

The Missing
Link: a joined up
approach to
addressing
harmful practices
in London

Executive
Summary

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INTRODUCTION

This study was commissioned and funded by the Greater London Authority to address a knowledge gap on the needs of black, minority ethnic and refugee (BMER) women experiencing harmful practices (HPs). The specific aim of the study was to provide a document which would help to engage commissioners, funders, policy-makers and frontline practitioners to improve the way London responds to HPs. The study was carried out between December 2010 and March 2011.

There is no universal definition nor is there an exhaustive list of harmful practices. The term 'harmful traditional practices' was used by the World Health Organisation in 1979 at a regional seminar held in the Sudan as a less contentious cover for raising the subject of female genital mutilation. It was used at a time when the issue was considered to be too controversial to be raised as a single issue.¹ Henceforth, other practices, including, early marriage and forced feeding, along with female genital mutilation were referred to as harmful traditional practices. Historically, there are also practices that would not be considered to be gender-based violence within the evolving definition of HPs. The United Nations has defined harmful traditional practices as:

"forms of violence that have been committed against women in certain communities and societies for so long that they are considered part of accepted cultural practice. These violations include female genital mutilation or cutting (FGM), dowry murder, so-called 'honour killings,' and early marriage. They lead to death, disability, physical and psychological harm for millions of women annually".²

In addition to the above list, acid attacks would also be a type of harmful practice.³ There are a number of reasons why these forms of violence may occur. First, harmful practices, as forms of violence against women, are rooted in gender inequality. Other reasons cited often include 'traditional' values, such as the authority and wisdom of parents and children's duty of obedience. However, the commonality between these forms of violence tends to be the existence of established hierarchical power-relationships between men and women and between parents and children. Despite their harmful nature and their violation of international human rights laws, such practices persist because they are not questioned and take on an aura of morality in the eyes of those practicing them.⁴ The United Nations recognises that "the ways in which culture shapes violence against women are as varied as culture itself".⁵ For example, some writers have referred to the phenomenon of 'date rape' as a cultural norm although it is not always labelled as such. Some academics have argued that there is inadequate focus on harmful practices in western societies. Jeffreys, for example, argues that prostitution and pornography are harmful practices yet are rarely discussed in the context of cultural practices.⁶ Furthermore, it is evident that new HPs are constantly

¹ WHO/EMRO (1979) Technical publication 2, *Traditional Practices Affecting the health of women and children. Report of a Seminar, Khartoum, 10-15 February 1979*, World Health Organisation, Regional Office for the Eastern Mediterranean, Alexandria

² UNFEM (2007) *Violence against Women – Facts and Figures*, available at www.unifem.org/attachments/gender_issues/violence_against_women/facts_figures_violence_against_women_2007.pdf (last viewed 4/2/11).

³ UN (2009) *Good Practices in Legislation on 'Harmful Practices' against Women, Expert group meeting organized by United Nations Division for the Advancement of Women, United Nations Economic Commission for Africa*, New York: UN, Division for the Advancement of Women, Department of Economic and Social Affairs, 4.

⁴ UN, Office of the High Commissioners for Human Rights (undated) Fact Sheet No. 23, *Harmful Traditional Practices Affecting the Health of Women and Children*, available at www.ohchr.org/Documents/Publications/FactSheet23en.pdf (last viewed 21/5/11).

⁵ See footnote 3 at 7.

⁶ Jeffreys, Sheila (2005) *Beauty and Misogyny: Harmful Cultural Practices in the West*, London: Routledge.

developing, and existing HPs have altered as a result of globalisation, migration and practices against women.⁷

For this study, the term 'harmful practices' was used instead of 'harmful traditional practices'. The use of the word tradition was considered to be inappropriate for a number of reasons. By framing violence in certain communities as a custom, tradition or within a religious context it implies that violence against women and girls is an accepted norm or practice and makes it difficult to understand and challenge from within the violence against women and girls (VAWG) framework. In addition, 'traditional' reinforces the ghettoization of violence against women in BMER communities.

Instead, HPs was used in order to take the discussion out of the context of such understanding and for ease of reference for this piece of work. In this report the term HPs was used to encompass forced marriage, female genital mutilation and 'honour'-based violence.

The results of the study show the incompleteness of data on prevalence rates of HPs and inadequate levels of specialist service provision across London, with some areas in London having no services at all. It also highlights the need for a more comprehensive and integrated approach to addressing: prevention, the safeguarding of girls, the long-term impacts of female genital mutilation and prosecution.

Internationally, there has been a stronger recognition of HPs as a violation of the human rights of women over the last twenty years. HPs are recognised as forms of violence against women and girls and as violations of women's human rights in a number of international and regional human rights treaties and consensus documents, of which the UK is a signatory party.⁸ A new Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence, which includes harmful practices, was open for signature on 11 May 2011. It is the first treaty in Europe to set legally-binding standards to prevent violence against women (VAW) and domestic violence (DV), protect its victims and punish the perpetrators. The treaty also establishes an independent monitoring mechanism to monitor its implementation. The monitoring body will consist of independent and highly qualified experts in the fields of human rights, gender equality, VAW and DV, criminal law and may include non-governmental representatives. The treaty is also open for signature and adoption to non-member States of the Council of

DEFINITIONS

Female Genital Mutilation (FGM): Involves the complete or partial removal or alteration of external genitalia for non-medical reasons. It is mostly carried out on young girls at some time between infancy and the age of 15. Unlike male circumcision, which is legal in many countries, it is now illegal across much of the globe, and its extensive harmful health consequences are widely recognised.

Forced Marriage (FM): A marriage conducted without the valid consent of one or both parties where duress is a factor. Duress may take the form of emotional, financial, physical and sexual threats and abuse. Forced marriage is also viewed by some as falling into the definition of 'honour'-based violence. Early or child marriage refers to any marriage of a child younger than 18 years old. The UN recognises it as a forced marriage because minors are deemed incapable of giving informed consent. Girls are the majority of the victims and hence are disproportionately affected.

'Honour'-based violence (HBV): Violence committed to protect or defend the honour of the family and/or community. Women, especially young women, are the most common targets often where they have acted outside community boundaries of perceived acceptable feminine/sexual behaviour. In extreme cases the woman may be killed.

⁷ See footnote 3 at 7, 11.

⁸ See Appendix 2 for full details of treaties and consensus documents which the UK is signatory to or has agreed to respect. See also UN 2009:11.

Europe, European Union member States and the non-member States which participated in its drafting. So far, 13 states have signed up to the Convention, although currently, the UK is not a signatory party to the treaty.⁹

In the UK there have been a number of legal developments, primarily criminal legislation on female genital mutilation, a Civil Protection Act on forced marriage, the development of risk assessment models on 'honour'-based violence and forced marriage, the production of multi-agency guidelines on forced marriage and female genital mutilation.¹⁰

The Mayor of London's strategy to tackle all forms of VAWG, including HPs, highlights the need to better address issues related to disproportionality and cultural sensitivity as factors that may make it difficult for women to seek help and receive adequate safety and protection.¹¹

FORWARD's study, which estimates the prevalence of female genital mutilation is still the most quoted piece of work on the subject.¹² The report estimated that 66,000 women resident in England and Wales in 2001 had undergone female genital mutilation and 23,000 girls under the age of 15 were at risk of female genital mutilation. In 2010, the UK Government's Forced Marriage Unit gave advice or support in 1,735 instances related to a possible forced marriage. Of these, 86 per cent of victims were female and 50 were people with learning disabilities. All forms of HPs are acknowledged as under-reported problems, and, as is the case with other forms of violence against women and girls, HPs have devastating consequences and in some scenarios, cost lives. For example, problems caused by female genital mutilation to the physical, sexual and emotional health of women and girls could also cause difficulties in the relationships between mothers and their new-born children, as well as negatively impacting relationships within the family. Similarly, forced marriage is linked to rape, forced pregnancy, forced child-bearing and other forms of violence. It can also include the withdrawal of a young woman from education which may then impact upon her life opportunities and economic situation. 'Honour'-based violence in its most extreme form leads to the murder of women.

OBJECTIVES

The specific aims of the study were to:

- Identify and report on harmful practices in London
- Outline the legislative and policy framework for harmful traditional practice
- Map out existing support services across London and identify emerging best practice in the sector
- Establish a series of commissioning objectives to inform policy development and identify innovative ways of ensuring sustainable funding for services

⁹ Council of Europe Website:

[https://wcd.coe.int/wcd/ViewDoc.jsp?Ref=PR312\(2011\)&Language=lanEnglish&Ver=original&Site=DC&BackColorInternet=F5CA75&BackColorIntranet=F5CA75&BackColorLogged=A9BACE](https://wcd.coe.int/wcd/ViewDoc.jsp?Ref=PR312(2011)&Language=lanEnglish&Ver=original&Site=DC&BackColorInternet=F5CA75&BackColorIntranet=F5CA75&BackColorLogged=A9BACE) and <http://conventions.coe.int/Treaty/Commun/QueVoulezVous.asp?NT=210&CM=1&CL=ENG> (last viewed 17/6/11).

¹⁰ See Section 3 UK National Policy and Legal Developments of this report.

¹¹ GLA (2010) *The Way Forward: Taking Action against Women and Girls, Final Strategy 2010-2013*, London: GLA.

¹² Efua Dorkenoo, Linda Morrison and Alison Macfarlane (2007) *A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales*, London: FORWARD with The London School of Hygiene and Tropical Medicine and City University

METHODS

The methodology included desk-top research, a review of existing statistics and a one-week snapshot survey to collate data on the numbers of HPs referrals across London. Interviews were held with key policy makers, local authority and primary care trust (PCT) professionals. This was complemented with a focus group discussion and key informant interviews with BMER women's groups and HPs specialists.

KEY FINDINGS

Data on harmful practices

Data on HPs is derived from published reports of contacts with the police, Crown Prosecution Service and other agencies and special requests made to individual women's organisations. Overall it is difficult to make any reliable estimates of the prevalence of HPs. The figures below are likely to be underestimates as the number of incidents which are not reported are unknown but likely to be substantial.

Female genital mutilation

Police data

No prosecutions have been brought under the legislation prohibiting female genital mutilation; however, the Metropolitan Police's Project Azure investigated 46 allegations of female genital mutilation in 2008/09 and 58 in 2009/10.¹³

FORWARD UK (voluntary sector)

A report published by FORWARD in 2007 estimated that in 2001, 4.5 per cent of maternities in Greater London were to women who were born in female genital mutilation practising countries and had some form of female genital mutilation.¹⁴

Since then, estimated numbers of births to women with female genital mutilation living in London have risen from 4,238 women giving birth in 2000 to around 7,000 in each of the years 2007 to 2009.¹⁵

These estimates do not include births to mothers and girls with female genital mutilation who were themselves born in the UK or other intermediate countries to which their own parents may have migrated.

Forced marriage and 'honour'–based violence

Police

During the 17 month period December 2008 to April 2010, 366 forced marriage incidents and 110 forced marriage offences were reported to the Metropolitan Police.

Over the same period, 414 'honour'–based violence incidents and 228 offences were recorded. There were wide differences between boroughs in the numbers recorded.

A report by the Metropolitan Police Authority showed that numbers of recorded cases of forced marriage and 'honour'–based violence combined in London boroughs increased from 127 in 2008/09 cases to 237 in 2009/10.

Forced Marriage Unit (FMU)

In 2010, 375 incidents related to possible forced marriage were reported to the FMU by residents of London, 330 of whom were women and 106 of whom were under 18 years old.

¹³ Metropolitan Police Service (2010) Metropolitan Police Service (2010) Female Genital Mutilation – MPS Project Azure, Report: 8. 4 November 2010, <http://www.mpa.gov.uk/committees/cep/2010/101104/08#h2005> (viewed 23/2/11).

¹⁴ See footnote 12.

¹⁵ Unpublished estimates, A Macfarlane, Midwifery Department, City University, 2011.

Crown Prosecution Service (CPS)

Over the six months from April to September 2010, there were 23 prosecutions for criminal offences related to forced marriage and 38 for 'honour'-based violence in London, 4 and 13 of which were successful, respectively.

Newham Asian Women's Project (Voluntary sector)

In the financial year 2010-2011, up until the end of January 2011, this project had between 16 and 21 new referrals per quarter and saw between 45 and 70 existing clients per quarter for support on domestic, sexual violence and harmful practices.

About **six women each quarter reported attempted forced marriage**. The majority were South Asian girls **aged between 11 and 15** who had either self-referred or were referred by schools.

National Domestic Violence Helpline (Women's Aid/Refuge) (Voluntary sector)

In 2009/10, the Helpline supported **137 women in London who identified as experiencing forced marriage and 136 women who identified as experiencing 'honour'-based violence**.

Data on female genital mutilation from specialist clinics

There are eight specialist clinics in London for women with female genital mutilation and some data are available, although data are not compiled routinely or consistently from all of them. The clinic at University College London Hospital saw a total of 169 women over the two-year period, 2009/10, about half of whom were pregnant when referred. Around 25 women a year underwent a de-infibulation (the procedure to 're-open' a vaginal opening) procedure.¹⁶

At the Whittington Hospital, the African Women's clinic's level of activity increased from seeing around 120 women per year from 2004/05 to 2007/08 to 194 women in 2008/09. Just under half of these were described as 'antenatal'. It undertook 38 de-infibulations in 2008/09, 22 of which were cases of women who were pregnant.¹⁷

Data on the One-Week Snapshot Survey

Seven organisations supporting women in London participated in a snapshot survey and these included referrals to specialist BMER refuges, help-line, advice and advocacy services and female genital mutilation clinics. This data could not be readily aggregated in numerical terms, but the information gives useful examples of what was happening to the women concerned. The organisations played a key role by helping women in a number of ways including accommodation, legal information, support and advocacy.

The data indicated the following:

A total of 81 new referrals within the snapshot week.

Over two thirds of the women were aged 25 or over.

The women came from a range of ethnic backgrounds, including Afghan, Turkish, South Asian, Kurdish, Arab, African, Irish Traveller and White British. Some had problems as a result of their immigration status, but they were in the minority.

There was a considerable amount of violence, with most reporting emotional and psychological attacks along with physical attacks, threats and harassment. A number also reported isolation and entrapment and

¹⁶ Creighton, S. Personal Communication.

¹⁷ African Well Women;s Clinic, Whittington Hospital.

sexual exploitation.

In most cases, the perpetrator was the woman's husband or partner but many also reported attacks by other relatives, including mothers, brothers, sisters, fathers, in laws and a few reported perpetrators in the wider community.

Many who had been forced into marriage or who were seeking divorce had been told that they were bringing their families into disrepute or shame. Others had been subjected to violence as a result of seeking help or were frightened of violent reprisals. A number reported that this feeling of shame led to their decision to seek help, report the violence or to leave home and go to a refuge, despite being reluctant to do so as this would lead to them being ostracised by their families. Some, who had children, feared the knock on effect on them.

A number of the women reported flashbacks and nightmares as a result of their experiences. A high proportion reported depression and panic attacks and nearly half reported an inability to sleep. A number reported eating disorders, self-harm or suicidal thoughts or attempts.

POLICY AND LEGISLATIVE APPROACHES

Integrating HPs into local policy and strategy

Policy responses to HPs have had a disproportionate focus on enforcement and criminal justice outcomes rather than holistic responses addressing the need for prevention, early intervention, advocacy, and advice and support services.

The issues and needs are not systematically integrated within local authority and local NHS policies, strategic plans and priorities.

In this study, a number of local authority commissioners stated that they did not think HPs were significant issues in their area or stated that they had not seen any data that persuaded them that this type of work should be prioritised. However, many also admitted that their awareness of HPs was limited and that they would benefit from more information being made available.

Respondents also felt that current policy approaches to addressing HPs were limited and that an integrated response would need to consider the following issues.

- There is a **misperception** that HPs are more prevalent within and linked to certain cultures and religions. This can act as a barrier rather than a motivating factor to women seeking help and access to support for some communities was considered as limited or non-existent. For example, in relation to female genital mutilation, the predominant focus is on women and girls from the Horn of Africa and consequently the needs of other affected communities remain hidden, particularly from Northern Sudanese, Eritrean, Ethiopian, Egyptian, Sierra Leonean, Gambian, Liberian and Kurdish communities.
- Women experience HPs within a broader spectrum of other forms of violence and abuse. The need to improve support for women experiencing HPs and rape and sexual exploitation were raised repeatedly as a gap in policy frameworks and support provision.
- There has been a lack of focus on the links between spiritual possession, witchcraft and other practices and women's experiences of violence. Accusations of witchcraft or possession can lead to and be linked to different forms of violence and abuse including HPs, trafficking and domestic slavery. Practitioners however urged for caution and greater understanding in this area as belief systems in themselves are not evidence of abuse.

BARRIERS TO REPORTING

The study found that BMER women experience multiple barriers. Risks with regard to HPs and key issues included:

- **Women will not always identify or associate their experience with abuse** and this is particularly so in cases of forced marriage and female genital mutilation, which are more likely to be framed within the context of family or community expectations rather than forms of abuse.
- **For young women**, the situation is much more complex especially for those at risk of forced marriage and female genital mutilation as they will be less aware of what is happening to them, have less access to external sources of support and therefore the likelihood of detection of risk is reduced.
- **The risk of on-going repercussions is central** to many women's decisions not to disclose. The consequences of seeking support often includes ostracism from the family and community, and extreme levels of guilt imposed by the perpetrators(s), combined with an increased exposure to the risk of further abuse, and murder in some circumstances. The potential of increased risks in coming forward for help, which can be exacerbated through interventions through the criminal justice system, limited the reporting on HPs. Women may also choose not to pursue action through the courts but prioritise safety over and above prosecution.
- **Racism, cultural assumptions** and cultural oversensitivity is still present in the practice of some agencies. A reluctance to intervene because *culture* was frequently linked to examples of inappropriate practice. A lack of cultural sensitivity and related assumptions, including notions that HPs are *normal* in some communities, was identified as a barrier to effective intervention by some professionals.
- **The inconsistent work in schools** was highlighted as a setback and without clear policy steer from central government, there was concern that schools were less likely to incorporate HPs as part of the curriculum.
- **A lack of funding for culture and gender-specific spaces** and organisations were also highlighted as key concerns and barriers that prevent women from accessing support.
- **Lack of routine enquiry and consistent assessment on HPs.** Women are more likely to be asked questions once they have been in contact with the police, Independent Domestic Violence Advisor service, BMER women's service or female genital mutilation clinics. However, the current approaches are not entirely effective, for example, methods of risk assessment are more developed on forced marriage and 'honour'-based violence compared to female genital mutilation mainly through the CAADA DASH risk assessment and where BMER HPs specialists have developed their own methods. Agencies are less likely to have frameworks in place to risk assess and safety plan for female genital mutilation, particularly where there may be links to 'honour'-based violence and forced marriage. Methods of routine enquiry and risk assessment could be improved across the range of services, such as health and social care.
- **Quality training on HPs is ad-hoc** and there is a lack of trained professionals within health, social services and education. Health and education professionals were identified as a key priority for training. There were also concerns about budgetary cuts which are likely to reduce the number of professionals trained on HPs.

- **Current approaches to HPs prevention and protection** are disproportionately focused on criminalisation. While laws are important in protecting women and girls from HPs, in themselves, they are not a sufficient deterrent. Community engagement initiatives that combine awareness-raising of the law and statutory obligations with longer-term programmes to educate and empower women and girls, young people and communities were considered to be much more effective in the long-term.

Concerns around existing legislation

Despite existing legislation, as at April 2011, there has been no prosecution under the *Female Genital Mutilation Act 2003* in the UK. In France, more than 37 cases have been tried in the highest criminal court. However, the French approach has been criticised as being overly intrusive, with families from practising communities reportedly delaying taking their children for female genital mutilation until after the age of six.¹⁸ During this study, key informants working with young women who have undergone female genital mutilation stated that victims were taken to their parents' countries of origin and for some practicing communities this has been a key way of circumventing the legislation.

Some respondents felt that legislation was important, as it sent out a strong message on VAWG and is a deterrent for some families. However, the police and other statutory agencies were not considered to be proactive enough in identifying cases of female genital mutilation or pursuing a prosecution.

Existing levels of under-reporting and the difficulties in achieving successful prosecutions were highlighted as on-going concerns across all forms of HPs. Improvements, in terms of consistency across units, specialist leads, trained officers – especially those working in the frontline – and stronger local partnerships with the voluntary/community sector have been highlighted as key to improving current responses.

In its report on forced marriage, published in May 2011, the House of Commons, Home Affairs Committee recommended that the government retains the civil remedy while criminalising forced marriage.¹⁹ The Home Affairs Committee made the recommendation having only consulted one organisation. However, debates would need to take place between the government and the wider women's voluntary sector in determining whether the benefits of criminalising forced marriage would outweigh the disadvantages. For example, there are a number of relevant criminal offences, including murder, rape, threatening behaviour, kidnap and abduction, which are highly applicable in cases of forced marriage and 'honour'-based violence. A more thorough debate is required to look at ways in which responses to HPs need to be strengthened within the framework of existing legislation and whether separate legislation is required to address this or whether current legislation should be strengthened in the area of HPs.

WAYS FORWARD

Identifying girls at risk of female genital mutilation and forced marriage

Since the majority of the primary victims of female genital mutilation are minors under the age of 10, detection is more difficult as girls are too young to resist, seek help or report the crime. Therefore greater and consistent levels of monitoring are required to protect girls from undergoing genital mutilation. An improved response would require that female genital mutilation is fully integrated into the safeguarding children framework. It is given equal weight and attention as with other forms of child abuse. Currently, the practice in relation to the safeguarding framework, is not consistently applied to female genital

¹⁸ Comic Relief (2010) *What are the key factors necessary to support government legislation to bring about abandonment of harmful traditional practices, with a focus on Female Genital Mutilation?* London: Comic Relief (Author: Isabel Turner)

¹⁹ House of Commons, Home Affairs Committee (2011) *Forced Marriage, HC 880, Eighth Report of Session 2010-12 Report, Together with Formal Minutes, Oral and Written Evidence*, London: TSO

mutilation and to a lesser extent forced marriage, although on paper they are recognised as forms of abuse.

Early intervention using the common assessment framework

The Common Assessment Framework (CAF), a holistic needs assessment tool, already recommended for use in *Working Together to Safeguard Children* is the central mechanism for assessing needs and risks and information-sharing between various agencies.²⁰ It should be systematically applied for the early identification of needs and provision to meet those needs of girls who are vulnerable to female genital mutilation and forced marriage. A key component of CAF is the appointment of a lead professional, who acts as a single point of contact.

The systematic application of CAF will address the needs of minors vulnerable to female genital mutilation and will be more aligned to the French approach of monitoring the under 6 year-olds but without the need for the intrusiveness of mandatory inspections of girls genitals. If a midwife helps with the birthing process of a mother who has undergone female genital mutilation and whose baby is a girl, for example, she should, using CAF, be able to flag up the potential future risk to the girl. This information should be shared with the under-5s health visitor who is in a unique position to be alert to the risk of female genital mutilation during on-going engagement with the family through the baby and child health clinics for the following five years. Since all families with children in the UK are registered with a GP practice, this should provide another avenue to flag up potential risk to girls from practicing communities for the attention of the appropriate safeguarding leads in child health clinics and schools.

The systematic application of CAF, in cases of forced marriage would help to prevent the risk of forced marriage as a consequence or precursor to female genital mutilation and the risks of forced marriage for young women aged 11-17 years. Better monitoring of girls through both primary and secondary school education would enhance joint working between professionals leading on child protection, safeguarding in GP practices, schools, social services departments and the police.

Voluntary sector engagement with HPs specialists is also a key part of a targeted safeguarding approach to ensure that older girls have access to information and are referred onto appropriate support services for housing, advocacy and emotional support.

Once the mechanisms for effective levels of multi-agency working are in place, professionals would then be required to abide by the rules of mandatory reporting to social services or to the police, similar to the duties that exist in reporting cases of child abuse. This should help to improve levels of third party reporting and detection.

A co-ordinated response

In addition to using the CAF, ensuring that local areas have more targeted responses through co-ordinated strategies, engagement with schools, training and community education would help to improve consistency across local areas and multi-agency working.

In addition to using the CAF, an effective integrated response would require:

- Strategic leads within local authorities and health to deliver co-ordinated strategies across all forms of HPs

²⁰ HM Government (2010b) *Working Together to Safeguard Children. A Guide to Inter-Agency Working to Safeguard and Promote the Welfare of Children*, at <http://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-00305-2010> (last viewed 19/4/11).

- Lead officers within the police to improve consistency across forces
- Awareness-raising and engagement with schools to improve the awareness and information available to young women at risk
- Training of all professionals that are likely to be in contact with a girl or woman at risk of female genital mutilation or forced marriage and/or 'honour'-based violence should be compulsory
- Investment in community education, prevention and engagement to challenge the values and attitudes that underpin female genital mutilation and forced marriage

Other actions that form part of a co-ordinated response to female genital mutilation

An integrated response at national and international government level. For instance, female genital mutilation should be part of a long-term national VAWG action plan and strategy especially given that the role of the Cross-Government Female Genital Mutilation Co-ordinator no longer exists.

Given the cross-border nature of female genital mutilation, an investment in work with diaspora communities in London including support for voluntary sector groups is essential in addressing risks and promoting awareness. The UK government should work on an international level to put pressure on governments, particularly where female genital mutilation is still legal.

The main difference in the approach of other European countries is greater co-ordination across government departments, cross-sector and joint working with voluntary sector agencies. Furthermore, the necessary training for professionals across all sectors has been a priority in improving levels of detection and reporting. There are useful lessons that can be drawn from the international arena.

CURRENT SERVICES IN LONDON

A snapshot of services for BMER women who have experienced harmful practices

The map of services in London (see Appendix 1) shows the locations of the current organisations that deliver services to assist BMER women who have experienced female genital mutilation, forced marriage or 'honour'-based violence. The map is colour coded to illustrate the percentage of the BMER population that exist in the boroughs where there are services. 37 organisations are listed in the map and these include a range of services including refuge provision, female genital mutilation clinics, resource centres and organisations that deliver short-term programmes of community engagement work.

A lack of recognition and long-term investment in HPs service provision

Specialist BMER services are more likely to identify and respond to HPs cases. A number of BMER women also feel safer in disclosing within these types of services. Despite a higher policy profile and awareness of HPs, there was concern that a commitment to legislation has not been matched by an adequate investment in voluntary sector activity. Respondents felt there was also a lack of understanding amongst policy-makers about the broader role of the HPs sector. As well as being involved in service delivery, they play a key role in the development of local and regional strategies on VAWG and HPs, and educating mainstream organisations about HPs.

Other gaps in current service responses

Long-term support needs and longer-term settlement	BMER women are likely to experience on-going violence and repercussions from the family and community upon disclosure, during and after legal proceedings. There is a need for funding frameworks to include advocacy and resettlement services.
Young women	There are few safe spaces, which are women-only, where women can talk openly to someone about the impact of female genital mutilation or forced marriage, There may be related issues in terms of their feelings of self-confidence, choices, sexuality, intimacy and relationships. In addition, young women are likely to need assistance to rebuild their lives, confidence-building, establishing a new home for themselves, developing networks of peer support and help with training or education.
Therapeutic support	A lack of appropriate support will often result in an exacerbation of, hidden or perceived mental health needs. Commissioning frameworks and services need to recognise that self-harm, anxiety, depression, post-natal depression, psychosis and trauma have clear links with cases of female genital mutilation, forced marriage and 'honour'-based violence. In addition, the value of different types of therapeutic intervention should be recognised, particularly services that recognise the cultural nuances related to BMER women's mental health needs.

Refugee and asylum-seeking communities

Regardless of their immigration status, women need to be offered equal support and protection. The impact of dispersal, a lack of gender sensitive screening and restrictions on access to health-care can lead to poor quality and inconsistent health-care and support. Other areas that require a greater understanding include the links between asylum, forced marriage and female genital mutilation as a precursor or consequence of trafficking; the particular vulnerabilities of young women aged 18 since local authorities tend to discard their statutory duties as soon as the women reach this age.

VALUE FOR MONEY

The total cost of domestic violence for England is estimated at a minimum at £5.5bn.²¹ Areas of the country with the highest total costs include London; with an estimated spend of £918m in health, housing, social services, legal services and lost economic output.

Policing: A homicide investigation costs in the region of £1-1.5m. The cost of an 'honour'-based violence investigation is likely to be similar. Where there are international dimensions to the investigation and multiple perpetrators, this is likely to have an impact on resources.

Health: Women who have female genital mutilation have increased risks of complications during pregnancy and childbirth. The national tariff for a normal vaginal delivery is £1,174 and comparatively, a caesarean section with complications costs £3,626.²²

Voluntary sector: A preventative programme on forced marriage and 'honour'-based violence in schools run by Ashiana Network in Waltham Forest on a budget of £31K pays for on average of **47 workshops on domestic violence, forced marriage and 'honour'-based violence to 1,163 students** across four boroughs. Ashiana's review indicated that 93% of the students they worked with stated that they were more likely to disclose an incidence of violence if it occurs, and 95% felt better able to form safe/healthy relationships.

Improvements in the implementation of safeguarding duties including forced marriage and female genital mutilation guidelines, multi-agency working, developing the capacity of existing specialist voluntary services to run support groups, outreach and advocacy, peer-development programmes in schools, would significantly enhance current practice and also reduce the need for more costly acute care and protection interventions.

²¹ The Henry Smith Charity, London Metropolitan University and Trust for London (2011) *Islands in the Stream: An Evaluation of Four London Independent Domestic Violence Advocacy Schemes*, available at <http://www.henrysmithcharity.org.uk/documents/IslandsintheStreammainreport2011.pdf> (last viewed 12/4/11).

²² Department of Health (2009) *Maternity Services and Payment by Results – A Simple Guide*. Updated 2009/10 Version; Gateway Reference: 11971.

COMMISSIONING SERVICES FOR WOMEN EXPERIENCING HARMFUL PRACTICES

1. Underpinning principles

A. BMER women-centred approaches to service delivery

Research and experience from within the sector indicates that women prefer to access women-only support spaces. Similarly, BMER women value women-led BMER spaces. Given the linked complexities in HPs where there may be multiple perpetrators, including parents, combined with pressure from family and or community members, the availability of these spaces becomes even more paramount.

It is evident from the study and from existing research that for many BMER women, their experiences of violence may have different dimensions and therefore they require targeted service responses that address the specificity of their experiences and needs. The Equality & Human Rights Commission's *Public Sector Guidance for Funders* acknowledges that women from BMER backgrounds are unlikely to report incidents of domestic violence, and that they may have additional needs in relation to support, including language, cultural understanding, immigration status, forced marriage, 'honour'-based violence and female genital mutilation.²³ Equally, BMER women are often dealing not just with their experiences of the violence from their perpetrator(s) but also the combined impact of other issues including racism, social exclusion and marginalisation within wider society. It follows then that BMER women are far more likely to approach and access specialist services that are able to recognise and respond to this duality of experience.

A report by Imkaan surveyed the experiences of 183 women who had sought help from a refuge, outreach and statutory services for support with domestic, sexual violence, forced marriage and 'honour'-based violence. Almost all of the respondents (99%) stated that the BMER service contributed to them feeling safer.²⁴

B. Agency expertise

Specialist BMER services provide a crucial avenue for support for women and girls, particularly those who are not engaging with statutory services. These services have a broad level of expertise that responds to generic forms of VAWG as well as having specialisms in HPs. Existing services are likely to be working towards a range of national service standards, including Supporting People standards. It is essential to fund those services that can demonstrate an effective knowledge and experience of working with BMER women and girls experiencing HPs. For example, services should be able to demonstrate the following – the list is not exhaustive:

- i. A strong awareness of the impact of and particular barriers to women, children and young people who have been or are at risk of being forced into marriage, have experienced 'honour'-based violence and/or female genital mutilation
- ii. An understanding of how coercion operates in cases of forced marriage and female genital mutilation and how this may affect disclosure to professionals

²³ Equality & Human Rights Commission (2009) *Public Sector Guidance, Cohesion and Equality: Guidance for Funders*, Manchester: Equality & Human Rights Commission, at http://www.equalityhumanrights.com/uploaded_files/PSD/cohesion_and_equality_guidance_for_funders.pdf (last viewed 19/4/11).

²⁴ Imkaan (forthcoming) *Vital Statistics, The Experience of Black, Asian, Minority Ethnic & Refugee Women & Children Facing Violence & Abuse*, London: Imkaan (Authors: Ravi K Thiara and Sumanta Roy).

- iii. Knowledge of complexities of risk and equalities issues that increase vulnerability to forced marriage, 'honour'-based violence and female genital mutilation
- iv. Practical knowledge of how to risk assess and safety plan in the context of multiple perpetrator(s)
- v. Have a clear understanding of the law, government guidance, policies and procedures on harmful practices
- vi. Have a good knowledge of the range of support services available to address harmful practices with clear mechanisms for joint working and referral
- vii. Leadership on HPs at a strategic level

2. Types of services that should be commissioned

A culturally specific response will vary across different communities and definitions of community in themselves will be diverse. It is essential that commissioners do not take a one-size-fits all approach to funding HPs services. Commissioners should not always seek to fund services by locating a singular BMER post within the structures of a large mainstream organisation with little experience of HPs or by funding an organisation that does little targeted work on women and violence. Therefore, commissioned services should be rooted both within a VAWG framework whilst being able to demonstrate that staff are trained, skilled and experienced in working with women experiencing HPs. A range of services should be considered as part of a holistic approach to addressing harmful practices:

- Crisis-based support: **refuge provision, advocacy, female genital mutilation clinics, services for children and young people (including targeted services for young women)**
- Early intervention and prevention: **work in schools and youth-based settings, community awareness-raising and engagement, outreach services (use of effective models of peer-development)**
- Long-term support: **Therapeutic interventions, resettlement and aftercare services**

3. Partnership approaches

Partnership approaches would help to achieve cost-efficiencies and potentially increase the availability of services across London. For example:

- A worker from an HPs specialist organisation could be located for a few days a week within a Rape Crisis Centre to jointly address the needs of women experiencing forced marriage and rape
- A specialist on VAWG and HPs could be co-located at a female genital mutilation clinic
- A partnership between a learning disabilities service and an advocate specialising in 'honour'-based violence and forced marriage

4. Outcomes

Projects should be working to achieve the following outcomes:

- Increased safety, reductions in repeat victimisation
- Reductions in murder
- Improved quality of life, confidence and self-esteem
- Improvements in physical and mental health and well-being
- Increased awareness of the risks and indicators of violence and strategies for avoiding future risks
- Improved ability to manage finances

- Specialist services will also have their own systems that identify the additional benefits and outcomes of their specific interventions on harmful practices.

DISCUSSIONS AND RECOMMENDATIONS

HPs have negative health, developmental, social and human rights implications for women and girls, similar to other forms of violence against women and child abuse. Despite the under reporting of HPs, the limited available data shows that there has been an increase in reporting. Without further exploration it is difficult to determine whether this is linked to an increase in HPs or an increase linked to larger numbers of women and girls accessing services. There has also been a lack of focus on women and girls in relation to their experiences of other forms of HPs, and there is a need to broaden the notion of HPs or to examine these issues in the context of VAWG. Spiritual possession, witchcraft and other practices were highlighted as the mechanisms used to justify and enforce sexual and other forms of violence, including trafficking and domestic slavery.

Despite criminal legislation on female genital mutilation, a Civil Protection Act on forced marriage, the development of risk assessment models on 'honour'-based violence/forced marriage and multi-agency guidelines on forced marriage and female genital mutilation, it is evident that HPs are not well integrated in policy and at the point of service delivery across local authorities and in the NHS. Women and girls are not receiving the protection and care that they need.

Current responses to HPs prevention and protection could improve through better integration of the issues into local policy, strategies and commissioning on VAWG, safeguarding of children and adults, reproductive, sexual and mental health services. Local Joint Strategic Needs Assessments provide an important mechanism for establishing need.

Harmful Practices have a significant impact on minors who are not afforded the space to speak out or access services that are age-appropriate. A focus on early identification of risk in cases of female genital mutilation and forced marriage, early intervention and prevention, would redress this imbalance. This will require joined up work across agencies with the voluntary sector. Training on HPs is inconsistent and professionals require on-going training to improve their skills and confidence in responding to HPs. Raising the awareness of professionals who work directly with families and children – health visitors for the under 5s, GPs, school nurses, teachers, A & E nurses, doctors, paediatricians – so that they are more alert to female genital mutilation and follow the protocols on mandatory reporting similar to the statutory requirements in cases of child abuse would provide a better strategy for improving prosecution rates.

Women and girls experiencing HPs do not have access to consistent, integrated support services across London. The particular vulnerabilities of certain groups, such as refugees or asylum seekers, women with learning disabilities, women with unresolved immigration status or young women, for example, also require specific support or interventions. BMER women's/community-based services are facing particular concerns in terms of the potential for further decreases in funding as a result of financial cuts to the public and voluntary sectors. The paradox is that whilst services are being reduced there has been an increase in demand for their services. In order for legislative and policy efforts to be effective, it is also necessary to invest in and preserve existing expertise on HPs. Those services that are instrumental in providing support to women and girls experiencing HPs that also demonstrate good practice and impact should be strengthened, sustained and developed.

An intelligent use of existing resources, improved monitoring and better co-ordination and leadership across London could significantly enhance our approach to HPs and this may not always have a financial impact. The recommendations from the study are as follows:

KEY RECOMMENDATIONS

A PAN-LONDON STRATEGIC APPROACH TO ADDRESSING HPs WITHIN A VAWG FRAMEWORK:

Co-ordinate a meeting with local authority and health commissioners, safeguarding leads, CJS and HPs specialists to share findings of the GLA HPs study. Use this group as a foundation for establishing a pan-London working group on HPs to promote a co-ordinated multi-agency approach to commissioning, needs assessment, service delivery, and regional performance monitoring across all forms of HPs. This should include the following:

LAs should review existing systems of data collection on VAWG ensuring that HPs are integrated LAs should invest in and co-ordinate sub-regional surveys on a tri-annual basis to capture long-term trends on HPs

Refresh existing Joint Strategic Needs Assessment frameworks to ensure that all forms of HPs are integrated

Develop a set of performance indicators or assessment tool specific to HPs to measure the impact of changes in legislation, policy and service developments

IMPROVING DETECTION, EARLY IDENTIFICATION, REPORTING AND PROSECUTION:

Co-design a pilot initiative to ensure that HPs are systematically embedded and integrated within safeguarding policies and practices using the Common Assessment Framework to address the needs of at risk groups including under 10 year-old girls and those aged 11-17 years who come from communities known to have high prevalence of female genital mutilation, forced marriage and 'honour'-based violence.

Other elements of the pilot should also include: a dedicated HPs strategy, established local champions on HPs within child protection and safeguarding in GP practices, schools, social services departments and the police, training for professionals and partnership working with BMER women's HPs specialists, community engagement work in schools other youth and community based settings to challenge the values and attitudes that underpin female genital mutilation, forced marriage and honour-based violence.

DEVELOPMENT & SUSTAINABILITY OF HPs SERVICES

Invest in existing and new HPs service provision to build the capacity of existing providers to improve sustainability of services.

Use future opportunities for health funding to commission services from voluntary sector HPs specialists who provide models of good practice and expertise in certain niche areas. This includes investment in the development of future services within existing and new organisations established to address HPs. New services should operate within established good practice frameworks on HPs. For example, build the capacity of HPs VAWG specialists to deliver a range of therapeutic interventions in partnership with mental health professionals, CMHTS, and rape crisis centres.

IMPROVING PREVENTION

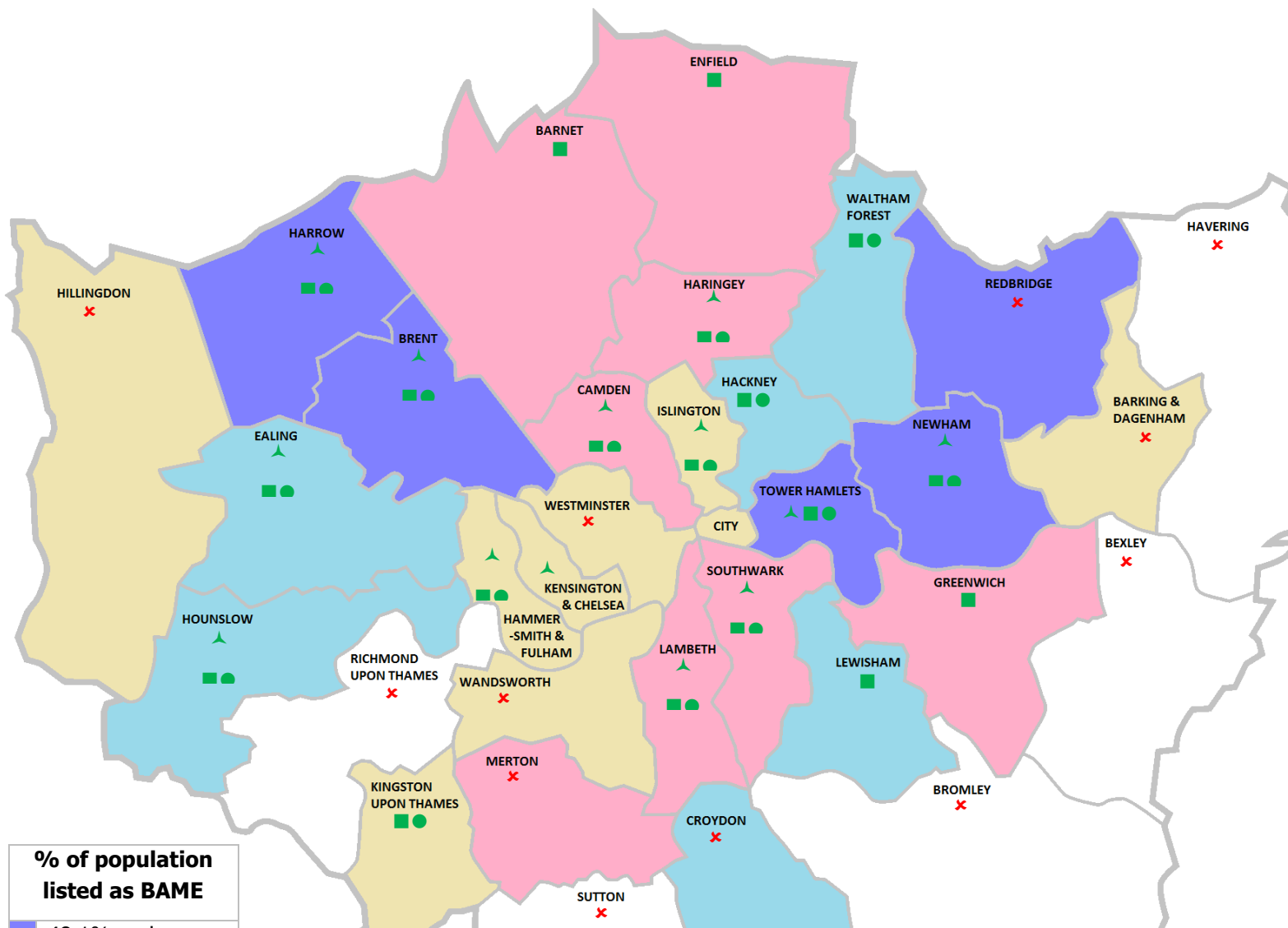
Work with Department of Education and other key stakeholders to look at ways of integrating HPs into a whole-school approach and other youth-based settings. Commission preventative work with adults that is framed within a VAWG framework in community based-settings.

This should be delivered in partnership with HP voluntary sector specialists

TRAINING, SKILLS DEVELOPMENT

Ensure that HPs are integrated into the core curricula and professional development of key agencies. This would include existing training initiatives e.g. safeguarding, VAWG.

This includes GPs, clinicians, nurses, midwives, community mental health teams (CMHT), drug and alcohol team (DAAT), health visitors, A & E staff, sexual health clinics, SARCs, housing, teaching staff, social workers, frontline police officers, mainstream VAWG agencies, commissioners (including parenting), sure start centre staff, family intervention projects, and the CPS.



% of population listed as BAME	
48.1% and over	[Dark Blue]
40.0% - 48.0%	[Light Blue]
30.0% - 39.9%	[Pink]
20.0% - 29.9%	[Yellow]
Less than 20%	[White]

Notes about this map:

We have included BMER services and mainstream services that provide BMER specific services. The symbols represent where there is at least one service that works around either Female Genital Mutilation (FGM ▲), Forced Marriage (FM ■) (similarly, 'early/child marriage'), or 'Honour'-Based Violence (HBV ●) physically located within a borough. Boroughs with no services as defined above are indicated by the following symbol (x).

Summary of organisations

37 organisations are listed in the map, this includes:

22 organisations providing refuges, **5** of which are BMER specific with a predominant focus on HPs. Others are mainly smaller BMER services within a large generic Housing Association or fall into the category of resource centres (advice), advocacy, and counselling services. **2** refuges have specific provision for young women (16-25 years) experiencing FM.

7 community/voluntary organisations deliver training, awareness raising and outreach on FGM. The majority are funded on short-term basis for singular posts or specific projects.

Some services targeted at specific BMER communities e.g. there are **2** services for Iranian women experiencing HPs, **1** service targeted at Irish Traveller women and **3** services for Turkish women.

8 FGM specialist health services. The majority offer sessional hours and a few are staffed by the same people. **7** have specialist NHS services that provide clinical care in particular antenatal care and de-infibulation services for women who have undergone infibulation (narrowing of the vaginal orifice with creation of a covering seal) and **1** offers health advocacy and counselling. Most are based in inner London.

DATA ON ETHNICITY – BY BOROUGH

The percentage of the population within a borough that is listed as BAME is highlighted purple, with deeper shades representing boroughs with a higher BAME population. In terms of ranking, in the far right column the 5 boroughs with the highest BAME population is highlighted green. The 5 boroughs with the lowest BAME population are highlighted red.

Statistics calculated using the 2009 data from:

http://data.london.gov.uk/datafiles/demographics/egpp_r2009_shlaa_revised_all_boroughs.xls

Map adapted from: <http://commons.wikimedia.org/wiki/File:London-boroughs.svg#filelinks>

BOROUGH	ALL ETHNICITIES	BAME POPULATION	% (BAME POP.)	RANK (BAME POP.)
Barking and Dagenham	173,300	50,000	28.9%	21
Barnet	328,200	107,100	32.6%	16
Bexley	218,200	27,600	12.7%	30
Brent	277,600	162,400	58.5%	2
Bromley	301,000	36,200	12.0%	31
Camden	208,100	61,600	29.6%	18
City of London	9,300	2,100	22.8%	25
Croydon	338,900	135,700	40.0%	11
Ealing	316,900	146,800	46.3%	6
Enfield	292,300	89,200	30.5%	17
Greenwich	232,300	76,200	32.8%	15
Hackney	226,600	93,400	41.2%	9
Hammersmith and Fulham	178,200	43,400	24.4%	24
Haringey	235,300	83,600	35.5%	14
Harrow	219,000	114,600	52.3%	3
Havering	230,500	17,100	7.4%	33
Hillingdon	255,000	75,200	29.5%	20
Hounslow	231,200	99,200	42.9%	7
Islington	202,300	51,900	25.6%	23
Kensington and Chelsea	167,300	37,900	22.6%	26
Kingston upon Thames	154,100	33,900	22.0%	27
Lambeth	292,700	109,800	37.5%	13
Lewisham	268,400	107,800	40.2%	10
Merton	197,500	58,300	29.5%	19
Newham	263,400	185,800	70.5%	1
Redbridge	253,300	121,900	48.1%	5
Richmond upon Thames	184,500	21,300	11.5%	32
Southwark	277,500	106,300	38.3%	12

Sutton	185,000	29,300	15.9%	29
Tower Hamlets	235,400	117,100	49.8%	4
Waltham Forest	227,100	94,200	41.5%	8
Wandsworth	290,300	63,600	21.9%	28
Westminster	213,100	61,100	28.7%	22