clearly defines the act as a violent act.

Circumcision is the term adopted as a direct translation often and will often be used by communities. With an overlap with the term male circumcision, many are concerned that using this phrase legitimises FGM or makes it a female equivalent of male circumcision, when there are significant differences. There are many other phrases used to cover what we mean by FGM.

Throughout my interviews and research, I am confident that I made clear that I do not support what I call FGM.

From the travel diary...

Travelling to where I went, as a Churchill Fellow

The WCMT support their Fellows in preparation for travel fabulously. They help us think through what is needed, without being prescriptive about what we need to do.

They also, very sensibly, ask us all to prepare to speak about Winston Churchill, as previous Fellows have found that many people they meet are interested in the Trust.

Photo 8: A Churchill crown, given as a 'thank you' to some interviewees.

I'm not really one for history, or certainly not details. But I did my best and learnt a lot more about Winston Churchill than I knew before. So off I go, prepared but slightly anxious that I would do WCMT proud.

It turns out this advice does not necessarily apply to all countries equally. I was not asked about Churchill. I was, however, asked how I felt about the history of the British Empire, particularly the impact this had on the countries I visited, about why British people are so poor at speaking foreign languages, and recent political upheavals. I was asked more often 'what the Churchill thing was', because my interviewees had not heard of him. This alone was a fabulous reminder to me, that we can and should remain open to the unexpected and remember not to assume anything

Coping with travelling

Many people who chatted to me have assumed that the interviews were the hard bit of the travelling, but as time went on, I realised they were the bits I could do best. I love listening and talking to people about their work to End FGM. But getting myself to where I needed to be, with all my bits and pieces, that is what kept me on my toes.

Lost luggage

As I checked in at Heathrow T2 on the first leg of my travels, I was a bag of emotion, but I remembered to ask very specifically about my short changeover in Cairo. I wasn't sure that 70mins was a good window to make sure that my luggage transferred in Cairo Airport. But I was reassured and headed off.

Cairo, some hours later. I get to the transfer terminal in good time, and it's a funny mix of hot and enclosed.

Skip forward a few more hours, and I get to Nairobi Jomo Kenyatta Int Airport at something like 5am, or 3am BST. I sit watching the decreasing items of luggage go round and round. I felt a sinking feeling growing, and at some point, realised that my suitcase was not going to arrive.

My first actions in Nairobi were therefore to patiently do what I could to help log a lost item and try to list everything I had in the suitcase there and then.

As I finally left the terminal, there was an absolutely beautiful sunrise. The lovely driver from the hotel had been so kind and waited when he hadn't heard why I hadn't turned up (being lost in the flurry of paperwork). Finally, I arrived at the hotel. Rather than arriving and being able to explore, I had to turn to the logistics of life without belongings.

Photo 9: Leaving the UK in late September.

Of the logistical challenges I had to deal with whilst overseas, I think I might be most proud of having sourced and replaced my malaria tablets within about 3 hours of getting to Nairobi. I then went to a supermarket for the absolute basics, and I had a sleep. The rest followed,

Photo 10: The delight at receiving my luggage meant it had to be photographed.

Uber in Arabic

In order to get to the many offices and meeting places, I had to be quite good at getting around cities. I discovered that with my local sim cards, Uber was an excellent and flexible choice. Being on my own and in some pretty unusual places, I was always security conscious and became adept at checking the number as they arrived. What I hadn't anticipated was that in Egypt was that the number plates would be in Arabic. But even more challenging, I would be sent messages in Arabic. That stumped me.

Within a couple of days, I could recognise the pattern of 'I'm on my way'. I never worked out how to send anything useful back, however.

Sierra Leone to Australia

A round ticket from London to Freetown to Sydney, arriving back on New Year's Day turns out to be quite pricey. So, coming back to the UK for 9 hours before heading off on a new ticket in Australia helps. It saved lots of money, and it gave me a chance for a complete suitcase swap, for a very different selection of clothes.

But what I didn't expect was how much it would throw my memory and confuse my reference points! On the Monday morning, I was at the University of Sierra Leone, at my last interview. Some point on Tuesday, or was it Wednesday, I'm on the itchy seats of a Southeastern train going back to my childhood home for a shower and a kip, having last bought a coffee in Accra, Ghana. Meanwhile the UK is having a general election on the Thursday, and I'm transferring at Hong Kong airport. And on Friday, I'm giving a lecture at the University of Technology Sydney I learn the surprise outcome of the election as I'm getting in the lift at the Uni.

As well as wanting to explore Sydney, I made sure I took a bit of time out to relax and adjust! The following week, I made it to 8 meetings, in 4 different Australian states.

National Museums

As well as my interviews, and the prep and follow up for each contact, I tried to understand a little of each country I visited.

In Kenya, I visited the National Museum, which led me to do the same in each country.

In Nairobi, female circumcision was spoken about as a cultural practice of the past. In Sierra Leone, the National Museum was very small, across a couple of rooms, but I was lucky to join a tour. Again, I heard about FGM. This time it was described within the context of the Secret Society and likened repeatedly to the Masons in the UK. In Egypt, the National Museum was across the road from where I was staying in Tahir Square, though it was focused predominantly on the ancient Egyptian history, of which there is of course very much. I never imagined that there would be tens of sarcophagi lined up against the wall, adding up to hundreds in the various enormous rooms.

Photo 11: Kenyan National Museum.

The trips to the National Museums helped me think about context, about the differences between the countries I was visiting and the UK but not just in relation to FGM, but life and society.

In Australia, the National Museum in Sydney was closed for a major refurbishment. But then the Museum of Sydney was closed too! I felt I was stymied, at that last hurdle.

Checking in to fly Sydney to London

I had more visas, tickets and paperwork to cope in the last four months of 2019 than I ever imagined possible. Except when I landed unexpectedly at a different Nairobi airport than the one I thought I was flying into, travel arrangements had been enormously smooth.

So, on 31 December, when I was checking in at Sydney airport I wasn't bothered when the self-check-in kiosk didn't seem to 'approve'. But quickly, it became painfully clear that I had overlooked one very important detail. To change flights in the US, you need an actual full blown 90 day visa.

At that point, a 38 minute countdown started, in which I needed to get a US visa whilst I was in Sydney Airport, on New Year's Eve. If I didn't, I was looking at a £600ish ticket to get back.

At the end of my Fellowship travels, I felt so immensely happy and proud. This final setback did feel like a bit of a bump, but also one last chance to prove that I could do anything.

I did it. I got a US visa in time. In fact, I had 12 minutes to spare

Findings

Over the course of the research, many themes emerged. Within this were unexpected findings, which led to thinking about the challenge from a different perspective.

This chapter summarises the evidence which supports the view that the many people who are involved in the work to End FGM do face a personal and professional strain as a result of their work.

The research findings also led to a searching question; what causes these difficulties for the people working to End FGM? If this can be answered, then we could change what leads to the burden, aiming to reduce or even remove it.

One conclusion is that it is difficult and traumatic to support survivors of the FGM, and that by listening and sharing stories with many survivors, professionals can become personally affected. This will always be the case, but the impact can be mitigated.

There is another consideration. There are strategic issues relating to how the global movement to End FGM is organised and delivered, and these issues also cause problems and burden to those working to End FGM. This includes that there are not enough people involved in the work to sustain it.

It is also important to note that these issues are interrelated; when people talked about what helps them cope, they said that hearing and knowing about how what they are doing is stopping girls from being cut is a very strong motivation. This diagram illustrates the complex relationship, and how some improvements both help End FGM as well as help to support the people involved.

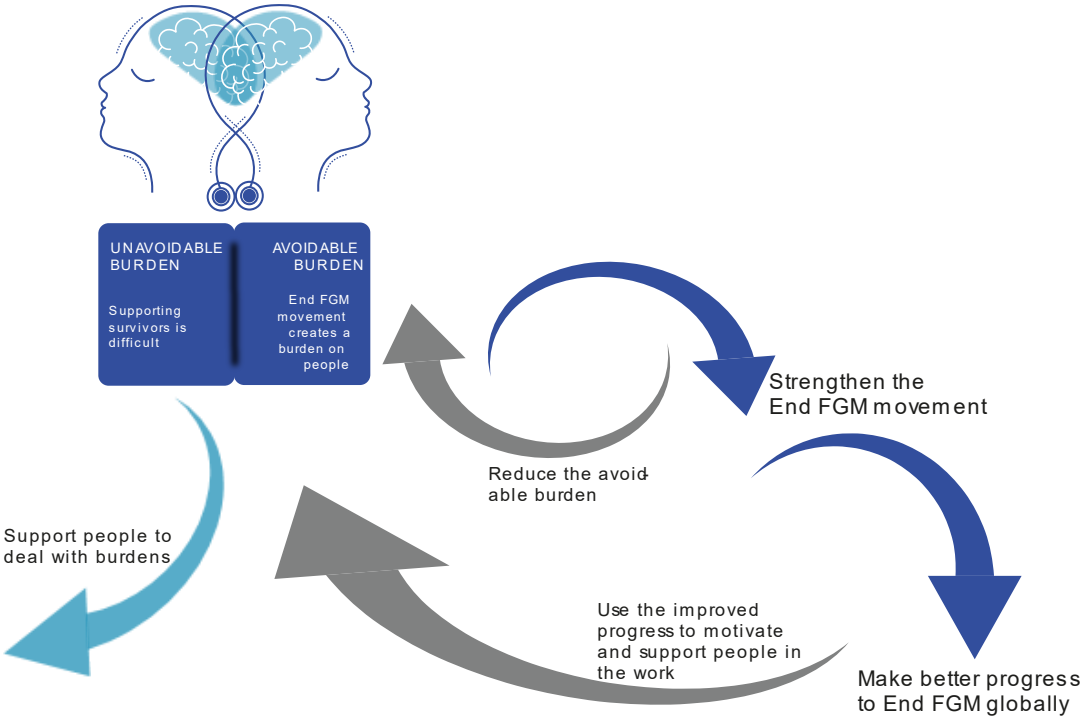


Figure 16: Illustrating how the End FGM movement and the burdens placed upon those involved in the work are interrelated.

1. People who work to End FGM face personal and professional burdens as a result.

Meeting Ester, a midwife in Ortum, she said a short phrase which summarises the majority of this report.

> *'We carry this trauma.'*

Ester herself grew up in a community where nearly every woman has type 3, infibulation. She is now a midwife living and working in the same area. Every day she supports women who are pregnant and need extra help because they have had FGM.

We spoke at length about what she meant by this beautiful but sad comment. She spoke about the many ways in which FGM affects her, as a professional, as a member of the community where she knows it is still happening, and as an empathetic woman, who cannot help but be affected by the stories of those she treats.

Another midwife, Naomi, was shy and relatively newly qualified. She had no experience or knowledge of FGM before she started to work in Ortum and had not learnt about it through her nursing and midwifery training in Kenya. When I asked how she manages difficult situations, she said:

> *'I take it within me.'*

As a midwife, Naomi has been trained to deal with the complex scenarios which present. However, FGM was something she had to handle without training. Again, this short phrase identifies how our professionals carry a burden as a result of their work.

The interviews with Ester and Naomi spent a significant amount of time exploring this, but the themes were explored with all interviewees.

Impacts from working against FGM

In the interviews, there was unanimous agreement that by working to End FGM, individuals are placed under personal and professional strain. From first-hand accounts to narrative from those with a strategic level responsibility or experience, there is a recognition that there is often a personal cost to those working in this area.

The examples related to everyone; healthcare professionals, campaigners and activists, those working in the third sector and community groups, those working in international organisations, social workers and teachers.

Examples of the negative impacts are wide ranging. Some of the impacts may be subjective, or more complex than highlighted. The answers given by people in frontline roles were consistent with those who are working as national or regional coordinators who described what they see working with many people and organisations.

Emotional: the emotional toll was evident on the faces of many interviewees.

- Midwives in Kenya nearly broke into tears when describing the sadness they feel when supporting women with FGM through their pregnancy. Many spoke of carrying the memory of when there was a tragic outcome for many years after the event.
- Many spoke of their husbands and family members having to support them, when they get home upset, quiet, angry, or despondent, again with a number of interviewees finding that talking about this also made them emotional.
- There is deep frustration by nearly everyone interviewed, as all spoke of interventions which they believe are not working.
- Individuals spoke of going through periods when they were burn-out or exhausted, or when they were concerned that they have become 'immune' to the reality of the harm that FGM causes.
- Many spoke of not being able to 'turn off', always feeling that women or girls they have seen may be at risk if the wider support network available does not feel sufficient to provide the protection needed. This appeared to manifest in feelings of anxiety.

Financial: in all countries, there was personal account of a financial impact, because those involved are expected to give time or money over and above what could (or should) have been expected.

- Having to work overtime to carry out work relating to FGM
- Taking annual/unpaid leave to attend training/conferences/network events
- Supplementing services or expanding the scope of projects and using personal resources to do this. This included taking in girls to live with families of community workers/midwives, paying school fees, funding rescues.

Patient safety: if a healthcare professional who is unprepared finds that they need to provide treatment when a patient presents and discloses that she has FGM, there is a risk that the care provided may not be high quality, and associated risk that it could further harm the patient.

- There is an additional element that an untrained professional treating a patient for FGM may find themselves very affected; a midwife in Kenya was clearly still affected by the shock from treating her first patient with FGM, and I learnt of the impact on an ambulance crew in Australia who supported an infibulated woman (FGM type 3) in Melbourne, but who did not know about FGM before this.

Personal relationships: in situations where the community did not support or understand the work to End FGM, individuals spoke about friends and family reducing contact with them and leaving them isolated. This was exacerbated where people were working in relatively isolated positions.

- Khadija Gbla is a survivor-campaigner working in Australia where there are very few survivors speaking out.
- Abel Lokeris spoke about how, as a man working to protect girls from FGM, he has been treated differently by others in his community.

Personal safety: Campaigners/activists spoke about receiving threats to their personal safety. They were all working in campaigning roles where they were publicly calling upon the community to End FGM. I did not see examples of professionals providing services who received threats. However, some individuals are both campaigners/activists and have a role in the health service.

Professional - individual: individuals gave accounts of how they are treated differently, as a result of having taken a stand to End FGM.

- Some spoke of being thought of as 'troublemakers', and therefore being overlooked for promotion, being moved on from a job they loved because they were being 'too honest' because they were identifying how their organisation needed to support girls better.
- Because they clearly knew how to support women with FGM, they were always being called upon to treat certain patients, rather than other team members trying to learn how to support patients. This sometimes meant having to accept additional work because of being of the few who could support certain women.

When speaking about difficulties, many were aware and concerned that their contribution to this report could cause them embarrassment or problems with their organisations. For this reason, certain details have not been included.

Professional – organisation: Several accounts were given where if organisations were known to hold a clear stance that they are against FGM, they were excluded from opportunities. This included invitations to bid for funding, involvement in roundtable events to discuss violence against women and girls. In one country, there were accounts that it was more difficult to obtain government certification as a community-based organisation, with the suspicion being that this was because of the taboo and secrecy surrounding FGM.

As well as negative burdens, there were examples of the benefits enjoyed as a result of working in this space. As well as it being important to recognise for completeness, these examples also give material to consider what support mechanisms could produce results to sustain the work.

Example of the benefits of working as part of the End FGM movement.

Personal: Contributors spoke about the joy, pride, and sense of personal fulfilment they enjoy as a result of being involved in stopping individual girls from being hurt and reducing the rates of FGM across populations and globally. This was unanimous and was always given as the primary reasons for involvement.

Networks: Women involved often spoke movingly of their connection with a global sisterhood, and all spoke of the support from their peer networks. Everyone recognised that no single project or effort on its own would End FGM. This feeling of being part of a wider movement appeared to give great confidence to individuals, meaning that when they were telling another person to stop FGM, whatever the context or detail of that interaction, this difficult conversation is made easier because of being part of that wider network.

Opportunity to develop: Campaigners and activists spoke about their pride and enjoyment in being involved in networks at regional, national and international levels. They spoke proudly of their professional developments and receiving capacity building training such as that offered by The Girl Generation.

Impacts as a survivor / man whose female relatives had FGM

Those who chose to disclose within their interview that they have had FGM gave similar accounts about the impact they felt. Additionally, there were aspects which were specific to these interviews with survivors:

Emotional: Whilst the interviews did not try to quantitatively measure emotional impact, it was notable that there was a higher emotional intensity to some of the conversations where a survivor (or male relative of a survivor) was now working in the End FGM movement.

- There appeared to be a correlation that those who recognised that their personal trauma is now driving their actions to contribute to the End FGM work; in these circumstances the emotion felt very raw and intense.

Personal relationships: Women spoke about their complex relationships with their mothers and family members, including feelings of anger, confusion and acceptance. Some had spent time exploring these feelings, either with a counsellor/peer or withing groups or by themselves. Some spoke of feelings of guilt and/or personal responsibility to other women and girls in their families and communities.

- Several interviewees (men and women) spoke of how they are doing this work in honour of their sisters / cousins / aunts because of what FGM had done to them.

Professional: Some midwives described the impact of the assumption made by their colleagues that, as they are a survivor, they would support women with FGM. This was complex. It made midwives both proud that they could support those from their community and a shared background, reflective because of the personal context, but there was frustration with the assumption that 'they always had to care for

women with FGM' and that others in their team had not taken the time to learn the skills to provide the care needed.
These midwives recognised that being a survivor was not an 'essential qualification' to be able to provide the best care.

Community context: Interviewees who came themselves from communities affected by FGM, regardless of whether they were survivors, often referred to their feelings about it being in their community. Men would equally make these comments, and it was not just those themselves who were survivors. The feelings were complex, and included elements of shame, concern, sadness, guilt and empathy.

Some of the statements made included:

'It is our core'

'I don't have feelings of hate for my mother, ..., but I know I carry bitterness to her and others who carry on with this'

'I think my people are backwards, but education will help us learn'

'It makes me sad to know that the people I care about carry on doing this'.

The frequency with which interviewees themselves brought up the interrelationship between their work to End FGM and their belonging to a community which perpetuates FGM, even if it was just a small proportion now, demonstrates that it is important to recognise and consider this.

Professionals for/against FGM

It is also clear that the healthcare professionals who were working to End FGM were, in the main, whole-heartedly against FGM, and many had dedicated years of their life to ending it. In all four countries, healthcare professionals have played a major role in getting the movement started, coordinated and listened to. This overwhelmingly demonstrates that healthcare professionals are one of the greatest assets available to the global movement to End FGM.

Having said that, in two interviews in Kenya and Egypt, I was not left with a certainty that those I had spoken to personally felt that FGM should end.

In Sierra Leone, I heard reports of the widespread support of FGM across health professionals at the moment, although the specific circumstances of Sierra Leone provide an explanation for this.

In Egypt and Kenya, I heard report of health professionals who either carried out FGM or continued to support it, but these were reported to be minority groups.

This evidence of mixed opinions is interesting and was evident even in Kenya where the public narrative is so clear in wanting to End FGM. This gives context that we should not assume that every healthcare professional will automatically agree with work to End FGM.

Summary

In the interviews, there was unanimous agreement that by working to End FGM, individuals are placed under personal and professional strain. These include:

- Emotional; professionals can carry the trauma they hear about
- Financial; many contribute their own time or resources

- Safety; impacting both patient (when a professional is unprepared but has to treat a woman with FGM) and personal safety (when as a result of being involved in End FGM work, someone is threatened)
- Personal relationships; a strain is often passed to those around them
- Professional – both as an individual and an organisation, those working to End FGM lose opportunities (not supported for promotion because of reliance upon an individual / identified as a 'trouble-maker' for advocating for women with FGM).

Contributors spoke positively about the joy, pride, and sense of personal fulfilment they enjoy as a result of being involved in stopping individual girls from being hurt and reducing the rates of FGM across populations and globally.

Interviewees who came themselves from communities affected by FGM, regardless of whether they were survivors, often referred to their feelings about it being in their community. Men would equally make these comments, and it was not just those themselves who were survivors. The feelings were complex, and included elements of shame, concern, sadness, guilt and empathy.

Some of the burden is caused because supporting women with FGM and working to protect girls is difficult; this is largely unavoidable but can be addressed.

The other elements of the burden are caused by avoidable factors, which with improvements in strategy and delivery, can be avoided.

Emotional Wellbeing project

In 2018, The Girl Generation launched a new project: 'Ending FGM and Promoting Emotional Wellbeing'. Led by Leyla Hussein, global strategist for The Girl Generation, prominent campaigner against FGM and psychotherapist, the project provided a package of support, with the aims to:

- Provide sustainable emotional support for women and girls affected by FGM, to enhance prevention efforts and support survivors,
- Ensure self-care for campaigners, staff and volunteers working to end FGM, particularly in grassroots organisations, and
- Break down the stigma associated with FGM and associated emotional or mental health issues.

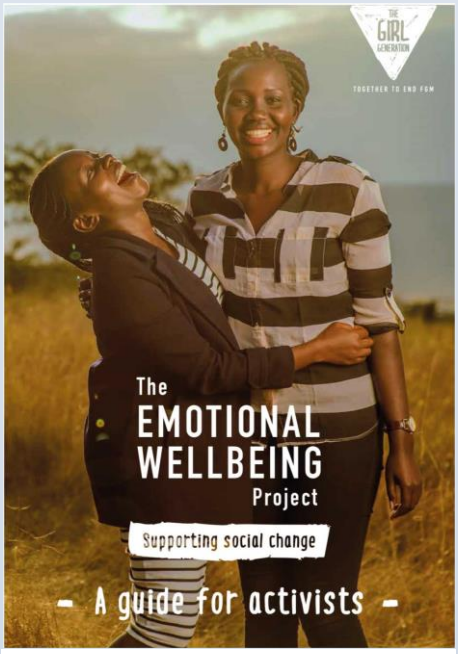


Figure 17: The Emotional Wellbeing guide for activists

Linking so closely with the considerations of this research, I met several Kenyan activists who had participated in or seen the outcomes from this work.

Catherine Mootian spoke about how much the approach had taught and supported her. She spoke movingly of the burden she carries due to being involved in fighting FGM, and how attending this project gave her ways to think about the impact it was having on her. She spoke about recognising when she was working and when she needed to stop (stopping work at a set time each day), making time to go swimming each week, and recognising when she needed to talk to someone. Whilst this did not remove the burden and how she can still be contacted by phone later in the evening if needed, it helped provide some balance.

She explained how she had been able to pass on the techniques to others she works with, as was intended by using a 'train the trainer' rolling implementation approach. She also hears about how others are taking the project plans and adapting to their own circumstances. In one district, yoga is offered every month, and attendance runs to several hundred women and has been an enormous success. In another district, where yoga is not well known and would not necessarily be well received, they have used the approach but substituted yoga for a form of traditional dance.

The Emotional Wellbeing resources are all found on The Girl Generation website; https://www.thegirlgeneration.org/resources/emotional-wellbeing-resources.

Following extensive research, this is the only project identified so far which explicitly aims to support those carrying out the work to End FGM. It was popular with those who had participated, and the approach is to support some of the burdens identified as being faced by professionals (and others). With the flexible model it offers, this can be adapted to fit many different scenarios.

2. An End FGM change programme works better when all aspects of society and Government are involved, using a whole system approach.

A **whole system approach** works with communities and all stakeholders to both understand the problem and to work together to identify solutions, test these, and deliver. It is a phrase often used by those involved in tackling public health challenges.

Kenya

The End FGM work in Kenya is very close to being a whole system approach. The Anti-FGM Board, a semi-autonomous Government agency is based in Nairobi. The board's mission is:

> *To uphold the dignity and empowerment of girls and women in Kenya through co-ordination of initiatives, awareness creation and advocacy against FGM.*[16]

Figure 18: The Anti-FGM Board publish guidance and provide leaflets to help raise awareness of FGM

[16] Anti-FGM Board Charter http://antifgmboard.go.ke/wp-content/uploads/2018/12/anti-fgm-board-charter-Copy.pdf

Their website outlines their role in coordinating, advising, designing policy and programmes, and they list customers from all society, including the general public, the third sector and all parts of the public sector.

During the trip to Pokot, I met women from rural communities and healthcare professionals. They all confidently listed how all parts of society were involved and reported that they were mostly consistent in delivering the End FGM message. Pokot is a very deprived region, with poor transport links but even in this remote location, the national message was clear and consistent.

When asked why this consistent approach mattered, the pregnant women staying in the maternity home, Agnes and Bernadette and others I met in the market said:

'We know that wherever we go, we will hear the same thing'

'We know our daughters will be taught about FGM, why it shouldn't happen'

'They even talk about it in Church'

'If someone involved in the anti-FGM group finds out that a family is about or has just had their girl cut, we know the family will get into trouble with the police and the Chief'

These comments show the impact of hearing the same message from all corners; confidence grows in believing this, 'everyone else' is saying the same thing, it becomes the new norm. Because this happened, the community members were telling me that they know that the Kenyan Government support this message, that many people are backing this message and they believe that there is a real chance of getting into trouble if they continue to carry out FGM.

The healthcare professionals working in the hospital said:

'I feel more confident saying that FGM should not happen, because I know she will hear the same from others'

Esther, community midwife

'I think that the more the women hear the problems and explanations about why FGM is harmful, the more they start to question if it should happen'

Christine, nurse midwife

Professionals said that they felt more confident to have a difficult conversation about FGM with their patient, because of the backing and support they feel from being part of a wider movement. They were also reflecting on the impact that this approach has and recognising the need for a repetitive approach to change the mind of their patient.

In other interviews, similar examples were given from projects in Narok, Isiolo and Nairobi. Interviewees often referred to the President's public statements and commitments to End FGM.

This is not to say that problems and challenges do not exist. Though the structure appears to be coordinated and comprehensive, interviewees described the following challenges:

- The coordination is limited; not all community based organisations (CBOs) are, or want to be, engaged with the Board. This leads to frustration if they want to be, and risk of inconsistency if CBOs choose to act independently.
- There are expectations that the Anti-FGM Board can or should fund work.
- There were examples where the police or social services 'should' have acted to rescue a girl but didn't. The local CBO said they thought this was because the police knew the CBO would rescue her, so they didn't need to use own resources.
- The President has made a commitment to End FGM by 2022. This ambitious target is very welcome in many regards, but activists said that they fear that this target will mean that chiefs and officials will deny or ignore reports of FGM, so as to support a claim that by 2022 they have stopped FGM. Subsequent discussions with activists in Kenya, since I returned to the UK, indicate that this is a growing concern.

Egypt

Egypt provided a mixed picture. Government policies are in place to suggest that the End FGM work uses a whole system approach, but the interviewees reported significant gaps between what the policy said should happen, and then the day to day efforts of the public sector organisations. Interviewees were clear that they considered the front-line activity to be insufficient, and there are few civil society organisations (CSOs) in place to the community-based work.

One example of where the policy is in place, but there are valid questions about whether this will be backed with investment and accountability is with *The National Strategy for Combatting Violence against Women*[17]. It was published by The National Council for Women in 2015, and it recognised that FGM is domestic violence. It is notable that the prevalence rates of FGM were not included alongside the statistics of other forms of domestic violence (page 13), despite being widely available and internationally recognised. The strategy lists a comprehensive stakeholder map. However, at publication, the cost and funding for delivering the strategy had not been set or agreed.

This strategy sets an expectation that there is a whole system approach in place. However, many interviewees explained that at the frontline the criminal justice sector, education, social services and the health service (be these public or private organisations) were not active in their support for of delivery of any work to tackle FGM. Examples given included:

- The police were said to want ample evidence to be handed over to them at the same time as a report of FGM if they were going to investigate and consider taking action.

[17] National Council for Women, (2015). The National Strategy for Combating Violence against Women, Deposit Number 9137/2015 https://evaw-global-database.unwomen.org/-/media/files/un%20women/vaw/full%20text/africa/egypt%20national%20strategy%20for%20combating%20vaw%202015.pdf?vs=2221

- Doctors performing FGM were said to be acting in the confidence that they would not be prosecuted.
- Schools can be reluctant to allow CSOs access to give lessons projects in to discuss FGM.
- Imams are widely thought to be involved in introducing families who want to organise FGM to a doctor willing to perform it.
- Becoming a CSO to tackle human rights and gender inequality / violence against women issues can be complicated and was said to be more difficult than registering as a CSO tackling less controversial subjects.
- Those in leadership positions are saying the right things so as to obtain favour (politically, both internationally and with the liberal elite Egyptian 'upper class'), but are not willing to invest to make this happen, as it will be controversial and unpopular with the majority of the population (and therefore voters).

Interviewees also spoke of what they consider to be the consequences of this disconnect between the policy and the frontline. These included:

- Work with the community being difficult, because families do not believe that they will get into trouble if they have their girls cut, so the law against FGM appears to be an ineffective deterrent.
- Without a clear and consistent message from the Government and various sectors (education, health, police etc), communities still practising FGM hear the message infrequently, leading to lesser impact; it is easy to ignore.
- Those in leadership positions were often described as the social elite. This group were said by all interviewees to have largely stopped supporting FGM themselves, as they see and participate in the wide-ranging global trends towards gender equality. However, this was then said to lead to a type of prejudice that FGM was continued by the 'poor and uneducated', which was believed by some to influence their willingness to really address the issue.
- Only a small number of people are willing to campaign and work against FGM. It takes great courage and they face personal risks by speaking out and feel they do so without feeling confident that they are part of a nationwide movement.
- Without all relevant parties involved, there is also a disproportionate burden on a few to carry out this work, which is difficult to carry as an individual working in this area.

Australia

In Australia, there is little doubt that the Government and general public support the ending of FGM. It is an issue which has only been seen in communities who have migrated from the countries where there is a long history of FGM happening. This is reflected in the Government strategies to end violence against women and girls, which also lays out a whole system approach.

However, the interviews gave an account of projects tackling FGM in Australia, but they there appeared to intend to support survivors who have been cut prior to migration. Therefore, the projects I heard about were all health and public health projects, supported by some work in community groups.

Interviewees did not talk confidently of any multi-agency coordinated responses that including health, social care, the police and education working together. Interviewees did know that they would make a referral under safeguarding to social services if they found a girl who has been cut.

Several interviewees (including healthcare professionals) said that a multi-agency response would not be needed, because the work in Australia only needed to support survivors who had had FGM prior to migrating.

In the recently published national prevalence estimate[18], issued by the Australian Institute of Health and Welfare, there includes commentary on why they have excluded second generation women and girls from estimates:

> *'Although there is no evidence to suggest that FGM/C is routinely conducted in Australia, Zurynski et al. (2017) and Moeed & Grover (2012) both report instances of its being performed in Australia. There have also been a couple of legal cases in Australia involving people accused of performing FGM/C or arranging for FGM/C to be conducted.'*

Figure 19: Front page of the research paper.

This report acknowledges reports of FGM happening within Australia, but also opens this sentence stating that there is no evidence to suggest FGM/C is routinely conducted in Australia. But there are only a small number of women with FGM in Australia, and the practice is deeply secretive. It could be argued that if assuming that there has been a steep reduction in the prevalence of FGM in a second generation family post migration, there could be a small ongoing population routinely conducting FGM, but that this has not been identified as the numbers would be very small and very difficult to identify. It is possible that in Australia, there is 'routinely conducted' FGM but it has not been identified, because the population is so small.

I believe that this reflection is critical to understanding why Australia has not adopted a whole system approach to End FGM, though they have set a policy which would lead to an expectation that such an approach were in place.

There was one notable exception, Khadija Gbla who is currently in a relatively isolated role as the more prominent survivor-campaigner, but who is also calling for more involvement from other sectors to End FGM, to mirror both the work in African counties such as Kenya but also elements of the UK response.

She is concerned that there is a small population carrying out FGM, resident in Australia, but that without putting in place a whole system approach supported by actions, this is unlikely to be identified. Also she expressed concern that the Australian response is not taking into account lessons about how challenging it is to change the views of people who believe in FGM, as described later.

Sierra Leone

In almost complete contrast to what is happening in Kenya, the lessons from Sierra Leone sadly demonstrate why it is so important to have everyone involved to End FGM using a whole system approach. The challenges that the Sierra Leonean End FGM work faces are far more extreme than most others, but the learning can still be shared. It serves as an important reminder of why the UK, Kenya and other countries who are making good progress must value and protect their progress.

Fundamentally the lack of national legislation against FGM challenges every aspect of the efforts to End FGM. Those who support it can confidently say that if it were that bad, it would have been made illegal.

[18] Australian Institute of Health and Welfare 2019. Towards estimating the prevalence of female genital mutilation/cutting in Australia. Cat. no. PHE 230. Canberra: AIHW. https://www.aihw.gov.au/getmedia/f210a1d8-5a3a-4336-80c5-ca6bdc2906d5/aihw-phe-230.pdf.aspx?inline=true

There are also many rumours circulating about high powered politicians will pay for a 'bush', the term used for an FGM initiation ceremony for a group of girls from one village. The personal view of the politician in question might even be against FGM, but the indication was that the votes of that village would follow accordingly. I could not verify these statements, but even the existence of such rumours is relevant for the wider messaging at community level.

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First Lady Fatima Bio seeks more opportunities for African Women, Praises Sierra Leone's recent policies on women and girls

Tangier, Morocco, Friday 15 November 2019 - Her Excellency Madam Fatima Bio has called on African leaders and the private sector to provide more opportunities for African women to gain their fullest potentials and praised her husband, His Excellency President Dr Julius Maada Bio for supporting women and girls in Sierra Leone.

She made the call whilst delivering a keynote address on the theme: "African Women: No Parity, No Development?" at a session of the 12th Edition of the Medays Forum in Morocco.

The First lady also told the audience that African women and girls faced a series of challenges, ranging from lack of economic opportunities, access to justice, legal protections to the lack of access to quality healthcare and education.

"We cannot achieve sustainable development in Africa if women and girls are left behind. We have to close the gender gap. If you keep all the women in the kitchen, we will only have smokes. Women must have equal access to finance, technology and other opportunities. We have a duty to ensure that women and girls in Africa are protected from rape, sexual violence and early marriage," the First Lady said.

Madam Fatima Bio also used the platform to showcase efforts of her husband to empower women and girls in Sierra Leone by protecting their rights. She highlighted the "Hands Off Our Girls" project, which she said was initiated by her husband to protect women and girls.

The First Lady cited "the amendment of the declaration of the State of Emergency on Rape and Sexual Violence, the Amendment of the Sexual Offences Act, the Special Court for Rape and Sexual Violence Offences, the access to financial inclusion through NCRA, the increase in women political appointments, the free quality education programme and increase in access to university for female students".

Later His Excellency Presiden Julius Maada Bio and the First Lady were taken to Tanger Med, the larges port on the Mediterranean and i Africa by capacity, located on th Strait of Gibraltar about 40 km east Tangier, Morocco. The Tanger M project is a strategic priority of t Moroccan government for t economic and social development the North Morocco region.

For More Enquiries:
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+23276758764/+23288269282

Photo 13: An article found in hotel lobby, referencing Hands Off Our Girls; the campaign was high profile and very visible.

The First Lady of Sierra Leone, Fatima Bio, heads up a campaign, 'Hands Off Our Girls' 2019-2022. There are billboard adverts across the country, hosting this message alongside an active media campaign. As I waited in a hotel lobby, I found a newspaper article referencing this. With rates of sexual violence and child marriage extremely high, this is also an immensely important campaign. It does not include FGM, so therefore the implicit message is that FGM is not child abuse, again giving confidence to those advocating for FGM to continue.

An example of what happens if a project tries to promote the End FGM message in Sierra Leone was from someone who used to work in a healthcare setting in Freetown. They spoke about how the service was running End FGM workshops, but these had been stopped. It simply did not make sense for the patients to hear one message to End FGM in a public health workshop, when they would then be seen in clinic by a healthcare professional who did not agree that FGM should end, and who was likely to tell the patient not to worry about what they had just heard. This shows how it can be difficult to set up effective projects to tackle FGM, where only 23% of women and girls who have heard about FGM think that the practice should end.

Interviewees highlighted:

*It is so **difficult** to be **one lone voice saying End FGM**, in the sea of many others who are continuing to advocate for FGM.*

Some interviewees also spoke about how it is draining to know that they were an isolated voice, and that even if they had been able to make a connection with a woman, they know that many others are likely to counter whatever they had said to her. It appeared to lead to a significant toll on those involved.

Do the actions of the international aid sector influence the views of communities?

International aid is still funding and supporting many aspects of life in Sierra Leone though their presence has reduced in recent years. These agencies all support the urgent need to End FGM, however their work in Sierra Leone appears to overlook it as a problem. Interviewees said that this in turn emboldens those who support FGM, because they perceive this as having implicit support not only from the Sierra Leonean Government, but from the international aid agencies as well.

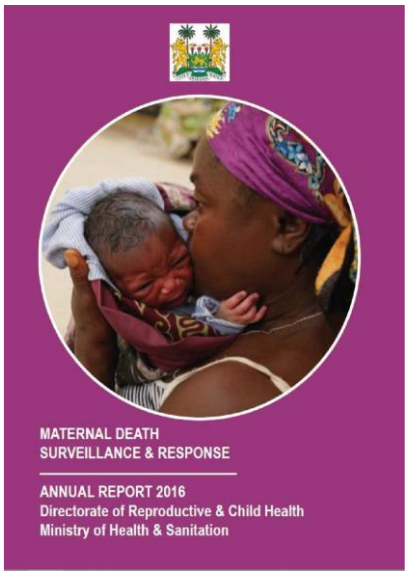


Figure 20: Front page of the report.

For example, the World Health Organisation WHO and United Nations Population Fund (UNFPA) both financial supported, and gave technical contribution to the 2016 Maternal Death Surveillance and Response report, which was authored (and owned) by the Sierra Leonean Ministry of Health and Sanitation[19]. Maternal mortality rates are extremely high, and the report recognises *'Maternal deaths accounted for 36 percent of all deaths among women age 15-49 (DHS, 2013)'*.

The report highlights that more than 32% of deaths caused by post-partum haemorrhage (PPH). Whilst FGM is not the only cause of PPH, it is likely that in a country where there are very high rates of FGM and a large proportion of maternal deaths are from PPH, there is some link.

FGM is not mentioned once in this report. This is a problem.

Interviewees consistently highlighted that this link needs to be considered. Several people were calling for the international funding organisations to make any further investment dependent upon either including FGM in the work, or making it illegal.

However, international aid tends to support only development projects which have been adopted and pursued by the local Government/society. Until the Government or public opinion reaches a clearer anti-FGM position, the aid agencies are unlikely to do much, certainly in public. And in the meantime, it appears that they will continue to invest in programmes which address the consequences of FGM, for example the National Nursing and Midwifery Strategic Plan 2019- 2023[20] even if the link between maternal health and FGM is not appropriately explored.

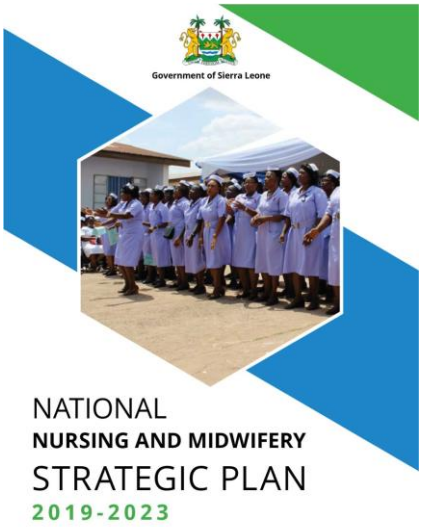


Figure 21: National Nursing and Midwifery Strategic Plan

The interviewees who worked for international bodies provided some defence to this position, that much work continues behind closed doors to negotiate with the Sierra Leonean Government. Without access to sensitive conversations (which it would have been inappropriate to share with me), I can only be optimistic that this is happening.

Talking to people in Sierra Leone outside of the formal context of the interviews and visits, and including those who did not know about my project, I heard that the UK Government is held in high regard, and their support during the Ebola crisis is still very valued. Then in the interviewees, many Sierra Leonean interviewees gave the opinion that it really would be acceptable and indeed welcome if the UK Government took a strong stance in relation to ending FGM, and they are the best international partner to do so. This demonstrates the potential for stakeholders outside of the country involved to contribute to a whole system approach.

[19] Ministry of Health and Sanitation, (2017). Maternal Death Surveillance and Response, Annual Report 2016. https://reliefweb.int/sites/reliefweb.int/files/resources/mdsrreport.pdf

[20] UNFPA Sierra Leone, (2018). National Nursing and Midwifery Strategic Plan 2019- 2023 https://sierraleone.unfpa.org/en/publications/national-nursing-and-midwifery-strategic-plan-2019-2023

Whole system approach at a local scale

On a more positive note, I visited a project in Port Loko where, despite the national mixed messages, the local project called AIM, run by Rugiatu Turay is taking the system approach to an even more extensive level than any project I had seen. As well as teachers, religious and community leaders, they are running awareness sessions for hairdressers, taxi drivers and shop keepers, giving them information about FGM and asking them to report what they hear.

Photo 14: Theresa was such a keen member of Rugiatu's team in Port Loko.

In this example, I was interested to hear that Rugiatu said she was no longer campaigning for FGM to be illegal, but she was confident that the decision to continue FGM was held by the community, and people would be most influenced by other people around them.

If success can be demonstrated, then this would indicate that a whole system approach could be effective in different types of system; some communities might need the country level approach, and others would change based on their local community.

Summary

The finding is that an End FGM effort works better when all aspects of society and Government are involved, using a whole system approach. This appears to be a more efficient model, thus reducing the burden caused, and placed upon the shoulders of those involved in the work.

There appears to be a positive correlation between the extent to which a country has implemented a whole system approach, and number of stakeholders giving positive examples and accounts of progress in tackling FGM.

Interviewees clearly said:

*When **all stakeholders and the community** are involved, the fight to 'End FGM' makes **more effective progress**, and does so **more efficiently**.'*

1. In Kenya, which appears to have the most active whole system approach, community members and professionals gave confident accounts of change happening.
2. There were mixed accounts and opinions in Egypt and Australia, where accounts and analysis determine the whole system approach is not complete.
3. There are examples of projects which are detrimental to the End FGM campaign in Sierra Leone, where it is very clear that there is no whole system approach to ending FGM in place.

In support of the finding, it appeared that communities were significantly influenced by the messages they received from a whole system approach.

Strong links were highlighted between professionals feeling supported and more able to carry out their work well, and the whole system approach being in place.

3. FGM is a gender inequality as much as gender-based violence and needs to be tackled as such.

By visiting many projects and spending time in communities, I saw from a different perspective how FGM is a gender inequality issue, and why to recognise it as such improves the work to End FGM. Consequently, where this was in place, the people delivering these projects felt support and satisfaction knowing that the effort they were giving was worthwhile.

In Kenya, Sierra Leone and Egypt

For the girls in Pokot and Isiolo in Kenya, in the upper regions of Egypt and in Waterloo, Sierra Leone, I heard so many stories that the day a girl is cut marks the exact point when her life course changes.

The 'different life course' takes many routes. It might mean a girl stops going to school, or she will soon marry. For a community in Narok County, Kenya, I heard that being cut meant a girl gains her adult voice and is listened to. In that community an uncut woman, no matter how old, is considered a child and without opinion or standing. The different treatment of siblings within a family demonstrates this, as brothers continue into high school and college, but their sisters stop going to school after they are cut.

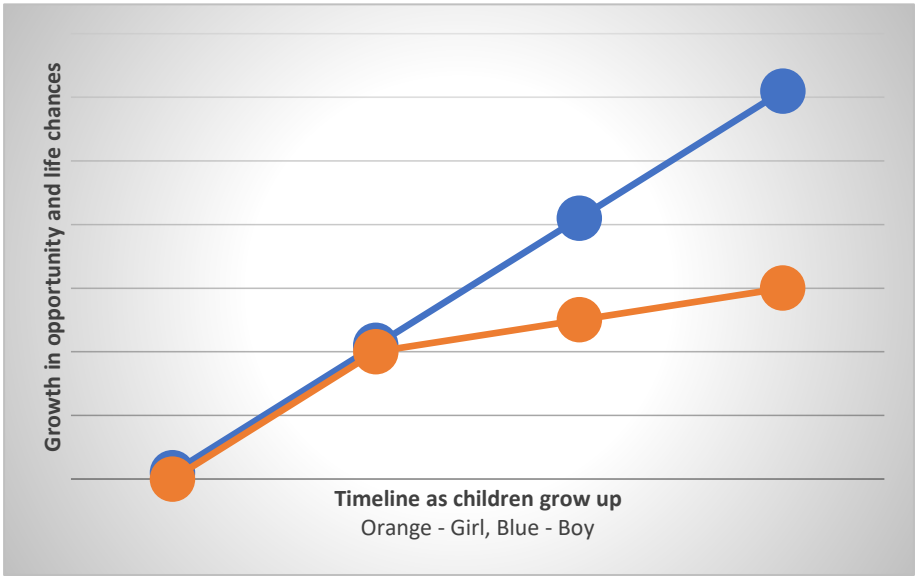


Figure 22: Visual representation of the change in the life course of a girl, divering from that of her brothers, at the point where she has FGM

This diagram visually represents this concept, that a girl's life course takes a different path from the point when she is cut. In early childhood, the treatment of girls and boys is relatively similar; they all play, attend school, carry out household chores. But after a girl is cut, her chances and autonomy reduce. In all likelihood, there are going to be other gender inequalities which influence her lift both before and after FGM, but the act of FGM often marks is a significant point in her life.

What became apparent is that there are some projects who want to stop girls from having FGM (and prevent child marriage) accept that the role of women is different, with less autonomy and freedom than that of a man. Other projects want to stop FGM and are motivated to do so to help make sure that a girl has all of the opportunities she can, and makes her own choices in life.

Projects such as the one I visited in Port Loko, Sierra Leone, are introducing 'alternative rites of passage' or ARP. With differences about how this happens from project to project, the idea is that the ceremony marking the transition from child to young adult is kept, but the act of cutting is exchanged for an alternative act. This might be lighting a candle, a dance, or other symbolic act.

ARPs are being keenly debated by many people in Sierra Leone, including some of those interviewed. The removal of the act of mutilation is patently good, but some ask if the ARPs preserve the concept that a girl transitions to being a young woman, and enters into a life where her choices are not her own, and she is subservient to her husband and her family. The turning point in Figure 22 is maintained. In Sierra Leone, the rite of passage also marks the initiation into the Bondo/Secret society, and supporters of the society will say that this involves her joining a network of women who will support her throughout her life. It cannot be ignored however that joining the society will often lead to child/early marriage, teenage pregnancy and stopping attending education.

Figure 23: One of the leaflets used by Girlz Empowered SL to spread the message.

The project, Girlz Empowered SL, was an example where tackling FGM is part of a change they want to see for girls' and women's' rights. They setup school groups to initially discuss FGM, but these continue to run as peer-support mechanisms. The girls choose the topics they wish to talk about, which have included menstrual health, sexual violence and access to education. The project aims to help girls reach their full potential, and change their life chances. Therefore, the intention is to bring the life course of the girls closer to that of their brothers, and the divergence of the lines in Figure 22 would not be as wide.

Both examples tackle FGM, and in doing so protect girls from violence and all the painful consequences. But they do not both address the gender inequality issues in the same manner.

So should the movement aim to end the violent act of FGM, or address FGM as a gender inequality issue?

In the African female-led movement at the forefront of the fight to End FGM, campaigners call for women and girls to live a life as equals and to their full potential, not just to avoid being cut.

In support, the UN and family agencies repeatedly recognise that FGM is 'a manifestation of gender inequality that is deeply entrenched in social, economic and political structures'[21], clearly linking FGM with much more than just the violent act of being cut.

[21] Eliminating Female genital mutilation An interagency statement OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO, 2008
https://www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf

Campaigners in Egypt explained that they were concerned that the focus is on ending FGM only. One interviewee explained that she sees that girls who are not cut placed under even more strict regulation by their fathers; without the perceived 'physical control' measure of being cut, the young girls have to behave in an even more controlled manner, with even fewer opportunities to attend education or for social interactions.

How is this fair? After learning about FGM at school, I begged not to be cut and I wasn't. But now I'm not even allowed out to see my friends!

Another interviewee in Egypt spoke of a similar challenge, gender equality versus female economic empowerment. Gender equality as perceived by our Western societies allows women to live their lives with independent choice and the same opportunities as men. Female economic empowerment is an important facet of this, making sure that women can earn money themselves and have financial autonomy. However, as interviewees suggested, if the fight to allow female economic empowerment is taken on separately from the fight for comprehensive gender equality, then improvements will be measured in seeing more women earning.

But in Egypt, women already significantly carry the burden of running the household, caring for children and elderly relatives (with the expectation of having many children). Therefore, them now having to earn an income too is not necessarily 'progress' in terms of gender inequality, because it has added to the already heavy load a woman has to bear.

These examples demonstrate the need for making sure that work to End FGM does not become detached from tackling gender equality, as doing so may unintentionally allow the further entrenchment or exacerbation of gender inequality.

In Western contexts

In Australia, the context is different. The major life changes a girl in Kenya would face after being cut are very unlikely to happen. With universal free education, and the minimum marriage age of 18, girls will continue to receive their education, and do not marry until they are adult. The same is true in the UK, although minimum marriage age is 16.

However, because FGM is a gender inequality 'deeply entrenched in social, economic and political structures', it is just as important to consider what those structures look like in a different (Western) context. The 'controls' may not be as stark as getting married at 13, but are they there?

Interviewees in Australia spoke of a real concern that FGM is related to wider gender inequality in their society. Discussed examples included whether there is a link to forced marriage, whether women in the communities affected by FGM have economic independence or if there are increased rates of domestic abuse. Other inequalities were also spoken of, for example if within a family, girls do not feel able to go to university because of an expectation to marry early, or care for relatives. Further research would be needed to try to quantify what this is, but given the significant link between FGM and other gender inequality in the millions of women living in Africa, and the strong association with family, it would seem foolish to assume that following migration, the context is so altered as to allow FGM to no longer be associated with any other gender inequality.

Comparing policy statements in Australia and the UK

Policies and strategies set the tone, context and ambition for how Governments and organisations tackle matters such as violence against women and girls.

The Australian Fourth Action Plan[22] sets out to tackle violence against women and children by promoting gender equality and makes this link very clearly in the foreword, subsequently repeated throughout the document. The plan recognises FGM as gender-based violence.

> *'Ending violence against women and their children starts with promoting gender equality and respect for all. Strong and growing international evidence confirms the severity of violence against women and the key role of addressing gender inequality to prevent and reduce this violence.'*

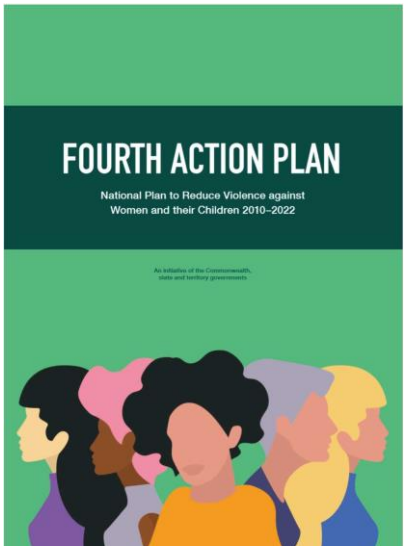


Figure 24: Australia strategy to tackle violence against women and girls

In comparison, the UK does not routinely identify FGM as a manifestation of gender inequality, nor set the expectation to tackle it in this way.

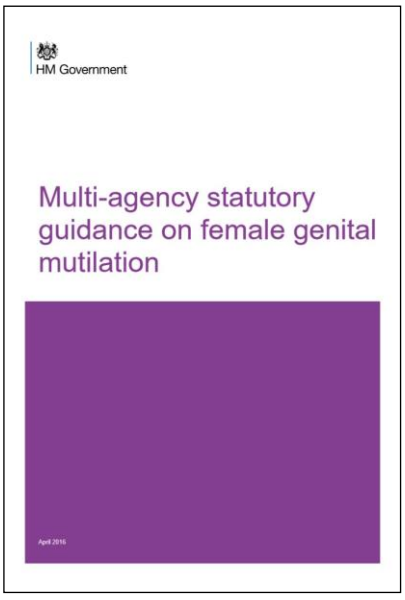


Figure 25: UK Statutory guidance

The *Multi-agency statutory guidance on female genital mutilation*[23] provides a roadmap for statutory agencies to understand how to respond to FGM. It therefore sets the strategic direction for the work in the UK. Chapter 2 is titled 'Understanding FGM', but only in the final two paragraphs is there the first and only recognition in the entire 86 page document of the wider context: *'FGM is a form of violence against women and girls which is, in itself, both a cause and consequence of gender inequality'*.

To conclude, Australia has recognised gender inequality in their policy guidance, but the UK has opportunity to do so more clearly.

Summary

FGM is not an isolated act of violence a girl faces, but manifestation of a complex gender inequality. The research has identified that, if FGM is treated as a simple one-off act of gender-based violence and stopped, we cannot be sure that the girls who are protected from FGM will not face other unintended negative consequences. The likelihood of this happening appears to be reduced when tackling FGM within the gender inequality context.

In the first finding, the research identified that many people involved in the End FGM work are motivated by the knowledge that they are helping young girls, and this helps them get through different periods. Therefore, to best support the people involved, the End FGM movement needs to make sure that efforts are targeted as best as they can be and are not leading to unintended negative consequences. This again supports the argument to tackle FGM as a gender inequality.

[22] FOURTH ACTION PLAN National Plan to Reduce Violence against Women and their Children 2010–2022, Department of Social Services (2019), https://www.dss.gov.au/sites/default/files/documents/08_2019/fourth_action-plan.pdf

[23] HM Government (2016), Multi-agency statutory guidance on female genital mutilation. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/800306/6-1914-HO-Multi_Agency_Statutory_Guidance.pdf

4. The message must stay 'End FGM'; anything else will slow us down.

One of the most consistent reflections from those interviewed was there is much frustration and significant inefficiencies caused if parts of the End FGM movement try to use messages which aim towards appeasement or compromise with FGM advocates, instead of working towards a complete stop of FGM happening.

Those interviewed put forward moving and strong arguments that the approach must therefore be a clear and consistent message to End FGM. This will make faster progress, and reduce the burden faced by those involved in the work.

The examples of mixed or incomplete messages are:

Medicalisation: interviewees in Egypt linked the rise in medicalisation as coming from using the message that FGM should stop *in order to* avoid health consequences.
The practice of FGM therefore evolved to it happening on in a manner which reduced health consequences but did not address the fundamental right to live without violence. Further detail in the medicalisation case study.

Pro-Choice / over 18s: In Sierra Leone, there is a growing call to allow FGM for girls over 18 if they give consent. Considered alongside the growing understanding of coercive control, can young girls truly consent when they turn 18? Many who work in this field believe that families and communities will groom young girls during childhood, so that it became an obligation and not a choice to be cut at 18.

Even in Kenya, where the message is more consistently End FGM, there is an ongoing court case where a doctor is arguing that the ban on FGM is unconstitutional and that adult women should be allowed to do what they want with their bodies.

Alternative rites: Projects which replace the violent cutting with an alternative acceptable ceremony are very popular in many countries and have been successful in ending FGM. In several interviews a concern was raised, with trepidation, that some projects pursuing the ARP model may be keeping so much of the ceremony surrounding the violent act of FGM, that it may not be giving a clear message that FGM should end. If everything about the ceremony is kept, including the involvement from the same cutters (though they perform a different role), the secrecy, the control over the girls going through the process, then is it not clear to the community involved that the message is that FGM has to stop. Some are concerned that this approach almost suggests that there are ways to work around it being illegal, and in the long run, potentially revert back to the 'full' ceremony when the scrutiny has passed.

Lesser types: Though there is little quantitative evidence, discussions in all four countries considered if there is a growing move towards 'lesser' types of FGM, with the general view that this is an insidious development.

Interviewees felt that families who are worried about there being evidence which could lead to them being prosecuted, are considering a smaller cut, without removing flesh. Those who want to avoid the health consequences of FGM are also believed to be moving in a similar direction, either making a smaller cut or removing less flesh.

Much of this mirrors the change seen in and around medicalisation, though it seems that this is a discussion which is very much emerging currently. However, as it is being spoken about by a number of people in countries as diverse as those visited, lessons need to be learned about how the medicalisation change emerged and developed, unchecked until relatively recently.

Interviewees gave accounts of why these mixed messages cause them such frustration and annoyance.

- Waste / inefficiency. If the huge investment of an End FGM programme does not stop FGM but instead means that the practice evolves into a more secretive form, then many interviewees were not happy that this had achieved the purpose.
- Confusion. Others spoke of how this leads to a lack of clarity about which message is the right one, and if in doubt, communities will continue as they currently are. The benefits of a whole system approach are not seen if an alternative message is either allowed or not challenged.
- Supposed compromise removes the argument to End FGM. Some interviewees reflected that any kind of acceptance of FGM, and therefore compromise, then means that the End FGM argument is no longer valid.

Smoke and mirrors

The final reflection was discussed by interviewees who, like me, were not from the country that I was visiting. They recognised that there were often inconsistencies in the narrative. I also experienced this.

For example, in Egypt, interviewees from Cairo and Alexandria immediately turned focus of the interview to what is happening in Rural Upper Egypt where in 2015, 84% of girls aged 15-19 have FGM. The interviewees said to me *'it isn't a problem in the cities'*. But the same statistic in 2015 show that 42% of girls aged 15-19 in Urban Lower Egypt have had FGM. This is nowhere near the same rate, but it is still a large proportion.

Summary

When incomplete or mixed messages are allowed to circulate unchallenged, this both significantly reduces the chance of Ending FGM, but also causes great frustration to those involved in the work.

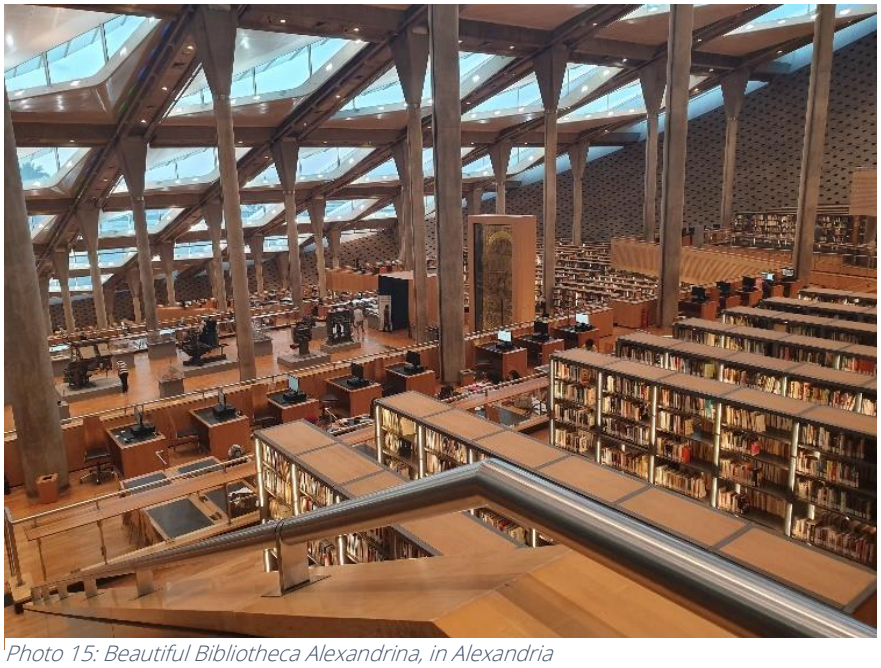


Photo 15: Beautiful Bibliotheca Alexandrina, in Alexandria

VIP tour of Alexandria Library

Photo 16: In the main library room.

Egypt was the most difficult place to arrange and then to finalise meetings. Within 24 hours of landing into Cairo, I found half of my appointments had cancelled or needed to be rescheduled. This was always with understandable reason, but I became more used to hearing that people were not available in Egypt more than anywhere else.

I asked for contacts from a range of colleagues, and through one route, I found myself in contact with an academic working in Alexandria University. It had taken quite a few emails to get in contact. This individual has published works around violence against women and girls, but I sensed that there was a reluctance to meet.

Unfortunately, on the day I was in Alexandria, my contact confirmed that they were not available to meet me. Instead however, I was given the most incredible tour around the new Bibliotheca Alexandrina.

Finished in 2002, the new library is architecturally stunning. The ancient Library of Alexandria was one of the largest and most important in the ancient world, and the new library relies heavily on this history, as well as being a vibrant and beautiful learning space.

I was looked after by four different tours guides, each specialist in their own field. I had a veritable entourage as we went through the main library, and the 3-D visual show was hosted just for me, as an unscheduled showing on a Thursday afternoon as the rest of Egypt was closely down for the weekend. I was treated as a VIP, whisked through turnstiles without paying.

I still find myself wondering if I was given such a fabulous experience, as it was easier to host me in this way than to talk about what could have been a tricky subject, FGM and gender-based violence.

At the end of the tour, I stayed at the library for quite a few hours until it closed at 7pm. The very first bookshelf I perused was the section of books about women, an elegant coincidence indeed. Soon after, at the other end of the library, I found myself skimming through UNICEF reports, UN Action Plans and UN Women statistical digests from the late 1990s through to current day, searching desperately for mention of FGM. I have a whole collection of photographs of tables, annexes, and of case studies looking at maternal mortality in Sudan, yet not once mentioning FGM. Of the challenges we face today, I feel that few are new. The lessons must be learned however, or the young girls of today and tomorrow will be the mums in twenty years living with the consequences of FGM.

Photo 17: Books and reports in the Bibliotheca Alexandrina

Medicalisation – the shift in how FGM happens in Egypt

There has been a shift in practice, which is that in Egypt, FGM is being commonly performed by healthcare professionals, and increasingly so over recent decades.

> *'FGM has become increasingly medicalized: Of those who underwent the practice, 4 in 5 girls under age 15 experienced FGM at the hands of a medical professional, compared to fewer than 1 in 5 women aged 45 to 49 years.'*[24]

Meeting representatives from the UNFPA Regional and Country Offices and from the National Population Council, the experts interviewed spoke about the impact of this shift, and the cause.

They spoke about the anti-FGM message used in the 1990s in Egypt being *'stop FGM because of the health complications caused'*. When one considers that FGM is a deeply held social norm, consequently the groups who wanted to promote FGM developed a counter message; *'if your girl is cut by a healthcare professional, then the risk of health complications (including death) are greatly reduced'*. Therefore, the practice developed so that FGM is performed in a manner where the risk of physical health consequences is reduced, thereby allowing FGM to continue with advocates of FGM able to say that if it was only that FGM should stop because of the health consequences, then this 'new' way of performing FGM was OK.

It is important to note that, despite the significant shift to medicalisation of FGM in Egypt, this type of FGM is still not legal.

The history is more complicated than this, and if interested in an in-depth analysis may wish to read the report[25] by UK charity, 29 Too Many, which details the legislative development in Egypt.

Of course, arguing that it is safe to have FGM if performed by a healthcare professional is not true.

- Not safe; There is no 'safe' way to perform FGM; there is no training about how to do it (safely or otherwise), and no evidence or medical research to define what it is. It is not a medical procedure. A doctor is likely to use their professional knowledge and skills, to reduce risk of infection, perhaps also offering pain management. However, there are important arteries in female genitalia; this is not an accepted medical procedure.
    - Those working to tackle FGM in Egypt were frustrated that there was not widespread recognition that FGM is not a medical or safe procedure, and that this is not discussed widely.
- Generates income; Those interviewed explained that a 'basic' salary as a doctor in Egypt is low, and it is normal for doctors to also have private clinics and supplementary activities to increase their income. The doctors who perform FGM find that doing so is a lucrative business, to supplement their salary.

[24] United Nations Children's Fund, Female Genital Mutilation in Egypt: Recent trends and projections, UNICEF, New York, 2020. https://data.unicef.org/wp-content/uploads/2020/02/FGM-Brochure-Recent-Trends-Projections-Egypt-English_2020.pdf

[25] 28 Too Many, 2018. Egypt: The Law and FGM. https://www.28toomany.org/static/media/uploads/Law%20Reports/egypt_law_report_v1_(june_2018).pdf

- **Compromises professional values:** Given the negative consequences caused by any type of FGM, a healthcare professional who performs FGM is working outside his or her professional values. Professionals are required to comply with these values but by putting either personal gain or perceived community interests above the rights of the child involved, his or her medical ethics are compromised.
    - The Anti-FGM Board in Kenya is scoping a project to work with healthcare professionals believed to be carrying out FGM in one county. At the moment, the HCPs involved are saying that it is better for the girl to be cut by them, with their knowledge of infection risk and wound care, than to be cut by someone without any medical training. This is more complex argument, put forward as a 'lesser of two evils' scenario.
- **Doctors widely known;** It was apparent that some people interviewed in Egypt knew or suspected which doctors were involved. When asked why they are not reported to the authorities, there is a complex situation that they do not want to be the one to report, they do not believe action would be taken, and feel that the level of proof they have would not be sufficient to be sure that the police would act, and other unspoken considerations.
- **Medication 'confidentiality';** When I asked how it is kept quiet, interviewees explained that medical confidentiality principles are 'misused' and a doctor can say that the parents have requested a private consultation for malaria; this specific example was offered in at least five interviews.

Some interviewees indicated that only a few doctors are active in performing FGM, because one doctor can cut many girls in a short space of time. One interviewee, a doctor by profession, spoke of her frustration that, in her opinion, the general narrative around medicalisation of FGM in Egypt does not recognise that though it is common for a girl to be cut by a doctor, this does not mean that all doctors are involved.

> *FGM happening in a medical setting, performed by a healthcare professional,* ***is not safe****.*
>
> *FGM performed like this* ***is not legal.***
>
> *There are still* ***painful health consequences.***

Interviewees were asked how FGM is arranged in this context. Participants explained that the family's religious leader, the imam in this predominantly Islamic country, will 'refer' them to a doctor who will perform FGM on a girl.

Those interviewed all highlighted that they considered it to be a mistake to have used the health-based message, *'stop FGM because of the health complications caused'*, because of how it has led to FGM happened in this medicalised manner. They all advised that other countries learn and take care not to focus solely on the health consequences of FGM.

Photo 18: Tahrir Square, at the heart of Cairo.

5. To change the view of someone who supports FGM is difficult.

When comparing the projects visited in Africa to the work in the UK, there is significantly more discussion of how much effort it took to change the minds of the people who currently support FGM. This was coupled with a recognition that the change of view can take time to achieve in just one community, to gradually bring everyone on board.

Interviewees also recognised that success motivated them to carry on when the End FGM work became difficult; they said they would look back and remember the young girls they had helped protect from being cut, and the fathers who had thanked them for helping them understand they could stop FGM.

Alongside this, when asked what would make things difficult in the first place, interviewees spoke about how they have to keep working repeatedly with a community, and that the effort has to last a long time and that it is difficult to keep going for as long as it can take. I was looking for why this was the case, to see what the most effective and efficient method was.

Interviews in Kenya, Egypt and Sierra Leone gave examples of why it is difficult.

Other issues in life are more pressing. If they are struggling with no money, famine, or family breakdown, an alternative to cutting their daughters may not feel viable. FGM can lead to an improved financial position for the family, if the daughter(s) can then marry and leave home. The argument of her staying in education to get a job herself is only viable if they can afford school fees.

Deeply held beliefs. They have a wider belief spectrum which means the arguments against FGM do not resonate, for example if they think that women should not have equal rights to men.

Not concerned about consequences from continuing with FGM. They believe that the consequences of stopping FGM will be worse than if they continue with FGM, because there are other negative consequences for the family if daughters are not cut.

- In Sierra Leone, this is that she is not perceived as 'marriageable'.
- In Egypt, interviewees said that a daughter willing to undergo FGM could be portrayed as a 'meek and mild potential wife', therefore would enhance the father's social standing. If a daughter was thought to be a troublemaker, because she refused to be cut, then a father may be more concerned about the impact on his reputation. The medicalisation of FGM has further engrained this attitude, as the risk of death from FGM and other serious health consequences is thought to have been significantly reduced.

Repeated failed efforts to End FGM has led to confidence in FGM advocates. Both in Egypt and Sierra Leone, examples were given about how repeated efforts to End FGM have failed, and this meant that people who support FGM feel more confident in their views, because they have 'won the battle' before.

End FGM message given by someone not respected. Midwives in Ortum spoke about how patients would relate very differently to a professional who had learnt how to speak the local dialect, and this would be a barrier in a woman with FGM being willing to believe or listen to an End FGM message.

Targeted messages

Projects in Kenya, Sierra Leone and Egypt all said they had made decisions to focus on working with children and young people, and young parents, as they believe this is the group most likely to change, and because it is easier and quicker to achieve this change. They work with this group to empower them, giving the confidence to protect both themselves, their peers and daughters born to them in the years to come. Interviewees were often buoyant and optimistic when talking about working with young people.

This is because in the resources and time available, the community group have all identified that the work with elders is much slower, and it is much more difficult to change the mind of someone who has a long-held view. However, many would still recognise that there needed to be the widespread public health message targeting all members of society.

Interviewees would speak about having mapped out their groups, and identify the appropriate messages, as well as the overlap.

This diagram is an example of how to segment the audience and identify plans about how to target certain messages to certain groups, who have been identified as being likely to react to and engage with this message.

	End FGM Message						
Audience	Human rights	Health impacts	Illegality	Illegality – you will be caught	Protect the girls in your care	Protect yourself / sisters / peers	Staying in education increases chances
Whole Population (FGM practising and non-practising communities)	✓	✓	✓				
Elders	✓	✓	✓				
Parents of girls likely to be cut	✓	✓	✓	✓	✓		
Young people – girls and boys	✓	✓	✓			✓	✓
Young girls likely to be cut	✓	✓	✓			✓	✓

Table 1: Example of targeted message segmentation.

Developing the kind of project which does change views

Those I met working in community groups in Kenya and Sierra Leone explained that if an anti-FGM message is poorly delivered or does not resonate with the audience, then people who currently support FGM may not be persuaded to stop. Some people will, but it is not likely to persuade everyone.

Think of a belief you hold deeply, perhaps religious, political, about how we treat each other in our society or similar. Imagine someone now trying to change your mind. For a moment, consider how you would feel if when they discuss this with you, they do not bother to find out what you actually believe or why. You are likely to be annoyed, consider them arrogant, or simply ignore them. And this is not likely to lead to you to change your mind.

The interviewees spoke to me about how this is the same when working to End FGM. In these instances, they also demonstrated how they then adapt their work to respond to this.

Why does FGM happen in Sierra Leone? Over 80% of women have FGM, for the vast majority of these it was to join the Bondo society.

How Waves-SL are responding to this? The project talks to girls and parents about how staying in education rather than joining the society will give girls much greater opportunity and benefit in their lives.

By whom are girls in Egypt cut? In Egypt, nearly 80% of girls with FGM were cut by health personnel.

How is a civil society organisation responding to this? Randa Fakhr is working with newly trained doctors to explore the role of doctors in the continuation of FGM.

Why does FGM happen in Kenya? In Isiolo, one county in Kenya, the majority those practising FGM do so because they consider it part of their religion, and as such it is not related closely to the age of a girl.

How does Every Girl's Dream project respond to this? Aisha spoke about how she works with parents and explores why they think it is part of their religion. She also takes into account that it is not associated with age, so she cannot target families where the girl is at a certain age.

This demonstrates that projects and work to change everyone's mind about FGM needs to be designed to reflect the views held by those involved in the specific discussion to successfully engage people with the work. It also reflects that if a poorly targeted approach is used, the work will last even longer, created an even greater burden on those involved.

If we need targeted approaches to change views on FGM, what does this mean in Australia and the UK?

In Australia and the UK, there are many small resident communities who come from many of the 31 countries in which UNICEF has published FGM prevalence rates. Statistics from the NHS indicate there are almost equal rates of FGM Type 1, 2 and 3 in the patients receiving treatment[26]. The NHS workforce statistics[27] recognise that there are NHS employees from 30 of the 31 countries where UNICEF has published FGM prevalence rates. Within these different communities, survivors will have been cut because of a huge range of reasons, they will have been cut in every different way (FGM type), and it will have happened to them at many different ages. There is not a common profile of FGM across the affected population.

Figure 26: Leaflets in a handmade bag, as given to patients at the midwifery unit at the Royal Women's Hospital.

In Australia, there were two main interventions described where interviewees explained where professionals have to discuss FGM with women. In pregnancy, midwives are expected to talk to women who have had FGM. However, this is not yet consistent practice. Secondly, the End FGM message is also included in the migrant health programme, which is a wide-ranging education programme, supporting people for a short time after they move to Australia.

Both of these interventions are relatively short-term. It is also assumed that once the education had been given a couple of times from professional to patient, (FGM is illegal and has painful consequences), then the practice will have ended. There are significant similarities with the UK approaches. This was different in contrast to the effort described in the African countries to repeatedly give many and targeted messages to community members about FGM.

[26] NHS Digital (2020). Female Genital Mutilation (FGM) – January 2020 to March 2020, experimental statistics https://files.digital.nhs.uk/C5/340282/Female%20Genital%20Mutilation%20%28FGM%29%20-%20January%202020%20to%20March%202020%20-%20Report.pdf

[27] NHS Digital (2019). NHS Workforce Statistics September 2019, https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/september-2019

Having accepted that projects need to have targeted models to change the minds of those who support FGM, built in response to the views in that particular community, it becomes important in countries like Australia and the UK that the work to End FGM recognises the different communities resident.

If the approach in the UK and Australia is currently too simple, then in the long run, does this present a risk that progress will not actually be made, but we thought the End FGM work was going well? Further thought should be given to whether relates to End FGM work repeatedly stopping and needing to restart. The stop/re-start nature of the work increases the burden on those involved.

Is there an impact from having the majority of professionals being themselves from non-FGM practising communities? Do unconscious biases influence?

Of the interviewees I met in Australia, more than 65% would identify their community of origin as being one where FGM is not part of a long history or social identify.

In the three African countries, at most, 15% of those interviewed came from communities where FGM has never been part of the social identity. Over 80% of the people interviewed grew up in societies where FGM was part of the social context, regardless of if it was part of their personal background.

I discussed this in many interviews, and a suggestion emerged that these factors may be related. If there is a the lack of understanding about 'what FGM really is' and a perception that it should be easy to change opinions by the members of a project team, is this because the majority of the team are not from countries where FGM is long term part of the social history? If there is a link, then there is a risk that countries like Australia and the UK may be taking too simple an approach to prevention work.

What is an unconscious bias?

Unconscious biases are inherent or learned stereotypes about people that everyone forms without realising that they do so. An example in this context is that for someone who has only learnt about FGM in the course of their adult professional life, it may be difficult to understand that a person who currently supports FGM does not change their view, when they are presented with the facts about the illegality and health consequences of FGM. This view, being an unconscious bias, can be mitigated, but is more likely to be successfully mitigated if it is acknowledged and discussed in the first instance.

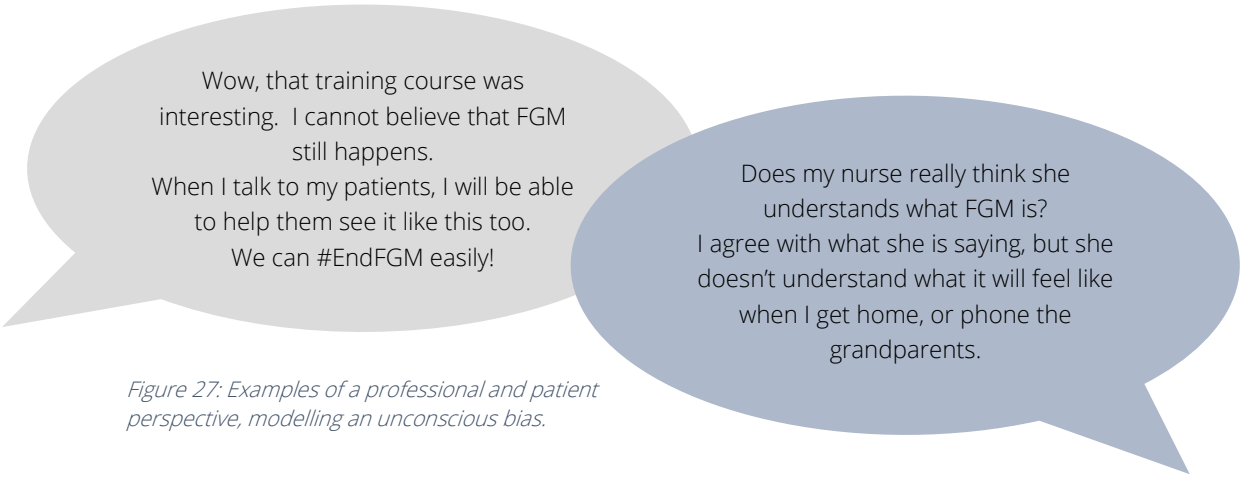


Figure 27: Examples of a professional and patient perspective, modelling an unconscious bias.

Summary

These findings highlight that projects and work to change everyone's mind about FGM needs to be designed to reflect the views held by those involved in the specific discussion, in order to engage people with the work. To achieve this, it may involve lengthy and repeated discussions.

This is needed because the people who were working to End FGM said they were motivated to continue when they felt that they were making progress; it is therefore important to make sure that End FGM conversations are effective as making progress in this area helps the End FGM movement sustain itself.

The interviews also demonstrated that there is a high likelihood that unconscious bias is influencing the practice of professionals working in countries like Australia and the UK, where the majority of the workforce do not come from FGM practising communities, nor have lived alongside these communities. This may also be influencing the perception of whether End FGM efforts are making progress.

More research would be needed to claim that this was an evidenced link, but in this complex area where work has to continue alongside the continued development of a research base, there is sufficient context to give consideration to this.

Photo 19: From the top of the Kenyatta International Conference Centre, the white building is Nairobi City Council, looking towards Kenyatta Avenue, downtown Nairobi.

Meeting the cutters

Whilst in Sierra Leone, I travelled to Kenema, a town in the east of the country and the centre of the diamond trade.

I met with a group of women who are cutters. They perform FGM

I thought long and hard before I arranged to meet them. Many campaigners are concerned that when people like me meet cutters, it can give them a confidence that they have a valid argument, and that they will feel that they are fighting back to maintain FGM. To counter this, I took time at the end to again re-state my position that I want to see Sierra Leone make FGM illegal and stop it from happening. Another aspect I had to consider was why do I think it is important to hear from them directly, when I also had (and continue to have) help from survivors telling me their experience first-hand?

But, the majority of the workforce, like me, does not have FGM in their background either. I have however been very fortunate to have worked with survivors for years, who have helped me to understand the social context. Yet still, sometimes, the ability to understand FGM absolutely fails me.

Another reason I met them is because in Sierra Leone, I was taken aback by volume of support for FGM, and I felt it would be shirking the subject to ignore this voice. Perhaps there is an added layer of protection, so that I cannot be criticised for failing to listen to the other side.

I met them. So afterwards?

I fundamentally disagree with their views, nothing they said in any way persuaded me. No surprise there. Actually, I think deep down, they know change is coming, because they were defensive, evasive. They jumped to defend themselves against my lines of questioning.

They lied so much. They denied there are health consequences. They denied having ever heard of obstetric complications. Tripping themselves up, they then said that 'all the women' who claim they have problems with birth are just lying themselves.

They tried to distract me with stories of Chinese traditional medicine, with Government approved registration schemes for cutters, with how important it is to learn how to bake and clean the house. They repeatedly stated they only do the initiation ceremonies because they get paid, but when I ask about why girls had to join the Society, they said it is the most important network available to women, and the most important thing to them.

A young lady, Katy, helped me with translation. She spoke to me afterwards and said that they were surprised that I knew so much about the cut, and that I knew what to ask. She said she could see that they were trying to control the conversation and avoid the act of FGM, and focus on other elements, which are not even true necessarily. But they were not expecting to find that I knew what I did.

One final example. In the meeting, they told me how one of them is a trained traditional healer, using herbal remedies to cure everything, and to whom the whole community will turn whenever they are ill. Later, as they left the house they asked if, as I work at a hospital, if I could source them any drugs and painkillers. A desperately sad example in many ways, this was yet more proof, if needed, that they are fighting hard, but I think they know deep down that much of what they say is nonsense

Photo 20: Katy, who helped me meeting the cutters, and me in the garden where we met the cutters.

6. End FGM networks (formal and informal) often face difficulties in being sustainable and effective.

Many contributors spoke with mixed feelings about networks. All but one interviewee recognised that networks are part of the support structure which helps them carry on with the work. However, interviewees also gave examples of problems with at least one network with which they are involved.

In Kenya, the Anti-FGM Board provides a network structure to the NGOs and campaigners to develop what its campaign request is, amongst the other work the Board does. It was established in 2013. Reflections on this network included:

- Beneficial to the Government to know how to liaise with / seek views from stakeholders.
- Stakeholders know the mechanism to contribute / take part in the national work.
- With ongoing multiyear funding, there is a high confidence that this network will remain active, therefore is worth supporting.
- Even within the well-coordinated effort, the third sector organisations still expect the board to be able to offer funding, when this is not part of the intention / budget.
- With no formal accountability, the board cannot make sure that policies / guidance is followed.
- Some interviewees challenged that because the board exists, other Government Ministries are less likely to carry out their responsibilities, when the role of the board is not to deliver the policy / legislative changes that only Government Ministries can provide.

Experiences were similar with the Coalition to End FGM in Egypt, which works with members to understand what their requests and objectives are, discusses and then agrees what their group policy is. Then, when any member of the network meets a Government body, they can speak on behalf of the network. The Coalition makes entry to the network dependent on signing up to the agreement.

Young activists in Kenya were critical of those networks which, in their opinion, were places for talk and did little. In contrast, The Girl Generation was frequently praised as being a useful network which helped start and fund many smaller groups. Catherine Mootian spoke about how through The Girl Generation network she took part in the Emotional Wellbeing project, which was a train-the-trainer programme for those running NGOs to learn about self-care.

Photo 21: I spoke to Catherine and Esmael, learning about the Emotional Wellbeing project.

Interviewees gave a mixed account of the national network in Australia. I joined a meeting with participants from several states. It was recognised that in recent years, there have been periods when the network was inactive, and each time it re-started, this

has led to concerns as to whether the previous network learning had been captured. It was notable that, with far fewer people involved in the End FGM work in Australia than in the other countries visited, the attendance at a meeting would be very varied. The network was aiming to support professionals, campaigners, and charity organisations alike, with different roles, responsibilities and concerns. This may have contributed to why the interviewees gave different accounts of why it is there, and what it does. Geography was problematic and interstate travel was often a barrier to attend.

In all countries, I heard examples of where networks have turned into self-congratulatory groups, where meetings were convened without attendance from the full range of stakeholders, which meant that those with different views were excluded, perhaps those who still wanted to provide challenge. In Sierra Leone and Egypt, there were several examples given where this would directly relate to politics.

In Australia, similar to the UK, people explained that it is easy for a network to evolve without including community representation. Without suitable representation from all groups, these meetings can be described as echo-chambers, where professionals not from FGM affected communities discuss how to End FGM without insight from the people who do understand the community dynamics. These examples had led to or exacerbated tensions within stakeholders, and sometimes had led to projects which were not effective. An echo-chamber or self-congratulatory network might support the small number of people within the structure, but given the amount of times I heard about such examples, these seem to create large amounts of friction across the stakeholder groups, seemingly to no end.

Personal relationships within a network

People in all countries spoke about tensions between stakeholders. The claims were sometimes intensely personal, questioning personal motivation and individual accountability. In subsequent discussions, either with the person at whom the claim was levelled or others in the network, I could see that these claims were often based on a lack of understanding or knowledge of what other projects are doing. There is of course a natural motivation of competition, in a sector where funding is competed.

This scenario is very much mirrored in the UK.

Interviewees recognised that the consequence of these difficult relationships is that their sector (be that third sector, health sector or Government coordination) is not communicating effectively, nor reaching consensus.

Using the example of where high-profile campaigners in the third sector have strained relationships, this meant that the third sector were not giving a consistent message to other sectors, for example the Government, about what they were campaigning for, and why.

In this scenario, seen particularly in two of the countries visited and in the UK, the Government and public sector can find it difficult to understand what the 'right' request is. There are some involved in the work who fear that in these scenarios, Governments have more often than not then opted for what is easiest or most suited to the current political environment, which may not have the girls who need to be protected from being cut as the top priority.

Having had experience of this scenario in the UK, but then seen it as a third party in two other settings, I recognised that this leads to enormous frustration and fatigue by both sides of this challenge. The impact on those involved is huge, and this spreads to many others across the End FGM network.

Summary

The support offered by helpful networks and networking was identified as an important support mechanism on offer to many professionals involved in the work to End FGM. Networks were also identified as a vital way to enable learning and sharing, which helps promote a strong movement against FGM.

However, in all countries visited and in the UK, there are issues with the networks in place. They need to be improved and valued more.

7. The End FGM movement has previously struggled to bring new people on board and to maintain momentum.

The research findings have thus far identified that the burden falls on too few people as there is more work to do that those currently involved can achieve. Also, the analysis of whole systems approaches identified that certain sectors are still not active in the End FGM work in some countries.

Both findings lead to the logical conclusion that more people need to be involved in the End FGM work, as well as making sure that we are keeping the involvement and expertise of those who are currently involved.

However, interviewees spoke about frequent tensions when new projects start, and difficulties.

- In Australia, those more recently involved spoke of how they can now see that when their project began, because previous efforts had stopped without being fully documented, they had to 're-learn' lessons which had been captured before.
- I heard sad stories across the research, (and have seen this in the UK), where dedicated experts had given years of service, but in the end the burden had been too much and they had to step away from the End FGM work in order to look after themselves. Their colleagues spoke of the impact this had, as their experience was missed.
- Another team in Australia explained that the manner in which a project had 're-opened' meant it was challenging to connect with the people who had been previously involved, though they were still close by.
- An individual with a senior role in a Government body (with a much wider remit than just FGM) spoke of their deep frustration that they were going to be moved into a new job though they asked to stay in their current role, believing this was because they were starting to challenge the status quo, without any opportunity to handover the work to the new individual.
- People working for international bodies supporting in Egypt, Kenya and Sierra Leone all reflected that the 'stop-start' nature of End FGM projects leads to significant strategic weakness.

This is closely linked to End FGM networks, which, if not structured to encourage new people and projects, can further exacerbate these difficulties.

When projects repeatedly stop and restart

Specifically considering the impacts of when projects stop and then re-start, the consequences are deeply felt, and include:

Loss of trust with the community, between colleagues and between survivors and public sector services/project; when there has been a strong partnership between survivors and public sector agencies (in whatever form, including third sector/NGO projects, Government bodies, health services) and the works ends, the survivors and community members who had been fronting the request for help and support felt let down.
When there is a renewed desire to work to End FGM by the public sector agency, the community and survivor groups have not stopped being affected or feeling hurt during the period of inactivity. Therefore,

the public sector body has to not only rebuild effort, but also overcome the damage done previously to the relationship by having stopped/reduced the work in the first place.

Fatigue; those who have seen this happen spoke of how much effort it takes for them to have to repeat the effort needed to begin a project, when they often looked back and could see that the only reason the previous project had stopped was poor planning or management, not because the need was not still there.

When a project stops, there is a likelihood that those who continue to support FGM will capitalise on the Government/movement's reduction in effort to End FGM, saying that the End FGM movement has 'given up'; similarly those who continue to practise and promote FGM do not reduce their activity if End FGM projects temporarily stop.

Meeting cutters in Sierra Leone

There is limited commentary in the report about when I met the cutters in Sierra Leone, beyond this account, because I chose to focus on those involved in the End FGM work, but it is worth mentioning that the manner in which they spoke to me came with an arrogance and confidence from having seen people come and go before.

They spoke about 'people like me' who came, made promises, and left, but nothing changed. They spoke about the many attempts to End FGM which have then stopped. The cutters used this as their justification that nothing would change. Much of these statements I do not believe, as even in Sierra Leone I think the tide is slowly turning. However, I worry there is bravado created by failed attempts to End FGM, which are likely to make the aim to End FGM harder and/or slower to achieve.

Summary

Given that there is a clear need to involve more people and organisations in the End FGM movement, any examples of barriers to join the movement need to be addressed swiftly.

Photo 22: The Gold Coast provided an alternative and beautiful Boxing Day.

8. Where the third sector is recognised as a profession, whose skills and capabilities receive investment, the outcomes are greater.

Notable in all African countries was a rigorous and professional approach taken by some community-based organisations, and how this approach stood apart from some of their peers and from the work often seen in the UK.

I met three small grassroots organisations supported by The Girl Generation in Kenya, as well as others supported by UNFPA and other international NGOs. The individuals who had been developed through these schemes spoke fluently about their strategy, including:

- the priority areas they are targeting,
- how they are approaching sustaining the message to End FGM.
- how they safeguard those they work with, and what to do when someone disclosed sensitive information
- networking, keeping in touch with the wider movement and sharing learning.

These examples are seen across the research, including in the social media case study, and the finding about how it is difficult to change the view of someone who supports FGM.

When asked where they developed this approach, the interviewees spoke about the capacity building programmes The Girl Generation, UNFPA and others offer and described how they had helped them understand what they could do, and how they could best achieve results.

Representatives from UNFPA in Egypt and the Anti-FGM Board in Nairobi spoke about the capacity building programmes in place, with their objectives being to instil the thorough approaches demonstrated, having learnt from the previous decades of wider development programmes. Also, the team at Equality Now described a comprehensive development plan to deliver these skills to their partners.

The UNFPA have published online a 'Manual on Social Change and Norms'[28] which provides a sample 5-day training course for training managers to promote the abandonment of FGM from a social norms perspective.

It was notable that, with far fewer campaigner-survivors and community based organisations working in Australia, there were no similar examples seen. Khadija, co-founder of the Australian branch of Desert Flower spoke of wanting support.

Having worked with similar groups in the UK for many years, the community-based work was different in tone and in structure and consideration should be given as to whether there is learning to adopt.

Why is this difference highlighted?

Whilst there are many issues around funding and finances, there was an assumption in the African countries that campaigners and activists delivering community work would be paid to do this; with no funding, they

[28] UNFPA, UNICEF (2016). Manual on Social Norms and Change. https://www.unfpa.org/publications/manual-social-norms-and-change

would not be able do the work. This was consistent across interviewees in the three African countries, and was reflected by strategic players such as the UNFPA.

In the UK, much campaigning and community work has been carried out without payment. Attendance at stakeholder groups is generally not paid, for example the Government stakeholder networks, health and police national strategic groups and attendance at Government hosted conferences and summits. There are many examples where people are asked to speak at conferences which are run by private profit-led companies, who do not offer payment for this. In the NHS, survivors have often been invited to contribute to training sessions or to speak at conferences without being paid.

In the UK, there is little ongoing discussion about capacity building or developing the skills of this part of the End FGM movement. There was little discussion about this in Australia also.

We should therefore consider: if funders were paying for what campaigners and charities deliver, would this lead them to better recognising the value of this work? The subsequent effect would be greater consideration of what skills are needed, and as appropriate, support and investment to address any gaps with offers of training and support.

Healthcare professionals also find themselves in this position in the UK. Many do not get permission to attend regional or national meetings or conferences as part of their contractual hours. They will attend on rota'd days off or take annual leave to do so. When attending in their own time, do they then represent their personal views or the views of their employer? In my experience, the organisation hosting the meeting will assume that those attending are doing so as part of their employment, but if this is not the case, it can complicate matters. This leads to the conclusion that work to End FGM is either not valued, not prioritised and NHS employers rely on the goodwill and personal motivation of those who want to be involved.

The research has identified the value that working with community-based groups brings, and how this is essential to effectively challenge views relating to FGM.

When people gave accounts of the burden they faced, they highlighted that they often have to give extra time and sometimes money because the contribution needed is not valued. Those who received support through the capacity building programmes identified this as a benefit which help them carry on the work.

Without the full recognition of what the third sector does, and therefore the need for capacity building, this finding indicates that there is a strategic difference between how the third sector is valued in the UK and Australia. This will lead to an exacerbation of the burden placed upon the third sector, and a limitation on their ability to contribute to the End FGM work in the UK and Australia.

Summary

The rigorous and professional approach taken by some community-based organisations in all African countries was notably, and how this approach stood apart from both their peers and from the work often seen in the UK.

The organisations which took this approach seemed far more able to communicate, plan and deliver changes which were leading to progress to End FGM.

9. Projects often face financial instability; this leads to many consequences and distracts from the aim to End FGM.

This report does not intend or attempt to assess whether finances are well used in the projects visited.

The community-based organisations in Kenya and Sierra Leone all said that funding is available but is not often given to the small community based organisations (CBOs) working with communities. I was told it is normally given to large and international NGOs because they have the resources and skills to make successful bids for funding, but who then sub-contract small organisations to deliver. This process uses a proportion of the funding.

This process causes immense frustration. CBOs feel untrusted and think that the money which is used in this process as it filters through to the frontline is wasted. I met more than 15 people across Kenya, Egypt and Sierra Leone who felt like this, and the strain this placed upon them was clear.

There is an argument however that there was little personal reflection, or recognition of the difficult situation in which the international funders find themselves. Stories of funding going missing were not at all uncommon, which is what drives the behaviour of the funders.

Problems seen first-hand: One project visited had recently faced serious financial issues, which included multiple grants being misused. It was interesting to hear first-hand about a situation like this, because examples are assumed by the interviewees to be part of why large funders are reluctant to fund small and community based organisations (CBOs).

The reluctance to fund the community-based organisations directly is itself a source of great frustration to the CBOs.

When I visited, there had been personnel changes since the problems happened, but I could not see any significant changes in governance or controls to protect against this happening again. Those still involved however continued to urge me to agree that the larger funders needed to change their behaviour, with limited acceptance that small organisations also need to be accountable.

Other problems relating to finances included:

- The cost of closing and reopening programmes and projects is not well recognised. Several projects in Australia spoke about how it would take 3-6 months to close or reopen a programme. If the programme is then re-opened 2 years later, this is a significant cost.
- Projects, both in the third sector and in Government run/funded services for example hospitals in Australia, spoke about the extra commitment needed from the dedicated workforce involved, how they felt that this is not recognised or talked about.

As highlighted earlier in the findings, there can be a personal toll when finances are not available to support the work. Another impact appeared to be a despondency felt by everyone involved in the work who could see money used inefficiently.

Summary

The community-based organisations in Kenya and Sierra Leone all said that funding is available but is not often given to the small community based organisations (CBOs). Issues around finances causes immense frustration. CBOs felt untrusted and think that the money which is used in this process as it filters through to the frontline is wasted.

As highlighted earlier in the findings, there can be a personal toll when finances are not available to support the work. Another impact appeared to be a despondency felt by everyone involved in the work who could see money used inefficiently.

From the travel diary

Getting cash in Sierra Leone

Getting money out had an air of jeopardy in Sierra Leone. The currency is the Leone. There are around 12,500Le to a GBP £. The highest denomination note is 10,000Le. Or 80p. And the whole country takes cash. Cash. That's 10 notes for £8, or 100,000Les.

You can't get Leones outside the country so on the first morning, I went to the ATM. My first credit card said yes....then no. Second card said yes....then no. I start to get worried.

I return to hotel, and they kindly exchange $20 for me, so that I can start to exist. The day continues, I visit a local organisation and carry out my first interview of the trip. In the afternoon I then get a taxi to the city centre to visit a bank branch, 15 mins before it closes for the weekend. Unfortunately, it starts again. The first machine says no. The man behind the counter says no. The second machine also says no. And of course, the second man no....panic really sets in now!

Third machine, round the corner, and I remember my emergency card. WHIPPEEEEEEEEE! I get my own Leones.

This story was basically repeated a few days later. FIVE ATMs didn't work, and the banks weren't even open. I don't know why. So, when I finally succeeded, I withdrew 1,200,000Les at once. ONE point TWO MILLION Les. Except I had to use the machine three times, because the maximum withdrawal is 400,000Les. And before I know it, this cash had already gone, and I start again.

Photo 23: Lumley beach, local football Saturday morning practice.

10. Evaluation and evidence of what works is still lacking; this hinders working together and much more.

This report does not include a literature review of research published on FGM. Instead, the conclusions are drawn based on the contents of the interviews.

The lack of reliable evidence and transparent accounts of what is happening, and specifically what works, to End FGM causes problems.

In Australia, I spent time meeting researchers at the University of Technology Sydney and University of Western Sydney who, through their projects, aim to provide an evidence base about FGM.

They spoke about the challenges they face:

- It is difficult to get funding for research into 'minority' issues.
- It is difficult to recruit large numbers of women (or families) who are willing to participate.
- Panels and committees in the Universities who need to approve work may themselves not be expert in FGM, and there are concerns that they may hold an unconscious bias, similar to that previous discussed.

Community workers in Kenya however spoke of their frustration at seeing multiple research papers which in their view always seem to conclude that the most important finding is to create more research, rather than tangible advice of what works to End FGM. This was annoying, because they see an immediate need to act to save girls today and tomorrow. However, they also wanted to have evidence and research, but their challenge was that previous research has not always helped them know what to do.

I heard about projects which have failed, and projects where funding has gone missing. I have carried out internet searches and have not been able to find information about these. Interviewees in Kenya spoke about one scenario where the funder choose to keep information about a project which got into difficulties private, not even reporting a potential crime to the police, for fear of the reputational consequences of recognising what happened. (Details are not included, as this is only one account and has not been verified, but similar stories were strongly inferred by other projects and in other countries).

Why is it difficult to prove what works?

There are fundamental challenges in proving outcomes of End FGM projects. FGM is a secretive and hidden practice, and it is difficult for researchers to identify if someone has had FGM. The main ways to capture this are:

A physical exam to examine for FGM. A reliable quantitative measure of the rate of FGM in a community is by physical examination of women. There is no argument which wins approval to support the introduction of mandatory physical examination, because the impact of an intimate examination does not justify the intention to measure rates of FGM. This method therefore is not acceptable in the End FGM movement globally.

Capture information during other intimate healthcare settings. It is possible however to, with appropriate communication, use confidential healthcare settings to collect information from intimate examinations which are happening through the delivery of healthcare. Maternity settings are an obvious setting for this. The time lag between the girls growing up and, hopefully, not being cut and when they present in maternity settings to give birth tends to range from a couple of years to more than 25 years. Therefore, the most 'reliable' mechanism to measure rates of change in FGM prevalence has a very significant time lag. It is also problematic, because not all women will present for this kind of healthcare treatment.

Asking people about if they have had FGM. In African countries, the household surveys which lead to the UNICEF published prevalence information are widely supported. In Kenya and Egypt, stakeholders highlighted that they are concerned that these household surveys are overdue and that they do not know when they will be repeated. In a small number of interviews in Kenya, stakeholders were also concerned that, with the increasing knowledge that FGM is illegal, families will start to deny that they are continuing with FGM. This was not widely perceived to be a problem in Egypt or Sierra Leone, and the surveys currently seem to have the confidence of the movement.
In Australia, interviewees expressed concern that surveys may not work with the increasing knowledge that FGM is illegal and the stigma associated. They were concerned that women and families are scared to disclose information, especially if this were then interpreted (rightly or not) that they might support FGM.

When projects which aimed to End FGM have either had problems or have been unclear if they have had an impact, interviewees also spoke about there being a reluctance to admit this publicly. This in part will be down to a natural desire not to admit problems, but the concern has been that a 'failed project' is seen as a step backwards in trying to End FGM.

What problems does the lack of reliable evidence lead to?

Interviewees gave the following examples of why this situation causes problems:

- The issues seen in the networks are exacerbated, because the evidence is not available to counter any claims or challenges, and discussion is based almost purely on opinion.
- People and organisations wanting to get involved in the End FGM movement find it difficult to learn about what has happened, and what they can do.
- Without systematically sharing learning, this means that many groups are having to re-learn what others have already discovered; it is hugely inefficient.
- Groups do not have evidence available to demonstrate why they should receive funding, nor whether the funding they have had has led to tangible outcomes.
- Those who are sceptical that FGM continues in countries such as Australia and the UK can point to the lack of clear evidence of what is happening.

These factors also exacerbate many of the burden felt by those involved in the work, because the End FGM movement is not working efficiently and because people are having to repeat themselves and endlessly make the same arguments, because there is not a clear evidence base upon which they can bring other stakeholders on board.

Summary

The lack of reliable evidence and transparent accounts of what is happening, and specifically what works, to End FGM causes problems.

Superwomen

When I was about to leave Sierra Leone, I found myself thinking about the resilience of the people involved in the work to End FGM. I had asked everyone I met about how they personally carry on.

I came to recognise a sub-set of the people, only women it has to be said, who have been at the forefront of the campaigns against FGM in their countries. They have worked for 20 or 30 years in their local community. They all spoke to me about being isolated at the beginning, most talked about threats they faced. I remember particularly one lady spoke about having been treated like a social pariah for about 10 years, before gradually people started joining her.

I would ask these hugely experienced women about how they kept going when it got tough, how did they deal with the sad and tricky times? More than once, I think they looked at me like I was soft. They are not just experienced, but they are strong and have a necessarily tough exterior. Have they built their personal resilience? Or did they have a predisposition or other experiences which led to this incredible drive to fight for what they know is right? Personally, I think a bit of both.

It has also fascinated me to think of them alongside women who throughout history have had the foresight to do something that society of their time told them not to.

Millicent Fawcett, probably my favourite leader of the suffrage movement, was instrumental in 1865 in bringing the first petition to parliament about women's votes when she was just 19. I only know a little of how we got our voices into parliament in the UK, but I am amazed to think of what it will have taken for her to persist. She was leader of the National Union of Women's Suffrage Societies from soon after this first petition, until the year after the first women had gained the vote in Representation of the People Act 1918.











Aphra Behn was one of the earliest women to make a living from writing. Is this as ground breaking as ending a millennia old gender based violence such as FGM? Maybe not for us today, but as she was born in 1640, I reckon she was revolutionary in her time. She also has (and contemporaneously had, I think) a certain amount of mystery surrounding her, her background, even whether she was a spy. I think she will have been pretty strong too.

Have I picked the best two examples? Of course not, there are many to choose from, even if they are not in many history books. But throughout time, I think there have been phenomenally resilient women, who have seen the future before anyone else. This has often been to their own personal, emotional and financial cost. They are often alone for years, but if they didn't have this incredible foresight, the movement would not be able to follow. I do not know how they did it.

They are superwomen. I can't describe it any better than that. How fortunate I am, to meet some women who have done this against FGM.

Recommendations

In all four countries, I met people who said that I wouldn't need to learn from the experiences they had, because I was coming from the UK and they had heard about the UK efforts to End FGM.

This could not be further from the truth.

It does recognise however, that a huge amount of work has happened in recent years in the UK. Many interviewees asked if they could use this research once published in their own country. The recommendations are therefore structured to identify what the specific lessons are, and how these can be applied generally. Each section then considers actions which have been identified for the UK to adopt, and then specifically how the NHS can improve.

As the steps the NHS can take to implement the recommendations often relate to more than one finding, I have presented these in greater detail as two action plans. One is proposed for the national leadership team to consider the next stage of the FGM Prevention programme, and then a second plan which may be considered by teams across the NHS, and multi-agency safeguarding initiatives.

Photo 24: Meeting women staying at the Ortum Hospital maternity home.

1. People who work to End FGM face personal and professional burdens as a result

.....so we need to provide help and support and reduce this burden as much as possible.

In support of the original premise, there is evidence that working to End FGM leads to personal and professional burdens.

Some of the burden is caused because supporting women with FGM and working to protect girls is difficult; this is largely unavoidable but can be addressed.

The other elements of the burden are caused by avoidable factors, which with improvements in strategy and delivery, can be avoided.

The recommendations will often note if they intend to:

- Provide support to mitigate the unavoidable burden that people face.
- Lead to changes which will reduce or remove what is described as the avoidable burden that people face.

There is also evidence that people from communities affected by FGM (including FGM survivors, women who have not been cut, and men) face specific feelings and impacts which need to be considered. These will need to be handled with great care, given the information from the reflection on stigma and isolation.

The findings indicated that everyone involved in the work may find themselves facing these burdens, including those working in the community, healthcare professionals, Government officials, teachers, social workers, police and everyone else involved.

The findings have highlighted that people working in roles where they are expected to deliver End FGM work will have personal views. In the UK, these may be influenced by unconscious bias, or we may have assumed that these views agree with the ambition to End FGM. This needs to be considered.

Recommendations for all countries/programmes

All programmes should aim to improve their End FGM work to reduce or remove avoidable burden.

However, given that this will both take time to achieve, and that there will also always be an element of unavoidable burden carried by people, there are specific support measures which need to be introduced.

Programmes should:

- Check they have plans in place, aligned with the workforce/resourcing strategies, to consider how to provide the right care and support to those involved.
    - *This will often be a new workstream.*
- If this does not yet exist, carry out an assessment of the people involved in their work, considering the burden people carry.
- Develop an action plan to meet these needs, and then delivered.
    - *Involved those affected in the assessment and in the development of the action plan*
- Specifically consider the link between support needed and what networks can provide, and if networks need to be improved / supported.
- Incorporate learning from other campaigns.
    - *Consider adopting the Emotional Wellbeing project, detailed in the case.*
    - *In Kenya, there was an example that in Ortum hospital those involved in the HIV programme regularly attend away days to support the staff.*

Funders / commissioners should consider:

- Requiring that bids / programme plans detail how they will provide support to address the wellbeing needs of those involved, including people both paid and unpaid.
- If existing programmes that they fund should be updated accordingly.
- If they should adopt a policy that a set proportion, for example 5% of the overall programme budget, will always be ringfenced to support those involved.

Research needed:

- Estimate of the cost of the burden.
    - *Similar studies relating to the impact of supporting other forms of trauma indicate that the benefit of keeping people involved in the work is worthwhile in terms of the wider benefits to the End FGM programme.*

Recommendations specific to the UK

The global recommendations should be adopted across the public sector and third sector. The following sectors / groups / bodies should follow the above approach to consider the needs of their workforce:

- Department for Education / Local Government Association
- Department for Communities and Local Government
- Home Office and The National Police Chiefs Council
- Those funding community work including Mayors Office, Comic Relief, The Kering Foundation and others
- Department for International Development.

Charities should consider:

- if support services, for example telephone helplines offering support to professionals suffering from domestic abuse, can also support those working to End FGM
- If / how they can promote these as an offer of support, and any funding considerations.

Professional bodies and trade unions may wish to consider if their advice should also be updated to recognise this need.

We should still feel able to ask for help when we need it.

Support is available, and if you feel unable to cope, make an appointment with your GP to discuss. There are also many other organisations you can speak to. The MIND website gives some details of where to ask for help.

We have a responsibility to each other.

If you work in this area, remember to look out for your colleagues and contacts. Ask if they are OK and take time to listen. If in doubt, talk to them about if they need to seek help.

Recommendations specific to the NHS

The above recommendations need to form a new workstream in the NHS FGM Prevention programme within the NHS Action plans. Support should be offered:

- through supervision and peer support mechanism, including reflective aspects to consider personal opinions relating to FGM
- training including unconscious bias and emotional resilience/wellbeing
- improving the online and other networks to support HCPs working to tackle FGM
- recognising within the working day time to attend networks, and peer support groups
- from the Employee Wellbeing services, which may need to be updated to be able to do this
- to help professionals to understand how they can campaign or volunteer their time to charities, by providing guidance about what needs to be considered.

Clinical Commissioning Groups commissioners and quality teams should consider:

- how do they make sure commissioned services are meeting the duty of care to employees
- how to take this into account when commissioning a service.

The Royal Colleges, professional bodies and unions and NHS Employers should consider:

- updating their advice on the wellbeing and support needs of professionals to help organisations to recognise that this should be a core element to service provision
- updating existing guidance about supporting employees who are victims of domestic abuse and violence, where this has included FGM but has not appeared to consider specific needs
- If they can offer support to members and how to do this.

NHS organisations should not take advantage of people willing to work in their personal time if this is to deliver NHS services. Organisations should recognise that services are not limited to one-to-one patient encounters, but for example, might include joining a community group to deliver public health messages as part of a discussion about ending FGM.

For the NHS to support HCPs from affected communities

There has not been a planned and sustained effort to identify how to support healthcare professionals from communities affected by FGM. There should be a specific sub-project commissioned by the national NHS FGM Prevention programme. This is included in the NHS Action Plan.

The remit should include:

- Review the training offered to / required by professionals who are in the process of migrating to the UK, to make sure that it includes not only the clinical information about FGM, but a reflective element to engage with the professional to consider his/her views.

- How to provide an opportunity to talk / address / explore feelings relating to FGM, recognising the need for this to be a safe environment within which the professionals should not feel worried with recognition of free speech within the legislative framework and within their professional registration.
- How to work with the many HCPs who are very actively working against FGM in the NHS.
- Consider if or how HCPs needing to access NHS services themselves can do so in a confidential way if this is what they choose.
- A priority to not 'profile' the workforce, avoid stigmatisation and isolation as a result of this project, and introduce a policy which confirms that there is not requirement for a HCP to disclose if they are from a community affected by FGM.

This project must be carefully evaluated, with the ambition to share learning to others in the UK and further afield.

Photo 25: When staying in Ortum, the exam results were published for the previous year nursing students. The results were very good, and the current cohort of students paraded around the village, celebrating loudly, singing and dancing.
Eva, herself, and known by many, was spotted from a distance and carried by the group. To my great surprise, I too found myself lifted and surrounded by such joyous noise and movement.
I learnt that the parade is also in part a recruitment drive, and public health message, continually lifting the profile of qualified nurses with the community.

2. An End FGM change programme works better when all aspects of society and Government are involved, using a whole system approach

.....so we need to make sure all stakeholders are involved and active.

The finding is that an End FGM effort works better when all aspects of society and Government are involved, using a whole system approach. This appears to be a more efficient model, thus reducing the burden caused, and placed upon the shoulders of those involved in the work.

All stakeholders and sectors need to contribute as appropriate to their role. An active stakeholder / sector cannot 'take over' delivery of the message on behalf of a stakeholder who is inactive. This is because:

- Much of the impact from what is being done is because of who is giving the message
- This will lead to an uneven delivery burden, with much greater pressure placed upon the sector currently doing well, opening their staff/volunteers up to unnecessary stress.

Recommendations for all countries/programmes

Currently, many countries and programmes worldwide do not have a whole system approach in place though they may say that they do. Some partners are currently taking a less active role.

Programmes / national and regional offices / strategy groups / networks should:

- Assess the existing work to identify how closely it aligns with a whole system approach, including identifying who is involved, considering the stakeholder list, and to what extent they are active
    - Community members / leaders
    - Health services / public health
    - Police and child protection services (social services)
    - Education system
    - Religious groups / leaders
    - Local / national Government
    - Charities / non-government organisations
    - International development agencies*

  **In some countries, descriptions and names will vary, as will involvement from the international development agencies.*

- Develop a plan to address if any stakeholder is not involved or is involved but not fully active.
    - Learning from Kenya, introduce a (semi)-independent body to coordinate and monitor the End FGM work at national level.

    - It may be possible to offer mutual aid to engage stakeholders; can one sector support another to bring them into the programme? This could be with joint planning, a buddy / mentoring system, collaborative training plans.
- Obtain the commitment from all partners to make sure that this carries on and is sustained.
- Implement / adopt the plan.
- Monitored and reviewed, with governance in place to address if a stakeholder does not deliver on their commitments.

Recommendations specific to the UK

The UK has set a clear and unambiguous message but faces significant challenges in turning this into a sustainable effort which is equally effective across all stakeholders/sectors and all geographical areas.

The UK Government should:

- Commission an independent body to review the End FGM work at a multi-agency level
    - The Child Safeguarding Practice Review Panel may be able to do this, ideally in partnership with the third sector.
    - Other bodies who could do or be involved include Care Quality Commission, Ofsted, and Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS).
- The review should:
    - Assess current stakeholder involvement the intention that all stakeholders are involved in the work, including the contribution of the Civil Service and UK Government (past and present).
    - Consider if there are regional or sector variations in involvement.
    - Consider the transparency of work commissioned and delivered since 2014 The Girl Summit.
    - Review the ongoing coordination and ongoing communication with the communities affected by FGM
    - Consider the ability of the End FGM movement in the UK to learn and improve.
- Create / commission a single body, which is (semi) independent from policy makers and which coordinates and drives the direction of the End FGM work across the UK, across all sectors and community groups.

In my opinion, such a review would highlight the following areas of concern:

- The communication between public sector services and campaigners / communities needs to be significantly improved.
- Some stakeholders/sectors publicly give their support and commitment, but do not follow up with action demonstrating this:
    - Children's Social services
    - Education services
    - Work with religious groups/leaders
    - *Review would likely identify that this is not due to the lack of desire or intention to support the work, but often due to not understanding what best to do, competing resources, a lack of leadership or inexperienced leadership. The review would also identify that there are small projects / areas of exceptionally good practice in these sectors.*
- National coordination of the End FGM effort is weak and intermittent
- There are issues with Home Office as the lead department, which could be addressed by establishing a national coordination body similar to the Anti-FGM Board in Kenya.
    - *This would allow coordination of the full UK-wide End FGM movement, rather than the current focus in England and Wales of the priorities of the current administration.*
- There is enormous variability across England, in health, police and community work. This is not limited to regions where there is low prevalence of FGM in the resident population.

Recommendations specific to the NHS

The NHS FGM Prevention programme in the NHS also needs to be reviewed, renewed, and updated independently. A framework to do this is outlined in the NHS Action Plans.

A little more detail...

Talking about sex

The interviews were all different. Some were fast paced from the very start; others involved a period of building trust between us before we started talking in more depth.

Some of the most unexpected changes in tack were when sex came into the interview.

In Ortum, I was talking in depth to a very considered and experience midwife, Christine. I think she had been careful to consider what I was doing, before getting into more detail about what she does in her professional role. And suddenly out of almost nowhere, she gave me the most brilliant lecture about sex, and why it mattered in relation to FGM.

When I raised the subject in Egypt, there were two distinct reactions. I was either moved swiftly on, *'well yes of course it is related'* or I would hear how incredibly frustrated my interviewee is at the controls in place across society, and lack of open discussion.

In Sierra Leone, I think the society was the most different from that of the UK. Several of the women I met loved talking about sex, they wanted to laugh, joke and lit up when they spoke about how it mattered to a relationship. There was no stiff upper lip. Some spoke about how in community discussions they would use it as the ultimate subject to find common ground between men and women, and the role of the relationship was a very strong justification to End FGM. Whilst it was the country where it was easiest to talk about the link between FGM and sex, it was also sad because I don't think that this is yet translating into policies, or formal strategies.

Perhaps we can all learn from the Sierra Leonean confidence; I think it would help the End FGM movement.

3. FGM is a persistent gender inequality as much as gender-based violence and needs to be tackled as such

4. The message must stay 'End FGM'; anything else will slow us down

..... so we should carry this message and work with everyone to support the End FGM message, not alternatives.

The lessons and recommendations relating to these findings are so closely intertwined that they are presented together.

FGM is not an isolated act of violence a girl faces, but manifestation of a complex gender inequality. The research has identified that, if FGM is treated as a simple one-off act of gender-based violence and stopped, we cannot be sure that the girls who are protected from FGM will not face other unintended negative consequences. The likelihood of this happening appears to be reduced when tackling FGM within the gender inequality context.

Some will argue this is an attempt to expand the End FGM movement into a feminist agenda. It is not. Instead, the evidence presented has demonstrated that where FGM has not been tackled as a violent manifestation of gender inequality, this has caused problems in the movement. Therefore, the progress to End FGM globally is slower, more girls will be cut before the practice is stopped, and there will be negative and avoidable consequences.

When incomplete or mixed messages are allowed to circulate unchallenged, this both significantly reduces the chance of Ending FGM, but also causes great frustration to those involved in the work.

The four areas which were recognised in the research are below, though this may not be comprehensive:

- Medicalisation of FGM to avoid the most severe health consequences
- Proposal to allow girls over 18 to 'choose' to have FGM
- Alternative rites of passage projects which keep everything the same except for the act of cutting
- Performing 'lesser' types of FGM to avoid the most severe health consequences and to avoid detection.

Recommendations for all countries/programmes

Programmes should:

- Review all projects, materials and messaging to use the End FGM as manifestation of gender inequality, and
    - *Make sure that community work does not isolate the health consequences argument as justification to End FGM.*
    - *Link the End FGM message to the change in the life course of the girl, enabling access to education and long term economic benefits (to the family).*
    - *Associate FGM with other harmful practices, for example child marriage and subsequent teenage pregnancy, recognising the health consequences of teenage pregnancies.*
- Engage with communities and partners to identify what alternative messages are circulating

- Design and implement a workstream actively engage with the 'alternative' narratives identified as relevant to the programme, to challenge and address these.

The World Health Organisation have given a period of sustained focus and raised their concerns that this is an emerging risk globally. The Royal Colleges and overseas partners, including Royal College of Obstetrics and Gynaecology and The International Federation of Gynecology and Obstetrics (FIGO), should:

- take a more active role in condemning the medicalisation of FGM
- consider how to support projects which specifically aim to challenge this practice.

Recommendations specific to the UK

There are many FGM guidelines and policies, including the statutory guidance, which largely focus on the medical impacts of FGM, and which do not reflect that FGM is a persistent gender inequality. These should all be reviewed and updated to consider how the End FGM message is presented. The World Health Organisation classification of the types of FGM should be supplementary to a primary definition, which could be the UNPFA or other. This report gives an example of how to combine both definitions. The documents to be updated include, but are not limited to:

- FGM Multi-Agency Guidelines, FGM Resource pack and eLearning training – UK Home Office,
- Suite on Government policies, guidance and training materials about FGM – bodies including Department for Education, Ministry of Justice, Crown Prosecution Service, and others.
- Materials used by groups including the National FGM Centre (LGA/Barnardo's).
- Local policies, guidance and training – organisations including police forces, children's social care departments, schools, charities and community groups.

In the UK, the following discussions are repeatedly emerging in networks and stakeholder events.

- Are communities are using perceived 'lesser' forms of FGM, moving to performing FGM Type 1 or 4?
- Are girls are being cut at much younger ages than would happen if they lived in the country of their family background?
    - Assumption that both changes are to avoid being caught, and for her not to be able to take effective measures to protect herself.
- What is the UK position relating to piercing and tattoos, cosmetic surgery and the FGM Act?
    - There is a lack of clarity about the issues surrounding the FGM Act and an argument that the legislation is both weak in being able to prosecute type 1 and 4 FGM, but also that it is discriminatory. This is a highly complex policy area.

In the UK, we need to find a way to engage with communities to understand host a series of debates, involving all part of the stakeholder movement and continuing with the discussions over a period of time. If a national coordination board is established, this group should be tasked to deliver this.

Developing the discussions with all stakeholders involved will also help to overcome any unconscious bias held by some professionals.

In relation to piercings, cosmetic surgery and the FGM, the Crown Prosecution Service (CPS) are often expected to provide the answer, but stakeholders need to consider if the remit of the CPS can address the issues. If, as has been suggested, there are fundamental challenges with the UK legislation, then the discussion should be the UK Government directly.

Recommendations specific to the NHS

Much of the NHS current guidance focuses on giving advice to patients and families about the health consequences and illegality of FGM, without the human rights/gender inequality context.

Reflecting about the need to actively engage in all discussions, within the NHS there have been issues which are difficult to resolve, and which need significant time and effort invested in the discussion. Efforts to date have been sporadic or have stopped before resolution or consensus built.

The FGM Prevention programme should:

- Reviewing all publications and online content in line with this recommendation, to make sure appropriate language and context is used.
- Host and facilitate in-depth discussions to explore the following topics:
    - The health response to FGM: engaging actively with the editorial in the BMJ Article[29] by Prof Sarah Creighton, entitled 'Tackling female genital mutilation in the UK', with a sub-heading 'The current response to FGM is disproportionate relative to other types of child abuse'.
    - Clitoral reconstruction: the current line that reconstructive surgery is not yet clinically proven is accurate but is also a way to avoid a subject about which little information is known.
    - FGM Information Sharing system[30]: there is an unfinished debate with professional bodies and some community groups about the FGM IS system, which is part of the NHS safeguarding response to FGM.
    - Cosmetic surgery, piercings, tattoos and FGM in the NHS: as a contribution to the wider debate, the NHS can discuss the impact that this issue has on the provision of healthcare services, and use information from the NHS FGM statistics published by NHS Digital to help to inform and quantify the issue.

These actions are included in the NHS Action Plans.

Survivors on stage, potentially unsupported

Given the progress since 2014, I hope that we can move away from 'putting a survivor on stage to repeatedly tell the story of the day she was cut'.

Whilst effective in some ways, this is also likely to embed unconscious bias, to focus on the violent act of FGM rather than its manifestation as a gender inequality.

As many campaigners will attest, there can be a very serious mental health impact on an individual if they tell this story repeatedly without having received appropriate support.

Effective communication about FGM is possible using other methods. We can (and have) videoed some interviews. There are beautiful and moving animations, which survivors and family members helped to make. There are plays, books and songs which all give an insight. We should stop putting women under immense pressure, just to persuade professionals to do their job.

As some survivors already do, what if we asked for help to understand how they have faced gender inequality in their lives, and how FGM was a violent manifestation of this? I still believe we should try to capture this in a safe and supported manner (video and similar), but we are unlikely to understand the wider context of FGM if the stories which are so movingly shared focus only on the appalling and violent act itself.

[29] *BMJ* 2019; 364 doi: https://doi.org/10.1136/bmj.l15 (Published 07 January 2019)
[30] NHS Digital, Accessed May 2020, https://digital.nhs.uk/services/female-genital-mutilation-information-sharing

5. To change the view of someone who supports FGM is difficult

.....so we need adopt an approach which targets the specific views they hold, whilst recognising that those involved in the work need to understand how difficult this can be.

These findings highlight that projects and work to change everyone's mind about FGM needs to be designed to reflect the views held by those involved in the specific discussion, in order to engage people with the End FGM work. As many professionals were motivated by feeling that they were making progress, it is important to make sure that End FGM conversations are clearly helping people change their minds.

Interventions were designed to take into account:

- why a community continues to perform FGM and to challenge this (religious requirement, rite of passage, pre-marriage requirement, belief that will control a girl and make her less interested in sex),
- when FGM happens, where, by whom,
- the actions taken immediately prior to FGM happening, with the following examples
    - in Egypt where the Imam makes an introduction to a doctor,
    - in Kenya where rumours circulate amongst the community that preparations are underway
    - in Sierra Leone where a bush is prepared.

Globally, there are endless permutations about how FGM happens. This leads to the recommendation that prevention work becomes more targeted to the audience.

The projects seen in Kenya, Egypt and Sierra Leone also recognise how difficult it is to change the minds of those who support FGM. They adopt a model which involves passing the message to the intended audience repeatedly, and that the message is given by different groups in many different contexts. This is distinctly different from the projects and service seen in Australia and those known in the UK, where the safeguarding interventions are much shorter in duration and with lower frequency.

The interviews also demonstrated that there is a high likelihood that unconscious bias is influencing the practice of professionals working in countries like Australia and the UK, where the majority of the workforce do not come from FGM practising communities, nor have lived alongside these communities.

Recommendations for all countries/programmes

Programmes should:

- adopt End FGM prevention techniques which use targeted and adaptive practice using the concept outlined in Figure 28: Developing a targeted prevention approach..

Figure 28: Developing a targeted prevention approach.

Countries / programmes where FGM is an issue seen first within migrant communities

In countries like Australia and the UK, where there are many different communities living in one country, there is a greater likelihood that a larger number of safeguarding and prevention techniques will be needed, but at the moment a single approach is largely followed. In these countries, the people involved in the work are less likely to understand what it means for FGM to be a social norm, and may carry unconscious bias.

There is an extremely important counter argument, that the work to End FGM has to allow for people to change their minds and to stop supporting FGM. Programmes must also recognise what it looks like when someone has committed to stop the practice in their family.

Programmes or projects should:

- be developed in partnership with community representatives,
    - To note; those supporting the development of End FGM prevention work should be able to advise on the community with whom the project will be working.
    - It is important to work with trusted colleagues, who can demonstrate their commitment to the End FGM agenda.
    - Professional safeguarding practice is supplemented and strengthened when developed alongside community representatives. However, this role will need to be understood, as advice will need to be considered within the professional safeguarding context.
- be developed with behavioural change / social development specialists with BME expertise.
- offer training and undertake reflective practice to understand what it means to have FGM as a social norm
- provide training / guidance to understand how to identify that someone does not support FGM,
- offer training and develop skills to mitigate unconscious bias.

Recommendations specific to the UK

Stakeholders have fed back to NHS meetings that the End FGM work in the UK has not developed with good community engagement. The regularity with which national stakeholder meetings have happened over the last three years indicates this. As a result, I suggest that some of the prevention work needs to be reviewed to make sure that it is working. There has not to date been ongoing discussion about unconscious bias, or whether the non-migrant workforce fully understands the issues relating to FGM. This is occasionally hinted at, but rarely discussed in full.

A recent example of good engagement has been with the MOPAC communications campaign. Police colleagues also regularly discuss the need to work with communities relevant to that area and / or case to obtain insight into their work, which recognises many of these communities.

Programmes should:

- Be reviewed to make sure that they include suitable engagement with community representatives who can advise in relation to FGM,
- Review their prevention / safeguarding work to make sure that it is aligned with the range of FGM profiles reflected in their communities,

Tackling poor quality training

There is unfortunately much experience of poor quality training within the UK, and the NHS specifically.

Many community stakeholders and charities have highlighted at network meetings that training sessions can embed stereotypes for example by using only photographs of women and girls from East Africa, or focusing on the physical consequences from type 3, infibulation, when only around 1/3rd of women treated in the UK had been infibulated.

As well as improving the quality of training, measures are also required to somehow challenge when poor quality training is delivered, and to allow people to more easily identify when the training they have received is like this.

- Consider how to learn from countries who have succeeded in reducing the prevalence rates of FGM with community engagement work.
    - This could be facilitated by the Department for International Development, recognising the outputs from The Girl Generation.
    - Whilst context will be different from the UK, with appropriate context and consideration, there is much to be learnt.
- Review all training materials (including Home Office eLearning) and introduce reflective practice to include
    - to understand what it means to have FGM as a social norm
    - to understand how to identify that someone does not support FGM,
    - to develop skills to mitigate unconscious bias.

The Department for Education should ask The National FGM Centre (Barnardo's/LGA) to carry out a practice development project. Within this, they would:

- consider how this can be delivered in the specialist social work provision they offer,
- explore the basis for these complexities in the UK,
- publish their learning.

Recommendations specific to the NHS

The NHS FGM Prevention programme should, in line with above:

- Update their training provision
- Review and update safeguarding practice to recognise this learning.
    - This means that HCPs need to be alert to risks of FGM, even when these are different in different families in their patient list
- Analyse the NHS statistics to consider how to obtain insight into the scale and diversity of the different 'profiles' of FGM for those living in England.

With the aim of consider alternative approaches, there are two proposals for very different models of service provision.

- A clinic to offer FGM support services to young people
- A project both offering counselling to women, but also creating a space for in-depth discussion about FGM in the UK.

These projects would both provide services which are needed by patients but would also provide opportunity to explore themes and some of the most difficult challenges faced.

It is important to note that both projects would need significant consultation and careful development. They will need approval from ethics and other groups and will need to be closely monitored and reviewed to make sure that the service is safe.

Young Person Clinic

Early feedback from the NHS FGM Support clinics has identified that young people, broadly in the 13-17 age group, may want to access services but cannot attend the new NHS FGM Support Clinics.

A clinic which supports Under 18s with specialist care, modelled where possible on the NHS FGM Support Clinics. For example, hosted in a non-hospital setting, allowing young people to make decisions relating to their care, and to access information. Referral from NHS / social care would not be needed. Safeguarding processes will need to be carefully followed.

Innovative partnership working with the police will allow for the Mandatory Reporting Duty to be followed, whilst keeping the needs of the patient central to the decision making.

If more complex medical needs are identified, the patient will be supported to access treatment.

Counselling project to provide insight into FGM in the UK

This service would offer group counselling and support to women with FGM, but also aims to explore issues around how to End FGM without leading to stigma and isolation, with the intention to use the insight to feedback into service delivery. The project would specifically aim to breakdown some of the communication barriers between communities and public sector provided services, but doing so in an environment which is supportive, does not assume or make judgement relating to personal views, and learns from the prevention work seen in countries like Kenya.

This would need appropriate ethics approval and would also need to be with the full and explicit consent of participants.

The project would replicate the aims and intentions laid out in the NHS FGM Support clinics projects, allowing easy access, providing support in a non-intimidating setting (community location).

Access to follow-up support needs to be offered.

These projects and steps are proposed within the NHS Action Plans.

Is there a link between this finding and the model of healthcare and support services offered in the NHS?

Speaking to a leading consultant in sexual and reproductive health, with significant experience treating women with FGM, after I returned to the UK, she asked whether my attempts to describe how we need a more mature approach to safeguarding against FGM, whether the same is true of service provision in the NHS.

Does a lack of understanding reflect in the current treatment model?

A woman can attend an appointment and be offered a de-infibulation procedure at the next appointment, but does not have to be offered counselling and follow up support; does this suggests that we consider this procedure to be simple?

If in the NHS, we can develop approaches to host and consider complex issues, this is another which can be discussed.

6. End FGM networks often face difficulties in being sustainable and effective

.....but we need to develop these networks to overcome this, as they are essential support networks.

The support offered by helpful networks and networking was identified as an important support mechanism on offer to many professionals involved in the work to End FGM. Networks were also identified as a vital way to enable learning and sharing, which helps promote a strong movement against FGM.

However, in all countries visited and in the UK, there are issues with the networks in place. They need to be improved and valued more.

Recommendations for all countries/programmes

Programmes / networks / regional or country-level strategic bodies should:

- When starting or re-opening a network, to make sure that there is support for at least two years, ideally longer, before launching
- Always have at least 6 months of meetings scheduled
- Consult with stakeholders about the networks,
    - what the networks aims to achieve,
    - how the network will be monitored and supported,
    - the logistics including if attendees wish them to be held outside of standard working hours.
    - An example of consulting about establishing a network has been published by The Orchid Project and ARROW[31]
- Once, established, continue to review the network's joint vision, objective and ways of working
- Make sure that they invest time in reflection, perhaps annually, to consider what is working in the network, and what can be improved.

Government bodies or organisations who wish to engage with networks to inform policy consultations should do so

- With transparency
- Having considered what the network can offer, including whether the network is representative

These bodies should also recognise their role in networks, with repeated examples having been seen where public bodies setup a network to meet their needs, and do not support the network for the length of time the stakeholders wish/need.

[31] Orchid Project, Arrow, 2020. Asia Network to End Female Genital Mutilation/Cutting (FGM/C) Consultation report. https://www.orchidproject.org/what-we-do/asia-network-to-end-fgm-c/

I have included a proposal for small networks to meet within a sector but across different countries, to share learning and experience between international partners.

Recommendations specific to the UK

Given the comments in the introduction, it is believed that there are significant challenges facing the networks in the UK, and poor communication channels which both do not help the work to End FGM, but also contribute to issues of misunderstanding and add to the frustration felt by many stakeholders. Clearly, this will not be the intention of those running the networks, hence the recommendation for this to be reviewed by someone independent from the situation.

Funding should be sought to setup a national network over a sustained period and using innovative engagement methods. This includes using digital hosting, following the rapid learning from the 2020 coronavirus global pandemic.

The End FGM movement in the UK would benefit from facilitated development sessions:

- to develop relationships, trust and a shared vision
- to give the (emerging) network skills and techniques to discuss topics which are difficult, complex or which might previously have led to defensive behaviour being displayed.

The Home Office and / or other public bodies should commission an independent review of the UK network arrangements in place.

If a separate coordinating body is established for the End FGM work in the UK, as per previous recommendations, then this should adopt the role of supporting and facilitating the national network, and work with the Government, public sector organisations and the third sector equally.

Recommendations specific to the NHS

Networks in the NHS need to go through a major overhaul. Nationally, they have not been held regularly, and when they have been held, have faced significant risk of being 'echo-chambers' as the attendance has not been representative of the patient needs. Many stakeholders would suggest that there is only very limited engagement with the national team.

Actions are included in the NHS Action Plan.

There is an online network site, hosted by the Royal College of Midwives[32]. The NHS Action Plan includes working with the RCM to renew and refresh this network.

As noted earlier in this recommendation, I plan to pilot small international networks, one of which will facilitate learning between health services.

[32] RCM FGM Specialist Online Network, https://www.fgmnetwork.org.uk/

7. The End FGM movement has previously struggled to bring new people on board and to maintain momentum

.....but we need to find ways to do this, as the movement needs more people involved to spread the burden.

Given that there is a clear need to involve more people and organisations in the End FGM movement, any examples of barriers to join the movement need to be addressed swiftly.

The End FGM movement needs to be sustainable, welcome newcomers and support those already involved. This will mean:

- Involving a greater number of people and organisations, including all professionals whose day-to-day roles mean they can contribute, and the wider third sector.
- To expand the movement, there need to be ways to join existing work:
    - To learn the lessons which have already been identified and
    - Adopt the skills which are leading to the best outcomes.
- The counter to these recommendations is that networks and organisations need to make sure that innovative and creative approaches are not stifled by being expected to comply with a certain template.

Whilst the people involved in the work today will understand the logic to expand, they are also faced with the challenge that their expertise has been hard won, deeply complex and requires sensitive delivery. Mistakes in this work, whilst mostly unintentional, can have devastating consequences.

This is not an argument to keep the work to the few, but instead a reason why we must spend time and effort making sure that more people can join the movement, and that they will be supported to do so.

Therefore, the End FGM movement should also focus on being transparent and open.

Recommendations for all countries/programmes

All programmes / networks / national and regional strategic bodies should:

- Review the current capacity and capabilities, and identify what resource / involvement they need to deliver their ambitions
- Develop plans to increase capacity to meet the need

Networks and programmes should make sure that they:

- Know how they will support people wanting to join the network / movement
- If not appropriate for someone to join, know where to signpost them so they can join a more appropriate network / project
- Consider if they can offer buddy / support arrangements to new partnerships
- Recruit / encourage the people / organisations who are missing to join

- Regularly host learning sessions to share knowledge and experience
- Publish and regularly update information about what they are doing, and why, and how people can get involved.

Networks can provide a platform at which this challenge can be debated and considered. In the third sector, where there may not be an overarching body (like the NHS), these networks can facilitate discussions to identify strengths and weaknesses at a strategic level.

Recommendations specific to the UK

Some projects in the UK provide excellent information online about what they are doing, but this is far from the norm. Networks are not functioning well, and new people and organisations can find it difficult to join the work.

Those in strategic roles should review their work to adopt these recommendations. These include

- the Home Office and other Government agencies,
- Department for Education, and Department for Communities and Local Government
- Professional bodies and Local Government Association
- National Police Chiefs Council.

Third sector funders should consider the need and opportunities available.

If a separate coordinating body is established for the End FGM work in the UK, as per previous recommendations then this should consider how to address this issue.

Recommendations specific to the NHS

The NHS needs to move from a one-year focus to a 5 to 10 year strategic focus. The cycle of annual planning needs to be refreshed, and the next national plan should cover the same term of the NHS Long Term Plan.

The NHS FGM Prevention Programme should:

- Review the current workforce capacity and skills, and identify gaps
- Develop and implement a plan to address
- Use the online network hosted by RCM in order to:
    - Facilitate shared learning
    - Support new professionals joining the End FGM movement.

There are growing concerns about the quality of services, as the work has spread across England at enormous pace since 2014, with little time for reflection. The national team should now:

- Introduce quality measures to help identify issues
- Consider what support mechanisms are in place to make sure that new developments can learn from existing projects/services.

A specific challenge relates to the provision of doctors who can provide expert medical opinion in court cases.

The NHS FGM Prevention should establish a sub-group with DHSC, NHS England, the Royal College of Paediatrics and Child Health, the Home Office and the Crown Prosecution Service to consider this need, identify a plan and then respond accordingly.

8. Where the 'third sector' is recognised as a profession, whose skills and capabilities receive investment, the outcomes are greater

.....so we need to find this investment and provide this support.

Where the third sector contribution to the End FGM movement is recognised and supported, this had led to better outcomes. Therefore, we should make sure this is a consistent approach across the End FGM movement globally.

Recommendations for all countries/programmes

Programmes working with the third sector should:

- If not already in place, introduce a workforce/resource workstream which plans to support and develop those involved
    - This needs to recognise that the third sector is often not directly employing the people involved, it is equally important to consider how to invest in, yet they still need support to develop skills.
- Make sure that there are role descriptions (job descriptions) and formal agreements in place to understand the scope of the contribution from the third sector,
- Consider if existing / planned support mechanisms currently offered to employees can also be offered to everyone involved in the work.
    - For example, if a telephone / text / online support network is recognised as providing support to professionals who are struggling with the burden, can this be extended and offered to those working in the third sector?
- Consider how to adopt (and / or adapt) the Emotional Wellbeing project
- Review and incorporate the UNFPA's 'Manual on Social Norms and Change'[33].
    - This is a training programme which can be delivered to community workers, campaigners and activists to support capacity building.

Partnership arrangements should be put in place which recognises the respective input from each group.

Community Group

- Insight into FGM
- Understanding of culture/society/family relationships
- Understanding of behaviours/sensitivities

Regulated professionals

- Professional skillset, adaptable to the needs of the presenting patient
- Experience and knowledge of safeguarding
- Knowledge of local context (e.g. NHS)

[33] UNFPA, UNICEF (2016). Manual on Social Norms and Change. https://www.unfpa.org/publications/manual-social-norms-and-change

When the programmes and bodies seek the advice from campaigners and community experts, this should be paid. Some individuals will want to contribute their time and effort without receiving payment, which is a kind and generous contribution, but this must not be assumed. The risk is that if valuable advice is not paid for, then those with the expertise and knowledge required may not be able to give what is needed, and programmes therefore may rely on inexpert advice.

Recommendations specific to the UK

There has meant that there has not been a sustained effort to support and develop the individuals and groups involved in the campaign community based work in the UK. There have been some examples of support, for example by Tostan or The Orchid Project, but more are needed. The Department for International Development also has expertise in this area.

The UK Government should consider this as a critical need. They should:

- Develop a support programme adapting and learning from examples overseas.
    - This does not need to be Government delivered, but lends itself well to being delivered by a partner,
    - This should partner with a similar programme in one of the 30 countries where FGM is recognised by UNICEF and include the experience and knowledge of the Department for International Development, who have delivered many similar programmes internationally.

However, learning can also be gained from the few third sector capacity building programmes in place in the UK. One example of a group which offers support to address one aspect of this challenge in a UK context and setting is Campaign Bootcamp[34], which supports campaigners through a residential course and other development schemes.

Recommendations specific to the NHS

With many opportunities to work alongside and with the third sector to tackle FGM, the NHS needs to improve engagement and challenge some internal behaviours which have in the past, limited the willingness to engage with community groups.

Where NHS organisations or groups have 'worked with the community', this has often been in the form of a survivor giving their personal story of FGM at a safeguarding meeting, or a community group delivering training. This can provide a deep and personal insight into the trauma of FGM so has a huge impact, but it tends not to help a healthcare professional know what to do, or what to ask their patient.

The FGM Prevention programme should:

- Review partnerships to understand how best to work with the third sector
- Develop guidance and role descriptions, based on where there have been effective partnerships.

Again, the issue of unconscious bias should be examined, considered where the relationship between a perceived 'non-professional' community group with perhaps limited English language skills and a workforce of regulated professionals had unexplored disconnect.

These actions are included in the NHS Action Plan.

[34] Campaign Bootcamp, accessed May 2020. https://campaignbootcamp.org/about/

9. Projects often face financial instability; this leads to many consequences and distracts from the purpose to End FGM

.....so we need to introduce measures to reduce the instabilities.

The financial instability faced by public sector and third sector/charity projects has a hugely detrimental impact on the efforts to End FGM.

Many costs appear not to be fully recognised currently, as campaigners and employees spoke of having to contribute time and resources to top up the funding.

Another tension was between the perceived reluctance of large funding organisations to give money to small grassroots organisations, which can be addressed by considered alternative ways of working and identifying ways to collaborate.

Recommendations for all countries/programmes

Commissioners and strategic funders should:

- Fund a programme / work for a minimum of 5 years
    - There can be review periods within this, where it could be closed or changed if needed, but the long term ambition is needed
- Consider how to support capacity building in the third sector to develop and enable new ways of working to allow the grass roots organisations to successfully bid.
    - Innovative and creative approaches could be trialled.
    - Consider using buddy partnership arrangements
    - Identify how to maintain strong and effective governance
- Require reporting against expenditure AND unfunded components
    - Including additional hours / unclaimed overtime, travel expenses
    - This should allow for a true total cost to be captured and understood.

Recommendations specific to the UK

The Government should consider there is a substantial risk; significant investment has been made in the last 5+ years, and the changes introduced need to be sustained. Stakeholders generally accept that more work needs to happen in the UK. Stopping early risks the consequences seen in other countries where the work has stopped and had to re-start.

The UK Government should consider the cost of failing to End FGM, and therefore the need to provide ongoing healthcare support to FGM survivors via the NHS.

To do this, Government and other bodies should use the report 'Estimating the costs of Female Genital Mutilation'[35] commissioned by DHSC in 2016 to provide insight to this debate. The report estimates that, if all patients were offered and accepted services to treat their healthcare needs, then *'the estimated annual cost of care for women with FGM is £100 million*.

Recommendations specific to the NHS

Clinical Commission Groups or national bodies generally leading the commissioning of services and projects should review arrangements in light of the above recommendations.

This presents a particular challenge as the NHS has a significant focus on annual planning and funding cycles. The Long Term Plan however provides opportunity to engage commissioners and services in a five year planning cycle.

The NHS should consider how to best use information about the cost of NHS treatment, to inform their work to End FGM. This will involve considering and using the health economics report. These steps are captured in the NHS Action Plans.

Photo 26: From the top of Cairo tower, views across the Nile and city.

[35] Hex, N, 2016. Estimating the costs of Female Genital Mutilation services to the NHS. York Health Economics Consortium. https://www.york.ac.uk/media/healthsciences/images/research/prepare/reportsandtheircoverimages/EstimatingCostsOfFGMServices.pdf

10. Evaluation and evidence of what works is still lacking; this hinders working together and much more

..... so we have to work together to overcome this and can try different ideas to work together.

The lack of reliable evidence and transparent accounts of what is happening to End FGM causes problems.

These factors also exacerbate many of the burden felts by those involved in the work. This is because the End FGM movement is not working efficiently and because people are having to repeat themselves and endlessly make the same arguments, because there is not a clear evidence base. However, there are systematic reasons which make it difficult to bring together the evidence about what works.

Interviewees repeatedly confirmed they want more information and to learn, but recognised that there are barriers, and no easy answers. Innovative and creative ideas are needed to try to break down this issue.

The recommendation is therefore to start to address and consider this strategic issue which I believe is emerging. The lack of evidence could become one of the most challenging problems faced by the End FGM movement if it is not addressed.

Recommendations for all countries/programmes

Most programmes already have an evaluation workstream or plan. All programmes should:

- Review this and invite challenge from external stakeholders for example academics and those with evaluation experience
- Identify any barriers to evaluation and proving change local to the programme
- Develop and pilot innovative / alternative approaches to address these.
- Consider linking to other indicators which may demonstrate change.
    - As a form of gender inequality, it is possible to monitor / evidence other changes which relate to both End FGM and wider gender issues?
    - For example, a link between FGM and leaving school, then consider tracking not only outcomes relating to FGM but also monitor the impact on attendance of girls in school.
    - Consider also rates of teenage pregnancy, rates of urinary tract infections (UTIs), and child marriage.

Networks should aim to tackle some of the understandable behaviours where projects are reluctant to admit where they have faced difficulties, by fostering a learning environment.

Recommendations specific to the UK

For all of the complex reasons outlined, the evidence base to demonstrate what has happened in the UK since 2014 is woefully lacking.

There are some examples of good practice, for example the final report evaluating the second phase of 'The Tackling FGM Initiative'[36], which combines some quantitative information with qualitative source, which was commissioned following a major investment over a number of years.

All groups in the UK should set themselves a challenge to consider what more they can do to change this difficult situation, recognising the significant strategic risk emerging if a reliable evidence base does not emerge.

Those in strategic roles should review their work to adopt these recommendations. These include

- the Home Office and other Government agencies,
- Department for Education, and Department for Communities and Local Government
- Professional bodies and Local Government Association
- National Police Chiefs Council.

Third sector funders should consider how to prioritise and enable the evaluation and monitoring elements of the programmes they fund.

Recommendations specific to the NHS

There are, of course, issues with the NHS services provision for patients with FGM, and there is continuous opportunity to learn and improve.

The difficulty at the moment is that without evidence which demonstrates what is happening, no-one can prove if their interpretation of the situation is right. This allows for ongoing and unresolved issues.

Some examples of these issues which are frequently debated but never resolved are:

- Are patients are asked about FGM every single time they attend an appointment? Critics say this is and they feel that doctors see only their FGM, not their wider health conditions. NHS leaders defend that if information is shared, guidance is to ask when the time is right.
- Are patients avoiding or delaying accessing health services because they do not want to discuss FGM, or more specifically, because they are not happy about the information which is collected about them? Critics say this is the case; NHS leaders say that the FGM Enhanced Dataset shows many patients accessing services.
- Do patients often go to the doctor, and show many the indicators which mean that a doctor should probably enquire about FGM, but he/she does not? Critics who say this is the case use this argument to introduce routine questioning, so that all women are asked in more settings. NHS leaders cannot prove if the current rate of asking questions is right.

The NHS FGM Prevention programme should:

- Renew and expand the evaluation workstream
- Identify what information would be needed (in ideal world)
    - Review the FGM Enhanced Dataset, to identify what insight can be provided from this, including quality improvement measures.
    - Identify alternative methods to capture information, likely to be at a more local level.

These steps are captured in the NHS Action Plans.

[36] Brown, E, Porter, C (2016) 'The Tackling FGM Initiative: Evaluation of the Second Phase (2013-2016)', Options Consultancy Services Limited, London https://trustforlondon.fra1.digitaloceanspaces.com/media/documents/Tackling-FGM-Initiative-Final-Evaluation-Report-Phase-2-2016-1.pdf

Complexities of stigma and isolation

Stigma is often discussed in relation to FGM. Through the course of the interviews, a much wider and more complex picture appeared than the narrative most frequently considered within the UK context to date.

One definition of stigma is:

> *'a strong feeling of disapproval that most people in a society have about something, especially when this is unfair*[37]

In most circumstances, in the UK the narrative suggests it is felt by women (sometimes men) who feel that they are being treated differently, because they come from a community where it is assumed she / family members have had FGM.

With the growth in public awareness, there is a growth in mis-informed assumptions, leading to increased stigma and feelings of isolation.

At one end of this spectrum, this might mean that someone with very little knowledge (or emotional intelligence) associates race and FGM, e.g. if a woman is black, she has probably had FGM. This is clearly ridiculous, but sadly with the increase in public awareness, there is a consequence of greater mistaken / wrong awareness. There are other changes in the general perception, for example assuming that all women who have had FGM are willing to talk about it, or that they all have the same health consequences, or that they all feel shame.

The use of terms such as 'brutality' and 'torture' have led to the general public being shocked and sensationalised, passing these judgements on to people who feel stigmatised and isolated, entirely unfairly.

If someone feels the effects of stigma and isolation, this can further complicate the delivery of healthcare, as a healthcare professional will need to establish a relationship with their patient and demonstrate that the patient can trust them.

Stigma as discussed in the interviews

Through the interviews, individuals spoke about stigma but in doing so would cover many different circumstances. This highlighted that through one woman's life, she might live with many different feelings.

For example, if living in Sierra Leone and uncut, someone might have grown up feeling a stigma that she had not been cut. But this may change if she moves to the UK. A different example might be if someone moves from Egypt where FGM is a strongly held social norm, so she felt no stigma from being cut, but when she moves to the UK as an adult, this develops.

Figure 29 demonstrates two pathways through the life of two women. Every woman has a different story, but these two demonstrate how complex issues around stigma can be.

[37] Cambridge Advanced Learner's Dictionary & Thesaurus © Cambridge University Press
https://dictionary.cambridge.org/dictionary/english/stigma

A little more detail...

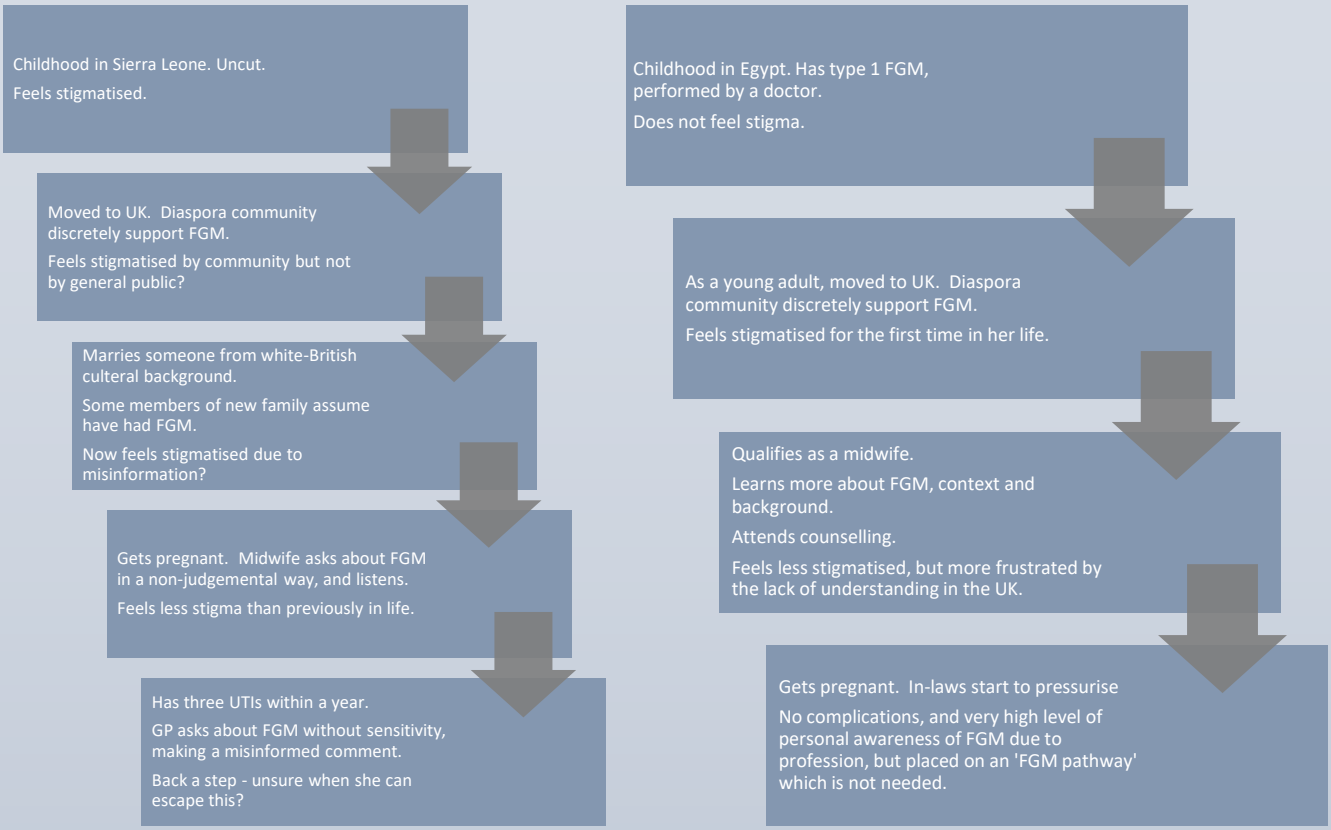


Figure 29: Examples of how feelings of stigma relating to FGM may alter as during their life.

Stigma/isolation caused by policy/research approaches

In Australia, Khadija Gbla spoke movingly of how the exclusion of south east Asian countries from the Australian prevalence estimate[38] has affected her. The Australian Institute of Health and Welfare published a report in February 2019 indicating the potential number of women and girls living in Australia with FGM. Largely using a similar method to that adopted by European countries, it applies country and age specific prevalence rates as published by UNICEF to the number of women and girls born in Australia.

The report does not include the Indonesian prevalence rates. The explanation is as follows:

> *One notable exclusion in the prevalence estimates in this report is Indonesia. In 2017, almost 47,000 Indonesian-born girls and women were living in Australia (ABS 2018). Although some Indonesian FGM/C prevalence data have been published—in 2013, 49% of Indonesian girls aged 0–11 had undergone FGM/C (UNICEF 2018)—the scope of these data was insufficient to estimate prevalence for all ages of girls and women born in Indonesia.*

If the 49% prevalence had been adopted, the overall figure is likely to have been around 33% higher than the published figure of 53,000 women and girls living in Australia. This is very significant.

[38] Australian Institute of Health and Welfare 2019. Towards estimating the prevalence of female genital mutilation/cutting in Australia. Cat. no. PHE 230. Canberra: AIHW. https://www.aihw.gov.au/getmedia/f210a1d8-5a3a-4336-80c5-ca6bdc2906d5/aihw-phe-230.pdf.aspx?inline=true

A little more detail...

Whilst the prevalence rates for Indonesia is more recently published, Khadija did not understand why it could not be used, nor why others were not questioning this approach. The organisations within the UN System have all adopted this prevalence rate, once issued by UNICEF as have many other organisations.

It has led Khadija to ask if this is related to a reluctance in Australia to discuss FGM with the Indonesia community resident in Australia, and whether this is oversight, unconscious bias, a form of political sensitivity which avoids difficult subjects, or institutional racism. But it also adds to the feeling of stigma and isolation.

Summary

Feelings relating to stigma and isolation are more complex than UK End FGM movement recognises.

The interviews highlighted that the factors which might influence how someone may feel a stigma, or feel isolated, span across life and society.

- Living in a country where FGM is highly prevalent / culturally 'normal', or not?
- Personal opinion and opinion of spouse is pro/anti-FGM?
- Government clear in support of End FGM?
- Migrated from country with high prevalence to country with low level of prevalence?
- Part of a family where all females have had FGM? Or previous generations.
- Practising a religion where your leader does/does not support FGM?

Whilst no interviewees related this to whether it relates to the burden felt by people involved in the work, it was an interesting perspective to capture, and would be helpful for the NHS and other End FGM efforts to consider the issues relating to stigma and isolation.

Projects in the NHS could think about how to support staff. This is likely to be through training and awareness raising. However, if as suggested in the recommendations, we work more closely with community members and patient groups, then we can explore ways to help healthcare professionals understand stigma and isolation relating to FGM.

Photo 27: Mosque of Al Qaid Ibrahim, Alexandria

NHS Action Plans

The NHS FGM Prevention programme has delivered sustained activity since 2013. This research has identified that there is a need to support healthcare professionals and others involved in the work to End FGM, but the FGM Prevention programme has not addressed this so far. Therefore, two plans have been developed to identify how to bring together and implement the recommendations across the NHS.

The plans:

1. Build on the existing work, identifying where improvements can be made, where existing efforts are not contributing to the work, and where new projects or aspects need to be developed.
2. Aim to address any inconsistencies in the implementation of the End FGM work in England, in order to sustain and support those involved.
3. Propose wholescale improvements in the communications and transparency about the work happening in the NHS, investing in the networks and learning structures. This is because of the significant link between the struggles that those involved face, and how they identified peer-support as one of the most important factors.
4. Introduce a significant focus on evaluation and monitoring, to make sure that efforts to End FGM and to reduce the burden faced by those involved are effective, sustainable and that they continue.

1. National NHS Action Plan

The National NHS Action Plan can be adopted by the NHS FGM Prevention programme. It is published and available alongside this report.

There are likely to be other actions / workstreams which also need to be planned and delivered, for example governance arrangements, and working alongside the other public sector groups and organisations.

It has however been developed in the context of restarting NHS FGM services following the initial restrictions related to the 2020 coronavirus pandemic. The plan will need to be further developed. These includes stakeholder mapping, timetables, partner engagement, delivery partners, and funding requirements.

Since completing this research, I have joined the NHS national team as an Expert Adviser, supporting the implementation of the action plans.

Resources / timetable

The plan, if fully funded and resourced is thought to be achievable within a 24 month timetable. The following delivery framework is advised:

Central team	Strategy adviser / SRO (part time- c0.2WTE)
	Programme manager (full time)
	Clinical / strategy adviser (part time c0.4WTE)
	Communications / network adviser (part time c0.4WTE)
	Community engagement / liaison adviser (full time)
	Commissioning manager / adviser (part time c0.4WTE)
	Support from regional / ICS networks to support delivery (in excess of 3 WTE)

Strategy	- Develop and publish 5-10 year strategy - Develop and publish strategies supporting the new / renewed workstreams, including workforce, networks, service provision and evaluation
Workforce	- New workstream – capture requirements / develop plan / identify stakeholders & funding, publish commitments, and start delivery - Commission project to support healthcare professionals themselves from FGM affected communities - Commission project to consider support similar to Emotional Wellbeing project
Networks	- New workstream – capture requirements / develop plan / identify stakeholders & funding, publish commitments, and start delivery - Create and support networks as a support mechanism - Host / facilitate debate and discussion on challenging policy topics
Evaluation	- New workstream – capture requirements / develop plan / identify stakeholders & funding, publish commitments, and start delivery - Commission a major evaluation of the FGM Prevention programme - Incorporate learning into all future plans
Service Provision	- Review and update existing commissioning guidance / service provision - Commission Young Persons Clinic - Commission Counselling Project discussion FGM in the UK - Review / update support to the NHS FGM Support Clinics - Plan for long term service provision
Communications	- Major update of existing materials / publications and create additional content for work not yet with information available - Adopt communications guidelines / strategy - Develop communications plan, and sustain effort for the duration of the work
Information / records	- Review and update the NHS Enhanced Dataset - Identify what information is needed relating to FGM in the long term - Consider / exploit the FGM EDS and other sources to identify what is available - Develop plan to address remaining gaps
Safeguarding	- Update processes, materials and guidance - Commission major safeguarding development practice review, identifying if changes are needed to the approach to safeguarding against FGM in the NHS - Develop plan and implement changes as needed
Training and awareness	- Update all training materials, standards and needs assessments - Include unconscious bias training - Introduce quality measures

2. Action Plan for NHS organisation / local system

Provided to be considered and adapted by local organisations and partnerships working across a system, this plan recognises a local need, and a greater focus on the workforce and services offered locally.

There is a recognition that local services need to be moved to a more formal footing, with appropriate commissioning arrangements which include review and quality improvement.

The team will be different, and each area will need to adapt the plan to deliver the components appropriate in their area.

For debate...

Does the third sector provide services or campaign?

In Kenya and Sierra Leone, and Egypt to a lesser extent, charities and third sector organisations are filling the gap of services which arguably the Government should provide, or, at least, purchase. When they do this, are they effectively linked to and coordinated with the police, social services and the associated public services?

It is part of the state's responsibility to protect those who cannot protect themselves, this includes children and vulnerable adults. If a Government has outlawed FGM, then in doing so, it must make sure that this law is upheld. The importance of doing this relates not only to FGM, but more widely, in respect of upholding the rule of law.

This is easy to argue, and more difficult to enforce.

If resources are limited, charities and the third sector then often support those not being helped by the state. This is how much of the End FGM work globally started. If no-one else will offer these services, then it is better that the gap is met. But, is this the long term and sustainable vision, and does it offer the best chance of success?

Through the interviews, the different consequences were discussed.

- The message that FGM is illegal is believed more if given by the police.
- Children consider their teacher to be an authority figure, so their involvement in the session increases the impact.
- Community based organisations have better access to the community and elders. They may be more trusted as they are not seen to be 'part of the establishment'.
- In one example the CBO members 'rescued' a girl, but then her family held the group to ransom in effect; the group were expected to pay for costs relating to the investigation, and for the ongoing education of the girl.
- Another example was that CBO members' businesses were boycotted because of their involvement in End FGM work.
- Community group members may not have the backup and support from the police when involved in complex and risky child abuse cases.

In conclusion, the End FGM faces potential conflicts, if the third sector both provide services as well as campaigning for the state / Government to provide sufficient services.

The End FGM movement is not alone in facing this challenge, nor are there easy solutions. This case study is documented for further debate.

To discuss:

- If establishing a partnership, could an agreement establish what each group is expected to deliver? And when third sector organisations can expect help and support, for example from the police?
- Do third sector organisations recognise this ongoing issue within their long-term strategy?
    - If a charity is campaigning for schools to offer lessons on FGM, if they succeed this may impact the revenue they currently receive from offering this service themselves.
- Can networks usefully facilitate a debate to help stakeholders identify what the best long-term model is?
- Can we learn from other partnerships, for example between the NHS and large national charities such as the Dementia Friends partnership, or the service provision model with Marie Stopes for abortion?

Making an impact

Post Covid opportunity to make change

Whilst writing this report, much of the world has been facing restrictions on normal life in response to the global pandemic of coronavirus. Elective care in the NHS has been significantly restricted, maternity services have drastically changed, and the number of women accessing the FGM Support Clinics has dropped.

There are reports of the rates of FGM overseas increasing, as communities take advantage of school closures[39].

We do not know if there have been changes in the communities in the UK, however there are also great concerns that inequalities will have increased during this period, with isolated communities facing challenges in accessing support.

It is sensible to consider what happened during and after the Ebola outbreak in Sierra Leone. There was a notable reduction in the rates of FGM happening when Sierra Leone was placed under significant controls on movement and gatherings. This was met with optimism by many, hoping that this was the start of a reduction of FGM. However, when restrictions lifted, there was a rapid return and those who might have normally been cut during that period were included in subsequent bushes. I believe that is because the change in practice was unrelated to a change in their views; the change was related purely to circumstances not motivation.

When restrictions lift, people will return to the activities which make them feel normal and safe. If a community for whom FGM is part of their identity and a social norm, this is unlikely to have radically disappeared during lockdown.

In the NHS

Prior to lockdown, these recommendations would have been made to a service which was up and running.

The report is now being published when services, if running, are not doing so in normal circumstances, or where many services have been suspended. Across the NHS, recovery plans are underway to re-start services.

This presents an incredible opportunity, during this recovery phase to incorporate improvements. This should be a balanced approach, restarting what was working, renewing what needed to be updated, not bringing back elements which can be stopped, and identifying where new elements should be incorporated or developed.

[39] The Guardian, 18 May 2020, accessed May 2020. https://www.theguardian.com/world/2020/may/18/fgm-risk-in-somalia-heightened-by-coronavirus-crisis

How to make an impact

As a result of this opportunity, the plan following publication has been updated. I intend to use this report in the following ways:

In 2020

1. Socialisation of findings.
   I will seek opportunity to discuss the report with key decision makers in the UK, and some international colleagues. This will continue across the first year. I will seek commitments from bodies responsible for or involved in professional wellbeing to recognise within policies that professionals working to End FGM may need support.
2. Advise the national NHS team to with regards the recovery plan.
   I have joined the national team as an Expert Adviser and am offering support to the national lead on the recovery plan related to the NHS. This will, in part, use the NHS Action Plan outlined.
3. Offer support to the recovery plan for local NHS teams.
   I will offer advice to local NHS organisations/system looking to review their FGM provision as the NHS returns to fuller provision of services. This will, in part, use the local version of the NHS Action Plan.
4. Introduce 'mini-networks' for health services and campaigners.
   I will recruit firstly healthcare professionals and then campaigners to take part in the proposal to run mini-networks, a new initiative to develop relationships to promote learning internationally over a sustained period.
5. Stakeholder coordination.
   I plan to discuss with stakeholders in the UK how to start to address some of the challenges facing UK networks, and the relationship between stakeholder and the NHS.

In 2021 and onwards

6. Develop the 'mini' networks' for health services.
   As the networks develop, I will review the early findings and build interest and support for this proposal from organisations which could help to support these in the long-term.
7. Stakeholder coordination.
   Dependent upon progress, I hope to support the development of a joint vision to which there can be broad agreement across the third sector stakeholders in the UK, to describe what the priority is for the NHS to deliver.
8. Tracking commitments.
   Where organisations agreed to adopt recommendations, I will continue to discuss and ask for information about the impact of these, offering support to track and evaluate measures if needed.

Progress will be tracked, and outcomes shared. The actions in 2021 may need to be updated dependent on outcomes from the initial phases of the work.

Networks Proposals

Mini-Networks

I plan to trial small mini-networks, which aim to develop relationships between projects working in the same sector / offering similar support, but across different countries and settings. These networks will aim to support long term relationships, exchanging ideas, and extending the scope of understanding of those involved.

Mini Network Logistics

- Representatives from three clinics from three different countries, ideally from three different regions
- 90 minute Skype/Zoom call every three to four months
- Every attendee presents two cases, and discusses what happened, what they did to help and support, and difficulties faced
- Attendees would have chance to ask questions, and explore the decision making
- Fully anonymised details
- Facilitated and support sessions, working in a learning environment.

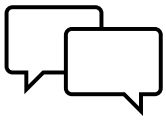
The network members will be invited to join and matched to make sure there is a balance of diversity of experience, as well as common ground upon which to learn.

Attendees will also agree to Terms of Reference and scope. This will identify that the main purpose of the networks is to share experience and learning and explore the different options which might have been considered in other settings.

Initially, attendees will be asked to feedback both as a group at the end of the session, immediately following, and at a later date as to the usefulness of the exchange.

Health Mini Network Proposal

Each clinic presents two cases each, and discusses what happened, what they did to help and support the patient, and challenges.



Campaigner / community group Mini Network Proposal

Each community group presents two examples of interactions, and discusses what happened, what they did to help and support the patient, and challenges.

Photo 28: Students breaking for lunch at the University of Sierra Leone.

Social media helping to sustain change

There was much enthusiasm about projects who had used social media, because:

- it had helped to reach youngsters who they haven't or couldn't reach in person
- it is a way to extend the amount of time someone is engaged with their project at little cost.

In West Pokot, CICR spoke about communities which they had not yet reached, but that the young people were borrowing smart phones of their uncles to look up information when they had heard about anti-FGM projects happening.

People who had worked with youngsters in Egypt, a very socially conservative society, said that with FGM and anything to do with sex being very difficult to discuss, they believed that young people were learning about FGM and sex online. Girls were learning that they had rights and choices including who or when to marry. They also reported however that any anti-FGM messages led to violent trolling.

Those who had worked with The Girl Generation spoke about the guidance and training they had received to benefit from social media. They spoke confidently about how to use it, and how it was helping build momentum. Others interviewed who were often, but not exclusively, of an older generation, spoke of believing that social media had enormous reach but that they did not know how to use it.

Photo 29: Meeting Diaka and Umu from GE-SL.

Girlz Empowered SL, a young and vibrant community based organisation is using social media as a core part of their strategy, and doing so alongside other media appearances, taking part in talk shows on the radio and television. Diaka spoke about how they had adapted their approach. At the start, they focused on the End FGM message. They found that, perhaps buoyed with the anonymity of social media, they were trolled and even threatened. They adapted their message, and found that by debunking the myths around FGM, they can engage in useful discussion.

Meeting Catherine and Esmael in Nairobi, both spoke about how the use of social media allowed them to stay connected with others involved in the work. Catherine spoke about how kept in touch with other campaigners and activists from the Emotional Wellbeing project on social media, supporting each other.

In the UK and the NHS

There are examples of where social media has led to some of the most incredible changes in the UK. However, there is little success to date of the NHS using this to reach and engage with young women, encouraging them to access NHS services.

For example, this video which gives information about recently opened FGM Support Clinics was developed by Integrate UK, a youth-led charity tackling FGM and other forms of abuse. It has been widely praised by stakeholders, but it needs to be promoted on the channels more frequently used by the target audience (18 – 25 year old girls with FGM in the UK).

Conclusion

Despite the enormous contextual differences between the UK and the countries visited within the report in Africa, there were strong synergies between the approaches, parallels with the challenges faced, and opportunity for an exchange of ideas and shared learning opportunities.

Healthcare professionals and other people involved in the work to End FGM find that they face professional and personal burdens as a result of their involvement.

End FGM programmes and employers have a moral duty to provide support to address these burdens. There is also evidence to suggest that if support is provided, people will be more likely to continue with the work, keeping experience and expertise within the movement, therefore strengthening it.

There is also evidence that the burden is exacerbated by issues within the movement itself. Some of the burden is caused because supporting women with FGM and working to protect girls is difficult; this is largely unavoidable but can be addressed.

The other elements of the burden are caused by avoidable factors, which with improvements in strategy and delivery, can be avoided.

A three part approach is recommended to address this situation.

1. Provide support to people working to tackle FGM to help them address the burdens caused as a result of their involvement in the work. In doing so, increase the likelihood that they, with their knowledge and experience will remain active in the work to End FGM.
2. Address the strategic issues facing the movement to End FGM. These issues vary in what they look like, and how they manifest, but improvements will both reduce the burden placed upon those involved, and will make sure that the ambition to End FGM will be achieved in the most efficient and soonest way possible. Importantly, communicate more about what is happening.
3. Involve more people and organisations in the work to End FGM, by making sure that stakeholders with a responsibility to be involved are active, and that anyone who wants to contribute can work out how to do this usefully. This will spread the burden which cannot be removed / mitigated to a wider group of people and lead the End FGM movement towards a sustainable model.

Whilst the ambition is to adopt all recommendations, it is acknowledged that there will be some challenges to do so. Many recommendations can be taken forward without being reliant upon each other and will offer incremental benefit. However, a partial adoption needs to be undertaken with care, because adopting some measures in isolation of the all of the recommendations could lead to further burden being imposed on those who are currently involved, and little or no progress in the ambition to End FGM.

Many contributors recognised how the support they received from their peers was the thing which made the most practical difference to them. Without fail, when asked what motivates them, they said that they think about the girls who are saved from this violent and meaningless abuse. By strengthening and facilitating the network and peer support mechanisms; the vibrant, diverse and resilient 'End FGM' movement can learn to support and sustain itself. By making sure that we can see progress and talk about it, the movement will also provide motivation to carry on, remained centred and focused on the young girls who rely on us for protection.

How to make an impact

I intend to use this report in the following ways:

In 2020

1. Socialisation of findings.
   I will seek opportunity to discuss the report with key decision makers in the UK, and some international colleagues. This will continue across the first year. I will seek commitments from bodies responsible for or involved in professional wellbeing to recognise within policies that professionals working to End FGM may need support.
2. Offer support to the recovery plan for the national NHS team.
   Having already presented early findings to the most recent NHS England & Improvement FGM National Steering Group, I will offer support to the national lead to advise on the recovery plan related to the NHS. This will, in part, use the NHS Action Plan outlined.
3. Offer support to the recovery plan for local NHS teams.
   I will offer advice to local NHS organisations/system looking to review their FGM provision as the NHS returns to fuller provision of services. This will, in part, use the local version of the NHS Action Plan.
4. Introduce 'mini-networks' for health services and campaigners.
   I will recruit firstly healthcare professionals and then campaigners to take part in the proposal to run mini-networks, a new initiative to develop relationships to promote learning internationally over a sustained period.
5. Stakeholder coordination.
   I plan to discuss with stakeholders in the UK how to start to address some of the challenges facing UK networks, and work with the FGM National Clinical Group to aim to address these.

In 2021 and onwards

6. Develop the 'mini' networks' for health services.
   As the networks develop, I will review the early findings and build interest and support for this proposal from organisations which could help to support these in the long-term.
7. Stakeholder coordination.
   I have been offered a role as Director of the FGM National Clinical Group to help develop a joint vision to which there can be broad agreement across the third sector stakeholders in the UK, to describe what the priority is for the NHS to deliver.
8. Tracking commitments.
   Where organisations agreed to adopt recommendations, I will continue to discuss and ask for information about the impact of these, offering support to track and evaluate measures if needed.

Progress will be tracked, and outcomes shared. The actions in 2021 may need to be updated dependent on outcomes from the initial phases of the work.

Annex A: NHS Workforce Analysis

		FGM prevalence among girls and women aged 15 to 49 years, by residence and wealth quintile (%)							Number of NHS employees defining their nationality as from these countries			Estimate of number of NHS employees with FGM		
		Residence		Wealth quintile										
Country	FGM prevalence among girls and women (%)	Urban	Rural	Poorest	Second	Middle	Fourth	Richest	Nationality	Male and Female Employees	Estimate of number of females (77% of total)	Using FGM Prevalence among girls and women	Using FGM Prevalence in Urban Residence	Using FGM Prevalence in Richest Quintile
Benin	9	5	13	16	14	10	7	2	Beninese	10	8	0	0	0
Burkina Faso	76	69	78	77	78	78	80	68	Burkinabe	8	6	4	4	4
Cameroon	1	1	2	1	4	1	1	1	Cameroonian	295	227	3	2	1
Central African Republic	24	18	29	34	31	26	17	15	Central African	79	61	14	11	9
Chad	38	40	38	46	42	37	30	37	Chadian	3	2	0	0	0
Côte d'Ivoire	37	31	44	50	44	43	34	20	Ivorian	59	45	16	13	9
Djibouti	94	94	98	97	96	94	95	93	Djiboutian	1	1	0	0	0
Egypt	87	77	93	94	93	92	87	70	Egyptian	1899	1462	1275	1131	1020
Eritrea	83	80	85	89	86	84	83	75	Eritrean	175	135	111	107	101
Ethiopia	65	54	68	65	69	69	69	57	Ethiopian	116	89	58	48	51
Gambia	76	77	72	68	78	85	81	67	Gambian	250	193	145	148	128
Ghana	4	3	5	13	4	3	1	1	Ghanaian	2708	2085	79	52	22
Guinea	95	95	94	95	94	93	96	95	Guinean	23	18	16	16	16
Guinea-Bissau	45	40	50	18	59	65	47	36	Guinea-Bissau	0	0	0	0	0
Indonesia	49	49						49	Indonesian	81	62	30	30	30
Iraq	7	7	8	1	3	3	6	22	Iraqi	341	263	19	18	56
Kenya	21	14	26	40	26	18	17	12	Kenyan	767	591	124	81	70
Liberia	44	37	56	58	56	51	38	26	Liberian	37	28	12	10	7
Mali	89	89	88	86	86	90	90	90	Malian	4	3	2	2	2
Maldives	13	14	12	14	12	12	15	12	Maldivian	23	18	2	2	2
Mauritania	67	55	79	92	86	70	60	37	Mauritanian	250	193	128	106	70
Niger	2	1	2	2	2	2	3	1	Nigerien	232	179	3	2	1
Nigeria	19	24	16	16	18	20	23	20	Nigerian	7516	5787	1127	1400	1157
Senegal	24	20	28	41	30	25	17	14	Senegalese	34	26	6	5	3
Sierra Leone	86	80	92	93	93	90	85	74	Sierra Leonean	526	405	348	324	301
Somalia	98	97	98	98	99	98	97	96	Somali	263	203	198	196	194
Sudan	87	85	87	88	82	81	90	92	Sudanese	680	524	453	447	479
Togo	3	3	4	4	4	3	4	2	Togolese	11	8	0	0	0
Uganda	0	0	0	1	0	0	0	0	Ugandan	520	400	1	0	0
United Republic of Tanzania	10	5	13	19	10	12	9	4	Tanzanian	160	123	12	6	5
Yemen	19	17	19	27	21	13	20	14	Yemeni	31	24	4	4	3
									Totals	**17102**	**13169**	**4190**	**4165**	**3741**

Notes: In Liberia, only girls and women who have heard of the Sande society were asked whether they were members; this provides indirect information on FGM, since it is performed during initiation into the society.
In Indonesia, residence / wealth quintile not avaliable, so using population level prevalence.
When estimating number of NHS employees with FGM (columns W, Y, AA), value calculated and rounded down to nearest whole number.

Source Columns A to P: UNICEF global databases 2020, based on Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and other nationally representative surveys.
Source Columns S to AA: NHS Digital - 'NHS Workforce Statistics September 2019',
Published 19 December 2019 https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/september-2019

Annex B: 'By-country' record of meetings / interviews

Kenya

Catherine Mootian	Catherine is founder and director of AfyAfrika, an organisation working in Narok County, Kenya, committed to ending FGM, child marriage and gender based violence. Catherine took part in the Emotional Wellbeing project and spoke about the help and support that this approach has given her. She is the Deputy Chair of the national Youth Council.
Esmael Omar	Esmael worked for The Girl Generation as Country Programme Officer, having previously worked with Catherine at AfyAfrika He is working on a new project, GirlVanize, networking and involving girls in local government and decision making on FGM, education and climate change. We spoke about; • Why working against FGM is difficult, the personal toll and impact on mental health • The outcomes from The Girl Generation, and the benefit of having the 'Do No Harm' guidelines to steer collective work • The role of local community, elders, regional and national Government • Innovative projects for example those using yoga or dance • The difficulties to get funding to deliver work, and debates such as small groups for intimate discussion vs large groups.

Photo 31: Catherine Mootian

Photo 30: Esmael Omar

Anti-FGM Board antifgmboard.go.ke Bernadette Loloju	Bernadette is CEO for the Anti FGM Board, and Carol is on secondment from the UN Population Council We spoke about; • How the Board was setup and its role • The benefits of having an organisation to coordinate all aspects of the work, linked to but independent from the Government, • Their partnership with the Ministry of Health and developing projects aiming to work with healthcare professionals • Opportunities to address FGM when professionals (and families) move to the UK • Cross-border issues which are presenting a challenge to the fight in Kenya, and emerging concerns around medicalisation.

Photo 32: Meeting Bernadette, the Board's CEO

Every Girl's Dream Aisha Hussein	Aisha setup 'Every Girl's Dream' two years after she had a difficult c-section birth, a result of which she learnt about her own FGM. She decided she wanted to start a conversation about FGM, to stop it from happening to other girls. I also met Jamal, their accountant, and Fadume who makes their videos. We spoke about; • How her work grew organically and the importance of her being from within, knowing and part of the community, • How she has segmented her messaging and then approaches a community, and gives the appropriate message to each group, • Her message, which focuses on empowering girls, and giving them every opportunity in life, • The challenges they face, including accessing funding, and how to establish partnerships which respect individual contributions, • The important role that social media is playing in joining up communities and opening conversations.
Ortum Mission Hospital - several visits	I visited a hospital, offering services to the rural and remote populations in and around Ortum, Pokot. It is a Catholic Mission Hospital. Treatment mostly has to be paid for but is relatively low cost. I met the Sisters from the Order running the hospital, nurses and midwives and visited the maternity home. Sister Domitilla spoke about the importance of education in ending FGM, and how men are very influential in deciding that FGM will happen. She spoke about what an important rite of passage FGM is in the local community. Sister Mercy spoke about how she has joined several outreach trips into remote villages, and how she wanted to be an active part of the work in the future. Nurse Ester is a nurse/midwife from Pokot herself, and spoke very movingly of her experience supporting so many women with severe complications from FGM. Being local to the area and speaking the language, she is often called on to support. Talking about healthcare professionals and the community jointly, she said *'we carry this trauma'*. She was visibly moved by my asking about how she felt, and she spoke to me about never having been asked about how she felt and how it impacted her. We spoke a lot about organisational and peer support mechanisms, and how having a consistent message from multiple sectors helps her as a healthcare professional to give the same message to women. Nurse Silas is relatively unusual as a male nurse/midwife, and he has worked in several areas where FGM is very highly prevalent. He spoke movingly about the need to engage with women and families, not just lecture against FGM. He uses real stories with his patients, describing the difficulties other women have faced, but he tends to talk about patients where there was a good outcome, rather than examples where the baby dies, as death is still a taboo subject. Nurse Christine was quite reticent, but also was the first person in my travels who brought up sex in relation to FGM, before I had asked if there was a link. When talking about how she carried on when things became difficult, I could hear and see her reliance on what seemed like a personal 'uniform' and her deep pride of being a nurse.

Nurse Naomi is a young nurse/midwife and was shy but spoke to me about the shock she felt when she started treating women who had type 3 FGM, when she did not know about FGM.

Maternity home

I met around 16 women staying in the maternity home, a free residential service for women, normally in their third trimester, who face high risk pregnancies. In this meeting, I was wholly reliant upon translation by Eva Prech (see below). They all lived in very remote locations, several hours walk from the hospital.

They told me what they knew about the efforts to End FGM and recounted the messages they hear. Some spoke more passionately about church, some about education of their girls. Some spoke of the benefit of the support offered by the outreach charity with whom Eva works.

I am grateful for their time and willingness to mee t, but given the context and complex issue surrounding our meeting, I think that some of them will have felt obliged to provide certain answers in line with what they perceived to be my expectations.

Photo 34: Meeting women staying at the maternity home.

Photo 33: Entrance to Ortum Mission Hospital

Centre of Indigenous Child Rights, CICR

New charity being established following changes in the Kenyan arm of Beyond FGM.

Eva Prech; Eva hosted my visit, organising and introducing all meetings, often translating. She also spoke to me a lot about her work, with Beyond FGM and now as they are re-building into CICR. She spoke about her motivation, the financial challenges faced, and the toll the work has taken on her and her family. Eva and I spoke about the expectations she and CICR colleagues had in relation to my ability to provide funding or even access to funding channels; it may have been a disappointment, but I believe that her hopes were in optimism not expectation and with her professional background, I know she understands the importance of research being undertaken without the involvement of financial incentive.

Abel Lokeris; Abel was both my driver in the area and spoke about his involvement with CICR as he sometimes helps facilitate rescues with transport. Abel would most often answer my questions about the challenges facing the work in the context of the financial challenges. We went on to discuss that he, as a man willing to support girls aiming to avoid FGM, can be isolated by friends and neighbours. His examples even included how the charity approach can lead to the families ridiculing those trying to stop FGM. The example given was if you are willing to spend you own money to hire a car/bike to rescue a girl, then the family will just keep expecting more and more. A rescue, leads to a demand for school fees, and a need for you to handle any consequences with the law authorities; you as the rescuer facilitated this problem and so you bring it on you to fix all consequences which follow.

Photo 35: Eva, my host, and Lokito who sings about FGM.

	Lokito is a travelling musician using transmission of messages through song, continuing a historic tradition. His repertoire includes song about FGM, HIV, hygiene amongst love, war, and loss. He plays the pkan, a traditional instrument and sings. Having been personally affected by FGM when his sister died in his arms, he uses his position as a travelling musician to pass the message. Regina – I met Regina, a young girl, several times in the village. She was always keen to speak to Eva, and to tell me how CICR (then Beyond FGM) had led to her not being cut and being able to continue her education. She is about to train as an accountant; Eva spoke proudly of her being a success story and an example for other families to understand the impact of stopping the cut.
Rhoda Lodio	As a founding member of Beyond FGM, Rhoda visited London with Miriam in 2002. She is practising as a nurse/midwife in Kapengueria, whilst studying for masters. Having been involved in the work for well over 20 years, Rhoda appeared hugely resilient. However, when she and Eva spoke about specific challenges facing their work, she was very sad. She was also offering support and guidance to Eva to navigate a very complicated situation. Rhoda spoke about focusing on saving individual girls and bring their many stories to mind when she found things difficult. She also talked about how being an excellent nurse and treating patients with FGM with dignity and compassion was part of her outreach work, by being an example to her peers and in doing so, challenging some of the stereotypes.  *Photo 36: Rhoda and me, about to travel in a matatu.*
Miriam	The third founding member of Beyond FGM, I met Miriam at her smallholding where she is soon going to enjoy a well-earned retirement. We spoke about her journey and how she has seen differences such as introducing the legislation against FGM help the fight. She is concerned about how communities are evolving the practice to allow them to continue without detection. With over 31 years working against FGM, I feel that Miriam sees that it is important that people develop their own resilience, as she did over many years.  *Photo 37: Miriam laughing as we took photos.*

Agnes and Bernadette	My last meeting in Pokot was with Agnes and Bernadette, who I'd met earlier at the market. They have 9 and 6 children respectively, with Agnes' eldest daughter now in High School and Bernadette's eldest daughter at college. Both were very proud of their girls receiving higher level educations and spoke about how their family are proud of the work, because it has led to the girls receiving such good educations, leading to good marriages. They noted that this is not just a campaign from a moral point of view, but that it makes sense for them to do this as it helps their economic outlook in the long run. They first got involved in the work with Beyond FGM many years ago and are proud to be involved in the work. I was struck by the importance they placed on communication with their friends, family and neighbours. They also spoke about how a woman will talk about her experience in hospital, and how that message will spread far and wide if the care was good or bad.

Photo 38: With Agnes, Bernadette and Eva.

Dr Hannah Kagiri, outgoing Head of Gender Unit, Ministry of Health	It was complicated to contact a MoH official prior to arrival, so I was delighted to meet Dr Hannah Kagiri, outgoing Head of Gender Unit at the Ministry of Health. Hannah spoke to me about the systematic and comprehensive five year plan the MoH are delivering, and the 5 workstreams covered by this. As part of this, they have developed a training manual, excerpts from which she explained including debriefs for staff to ensure wellbeing. Some of the plans relating to the collection of health-based statistics are hugely interesting and will provide basis for learning for other health sectors including the NHS, though this remains outside the immediate remit of this report. I await the publication with anticipation as of course I was not able to have a copy of the work prior to publication.
Dr Tammary Esho, Clinical Sexologist	Tammary told me about the reconstruction clinic in Nairobi, at which she supports women with counselling prior to deciding whether or not to have the procedure. I was also interested to hear about Tammary's research about FGM which she had just presented at the WHO, and her thoughts about the work in Kenya in context with what she has seen in Belgium. We spoke about how she sees HCPs and activists in Kenya carrying the burden of doing the work. As well as saying she was interested in looking into medicalisation in Kenya, we also spoke about the complex situation some HCPs may feel that they are doing their friends/families a favour by keeping quiet, or potentially even facilitating or carrying out FGM under circumstances we would call medicalisation.
Equality Now team	I met Judy Gitau, and her team, Flore, Nina, Caroline and Natori at the Equality Now office in Nairobi. A human rights organisation, Equality Now are working to create a just world where women and girls have the same rights as men and boys. The Nairobi office works across African countries. I learnt from the team about their intensely thorough and forensic approach as they offer legal advocacy and seek accountability to existing laws for women and girls. What they do is very different from what the health service can offer, but opportunities to learn and reflect are clear. Their methods were so considered; whilst clearly fighting for something the team members all hold dear, the approach felt like the assumption is that progress would be slow and needed to be sustained for many years to come. The discussion was in

Photo 39: Meeting Dr Hannah Kagiri

	context of a long term effort, and therefore felt different in mindset to much of the UK work.  *Photo 40: Meeting the team at Equality Now*
Divinity Foundation	Having visited the Divinity Foundation Rescue Centre in Amboselli in 2017, I was delighted to meet Nav Mathuru, Lawrence Andiika and Lenny Royal to hear how the centre and work is developing. I spoke to Nav about the complexities of working in a stakeholder network, and her thoughts around the challenges faced by the work.  *Photo 41: Meeting Nav Matharu*

Egypt

Coalition of NGOs against FGM Dr Randa Fakhr	Dr Randa Fakhr has been with the Coalition since inception, a group which coordinates over 100 NGOs and agrees their group messaging. We talked about how this supported the civil society movement. I also listened as Randa spoke about the impact on her and others' work when there are aspects, for example law enforcement which are seemingly ineffective. Randa spoke movingly about the difficulties and challenges in working against FGM in Egypt and the highly complex political situation. We spoke about doing this work within that environment. As a doctor herself, Randa spoke to me at length about medicalisation.
British Embassy, Social Development	Meeting Ed Barney, First Secretary Social Development I learnt about work between the UK Foreign and Commonwealth Office and teams and organisations within the Egyptian Government. I also heard about some of the social context of the work, and FGM in context of women's rights and other development issues and the context in which medicalisation emerged.
Alexandria Regional Centre for Women's Health	Meeting the Head of the Centre and his deputy, I learnt about the services offered at the ARC and heard from them about their awareness of the work tackling FGM. I also met Sherine Farag, Director of Women's Development. She outlined the services she offers, including community work tackling FGM alongside support services to victims of domestic abuse.  *Photo 42: The outside of the ARC building.*
UNPFA Country Office May ElSallab	Leading the work at the Country Office, May spoke about the overall UNFPA programme locally, and how different bodies (international NGOs, NGOs, Community Development Agencies, Civil Society Organisations) function, the dynamics about the interrelationship between them, and interaction with Government bodies, and challenges relating to funding. May explained some of the dynamics around medicalisation and the long-term consequences they face following this.
UNFPA Regional Office Farida Mahgoub	Farida Mahgoub is Regional Research Analyst/ Programme Coordinator at the UNFPA Arab States Regional Office. We spoke about the regional office support, which aims to support countries to develop interventions appropriate to the need, in doing so building the capacity of local organisations to intervene effectively. She also described ways in which they aim to share learning across programmes.  *Photo 43: Meeting Farida Mahgoub*

Population Council Nada Wadha	Nada Wabha spoke to me about a 5 year project they are completing, with financial support from Department for International Development. Nada highlighted that in moving towards medicalisation, she is concerned that this also normalises the practice, and that the discussion focuses enormously on how FGM is happening, and in doing so, focus is lost on the root cause of why parents want their girls to have FGM.

Photo 44: Meeting Nada Wadha

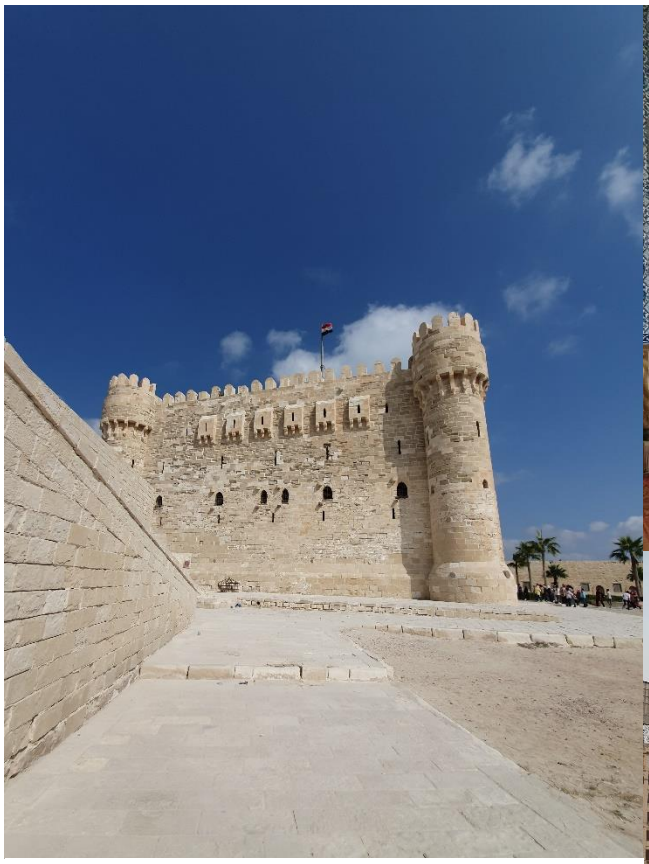


Photo 45: From Fort Qaitbey looking of site where the ancient and legendary Pharos lighthouse was, to the decadent Manial Palace, to Tahrir Square which as a result of some recent protest had a significant police presence, Egypt was as diverse as it was perplexing.

Sierra Leone

Alexandra Rigby	I met Alexandra in a personal capacity. She is a manager of the Aberdeen Women's Centre, a charity-run hospital. I also learnt about her experience of working in several organisations supporting women in Sierra Leone. Alexandra talked to me about the complexity of working within a society where there is widespread support of FGM, including by healthcare professionals. I heard about some of the deeply complicated links between FGM, the challenges Sierra Leone as a country faces (following the Civil War, Ebola and economic pressures), and links between Sierra Leone and the UK, often in the form of aid.
Katie Ganda	Katie supported me on my trip to Kenema and Bo, providing help with translation and logistics. I spoke to Katie about what is like hearing about the Secret / Bondo society as a young girl growing up, and her perception of it. She is working as a teacher and looking forward to training as an accountant.
Group of soweis – cutters	I met a group of soweis, who collectively have spent many years cutting girls. Within the conversation there were many inconsistencies, denials and untruths, and they tried to control the conversation. Having listened back to the meeting, I believe I challenged them as effectively as I could. A personal reflection upon the meeting is included.
WAVES-SL	Hannah Koroma, who has been working against FGM in Bo for many years, spoke to me about how Waves-SL grew, and how she is trying now to harness social media, and work to develop young advocates. She spoke about working as part of a network, with the different opinions which invariably arise in this situation.
UNICEF	I met James Gray, Chief in charge of Child Protection and Yuichiro Yamamoto, UN Volunteer Programme Officer. I learnt about the plans UNICEF have, starting with an ethnographic study to understand where things are following a hiatus in their work, in part following the Ebola outbreak. It was interesting to hear their perception of and what involvement they have with activists and grassroots organisations.

Photo 46: Meeting Alexandra where she works.

Photo 47: Hannah in her office.

Girlz Empowered SL	I met Diaka Salena Koroma, co-founder, and Umu Alberta Koroma. Girls Empowered SL is a girls-focused initiative, which allows young people to lead the discussions, to talk about what matters to them, and to create peer support networks and empower girls to reach their full potential, as well as giving them the confidence and knowledge to protect themselves against FGM. Using social media and other outreach mechanisms, Diaka and Umu explained how they have developed their messages; if messages saying End FGM were leading to backlash, then at this point, they are more able to engage in useful dialogue when 'myth busting'. Diaka also has a social enterprise arm, selling upholstery and clothing to provide a funding stream for the work of GE-SL.
Rachael Freeth	Having also kindly supported me prior to arrival, Rachael Freeth helped me understand the work of Department for International Development (DfID).
Rugiatu Turay, Amazonian Initiative Movement (AIM)	When I met Rugiatu, she was running workshops for local soweis (cutters) in preparation for an alternative rites' ceremony taking place within a fortnight of my visit. It was interesting to see one of the final preparations where they were selecting the soweis (cutters) who had attended the workshops and participated sufficiently to be selected to take part in the alternative rites camp. I also learnt about her work for over 18 years and how the challenges from the early days had changed. She spoke about the interaction between the work and local politics/community leaders, and some of the context which leads the practice to continue. I also spoke to Theresa and John from Rugiatu's team, who shared with me their experience and thoughts.
Dr Aisha Ibrahim, University of Sierra Leone	A lecturer in social sciences, Aisha spoke to me about the role she has in the Forum against Harmful Practices as adviser, as she has carried out research in this area. Aisha is very clear that her arguments against FGM come from her strongly held beliefs as a feminist though she recognises this is not shared by all activists and nor does it need to be; her ambitions relate to reforming the society recognising that strong links between women can be hugely beneficial, but that mutilation does not form part of that in the future.

Photo 48: Rugiatu, on a break from delivering community sessions.

Photo 49: Meeting Aisha at the University

Photo 50: Airport transfer across to Lungi, sunset from the hotel, Clarissa the hotel's crested crane and a colourful shopping scene.

Australia

On arrival into Sydney, my first appointment was to give a lecture at the University of Technology Sydney (UTS). Around 20 people joined, with some having travelled inter-state. The group had a mix of people who had been working in the field for many years, and those studying for whom the topic was new. I introduced my research and outlined some of the early findings and recommendations. Following this, there was a lively debate which covered many topics including the role of men, why FGM happens, whether the link to child abuse should be made explicit, and the role of the media and youth activists in the fight.

Professor Angela Dawson, University of Technology Sydney	Having carried out much research in FGM, I met Angela in 2015 and since when she visited the UK to learn about what we were doing to tackle FGM. Angela spoke to me about the context and history to the work in Australia, and the research she has undertaken. We spoke about some of the challenges for the work to happen in Australia, and the influence of politics. We also discussed the challenges in sharing and networking.

Photo 51: Angela, colleague Caroline and me

Dr Oladiye Ogunsiji, Western Sydney University	Oladiye shared her research and findings, which included identifying the knowledge levels of various healthcare professional groups. Her focus has often been to consider the experience of women in receiving care. She spoke about her concern for midwives who carry the burden, and we spoke about how she feels that many more are now aware, but progress next needs to translate this awareness into changed care episodes.

Photo 52: Meeting Oladiye on campus.

Sabera Turkmani, PhD student at UTS	 *Photo 53: Meeting Sabera* In the final stages of her PhD, I spoke to Sabera about her research into the maternity experience of women who have had FGM. It was interesting to understand her approach and some of the challenges completing with a relatively small sample of patients.
Monika Latanik and Dipti Zachariah, Integrated & Community Health, NSW Health Dept	 *Photo 55: Dipti, me and Monika* Meeting Monika and Dipti, I learnt about the New South Wales (NSW) Health approach to providing services, and I learnt about the role of a bilingual communicator, a role which is most similar to that termed 'health advocate' in the NHS. They discussed some of the strategic challenges they have faced, as funding profiles have changed over time, and some of the consequences they have faced if following a period of lesser activity, they try to restart work. They also described an ongoing challenge to integrating the FGM services into the wider service provision of their organisation.
Boipelo Besele, Multicultural Centre for Women's Health (NEFTA)	As the national facilitator for the National Educational Toolkit for Female Genital Mutilation / Cutting Awareness (NEFTA) project, Boi explained how the project is setup and funding, and the aims. Boi explained the points at which decisions were made to carry out the work differently from the approach in the UK, particularly the decision to not target media or aim for a public awareness campaign. She spoke about the engagement with community groups in developing this approach, and the many complications in coordinating a network as complex as theirs.  *Photo 56: Meeting Boi, under a tree of wishes written by women the Centre supports*
Nigisti Mulholland,	At the well-respected Women's Hospital in Melbourne, I learnt about the Family and Reproductive Rights Education Program (FARREP), Nigisti outlined the services

FARREP Coordinator and Marie Jones, The Womens Hospital Melbourne

offered, and how they work with women from many backgrounds to provide a holistic service.

We also spoke about the importance for healthcare professional training, recognising the impact that an unprepared/untrained HCP may be, not only themselves feeling traumatised by a difficult care intervention, but also not being able to provide the best care to patients. They spoke about the networking and importance in sharing between clinics and services, to avoid re-inventing good quality services.

Photo 57: Nigisti, Marie and me

Megan Taylor, Women's Health Service, Canberra Health Services

Meeting Megan, I learnt about how a relatively small heath service with proportionately low prevalence (Canberra being the smallest state in Australia) was considering the issues relating to FGM. The challenges including being able to identify the need, and gain traction with healthcare professionals who may only very rarely treat a woman with FGM.

Photo 58: Meeting Megan at breakfast

Khadija Gbla, Co-Founder of Desert Flower Australia

Khadija spoke passionately about her work advocating for women's rights as an activist in Adelaide and speaking as a survivor having been cut in Sierra Leone. In contrast to the UK, Khadija is very unusual in her position, with little peer support. Khadija is very clear in her position, that she wants the work in Australia to identify FGM as child abuse more explicitly. We also discussed the issues surrounding the prevalence figures. We spoke at length about differences in understanding of terminology, especially in relation to reconstruction, which I found had a different scope in different projects. We spoke about working alone, the need for personal resilience, and the challenges in how to give more to the fight but still be OK.

Photo 59: Meeting Khadija, on one of the hottest days ever in Adelaide

Monica Diaz, Consultant Midwife, Adelaide and Churchill Fellow	I learnt about Monica's journey to complete a Churchill Fellowship herself, which was researching maternity services on offer to women with FGM. She spoke about difficulties in linking with contacts, and her ambitions to implement her recommendations within a service in Adelaide.

Photo 60: Last but by no means least, meeting Monica, a midwife and also a Churchill Fellow.

Photo 61: Sydney Harbour Bridge

Black Lives Matter

I am finalising this report at the same time as widespread demonstrations in the wake of the brutalised murder of George Floyd. The anti-racist and Black Lives Matter movements are being discussed in nearly every corner of society, and I hope this finally means that we start to acknowledge how widespread racism is in our country.

I have learnt an enormous amount more about racism since joining the End FGM work, and this has included some insight into how my friends and colleagues' lives are affected every day because of the colour of their skin. I continue to learn, and I need to, but I am often horrified as I do.

I know that my white privilege has been part of me being able to travel around the world to research this subject. Never have I felt this more acutely than since being awarded my Fellowship.

FGM does not happen because of your race; if you are at risk of having your genitals mutilated as a child, this is not because of the colour of your skin. Yet, the way the UK has and continues to respond to FGM has included deeply entrenched racist attitudes and behaviours. As discussed in the report, unconscious bias is affecting the treatment of black women. The health inequalities between white and black and minority ethnic communities are shocking. Black and minority ethnic staff in the NHS are not treated equally, and the statistics back this up. We have to talk about this, recognise this and do everything we can to stop this being true.

A personal note

This is different from the acknowledgements, and the rest of the report. I feel that I need to take a moment to tell anyone still reading about what an enormous adventure this has been.

I had a dream job, having led the End FGM work in the health service since 2013, but it was time for to change. Straight after Christmas, I applied for a new job in Dorset.

I attended interview for the job and I was interviewed for the Churchill Fellowship in the same week. At this point, I couldn't imagine how these two could possibly happen together.

Excitingly, I was offered both. Just 7 weeks after the interviews, I moved from Sevenoaks to Dorset and I popped back to London the very next week to attend my Fellowship induction. Daily life as I knew it completely changed.

In the middle of this, a close family member got engaged and then married a fortnight before I flew to Kenya.

Another unexpected chapter in this mad story was when in an Uber heading to Cairo airport, I heard that my mum was rather poorly. She totally stole my thunder when I landed back in Heathrow.

A few weeks later, I set off again to Sierra Leone. The logistical challenge was even more complicated, to then head off to Australia. Once the time to relax came, I spent Christmas in the Gold Coast, enjoying shrimp on the barbie. I arrived back on 1 January 2020, having quite confused myself about New Year's Eve and when or where I repeatedly cross the date line. This is an insight into my 2019.

had less than 12 hours in London, which allowed for a lovely Christmas bauble experience at Heathrow Airport at check in with my parents!

Over the same period, even my perception about my role in the efforts to End FGM transformed. For years, I had spoken knowing I was doing so representing HM Government, and now I was getting used to using my own voice, and giving my own opinions.

So, January 2020 kicked in. I started writing up my report. Then Covid-19 changed all of our daily lives. In those first weeks under the lockdown arrangements though I was fortunate in my circumstances, I found myself struggling to concentrate, let alone write up my report. My job in the NHS was changing daily, and across our team, everyone was facing personal and professional upheaval.

Eventually the clouds parted, and I worked out what to do. I am very grateful however to WCMT for their understanding, and to have been given an extension to complete my report.

I know I will always remember my trips, and so many memories can still render me speechless. I still feel honoured and thrilled to have had this opportunity.

So aside from the formal acknowledgements, this is a very big and personal thank you to the countless people who showed me kindness last year.

Photo 63: Goodbye and thank you from Darling Harbour, Sydney. 30 Dec 2019