

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

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REPORT AUTHORS:

Sumanta Roy Dr Patricia Ng and Ikamara  
Larasi (Imkaan)

With Efua Dorkenoo OBE (Equality Now)  
and Professor Alison Macfarlane (City  
University, London)

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# 1. 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.<sup>1</sup> Henceforth, other practices, including early marriage and forced feeding, along with female genital mutilation were referred to as harmful traditional practices. Historically, there are 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" (UNFEM 2007).*

In addition to the above list, acid attacks would also be a type of HP (UN 2009:4). 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 (UN, Office of the High Commissions for Human Rights, undated). The United Nations recognises that "the ways in which culture shapes violence against women are as varied as culture itself" (UN 2009:7). 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 (2005), for example, argues that prostitution and pornography are harmful practices yet are rarely discussed in the context of cultural practices. Furthermore, it is evident that new HPs are constantly developing, and existing HPs have altered as a result of globalisation, migration and practices against women (UN 2009:7,11).

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 (VAWG) is an accepted norm or practice and makes it difficult to understand and challenge from within the VAWG framework. In addition, 'traditional' reinforces the ghettoisation of violence against women in BMER communities.

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<sup>1</sup> 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.

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 harmful practices was used to encompass forced marriage, female genital mutilation and 'honour'-based violence.

The results of the study show the incompleteness of data on HPs prevalence rates 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.<sup>2</sup> 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.<sup>3</sup>

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 (GLA 2010).

FORWARD's study, which estimates the prevalence of female genital mutilation is still the most quoted piece of work on the subject (Dorkenoo, Morrison and Macfarlane 2007). 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

## 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.

<sup>2</sup>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.

<sup>3</sup> See Section 3 UK National Policy and Legal Developments of this report.

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

## METHODS

The methodology included desk-top research, a review of existing statistics, interviews with key individuals and a focus group. More specifically:

- **A short review of current UK research and policy:** Desk-top research using web search and existing networks, including the Imkaan resource library, UN documents, voluntary sector publications, government funded research. In addition, information was gathered on 13 London Boroughs to gauge the inclusion of HPs within current local authority strategic documents.
- **Snapshot survey and statistical analysis:** A one-week snapshot survey with seven agencies to gather data on women accessing refuge provision, female genital mutilation clinics, advocacy and other services needing support with HPs. A review of data from the police, Crown Prosecution Service and other agencies. Special requests were also made to individual women's organisations.
- **Interviews:** Using semi-structured questionnaires, interviews were conducted with key policy makers, local authority and primary care trusts (PCT) professionals and some funding bodies. There was a low response from local authority and PCT commissioners and Public Health Directors. This may be due to their volume of work with some feeling unable to contribute. Others did not respond. Interviews were also carried out with key informants such as BMER women's groups and HPs specialists.
- **Focus group:** A focus group was undertaken with young BMER women, which included women who have undergone female genital mutilation.

## 2. KEY THEMES FROM CURRENT RESEARCH ON HARMFUL PRACTICES

Below, is a summary of significant themes from existing research and literature related to prevalence, the impact of HPs and gaps in policy and support service provision.

### PREVALENCE AND WHO IS AFFECTED BY HPs

The literature identifies communities that may not commonly be associated with HPs, for example, forced marriage has mainly been associated with South Asian communities, yet, it is also practiced in some African, Middle Eastern and parts of Eastern European communities (Khanum 2008:9; Imece 2009; Refuge 2009). 'Honour'-based violence is known to occur in South Asian communities. However, this form of violence can also exist in Latin America, Mediterranean societies, various European cultures, communities in many of the countries in the Middle East, in Iraqi Kurdistan and in the Kurdish diaspora in the UK, see for example, Begikhani, Gill & Hague 2010.

While female genital mutilation practicing communities are known to be from the African countries, such as Somalia, Sierra Leone, Guinea, Egypt, Djibouti, it is also practiced to a lesser extent by communities in Uganda, Niger, Ghana and Cameroon; some communities in a number of countries in Asia, such as India, Indonesia, Malaysia, Pakistan, and among some groups in the Arabian peninsula, such as Oman and Yemen; Iraqi Kurdistan; occupied Palestinian territories (Comic Relief 2010:4). Female genital mutilation is generally performed on girls between the ages of four and 12, and in such situations it could be viewed as a pre-requisite for marriage. In some communities, female genital mutilation can be carried out as early as a few days after birth or as late as just prior to the marriage or even after the birth of a first child. The girl or woman could be cut more than once (Comic Relief 2010:3).

**Impact:** Forced marriage, 'honour'-based violence and female genital mutilation have negative developmental and social repercussions for women, which are similar to other forms of violence against women. Female genital mutilation can lead to chronic infections, illnesses, birth complications, which could then have a negative impact on the relationship between the mother and her new-born child and also relationships within the family (Options & FORWARD 2009:24-25). Forced marriage is linked to violence, rape, forced pregnancy and forced childbearing; girls and young women being withdrawn from education or women being prevented from earning their own money, as well as excessive monitoring by families. Economic dependence is a significant barrier to leaving (Taskforce on the Health Aspects of Violence against Women and Children 2010:1). Forced marriage could be regarded as a highly specific form of domestic bullying. It is seldom an isolated episode, but forms part of a longer term pattern of abuse (Khanum, 2008:11).

Finally, in terms of 'honour'-based violence, women and girls experience physical violence, assaults and killings in the name of honour, curtailment – sometimes very extreme – of liberty, basic rights or education, suicide and coerced suicide, enforced self-immolation, starvation, poisoning and forced marriage of women on the grounds of honour, including to men who have raped them. Other acts may include abandonment, removal of children, aspects of female genital mutilation, forced virginity, forced hymen repair, forced abortion, imprisonment of partners who are disapproved (Begikhani, Gill & Hague 2010:14).

**Motivations:** Reasons cited include traditional values, such as the authority and wisdom of parents, children's duty of obedience and the links to the traditional hierarchical power-relationships between men and women and parents and children. (Khanum, 2008:14, 44; Comic Relief 2010:2). Female genital mutilation has been characterised as a "self-enforcing social convention – families and individuals continue to do it because they believe that their society expects them to do so" and

families fear social consequences such as derision, marginalisation and loss of status” (Comic Relief 2010:2). Additionally, there is an increasing link with religion, especially in relation to female genital mutilation, although female genital mutilation pre-dates Islam and is not prescribed by Islam or Christianity and many religious leaders have denounced it (Comic Relief 2010:2).

## **GAPS IN SERVICE PROVISION**

The key issues arising from some of the literature in relation to gaps in service provision of harmful practices is viewed within the context of the decline in funding for BMER frontline services, with the needs of BMER women and children not being addressed by the statutory and criminal justice initiatives (FORWARD & Imkaan forthcoming; Imkaan 2008). More recent data reinforced the earlier concerns over the financial instability of many BMER women’s organisations, and the need by organisations of significant support in relation to funding and staffing to help maintain or develop activities (see for example, Women’s Resource Centre 2009). The instability of BMER organisations is partly linked to the funding cuts women’s organisations have experienced over the past three years and the fact that groups are disproportionately reliant on local authority funding. A lack of recognition of the value of BMER specific services has also meant that increasingly, more generic services are funded over specialist services. Additionally, local authorities are seldom able to provide appropriate services for BMER women, preferring instead to merge BMER services into generic provision (FORWARD & Imkaan forthcoming).

The issues related to services included:

- Therapeutic interventions and the need for PCTs and Children’s Trusts to ensure that ‘evidence-based psychological treatment’ services are made available to and are accessible to women and children who are at risk of, or are experiencing such abuse (Taskforce on the Health Aspects of Violence Against Women and Children 2010:27-28). Recommendations include the need for psychological treatment services to promote access to specialists in harmful practices, ensure multi-agency collaboration, to include statutory mental health services, Child and Adolescent Mental Health Services and specialist voluntary sector organisations that deliver services to children and provide advocacy. Partnership working between grassroots organisations, psychologists and therapists should be encouraged to adapt psychological treatments that are culturally and linguistically appropriate for women who have been harmed.
- The needs of young women are different in relation to female genital mutilation, and existing services need to be made more accessible to girls and young people. In addition, young people need to be trained in order to assist with the engagement process, and are more likely to participate in discussions provided they are given a safe space to talk (Options & FORWARD 2009; FORWARD 2010).
- A victim and witness support network could help women to share experiences, access emotional and practical support, as well as assist in raising awareness of potential options available, and would help to prevent isolation (Khanum 2008:39-40). The need for therapeutic services in relation to forced marriage and counselling may be required to assist the victim to arrive at a decision to consider their options, and women would also require on-going support after they have made the decision to leave (Khanum 2008).
- There is insufficient specialist support available to enable women facing forced marriage. Women who require a forced marriage protection order (FMPO) need to be aware of, or

understand the law and policy in relation to forced marriage. Women who are affected by forced marriage are aware of the remedies available, but may not be able to access them because of a lack of legal advice and representation (Rights of Women 2010:89). There is limited availability of legal aid for women to apply for FMOs. Women with an income of over £733 per month or with a capital of £8,000 or more will not be eligible for free legal advice and representation to make applications (Rights of Women 2010:84).

- A need to raise awareness among communities and professionals as well as the provision of training for professionals working across all sectors is a strong theme within existing sources of research (Comic Relief 2010; Taskforce on the Health Aspects of Violence Against Women and Children 2010:19).

#### **EXAMPLE OF TARGETED CASEWORK AND REFUGE SUPPORT**

**Solace, Irish Travellers Outreach & Resettlement Service** meets the gap in service provision for Irish Traveller women and children who are experiencing violence, including 'honour'-based violence and forced marriage. Women can access refuge provision, resettlement support, advocacy, and translation. Over the last year the worker had 138 active cases and this figure is increasing. Many of the women find out about the service through word of mouth and from other women who have been assisted before. Women trust and value the service's approach, flexibility and understanding of the context in which they are facing VAWG. Solace provides the only dedicated service for the Irish travelling community.

## **EXISTING DATA ON HARMFUL PRACTICES**

The lack of or inadequate monitoring of harmful practices means that evidence-based data is not consistently available to establish and address needs (Khanum 2008:41; Options & FORWARD 2009:8; Cemlyn, Greenfields, Burnett et al 2009:136; Begikhani, Gill & Hague 2010:29). The lack of proper recording of harmful practices exacerbates the situation regarding a lack of data on HPs. Some of the problems with current levels of HPs monitoring include:

- Forced marriage not being reported as such, and this leads to agencies keeping inconsistent records (Khanum 2008:41). In any case, forced marriage is acknowledged as an underreported problem and the reported statistics are considered to represent only a fraction of the incidents.<sup>4</sup> There is anecdotal evidence, which suggests that as many as 10 per cent of those affected by forced marriage have learning difficulties (Rights of Women 2010:80). There is a lack of research about forced marriage outside of the South Asian communities. A consequence is that women who are from other communities may not recognise and define their experience as forced marriage, and as a result, may not seek assistance. Hence all material produced to raise awareness of forced marriage should mention that forced marriage affects women across all communities (Refuge 2010:18).

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<sup>4</sup>The Forced Marriage Unit (FMU) received reports of 1,682 incidents of forced marriage in 2009, and 86 per cent of the forced marriage involved women. 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.

- The shortage of data about prevalence of female genital mutilation in the UK (Options & FORWARD 2009:8) means that FORWARD's study on the estimation of the prevalence on female genital mutilation is still the most quoted piece of work in this area in England and Wales. At best, it is a crude estimate as it was based on the female genital mutilation prevalence figures in countries of origins and the 2001 census of the number of migrant women in England and Wales from high risk areas (Dorkenoo et al 2007). The study found that 66,000 women in the UK have had female genital mutilation and 23,000 girls in England and Wales under the age of 15 are at risk of female genital mutilation.
- Cemlyn, Greenfields, Burnett et al (2009:136) found that there is a lack of systematic ethnic monitoring of Gypsies and Travellers who use public services, which underpins the lack of hard evidence about the nature and extent of the problems they face. Census information on the number of Kurdish migrants, including refugees residing in western countries is not available in many countries since the statistics collected by the various government agencies are based on country of origin; Kurds are considered to be Iraqi, Iranian, Syrian or Turkish nationals (Begikhani, Gill & Hague 2010:29).

### 3. LEGISLATIVE AND POLICY FRAMEWORK

#### INTERNATIONAL FRAMEWORK

Harmful practices 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.<sup>5</sup>

The *Convention on the Elimination of All Forms of Discrimination against Women* recommendation 19 on violence against women particularly asks "States to consider family violence and abuse, forced marriage, dowry deaths, acid attacks and female circumcision as prejudices and practices that may justify gender-based violence as a form of protection or control of women".

The *Convention on the Rights of the Child* states that any person below the age of 18 has the right to protection from activities or events that may cause them harm and that they need special safeguards and care, including appropriate legal protection.

The United Nations Educational, Scientific and Cultural Organisation (UNESCO) Convention on the Protection and Promotion of the Diversity of Cultural Expressions 2005 declares that cultural diversity can be protected and promoted only if human rights and fundamental freedoms are guaranteed. No one may invoke the provisions of this Convention in order to infringe human rights and fundamental freedoms as enshrined in the Universal Declaration of Human Rights or guaranteed by international law.

The consensus document – the *Beijing Platform for Action* – requests States "to develop and monitor legislation to eradicate harmful customary or traditional practices, including female genital mutilation, early and forced marriage and so-called 'honour' crimes". The Beijing Platform for Action recommends that indicators for measuring state progress on violence against women (VAW) should include the development of policies or action plans, budgetary allocations, the availability of support services, and the implementation of measures for data collection and preventative initiatives to raise awareness.

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 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 Europe, European Union member States and the non-member States which participated in its drafting. So far, 13 States have signed up, since the treaty has been open for signature, although, currently, the UK is not a signatory party to the treaty.<sup>6</sup>

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<sup>5</sup> 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.

<sup>6</sup>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> (viewed 17/6/11).

## NATIONAL FRAMEWORK

### FGM

The UK has had specific legislation outlawing female genital mutilation in place since 1985.<sup>7</sup> It is an offence for anyone, regardless of their nationality and residence status, to perform female genital mutilation in the UK or to assist a girl to perform female genital mutilation on herself in the UK. Provided that the mutilation takes place in the UK, the nationality or residence status of the victim is irrelevant. Under the 2003 Act, it is illegal for a UK national or permanent UK resident to perform female genital mutilation, or to assist a girl to perform female genital mutilation on herself, outside the UK. It is also an offence to assist in carrying out female genital mutilation abroad by anyone – including foreign nationals – although in some cases the offence is limited to the situation where the victim is a UK national or permanent resident.

A cross-government national Female Genital Mutilation Co-ordinator was appointed in October 2009 to raise awareness of the issues, improve co-ordination across government, statutory and voluntary professionals however the post no longer exists.<sup>8</sup> A national multi-agency female genital mutilation forum has been established to share good practice and inform on-going work. Multi-agency guidelines on female genital mutilation have also been recently launched.

### Forced Marriage

There is no specific criminal offence on forced marriage or 'honour'-based violence. However potential offences are encompassed in existing legislation (e.g. *Domestic Violence Act 2004*) and may include kidnapping, abduction, common assault, grievous bodily harm, sexual or domestic violence and murder.

The government consulted widely on the proposal to create a specific criminal offence on forced marriage in 2005.<sup>9</sup> The proposals were not supported, with respondents arguing that this would deter women from coming forward for help, driving the practice underground, and what was required instead was a strengthening of existing civil legislation and a centrally coordinated VAWG strategy. The *Forced Marriage (Civil Protection) Act 2007* came into force on 25 November 2008.<sup>10</sup> The victim or anyone on their behalf, with the permission of the court or a relevant third party (RTP) can apply for a forced marriage protection order. Local authorities were given RTP status on 1 November 2009. The Immigration Rules were also changed in 2008 and the minimum age for sponsors and applicants for marriage visas was raised from aged 18 to 21 as a measure for protecting women from forced marriage. However there was some concern that this would not be effective in itself, given that a large number take place in the UK. In its report on forced marriage, published in May 2011, the House of Commons, Home Affairs Committee recommended that the government retained the civil remedy while criminalising forced marriage.<sup>11</sup> The Home Affairs

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<sup>7</sup> In England, Wales and Northern Ireland all forms of FGM are illegal under the *Female Genital Mutilation Act 2003* and in Scotland it is illegal under the *Prohibition of FGM (Scotland) Act 2005*.

<sup>8</sup> The post of cross-government national Female Genital Mutilation Co-ordinator was abolished at the end of March 2011, however, the work may continue as part of the national female genital mutilation network meetings.

<sup>9</sup> The Foreign and Commonwealth Office and the Home Office published a consultation paper, *Forced Marriage: A Wrong not a Right*, September 2005.

<sup>10</sup> The 2007 Act introduces powers that require individuals to, among other things to hand over passports; stop intimidation and violence; reveal the whereabouts of a person and stop someone from being taken abroad.

<sup>11</sup> 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.

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, 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.

The Forced Marriage Unit (FMU) was established in 2005 based on the principles of protection, prevention and support. The unit offers case-based support including help for victims to return to the UK if abducted or held captive, and part-funds the Honour Network and Helpline.<sup>12</sup> The FMU also takes a proactive role in improving national, local and international responses to forced marriage. A funding initiative for UK voluntary sector activities has been established. The unit is actively involved in awareness-raising, and good practice materials have been produced, including an e-learning package and multi-agency guidelines on forced marriage, incorporating guidelines that address the links between sexuality, learning disabilities and forced marriage.

### **'Honour'-Based Violence**

The high profile media coverage of the murders of Heshu Yones and Bahnaz Mahmood paved the way for a number of changes within the police. The Strategic Homicide Prevention Group was set up by the Metropolitan Police Service (MPS) in 2003 and Scotland Yard decided to re-examine a series of murder cases of BMER women. The Association of Chief Police Officers launched an 'honour'-based violence strategy and action plan in 2008 which is currently being revised. Other changes include specialist training, improved models of risk assessment on 'honour'-based violence/forced marriage,<sup>13</sup> partnership working with specialist agencies, and a recommendation that each area produce an 'honour'-based violence strategy and action plan. The MPS Violent Crime Directorate's Community Safety Unit in London has also developed a range of information resources including an e-learning package on 'honour'-based violence and forced marriage. Project Azure has been set up within the MPS' Child Abuse Investigation Command to specifically address female genital mutilation violence, with an active involvement in prevention-based work and multi-agency partnership working.

### **Harmful Practices**

The Crown Prosecution Service (CPS) embarked on a pilot project in December 2007 to explore methods for improving prosecution rates in forced marriage and 'honour'-based violence cases. The pilot consisted of the introduction of a flagging system to improve monitoring of such cases; specialist guidance and training for prosecutors; and a legal digest which aims to disseminate good practice across CPS areas. There are now 25 specialist CPS lead prosecutors across London with an expertise on forced marriage and 'honour'-based violence.

The Home Office and Department of Health (DH) recently published two strategic documents related to VAW (HM Government 2010a; Department of Health 2010). The Home Office document

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<sup>12</sup>Delivered by Karma Nirvana since 2008, based in Leeds.

<sup>13</sup>CAADA-DAASH risk assessment model was accredited by the police in 2009.

makes some specific commitments in relation to HPs, notably the development of multi-agency guidelines on female genital mutilation. Additional aims include the production of a resource pack on 'honour'-based violence, to inform new and recent entrants to the UK of rights and services, integrating a gender-sensitive approach to the asylum process. There are also plans to improve the protection and safeguarding of children bearing in mind the future role of GPs, and to undertake engagement and awareness-raising with communities and practitioners. Helping local areas to understand the role of specialist-women only services in meeting local need as part of intelligent commissioning is also highlighted. The Home Office published a national action plan in March 2011 to further elaborate on the strategic vision.<sup>14</sup>

The DH has integrated HPs within its overall strategic plan on VAWG. Amongst other goals, the DH will review current training within the health sector whilst also developing an e-learning package for GPs on VAWG. A public health campaign will be developed. More recently, specific commissioning guidance on VAWG has been produced and disseminated to local areas. The DH plans to review the extent to which the VAWG Guidance is implemented, particularly since the process of commissioning is being transferred to the new health and local authority led partnership structures. Ultimately, within the framework of localism, the extent to which HPs are addressed in each local area will depend on the level of local understanding and commitment to addressing the issues.

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<sup>14</sup>Available at <http://www.homeoffice.gov.uk/publications/crime/call-end-violence-women-girls/vawg-action-plan?view=Binary> (last viewed 3/5/11).

## 4. KEY FINDINGS

### LONDON DATA ON HARMFUL PRACTICES

#### 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.

#### 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 cases in 2008/09 to 237 in 2009/10.<sup>15</sup>

##### 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.

##### 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**.

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<sup>15</sup> Metropolitan Police Authority (2010) MPA Overview of MPS Domestic Violence Performance. Report by the Chief Executive to the Strategic and Operational Policing Committee. 10 June 2010.

## **AN EXAMPLE OF AN ADVICE, SUPPORT AND ADVOCACY SERVICE FOR WOMEN EXPERIENCING FM AND HBV**

**IKWRO** works on a pan-London basis with Iranian, Kurdish, Afghan, Arabic and Turkish women in relation to domestic violence, forced marriage, female genital mutilation and 'honour'-based violence. They provide telephone advice, face-to-face casework, advocacy and outreach, training for women and professionals. They are also involved in campaigning work to raise awareness and influence local and national government policy.

Many women are referred by former service users through word of mouth. The service has grown significantly, with caseload increasing by 400 per cent between 2005 and 2010. IKWRO has been able to assist more than 1,500 women and girls through confidential advice, emotional support, referrals, translation and advocacy. 504 of the clients needed extensive casework (400 in London), and of these clients, 134 of them were at high risk of 'honour-based' violence and/or forced marriage. IKWRO's assistance and support has enabled the women and girls to understand their rights and entitlements in the UK and to escape violent situations.

## **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.<sup>16</sup>

### **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 (Dorkenoo, Morrison and Macfarlane 2007).

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.<sup>17</sup>

These estimates do not include births to women and girls with female genital mutilation born in the UK or in other countries to which they may have migrated before coming to England.

## **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 procedure (the procedure to 're-open' a vaginal opening).<sup>18</sup>

<sup>16</sup> 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).

<sup>17</sup> Unpublished estimates, A Macfarlane, Midwifery Department, City University, 2011.

<sup>18</sup> Creighton, S. Personal Communication.

At London's Whittington Hospital, the African Women's Health 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.<sup>19</sup>

### **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 in helping women with 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 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.

### **Feedback from focus group with young BMER women**

#### **The experience of young women from FGM practicing communities**

A focus group discussion with young women from female genital mutilation practising communities centred on the following main issues: (1) awareness and understanding on the issues facing BMER young women in relation to violence; (2) concerns that funders, people in government and other professionals need to understand; (3) barriers to BMER young women accessing support and help to leave violence; (4) what an effective service for women and girls who have had or are at risk of female genital mutilation or other forms of violence would look like.

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<sup>19</sup> African Well Women's Clinic, Whittington Hospital.

### **The hidden nature of female genital mutilation**

Overall, the hidden nature of female genital mutilation was evident. Some felt that the 'normalisation' of female genital mutilation creates a barrier to doing effective prevention work. It was also felt that work with parents was paramount, that "parents' values needed to be changed" and that "they needed the most change". Young women wanted more open discussion and stronger images of the actual practice of female genital mutilation. They felt that this would help to represent the detrimental impact of the practice on women's lives and stop it from being hidden or a taboo subject.

### **Action required to prevent female genital mutilation**

Young women want the government to take more decisive action in responding to female genital mutilation. The message about how some of the young women felt about female genital mutilation was clear, as was the nature of action needed to be taken by the government, "Be culturally sensitive, but either it's a human rights violation or it's not". One of the women felt that the government needed to declare that female genital mutilation *is* child abuse, "understand why it happens but put money into work on stopping child abuse." This has an impact on the reporting of female genital mutilation to the authorities if female genital mutilation *is* treated as child abuse, "then kids wouldn't feel that they are ratting on parents and the community". The importance of working with young women through age-appropriate interventions was repeatedly highlighted as a need whether this is through social media, support groups or services that address specific needs. The necessity for teachers to be confident in identifying girls at risk and responding was a strong theme. Training for professionals across health, education, children, sexual health and other services was also highlighted as lacking.

### **Media portrayal of female genital mutilation**

The sensationalisation of female genital mutilation by the media was considered to be unhelpful in preventing female genital mutilation. This was combined with a concern over exactly how many people were educated about harmful practices. However, it was felt the "right kind of publicity" was needed, and that the journalists "who want to do something about it" would help to portray the right kind of messages in a way that present the reality but do not stigmatise communities at the same time.

### **The need to support and empower young women**

The support and empowerment of young women as a process to assist in the changing of attitude within the women themselves is vital. The young women discussed the importance of role models for young BMER women in general. To some extent they felt that there were few role models for young women, and education could enable BMER women from the female genital mutilation practicing communities to be the person the woman wants to be and "not what the community wants you to be".

Young women spoke about dynamics within the family that are effectively used to control female members of the family and the lack of choices their mother have in rejecting female genital mutilation. For a number of young women, this brings up complex issues and questions around the course of their own futures, choices, and how to navigate their relationships with their mothers and older women in the family. One young woman commented, "You have to do FGM to get married, then you have to get married. When you reach fifty, when the children are grown up, what do you do?" Education and building self-esteem were consistently highlighted as two important areas that need to be addressed in working with young people from the female genital mutilation practicing communities, as well as work with the wider community.

### **Accessing services**

The normalisation of female genital mutilation was identified as a barrier to women accessing support. More awareness-raising and work with women to highlight these issues as forms of VAWG would encourage more women to come forward. One of the focus group respondents commented that she did not realise female genital mutilation was wrong but thought it was normal, "Had we known it was wrong, we would have protested". While another remarked that, "To go to a support group, you need to know there is something wrong".

Making sure that there is a safe space for women to have discussions and more open debate was recommended by the majority. The importance for women to get reassurance, support and understanding from their peers was suggested as key to providing women with a safer environment to disclose, discuss and share concerns. The potential of social networking was also raised as a method of connecting with young women. There was recognition of the 'impressive' work of grassroots organisations, and the need for better resources for these organisations. Increasing the visibility of organisations working in the area of harmful practices and other forms of VAWG was also raised.

Young women stated:

"People need to see it [female genital mutilation] for what it is, showing actual practice for what it is. It shouldn't be hidden, it shouldn't be taboo".

"It is important to work with young girls so that they feel empowered to vocalise what is going wrong in life, get them going, allow them to adopt a mentality that violence is not acceptable, and act on its unacceptability, so other young women can be helped in the situation".

"You need to work in her environment – making sure she is getting the right information". There was a call to protecting girls and to "change the world she lives in, making sure she gets the right information".

"Everybody can be trained at school through every stage of the girl's life - support at every level, and at every stage of the girl's life: nursery, school teacher, GP, sex education at school, mid-wife".

"Some women are taught not to complain, and when something goes wrong, they don't know they are being abused".

"VAW as an issue should be something that everybody is made aware of every day".

"Society needs to give girls confidence, if kids are taught about equality and rights and with self-confidence, self-esteem tools, they can be everything they want to be, so they don't have to give up".

## **AN EXAMPLE OF COMMUNITY ENGAGEMENT ON FGM**

**Sudan Women's Association** provides a safe and supportive space for women where they benefit from support, training and community based activities which aim to alleviate isolation, poverty, social exclusion, and promote the education and development of community members. Funded through Trust for London they recruited a part-time FGM worker to carry out awareness-raising and education. They have so far run a series of workshops, seminars, focus group discussions, using case studies, as well as working with women in confidence building. SWA also collaborated with Community Partnerships at Voluntary Action Camden and Camden Safeguarding Children Board to deliver training to Camden based organisations for staff, volunteers and trustees to raise their level of knowledge and understanding of safeguarding children issues. In 2009, SWA were one of five organisations in London chosen to participate in a two-year research project carried out by the Women's Resource Centre on Social Return on Investment (SROI). SROI is an analytic tool for measuring and accounting the value of an organisation's work in monetary terms, particularly the social and environmental benefits.

## **POLICY APPROACHES**

### **1. Overall integration of HPs**

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

A range of guidelines and technical materials on HPs are available but the issues and needs are not systematically integrated within local authority and local NHS policies, strategic plans and priorities. In some areas despite a reference to HPs it is difficult to determine the extent to which this is used to drive and implement policy and service planning priorities across health and social care.

Where strategies did include key actions, this was predominantly in relation to the development of awareness raising activities, which are generally ad hoc, and commitment to this type of work was generally inconsistent. Some boroughs only focus on single issues such as forced marriage or female genital mutilation. Furthermore, female genital mutilation is more likely to be framed within health strategies rather than VAWG frameworks. Overall, there were few references to actions in relation to 'honour'-based violence.

### **2. Other gaps in policy responses**

#### **Definitions on VAWG need to consider other forms of HPs**

Practitioners felt that there had been a lack of focus on women and girls in relation to their experiences of other forms of HPs and that there was a need to broaden the notion of HPs or look at these issues in the context of VAWG.

There has been a lack of focus on the links between spiritual possession, witchcraft and other practices and women's experiences of violence, particularly in relation to cases that involve women that have been trafficked or have experienced domestic violence, and who had also been branded or denounced as a witch or *problematized* in another way by the perpetrator(s). The combination of these factors can impact significantly on women's mental health and effectively silence women, making the prospect of accessing any form of support even more difficult.

Linked to these concerns is the lack of professional understanding about how to respond when faith or other belief systems are a factor, as articulated by an expert in this area: "It's not the belief system but the point at which aspects of people's faith becomes pathological which is difficult for agencies to understand". Practitioners, however, urged for caution and greater understanding in this area as belief systems in themselves are not evidence of abuse.

## KEY ISSUES

There is a lack of understanding among professionals of how to respond when faith or other belief systems are a factor.

Practitioners felt that the analysis of HPs should include a consideration of other belief systems and practises within a framework of VAWG.

### **Limited understanding of HPs and a misperception that it only affects a few communities**

There is a strong emphasis on particular communities within existing discourses and policy frameworks to address VAWG which has led to a limited understanding of the needs of other communities affected by HPs. This has created a **mis**perception that HPs are more prevalent and linked to *certain cultures* and religions, acting as a barrier rather than a motivating factor to women seeking help. For example, in relation to female genital mutilation, the predominant focus is on women and girls from the Horn of Africa. As a result, the needs of affected women and girls particularly from Northern Sudanese, Eritrean, Ethiopian, Egyptian, Sierra Leonean, Gambian, Liberian and Kurdish communities remain hidden.

Access to support for some communities was considered as limited or non-existent. Respondents felt that policy makers, researchers and other professionals need a better understanding of how to support communities that are less visible within current strategic policies, research and service interventions, "That while forced marriage and 'honour'-based violence can occur across communities and sub groups, there are culturally specific responses appropriate for certain groups of people" (BMER refuge).

It is important that commissioners do not take a one-size fits approach to commissioning services on HPs (see section 6 on commissioning services for further discussion).

## KEY ISSUES

A strong emphasis on particular communities within existing discourses and policy frameworks to address VAWG has led to a limited understanding of the needs of other communities affected by HPs.

There is a need for a better understanding of the needs and what services are most effective for communities that are less visible within policy, research and service responses on HPs.

### **Links between HPs and other forms of VAWG**

There is a tendency to categorise HPs as individual forms of violence without exploring other aspects of BMER women's experience of violence, risk and need. For instance, the links between sexual violence, abuse and sexual exploitation were raised repeatedly as issues missing from current approaches to HPs. One sexual violence service offering dedicated support for BAME women states, "I am coming across cases of sexual violence and exploitation where there were links to forced marriage and 'honour'-based violence but I'm the only BAME sexual violence worker in London". Another commented on the limitations of current sexual violence services, stating that

“the links between female genital mutilation and rape/sexual violence are not being picked up by sexual violence services”.

Sexual violence services, including sexual health clinics, were identified as potentially playing a larger role in developing partnerships with specialist BMER services to deliver more integrated services. This would improve opportunities for knowledge exchange, reporting, referral and support for women who experience HPs and sexual violence.

There is a concern that local areas are still predominantly focussed on domestic violence and strategies do not adequately reflect the range of HPs and the links to other forms of VAWG. Some domestic violence co-ordinators are not considered to have a strong enough understanding of the issues. Local areas need to develop VAWG strategies to ensure responses are more integrated and relevant to women experiencing HPs. One agency stated, “A lot has been done to acknowledge ‘honour’-based violence although this is mainly the police... There should really be a VAWG co-ordinator in each area to ensure that ‘honour’-based violence and forced marriage is understood and integrated”.

“Female genital mutilation is practiced in the Middle Eastern community as much as the Somalian community and I have seen increases in the Iraqi and Iranian Kurdish communities”.

“We are a health advocacy service and we come across a lot of forced marriage and ‘honour’-based violence cases in the Turkish, Kurdish and Cypriot communities. We are only one of three services I am aware of in London”.

“Not many agencies are aware that forced marriage and ‘honour’-based violence are big issues in the Irish Travelling community. Women will experience a huge level of discrimination. The cases I deal with can involve dowry – related abuse, girls being pulled out of secondary school education and being escorted when they go out. Their first experience of sex and intimacy in marriage is often in an unwanted (forced) marriage and there is a great deal of pressure to remain in the community. If a girl is not married by the age of 14–16 years it is considered shameful”.

## KEY ISSUES

Current policies and service responses do not recognise the links between HPs and other forms of VAWG. For example, the combined impact of women experiencing forced marriage or female genital mutilation and rape or sexual exploitation.

Sexual violence services could develop partnerships with HPs specialists to improve opportunities for knowledge exchange, reporting, referral and support.

Local responses are still too domestic violence focussed. HPs would be better addressed within VAWG policy frameworks.

### EXAMPLE OF FGM AWARENESS-RAISING AND EARLY INTERVENTION

**African Advocacy Foundation** takes a 'whole family approach' to female genital mutilation prevention. Women are supported to overcome the trauma, stigma and other barriers that prevent them accessing treatment for medical complications of female genital mutilation and support whilst also accessing support and advice on domestic violence. Early intervention through relationship-building is critical to their approach. Birthing/naming ceremonies, weddings, and community events provide avenues for engagement on female genital mutilation. Last year, they supported 600 women for support with female genital mutilation; 300 women through a peer-support group; 122 through the DV support programme and 66 women received counselling and advice.

### 3. Commissioner awareness

Overall, respondents felt that local commissioners lack awareness and understanding of HPs and this has created a difficult environment for the sustainability and development of women-only spaces dedicated to addressing HPs. One respondent stated, "There is an even bigger gap in commissioners' understanding of harmful practices. They have yet to acquire an understanding of VAWG as many continue to ask why women only services are needed. The lack of understanding actually leads to exclusion of gender in policy and commissioning".

**This issue was confirmed during this study, with a number of local authority commissioners stating that they did not think HPs were significant issues in their area or 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. For instance, a small number of boroughs acknowledged a need to map local prevalence to improve their understanding of the true extent of the issues and need.

Health commissioners were contacted during the study, however a number of leads were unable to comment on the subject of HPs. This was largely related to the fact that the government is currently within a transitional period of change and consultations on the future restructure and role of health in commissioning is still on-going. However, there was some recognition by some commissioners of the gaps in local strategic frameworks, the need for evidence-based data to help prioritise the issues locally, and recognition that localised mechanisms of data-collection on HPs was largely lacking. Some felt that more cross-borough co-ordination of services would present opportunities for improving the accessibility of services for women experiencing HPs. The development of local champions on HPs was also highlighted as a potential way of embedding HPs into local policy and strategy.

In general, the lack of identification of HPs overall within local strategies and dedicated needs assessment correlates with inconsistencies in commissioning HPs services across London. The needs of BMER women across the different forms of HPs are not sufficiently prioritised within local commissioning frameworks, discussions and actions of local strategic partnerships.

### Promising local authority practice

During the study only four out of 13 boroughs contacted emerged as being more aware and proactive in addressing one or more forms of HPs. For example:

- Waltham Forest view work on forced marriage as a high priority and this is illustrated by the fact that they agreed to re-fund the local service despite the economic climate. The service is

well-regarded by Councillors and there is a good history of partnership working. A distinct rights-based approach to working with children and young people also highlights BMER needs. It was one of the first authorities to commission direct preventative work in schools. They also have pathfinder status on GP commissioning. They have a local authority representative on their Health and Well Being Board and a GP on the Supporting People Board to ensure that violence against women issues are integrated across different strategies. However, there are some concerns about the recent closure of the female genital mutilation clinic in the borough.

- Tower Hamlets commissioned research on forced marriage in the borough in 2002 and co-ordinate the Safer Schools partnership, a joint initiative between local schools, colleges, voluntary sector and the police to provide specific advice and counselling to women experiencing forced marriage and 'honour'-based violence.
- Barking & Dagenham Local Safeguarding Children Board has a Female Genital Mutilation Strategy and Action Plan. There are strong links between health and violence against women. For instance, the Executive Director of Nursing is the domestic violence strategic lead for the local NHS and an NHS representative is vice chair of the borough's Multi-agency Risk Assessment Conference, as well as the chair of the borough's Safeguarding Children's Board FGM Strategy Group. They are also committed to training mid-wives on female genital mutilation; will explore the way in which GP practices are responding to female genital mutilation in terms of new patient registration and there may be plans to establish a sector wide health VAWG group.
- Hillingdon Council place prevention on VAWG at the forefront of their work, with partnership between the statutory and voluntary sectors as key to defining the VAWG approach. There is an emerging partnership on HPs. Elected members participate in the Domestic Violence Forum and the Domestic Violence Steering Executive.
- Hounslow Council were considering integrating work on HPs. One area of work being planned by Hounslow's Public Health is a study of the local population. In carrying out this audit, statistics from Accident & Emergency, Sexual Health Clinics and Social Services will be collated. The borough has previously carried out health awareness-raising and promotion among communities affected by female genital mutilation.

#### **AN EXAMPLE OF EARLY IDENTIFICATION AND REFERRAL**

**IRIS** is based at the nia project in Hackney. The **I**dentification & **R**eferral to **I**mprove **S**afety project delivers a primary care domestic violence and abuse (DVA) educational and support programme for general practices to help them identify and refer patients who are experiencing, or who have experienced, DVA. An electronic prompt is used, which appears in the patient medical record, is linked to health symptoms of DVA, and acts as a reminder to enquire about DVA and to ask a safety question. IRIS also provides care pathways for all patients living with DVA and specialist advocacy for female survivors. IRIS is a partnership between third sector specialist agencies and primary care.

## **Promising practices on female genital mutilation**

Bristol is viewed as an area of the UK that has taken a strong lead in developing an effective local response to female genital mutilation which focuses on prevention, education and protection and recognises this as an issue of child protection.

Given that most of the victims are under-aged children, Bristol Council have initiated a targeted approach which has so far involved:

1,500 front-line professionals working in health, education, the police, social services and the voluntary sector have been trained to recognise the signs in girls who might be vulnerable to female genital mutilation.

The southwest Bristol Police Board has allocated a full-time lead officer in the child protection team to work on female genital mutilation. His task is to investigate and also provide awareness of his role and the Female Genital Mutilation Act. He works closely with the NHS child protection team, sits on the safeguarding board and links with social services and schools.

Bristol Council has established a Public Safety Board, represented by VAWG local authority leads, NHS leads, child protection teams, the police, local and national women's organisations with a specialism on female genital mutilation. The group is currently developing a female genital mutilation strategy which will seek to improve multi-agency responses, levels of reporting, protective mechanisms and access to support services.

Voluntary sector relationships: FORWARD have been commissioned to work with community groups, train local advocates, talk to young people, run a pilot drop-in advice centre and provide feedback and training to health workers to improve services. They are also working with Daughters of Eve to explore effective ways of engaging with young people.

## **European and international practice on female genital mutilation**

Other ways of improving the UK approach to female genital mutilation overall should include a more integrated response on a national and international level. Respondents highlighted the need for the following:

1. The integration of female genital mutilation in a long-term national VAWG strategy and action plan to improve national and local co-ordination and monitoring, particularly given that the role of the Cross-Government Female Genital Mutilation Co-ordinator no longer exists.
2. 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. This would also include the UK government co-ordinating more 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. Lessons can also be learned from countries outside the European Union (EU) where legislation has been introduced and from countries across the EU. For example:

- Toll free helpline to facilitate third party reporting: The Burkina Faso National Committee on Female Genital Mutilation which advocates against female genital mutilation and is supported

by the Ministry of Social Action and the Family, uses a helpline to enable third party reporting and to protect girls who are in imminent danger of female genital mutilation. In Italy, the Ministry of Interior, working with the Ministry for Equal Opportunities and the Ministry for Health created and launched a toll free number in September 2009. This has not worked, since, as at March 2011, only one call was received that concerned female genital mutilation while the majority of the calls received were about other (unspecified) topics or were unrelated to female genital mutilation (WHO and Communication with the Italian Association for Women and Development [AIDOS] 2011).

- Legislation on female genital mutilation that includes allocated funding: The Italian law on the prevention and prohibition of practices of female genital mutilation includes funding that has been allocated for specific work to be carried out. For example, the Ministry of Equal Opportunities (MEO) was able to allocate funding for sensitisation/information campaigns in relation to migrant, women and specialist NGOs. In addition to running an advertising campaign on billboards, buses and newspapers against female genital mutilation in several African languages in 2007, the MEO also invited proposals from NGOs and local authorities for projects that addressed three areas of work in relation to female genital mutilation. The three areas were: research/ action; production, dissemination of information on female genital mutilation and sensitisation work; training. It is difficult to measure the impact of the work carried out, since this information is generally not readily available. The Italian Association for Women and Development, did, however, attempt to petition for an overall evaluation of the two major projects that the Ministry of Equal Opportunities carried out although the evaluation was not forthcoming (Communication with AIDOS 2011).
- Holistic approaches: The Tasaru Ntomonok Initiative (TNI) working with the Massai community in Kenya provides refuge for girls (10 years and over) fleeing FGM and works with district authorities to offer protection for girls. TNI promotes the education of girls and community education which includes the introduction of an alternative rite of passage. Girls now undergo training and graduate into womanhood without being cut. From 2007–2009, two alternative rites of passage ceremonies were held which resulted in 137 girls graduating into adulthood without female genital mutilation (Comic Relief 2010:16; Communication with Equality Now 2011).
- Training of all care professionals to improve rates of early identification of female genital mutilation: In the Netherlands, work was carried out intensively in six regions to train care professionals. Since 2010, the training programme has been rolled out on a national basis and in partnership with other sectors. For example, in Amsterdam, the following were involved: representatives of the Somali, Sudanese, Eritrean and Ethiopian communities, the Federation of Somali Associations Netherlands, the home care services, the youth healthcare services, the Advice and Reporting Centre of Child Abuse and Neglect, the Child Protection Board, the police and the obstetric services (Communication with Pharos – Centre of Expertise on Health for Migrants and Refugees, The Netherlands, 2011).
- A Declaration against Female Genital Mutilation was produced, with signatures from the State Secretary of Health, Welfare and Sport and the Minister of Security and Justice, among others, stating that female genital mutilation is unlawful in the Netherlands, even if the cutting is carried out in another country. The Declaration is disseminated by the youth healthcare services, and is to be used as a tool for parents originating from female genital

mutilation practising communities, to combat social pressure, for example, when they visit family (Communication with Pharos, 2011). Radio Netherlands Worldwide reported on 10/3/11 that the declaration does make an impression when parents defend their decision not to carry out female genital mutilation on their daughter. As an official document, it is proof that female genital mutilation is unlawful in the Netherlands (<http://www.rnw.nl/english/article/new-dutch-campaign-against-female-circumcision>, viewed 27/4/11).

## KEY ISSUES

HPs are not systematically integrated within local authority and local NHS strategic plans and priorities. A lack of consistent inclusion of HPs in local strategies and dedicated needs assessment correlates with inconsistencies in commissioning HPs services across London.

Some commissioners feel they have an inadequate understanding of prevalence and need, and this has been linked to a lack of commissioning or not viewing HPs as an issue of local concern.

Local champions with a lead on HPs and a stronger multi-agency approach would improve the co-ordination of policy and work across London.

## BARRIERS TO REPORTING

### BMER women:

The study found that BMER women experience multiple barriers and risks with regard to HPs and significant issues highlighted during the study included:

- **Self-identification:** 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 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, which 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 using 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.
- **The inconsistent work in schools** was highlighted as a setback and without a clear policy steer from central government, there was a 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 significant concerns and barriers that prevent women from accessing support.

Agency responses: There were concerns about a lack of routine enquiry and consistent assessment on HPs. Overall, the majority felt that the number of women presenting to services was likely to be an underestimate as organisations are not necessarily aware or are asking the right questions about the range of HPs. As one health professional commented: “unlike domestic violence, the system is not there. Women should be asked at the ante-natal booking. In Liverpool you can’t finish a booking until a question about female genital mutilation is asked. Making sure it’s captured at the ante-natal booking stage would ensure that we could link this to any future unborn girls she may have”.

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. Overall, methods of routine enquiry and risk assessment on HPs could be improved across the range of services, such as health and social care.

## KEY ISSUES

Levels of under-reporting are also linked to the fact that organisations are not necessarily aware of or are asking the right questions across the range of HPs.

There is scope to improve methods of routine enquiry and risk assessment across the range of HPs within health, education and the voluntary sector. HPs should be integrated within existing methods, a good level of understanding is needed, combined with clear mechanisms for referral and support in order to provide effective services for women and girls.

**Racism and cultural assumptions:** Racism, cultural assumptions and cultural oversensitivity is still present in the practice of some agencies and was identified as a barrier to effective intervention by some professionals. A reluctance to intervene because of *culture* was frequently linked to examples of inappropriate practice. As highlighted by one participant:

The barriers are the same now as they were perhaps 10 years ago and include experience of service failure at statutory level, racism when attempting to access services, feeling that issues will not be understood; lack of understanding of culturally specific issues; language; lack of understanding of the need for safe space; breakdown in confidentiality [by GPs]” (BMER VAWG Sector Respondent).

This included the notion that HPs are *normal* in some communities, was identified. This was more so in relation to female genital mutilation and despite the outlawing of female genital mutilation in the UK some professionals are unsure of how to respond: “Agencies are anxious as being seen as being racist and don’t want to be seen to be insensitive to other cultures when dealing with female genital mutilation”.

**A lack of training:** Whilst it was acknowledged that there were extremely committed and skilled individuals, the responses of professionals to women who have experienced HPs, are still considered poor and inconsistent. Access to training was far too limited and there can be a tendency to refer cases onto other smaller community organisations instead of professionals being proactive in the use of existing safeguarding procedures. A case in point is: “An 11 year old who requested help from her teacher because she felt she might undergo female genital mutilation. Despite the fact that the protocols for reporting abuse to the statutory agencies is very clear, the

teacher recommended the girl write to Equality Now for support”.<sup>20</sup> In another case, the manager commented:

“We were trying to help a woman who was high risk and it was an ‘honour’-based violence case. There was no answer at the housing department or the DV Unit so we took her to the police. We were astonished and angry that the police officer said why are you dumping her on us. It took us four days to find her somewhere to stay and during this time she had to spend two nights sleeping at the station”.

Despite providing an important point of access for support and information, some GP practices were viewed as exposing women and girls to greater risks, in cases where confidentiality had been breached and there had been attempts to mediate in high-risk situations. Within this context, the need to train GPs and work in partnership with GP commissioning consortia was expressed by many:

“We know that women experiencing harmful practices will not disclose information to the GPs. This is particularly true for young women who have experienced a breakdown of trust and confidentiality with their GPs, when GPs report back to parents around issues concerning the young woman’s sexual health, sexuality and experiences of violence. A very important aspect of commissioning will be transplanted to GPs who lack understanding of gender violence and who generally feel that an appropriate response is family mediation”.

Quality training on HPs is ad-hoc and not mandatory. Specialist units within the police or CPS are more likely to be trained on forced marriage and ‘honour’-based violence. However training is less likely to be available in relation to female genital mutilation. This study also highlighted concerns about future training linked to the public spending cuts in policing. This is likely to reduce the number of officers trained on forced marriage and ‘honour’-based violence and may lessen the future functions of the MPS Violent Crime Directorate, Domestic Violence and ‘Honour’-Based Violence Crime Unit, both of which have been linked to improved police performance on HPs.

However, where training is available, the knowledge and confidence of professionals has increased. Consistent multi-agency training would improve current practice. Health and education professionals were identified as a key priority for training.

Many spoke of the positive impact of training. For example:

“One of the groups stated that following training on female genital mutilation/‘honour’-based violence, the social worker received a referral of a case of a 20 year old woman whose life was under threat as the parents discovered that she was pregnant. Rather than refer the girl on, the social worker was able to intervene swiftly and both the woman and child are now safe. The department has since seen an increased level of referrals of cases, indicating that the training has greatly assisted in identification of potential cases”. The CPS also reported that there are clear benefits of having trained specialist prosecutors on ‘honour’-based violence and forced marriage: “When comparing those that had been trained with those who had not, it was clear that the confidence of trained prosecutors had fundamentally changed compared to those who had not been trained”.

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<sup>20</sup>Equality Now, November 2010

## KEY ISSUES

Access to training on HPs has been far too limited, and there can be a tendency to refer cases onto other smaller community organisations rather than use existing safeguarding mechanisms.

There is a need for consistent multi-agency training on HPs to improve current practice, particularly in relation to health and education professionals. Partnership working with GP commissioning consortia is vital. There are concerns about the future training of the police on HPs in the light of cuts in public spending on policing.

Where appropriate training has been available, the knowledge and confidence of professionals have been increased.

**Community engagement:** Study respondents felt that 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.

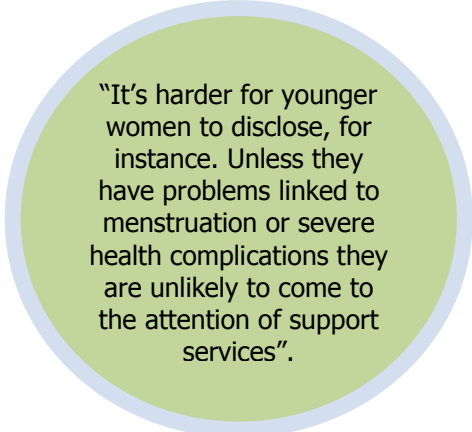
### AN EXAMPLE OF COMMUNITY ENGAGEMENT ON FGM

Asha-Kin Duale is the Community Partnership Advisor, based at Camden Voluntary Action. She has spent many years doing preventative work on female genital mutilation, forced marriage and 'honour'-based violence through training, awareness-raising and also regularly advises statutory agencies about suspected cases of female genital mutilation. Community-led events, ownership and partnership are the most important factors to consider in delivering successful community engagement, and she ensures that any work is co-ordinated with the full involvement of the community in organising the day, participating and planning the agenda. For example she states, "I helped a local primary school raise awareness of female genital mutilation through an event targeted at parents from female genital mutilation practicing communities. The great thing is that since we ran the event in 2010 the parents are now part of a community forum, which is directly linked to the school. It means that the schools are more aware and have regular contact with the parents and we can respond quicker if any concerns are raised".

### 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 (Comic Relief 2010). 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 significant way of circumventing the legislation. Limited capacity is also clearly an issue for the police, as there is only one small police unit – Project Azure – that is specifically dedicated to responding to female genital mutilation.

A number of comments from focus group discussions were made in relation to the lack of prosecutions under the Female Genital Mutilation Act. Some respondents felt that legislation was important, as it sent out a strong message on VAWG and even if underused, the prospect of prosecution was a useful education tool and served as a deterrent for some families. However, there was also a feeling that the police, and other statutory agencies, were not proactive enough in identifying cases of female genital mutilation or pursuing a prosecution. Police interventions on female genital mutilation are less common in practising communities when compared to similar interventions in relation to forced marriage.



"It's harder for younger women to disclose, for instance. Unless they have problems linked to menstruation or severe health complications they are unlikely to come to the attention of support services".

The CPS does recognise the low numbers of successful prosecutions in these types of cases. The low numbers is partially linked to the fact that the CPS pilot on forced marriage and 'honour'-based violence was only implemented in 2010 and hence prosecutors are still adapting to a new system. Also, the overall low rates of prosecution mean that few cases reach the stage for criminal proceedings. Therefore it will take longer to assess CPS progress. Local CPS areas will be required to provide the central policy unit with performance related data on forced marriage and 'honour'-based violence and this will provide an improved method for monitoring local performance in the future.

### **Concerns around the application of guidelines**

Current responses to HPs can be crisis-driven and reactive instead of early intervention and prevention-focused. Interventions are predominantly targeted at protecting adult women who have already undergone female genital mutilation or forced marriage, yet those at high risk are likely to be minors. Girls under the age of 10 years fall into the category of high risk in relation to female genital mutilation and data on forced marriage indicates that it has a significant impact on minors. Yet there is little information to demonstrate the extent of joint working between law enforcement, child protection teams, education and primary health services to identify and respond to potential risks and child protection concerns. Practitioners suggested that there is a need for a more targeted approach to protect children at risk, "You need to work with children specifically between the ages of 5-10, as this is a high risk period. These girls do not have a voice and they have specialist needs as some of them may have experienced female genital mutilation, or they are at greater risk than the 14-25 year olds who are likely to have had female genital mutilation done".

Although locally, policies and mechanisms exist to support joined up work on vulnerable children and families, such as the Common Assessment Framework, female genital mutilation or other forms of HPs are not fully embedded within these processes. As stated: "professionals are not making the links between existing safeguarding child protection mechanisms and female genital mutilation". Another commented, "if every practitioner understood and applied the forced marriage guidelines we would not have a problem". Where multi-agency guidelines have been produced, for example, in relation to forced marriage, voluntary sector service providers identified reluctance by some local authorities to implement the guidance, commenting that a large number do not see it as their role to intervene despite statutory obligations. Schools and colleges provide an important opportunity for practitioners to identify potential cases of forced marriage, yet they were considered as being least likely to refer women to support services.

## KEY ISSUES

Current responses are too reactive and crisis management led with less emphasis on supporting minors who face disproportionate risks through early intervention and prevention.

NHS staff, including GPs consortia, midwives, health visitors, school nurses; local authority staff, children's social workers, housing officers; teachers and other educational professionals as well as the police, need to take a more pro-active role in the prevention and protection of girls from HPs.

HPs should be better integrated within the Common Assessment Framework as this provides a vehicle for the early identification of issues, risks and the support needs of children. Local areas need to implement the multi-agency guidelines on forced marriage and female genital mutilation on a more consistent basis and this should include a system of monitoring.

## 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 and forced marriage is fully integrated into the safeguarding children framework and that it is given equal weight and attention as with other forms of child abuse.

Currently, the safeguarding framework practice is not consistently applied to female genital 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 (CAF)

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 (HM Government 2010b). It should be systematically applied for the early identification of needs and provision to meet the 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 use 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



"Best practice in community engagement is through peer-development – working with community/specialist voluntary groups, finding and supporting the progressive voices and getting them to tailor this work to different groups e.g. women, priests, Imams, young people, children". (Trust for London)

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.

In this context, all new refugees and asylum-seekers registering with GP surgeries from practising countries with girls should be asked whether the girls have undergone female genital mutilation and this should be followed up by the appropriate professional. Safeguarding leads in schools should also be alert to the fact that girls are most vulnerable to the risk of female genital mutilation during the primary school stage.

The systematic application of the 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 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:

- a. Strategic leads within local authorities and health to deliver co-ordinated strategies across all forms of HPs, lead officers within the police to improve consistency across forces

The factors that have improved levels of reporting in these cases have been identified as strong leadership, with lead officers having a specific remit to address 'honour'-based violence and forced marriage, a local policing strategy, the development of risk assessment procedures and protocols – currently the Co-ordinated Action Against Domestic

### **AN EXAMPLE OF AWARENESS-RAISING WITH YOUNG WOMEN ON FEMALE GENITAL MUTILATION:**

Daughters of Eve aim to engage more young people and gather greater momentum in effecting a change in attitude from young people towards the practice of female genital mutilation. Working widely with young people, through many mediums but mainly via Facebook and online because of its mass communication potential, they hosted a conference for young people in the UK. The aim of the conference was to exchange information and to build a network to explore ways of protecting girls at risk. 60 young people attended the first conference, which was a valuable forum to share information about female genital mutilation. A support group, Blossom, has been set up – the first of its kind – to provide a space for discussion and peer-support. This group has provided a lifeline to many young women who have not previously had a trusted and non-judgemental space to freely discuss their concerns and issues. DoE are an unfunded organisation and all 3 workers are volunteers, however they have plans to develop on-going work with young people including peer education and work in schools.

Abuse, Stalking and Harassment and 'Honour'-based violence (CAADA DASH), risk identification, assessment and management model. As highlighted earlier, establishing leads within safeguarding would help in detection and protection. Equally, leads within local authorities and NHS would enable a co-ordinated response in terms of strategy and service delivery.

Additionally, more extensive training would assist, as would good multi-agency relationships with local BMER women's groups to advise the police and provide on-going support to victims. Training for any professional that is likely to be in contact with a girl or woman at risk of female genital mutilation, forced marriage and/or 'honour'-based violence should be compulsory.

- b. Awareness-raising and engagement with schools to improve the awareness and information available to young women at risk

Awareness-raising and engagement with schools is critical to improving the awareness and information available to young women. Project Azure investigates cases involving children whilst also having a role in undertaking awareness-raising and preventative work with other statutory professionals and communities. For example, they are currently developing a five-minute film in partnership with Daughters of Eve, Kids Company and other groups, which they hope to roll out in schools as part of the personal, social, health and economic education classes.

Lessons could be learned from the approach that has been taken in cases of forced marriage and 'honour'-based violence, to improve levels of detection and prosecution rates on female genital mutilation. For example, some police forces have engaged local colleges and schools as part of the Safer Schools Partnership. Tower Hamlets College represents a constructive approach to joint working, whereby young women who fear a forced marriage are provided with advice, counselling and support through teams and a police officer based at the college. This approach has led to an increase in referrals. The work in schools undertaken by HPs specialists including Ashiana, Newham Asian Women's Project, FORWARD UK have also been effective in improving both awareness, levels of disclosure and opportunities for swift intervention. Engagement using other forms of social media that are age-appropriate provide important opportunities to raise the awareness of girls.

- c. 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
- d. Investment in community education, prevention and engagement to challenge the values and attitudes that underpins female genital mutilation and forced marriage

There is growing recognition by government bodies and funders of the need for community engagement. For instance, the FMU state that community engagement via grassroots organisations will be a strong theme in future work: "We are asking ourselves, are we doing it in the most effective ways in which we will get buy-in [which] will be through partnership [working] with good grassroots organisations, not by going in cold as government". Practitioners stated that female genital mutilation work would not be effective unless wider family dynamics and patriarchal factors are addressed, and those seeking to shift attitudes are able to engage and challenge communities constructively without alienating or 'otherising' communities.

Others pointed to the importance of working with progressive community voices through peer-development and supporting adult survivors of HPs to work around prevention. The role of women's groups and advocates was also highlighted as key to prevention, as were women's safety and the need to build the capacity of women who are at risk of or have undergone female genital mutilation and other HPs to help change attitudes. This is reinforced by the following statement: "You need to address the power and role of women in the community. By working with key women who are respected within the community and changing their attitude, you reinforce why female genital mutilation or forced marriage is detrimental". Engagement with women's groups is considered

essential, given the fact that some generic community organisations have been known to collude with rather than challenge HPs.

## KEY ISSUES

There are substantial numbers of girls who are likely to have undergone female genital mutilation, forced marriage and 'honour'-based violence.

Better monitoring of girls using the CAF would be more aligned to the French approach of monitoring all girls under the age of 6 years old.

Monitoring 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.

A dedicated HPs strategy, established local leads 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, and community engagement would form part of an integrated, preventative response.

Women's groups and advocates are key to prevention work in addressing wider family dynamics and patriarchal factors in female genital mutilation. Women's safety and building the capacity of women who are at risk of or have undergone female genital mutilation and other HPs to help change attitudes are vital.

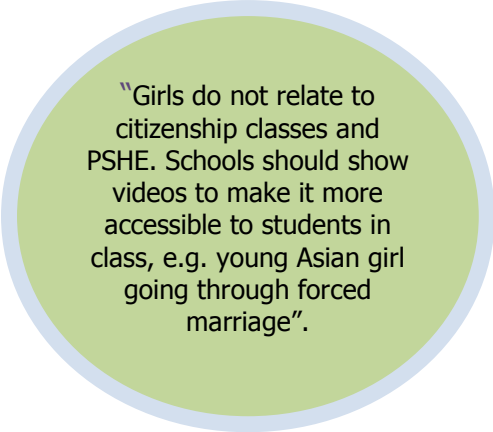
## AN EXAMPLE OF PEER DEVELOPMENT WORK WITH YOUNG PEOPLE

**The Foundation for Women's Health Research and Development (FORWARD)** is an African diaspora-led campaign and support charity, working to advance and safeguard the sexual and reproductive health and rights of African women and girls, particularly those affected by female genital mutilation. The Young People Speak Out (YPSO) Programme is a youth-led initiative supporting young people from the African diaspora to acquire knowledge, skills and confidence to challenge gender-based violence. YPSO currently operates in Bristol, London, Rochdale and Middlesbrough. In partnership with the African Women's Welfare Group, this project engaged 20 young people in a creative initiative to educate and empower their peers and community to abandon the practice of female genital mutilation. They worked together over a six month period to produce a film entitled "Think Again" exploring the implications and misconceptions of female genital mutilation, based on the real life experiences of women in the UK who have undergone female genital mutilation. YPSO was youth-led and participants developed skills in acting, filming, editing, event management and campaigning, and reported that the project enabled them to motivate, support and encourage each other and feel less isolated. The film will be used as an integral resource to support FORWARD in delivering a peer education schools programme.

## CURRENT SERVICES IN LONDON

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

The map of services in London (see Appendix 4) 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.



"Girls do not relate to citizenship classes and PSHE. Schools should show videos to make it more accessible to students in class, e.g. young Asian girl going through forced marriage".

37 organisations are listed in the map and these include:

22 refuges, five of which are BMER specific with a predominant focus on HPs in all aspects of their service delivery as well as policy, training and strategic work.

Others are mainly smaller BMER services that fall under the umbrella of a larger generic Housing Association. Other services fall into the category of resource centres with advice, advocacy, and counselling services.

Two refuges with specific provision for young women (16-25 years) experiencing forced marriage.

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

Some services are targeted at specific BMER communities. For example, there are two services for Iranian women experiencing HPs, one service targeted at Irish Traveller women and two services for Turkish women.

There are eight female genital mutilation specialist health services in London. The majority of these offer sessional hours and a few of them are staffed by the same people.

Seven 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 one promoting health advocacy and counselling support services. Most of these specialised female genital mutilation services are based in inner London.

### A lack of recognition and long-term investment in HPs services for BMER women

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 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, regional and national strategies on VAWG and HPs, and educating mainstream organisations about HPs.

Many services were concerned that with the ensuing public spending cuts and a move towards the notion of Big Society, this would in effect lead to the further erosion of specialist services, particularly as VAWG issues within BMER communities are not consistently prioritised. A number of HPs specialists in London are struggling to maintain their services in the current environment. For example:

Ashiana Network and Southall Black Sisters are services that have been identified as providing good practice models of working on HPs. However, they are experiencing proposed cuts to their London Council grants, as has ELBWO, an organisation which provides counselling, an area of service provision where there is great demand.

IKWRO face proposed cuts of about £30,000 which will potentially affect more than a fifth of their advice and outreach services for women and girls from Middle Eastern communities, particularly their outreach and home visiting service with *hard to reach* groups. **Over the past six months, they have seen an increase in calls for help, equivalent to a seven per cent increase over the last financial year.**

Asha Projects are facing reductions of approximately 30 per cent and are struggling to sustain elements of the work, such as networking, maintaining up-to-date knowledge, partnership working and fundraising which are critical to the sustainability of the service. **Demand for their service has increased over the past six months.**

Newham Asian Women's Project has experienced cuts to their counselling provision and the training and employment service for clients has been closed. **They are seeing more clients with high risk and more complex need and more clients are accessing NAWP's legal service because of the closure of a local legal service.**

#### **EXAMPLE OF AN FGM SERVICE PROVIDING CLINICAL CARE, COUNSELLING AND SUPPORT**

**Acton African Well Woman Centre** is a community-based partnership project based at a surgery. The centre delivers holistic support including health advocacy and promotion, counselling, advice and signposting. The project facilitates fast-track referral enabling women to see a specialist within three weeks. Since the service has been advertised on Somali satellite television and YouTube in 2009, approximately 200 women have accessed the service. In most cases, this will be the first time that women will have received any form of healthcare and emotional support as a result of female genital mutilation. The clinic was shortlisted for two awards in 2009-10: the Nursing Times and the other by the Royal College of Midwives in the category of Inequalities of Health.

### **Study respondents highlighted other gaps in current responses**

**Addressing long-term needs and multiple risks:** There was a major concern about gaps in services to address the longer-term support needs and multiple risks of BMER women. This was considered to be crucial for BMER women, given the greater likelihood of further violence or repercussions from the family and community upon disclosure, during and after legal proceedings, and also in cases where women are at risk of repeat female genital mutilation or forced marriage.

As one respondent commented, "there is very little on the ground in terms of aftercare or links with health visitors. If she goes back to the community there is no engagement with her or assessment of risks to her child, or anyone assessing whether there is the potential for repeat female genital mutilation".

The need for longer-term resettlement, safety planning and advocacy work is rarely recognised within funding frameworks. Where groups were formerly funded to deliver some limited level of resettlement work, many BMER women's groups now have to reduce or cut this element of their work because of the nature of funding cuts they have experienced.

## KEY ISSUES

Women and girls require specialist advocacy services having had treatment from a female genital mutilation clinic or on leaving a refuge, or other service.

Longer-term resettlement, safety planning and advocacy are not recognised within funding frameworks. BMER women's groups currently have to reduce resettlement and/or longer-term advocacy services in the current economic climate.

Improving access to mental health services: The mental health needs of women experiencing HPs were highlighted as a gap in policy and commissioning. Self-harm, anxiety, depression, post-natal depression, psychosis and trauma have clear associations with cases of forced marriage, female genital mutilation and 'honour'-based violence, yet this is rarely recognised in commissioning frameworks or service provision.

A lack of appropriate support will often result in either an exacerbation of perceived, or hidden mental health needs and issues. "I saw one woman who kept coming to the clinic. I saw one bruise and because I explored it further I eventually picked up that she had injuries all over her body. The self-harm had been completely missed".

### AN EXAMPLE OF NATIONAL POLICY WORK AND HOLISTIC SUPPORT

**Southall Black Sisters (SBS)** runs a holistic resource centre offering information, advice, advocacy, outreach, counselling and support to BMER women and children in crisis situation and in need of medium to long-term support. It also undertakes support group activities, and educational, developmental, policy and research work on preventing and addressing violence against BMER women and girls at a local and national level.

**Benefits:** SBS has been at the forefront of reforms on domestic violence and immigration law, no recourse to public funds provision, suicide and self-harm, the *Forced Marriage (Civil Protection) Act 2007* and guidelines, policies and practice on 'honour'-based violence developed by the police, the CPS and other bodies. The service deals with over 3,500 enquiries per year, and has a rate of 85-96% in successful outcomes, helping women to lead independent lives free from further abuse (and 100% success rate in immigration cases). The project is recognised as an example of best practice by Ealing Council – that wants to replicate it for all women in the borough – and by many other bodies, including the DH Taskforce on the Health Aspects of Violence against Women and Girls Sub-group on Harmful Traditional Practices.

Female genital mutilation can have a tremendous impact on girls and women, causing depression, nightmares, flashbacks and many of the psycho-sexual issues that are common in cases of sexual violence. Yet, support services for female genital mutilation are mainly geared towards obstetric care and de-infibulation services. Service providers also felt that despite a heightened awareness of the links between suicide, self-harm, violence and BMER women, there was a lack of investment in appropriate therapeutic services, including one-to-one therapies, group-work and other forms of self-development. Respondents questioned the presumption amongst many health professionals about mainstream clinical models of care as the most appropriate mode of recovery or healing for women who have experienced HPs and other forms of violence. Additionally, there is concern that current therapeutic approaches rarely reflect or respond to the specific experiences and needs of BMER women. Where BMER therapeutic models do exist, they rarely recognise that women's individual needs and experiences are likely to vary between different BMER communities.

Increasingly, faith based groups are being commissioned to offer counselling support services for BMER communities. It is important to note that gender-neutral organisations may not always be the most appropriate spaces for women, as there have been instances where these groups have actively participated in colluding to promote HPs rather than challenge practice.

Models other than traditional psychiatric or psychotherapy modes of support could have potentially equal benefit, particularly services that recognise the cultural nuances related to BMER women's mental health needs. The possibility for a more joined-up approach between the voluntary and health sector was observed by a clinician:



"I am seeing a lot more cases of vulnerable women who have been through FGM or a FM and are trafficked or vice versa".  
(Immigration Judge)

"It's not always beneficial to frame these issues within a psychiatric context or pathologise female genital mutilation as sexual dysfunction, as women already feel damaged and isolated... Rather than refer women to mainstream psychotherapy services, commissioners could be more creative and support grassroots groups working on female genital mutilation, forced marriage and 'honour'-based violence to receive clinical training and supervision from mental health professionals. A community-based approach to providing mental health support is likely to be more beneficial and could be delivered quite cost-effectively".

## KEY ISSUES

Commissioners should consider models other than traditional psychiatric or psychotherapy modes of support, which have potentially equal benefit, particularly those services that recognise the cultural nuances related to BMER women's mental health needs. This may include group-based support delivered in conjunction with specialist women's projects.

**Immigration factors and the impact on care and support:** The particular vulnerabilities of women with unresolved immigration status were highlighted as an ongoing concern and the necessity of a long-term solution to ensure that women, regardless of their immigration status are offered equal support and protection. On seeing an increase in asylum cases where forced marriage and female genital mutilation have taken place, either as a precursor or consequence of trafficking, one legal expert commented that there is a need for practitioners to have a better awareness of the links between HPs and trafficking.

Refugee and asylum-seeking women face particular vulnerabilities and barriers that prevent access to equal levels of protection and support. A combination of legal restrictions, a lack of appropriate gender-sensitive screening procedures, restricted access to health services are some of the contributory factors. For example, "there is a protected period (4 weeks before and after birth), however in practice this is not enough. It leads to poor health outcomes for the woman and even in practice, this period is not adhered to and this is problematic for women who have undergone FGM". Dispersal to another area of the country also leads to inconsistent and sometimes poor quality healthcare support which impact on women's long-term health, especially when the communication between the initial health service that treated her and the one she is referred to is ineffective. For example, "Asylum-seekers are being dispersed into other areas of the country and communication between the services is poor [in relation to departing and incoming services]. A lack of support for young women seeking asylum over the age of 18 is a particular concern, "when

they turn 18 it's like they don't exist anymore, no one wants to know them despite their experiences of violence as there are no longer any statutory obligations".

## KEY ISSUES

There is a need for practitioners to have a better awareness of the links between HPs and trafficking. Asylum-seeking women experiencing HPs face particular vulnerabilities and poor levels of care.

**Improving access to services for young women:** There is a lack of dedicated spaces and targeted provision for BMER young women experiencing HPs. Female genital mutilation support services are predominantly offered through maternity-based services. There are few safe spaces where women can talk to someone openly about the impact of female genital mutilation, in relation to their feelings of confidence, choice, sexuality, intimacy and relationships. In addition, there are substantial numbers of girls under the age of 15 who are likely to have undergone female genital mutilation. Girls with female genital mutilation Type III may have restricted mobility in case the scar splits. These girls also have difficulties in participating in sports, difficulties with urination and menstruation and they may need psychological support. In order to improve access to health care and support for affected young people, it is important that professionals in the health and education sectors are alert and respond to their needs.

Young women who have had to leave the family home because of the risks, or actual incidence, of forced marriage/'honour-based' violence often require ongoing support to rebuild their lives. They may also be dealing with the added emotional impact of being ostracised from significant family members. Support with confidence-building, establishing a new home for themselves, developing networks of peer support and help with training or education is key to recognising their needs.

Young women who have experienced or who are at risk of female genital mutilation or other forms of HPs are highly unlikely to find mixed-gender youth provision as appropriate or safe spaces for support and disclosure. The additional factors being that these types of provision are also more likely to expose girls to greater risks of being found by the perpetrator, "[BMER organisation] service users inform us that they are unlikely to access single access points, as such spaces are not perceived as safe and free of violence – as perpetrators and predators will be accessing the same points".

### AN EXAMPLE OF ENGAGEMENT WITH YOUNG WOMEN EXPERIENCING FORCED MARRIAGE

Zindaagi Project (Newham Asian Women's Project) is a specialist support service providing preventative and early intervention work to young Asian women across east London, vulnerable to self-harm and suicide. A third of clients accessing Zindaagi are at risk of, or are concerned about, forced marriage. The service addresses the issues impacting on the daily lives of young women, supporting their personal development and increasing self-esteem, confidence, coping strategies, social and life skills. Activities include issue-based workshops, residentials, training, age-specific support groups and counselling in Asian languages. The project encourages young women to engage in dialogue with each other and express themselves assertively.

Participants emphasised the important role of independent BMER young women’s services in providing a safe access point for support, particularly as some young women did not want the police, or other statutory agencies to intervene but rather wanted support: “Service users are very clear in their needs assessment that they require prevention and support”. Projects that offer young women safe spaces to access information on their choices and rights, counselling and support to develop life-skills and tools to prevent female genital mutilation or forced marriage provide effective opportunities for prevention work. “Workshops on forced marriage conducted under the violence prevention framework are in high demand as these activities raise awareness, present options and help service users plan in ways to prevent harmful practice”.

The lack of consistent work in schools is a missed opportunity for engaging with young women on HPs. It was felt that without a clear policy steer from central government, schools would not feel obliged to incorporate HPs as part of the curriculum. The increase in independently-run schools would also make it easier for schools to set their own agendas, which would further undermine the need for appropriate work on VAWG.

### **KEY ISSUES**

There is a need for dedicated spaces and targeted service provision for BMER young women experiencing harmful practices.

Independent BMER young women’s services play an important role in providing a safe access point for support, particularly in circumstances when young women do not want the police or other statutory agencies to intervene.

## 5. VALUE FOR MONEY

The total cost of domestic violence for England is estimated at a minimum at £5.5bn (The Henry Smith Charity, London Metropolitan University and Trust for London 2011). Areas of the country with the highest total costs include London, with an estimated spend of £918m in health, housing, social services, legal 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 (DH 2009) and comparatively, a caesarean section with complications costs £3,626 (DH 2009).

### EXAMPLE OF JOINT WORKING – HEALTH AND SPECIALISTS ON HPs

Derman has provided services to Kurdish, Turkish, and Turkish Cypriot communities in Hackney for twenty years. Last year, of the 19,000 people who contacted Derman for support, 70 per cent were women and children. The advocacy worker runs a satellite service from GP surgeries, offering advice, support and referral in cases of violence. Women also have access to 6-12 weeks of intensive counselling. Alongside one-to-one support, Derman has developed a 10 week safety and empowerment programme for all women accessing the project. The programme aims to help women to develop longer-term strategies to live free of violence. The safety and empowerment programme has encouraged women to disclose, often for the first time, their experiences of domestic violence, forced marriage and 'honour'-based violence. Having the advocate work between the GP surgery and Derman has been beneficial in raising the awareness of local health practitioners and provided an important avenue for women to access culturally specific advice and support from a specialist female advocate.

### Voluntary sector:

- **A preventative programme of schools work on forced marriage, 'honour'-based violence and domestic violence run by Ashiana Network** in Waltham Forest, on a budget of £31K pays for on average of **47 workshops to 1,163 students** across four boroughs. Their review indicated that 93 per cent 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.
- **A mental health project at Newham Asian Women's Project (NAWP)** purchases two specialist workers, intensive counselling and a range of workshops and activities for one year at a cost of £100K. 80 per cent of women NAWP worked with stated that they can make better decisions about their lives and this includes accessing further education, seeking employment, thinking about a different kind of future, dealing with issues around violence and self-harm and equipping them to prevent forced marriage.
- **An FGM clinic** on average will cost approximately £20,000 each year to support 50 clients and this will include follow-up appointments.

Addressing HPs through a more co-ordinated approach, which includes early intervention, prevention and support would improve current efforts in dealing with HPs. A greater level of implementing safeguarding duties, including the forced marriage and female genital mutilation guidelines and better levels of multi-agency working is required. An investment in developing the

capacity of existing HPs specialists to deliver housing support, counselling, support services, outreach and advocacy, peer-development programmes in schools and other settings would significantly enhance current practice and would inevitably reduce the need for more costly acute care and protection interventions.

**EXAMPLE OF AWARENESS-RAISING AND PREVENTION WORK IN UNIVERSITIES ON FORCED MARRIAGE AND 'HONOUR'-BASED VIOLENCE**

**Asha Projects** is a VAWG service for South Asian women which also has targeted refuge provision for young women experiencing HPs. "Change Together" is a pilot project funded by the Forced Marriage Unit and Foreign Commonwealth Office. The pilot includes research, training, an online support system and guidelines to assist universities in raising awareness of and responding to potential cases of forced marriage and 'honour'-based violence. The findings will be used to inform services for young people and the training of practitioners including staff at university welfare services. Since the project began, they have seen an increase in referrals of potential cases and a number of other universities have shown an interest in the programme.

## 6. COMMISSIONING SERVICES FOR WOMEN EXPERIENCING HARMFUL PRACTICES

### UNDERPINNING PRINCIPLES

#### BMER women-centred approaches to service delivery

Research and experience from within the sector indicates that women prefer to access women-only support spaces, that these services are fundamental to women, in terms of providing practical support and an important sense of physical and emotional safety. Similarly, BMER women value women-led BMER spaces. Given the linked complexities in cases involving HPs where there may be multiple perpetrators, including parents, combined with pressure from family and or community members, the provision of these spaces becomes even more paramount.

It is evident from this 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 (Equality & Human Rights Commission 2009). 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 refuges, outreach and statutory services for support with domestic, sexual violence, forced marriage and 'honour'-based violence. Being around other BMER women, being able to communicate in their own language and the specialist expertise of workers were the top three reasons for accessing BMER services. Almost all of the respondents (99 per cent) stated that the BMER service contributed to them feeling safer.

#### Agency expertise

BMER specialist services provide a crucial avenue of support for women and girls, particularly those who are not engaging with statutory services. They have a broad level of expertise on generic forms of VAWG as well as having specialisms in harmful practices. 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 harmful practices. For example, services should be able to demonstrate the following – the list is not exhaustive:

#### Indicators of expertise on HPs

1. 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.
2. An understanding of how coercion operates in cases of forced marriage and female genital mutilation and how this may affect disclosure to professionals.
3. Knowledge of complexities of risk and equalities issues that increase vulnerability to forced

marriage, 'honour'-based violence and female genital mutilation.

4. Have an understanding of and practical knowledge of how to risk assess and safety plan in the context of multiple perpetrator(s).
5. Have a clear understanding of the law, government guidance, policies and procedures on HPs.
6. Have a good knowledge of the range of support services available to address harmful practices with clear mechanisms for joint working and referral.
7. Leadership on HPs at a strategic level.

## Commissioning services addressing HPs

There are different dimensions to culture and community and both are fluid concepts in themselves. In other words, 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. For example, a young second generation woman at risk of forced marriage who is also dealing with issues related to sexuality may not identify with services that only address sexuality or those that only address forced marriage. It is likely that a targeted response where workers are experienced in both areas would be more effective.

It is important that women's experiences and needs are understood within the context of several factors for example:

- age, sexuality, disability and other equality-based characteristics
- patterns and histories of migration (these needs will differ between recently arrived second or third generation communities)
- spoken language needs
- culturally literate ethos: organisations and staff embody an approach that reflects a strong understanding of the different BMER women's experiences.

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.

Commissioning frameworks and service specifications should recognise the significance and benefit of both women-centred and BMER women-centred approaches, whether this is through the funding of individual organisations, collaborative projects or through the delivery of satellite services within mainstream services. An important aspect of achieving this will require a meaningful involvement of BMER organisations and service users in the local planning and delivery of services. A range of services should be considered as part of a holistic approach to addressing harmful practices. These include:

- **Refuge based support services:** Services could be delivered sub-regionally through a cluster model approach, which would help to reduce costs, and improve service co-ordination and accessibility across local authority areas. Given the high proportion of young women experiencing forced marriage and/or 'honour'-based violence and female genital mutilation, local areas will need to consider a range of suitable accommodation options, as current

services are mainly geared towards the needs of adult women. Services are also less accessible for some BMER communities, for example, women from different parts of Africa and this should be addressed within local needs assessments.

- **Resettlement and aftercare services:** These services provide women with ongoing practical and emotional support and are particularly important in helping women to readjust into new communities. Such services should be offered on a long-term basis depending on need. For example, aftercare services are essential for women who have undergone female genital mutilation to prevent repeat incidents and also to ensure that any physical and emotional support and care needs are addressed.
- **Advocacy and outreach services:** Different models of advocacy and outreach provision that provide a specialism on harmful practices should be explored. Access to ongoing casework support and advocacy is highly beneficial, particularly for women who have not accessed refuge provision or any other type of formal support. A number of HPs specialists have different well-established models of working which could be strengthened and developed. For example, Newham Asian Women's Project have developed effective ways of engaging with young women. Solace Women's Aid have developed a specific method of reaching and supporting Irish Traveller women, which takes into account the specialist needs and transient nature of the population. Advocacy services could be delivered in a peripatetic way to target particular vulnerable groups.
- **Therapeutic interventions:** The lack of services to address the mental health impact of harmful practices has been identified as a gap in current service provision. There is a lack of appropriate interventions that respond to the diversity of representation within the BMER community itself. Few interventions consider the needs of other groups, including women from Turkish, Iranian, Kurdish African, African Caribbean, North African, Irish Travelling communities. The Government Taskforce on the Health Aspects of Violence Against Women and Children reinforced the need for PCTs and Children's Trusts to ensure that 'evidence-based psychological treatment' services are to be made available and accessible to women and children who are at risk of, or are experiencing harmful practices (Taskforce on the Health Aspects of Violence Against Women and Children 2010). The report also highlighted the need for partnership working between grassroots organisations, psychologists and therapists to adapt psychological treatments that are culturally and linguistically appropriate for women who have been harmed.
- To be effective, services should not always be delivered within the framework of clinical care but by using models of social recovery. This includes group-work, holistic therapies, activities that promote good health and well-being as well as age-appropriate responses for young women.
- **Female genital mutilation clinics:** These should be funded according to a proper assessment of local need and demand. Data from a limited number of clinics indicates that there is an increase in referrals over the last financial year. Also, an update on the estimation of prevalence<sup>21</sup> indicates that there have been more births to women from female genital

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<sup>21</sup>Unpublished estimates, A Macfarlane, Midwifery Department, City University, 2011- see data section of this report.

mutilation practicing communities since 2002. At present most services are based in inner-London, offer sessional clinics and some are run by the same staff.

- **Work in schools and youth-based settings:** Large numbers of young women are affected by harmful practices. Therefore, the delivery of awareness-raising initiatives in schools/colleges, youth-based and community-based settings is critical to improving disclosure, early intervention and ensuring that young women are more aware of existing support services. Peer development models are a good way of reinforcing positive messages and providing crucial information, for example, groups could be funded to support young women to develop as peer educators to raise awareness of harmful practices.
- **Community awareness:** This would include targeted educational and awareness-raising work with hidden communities experiencing HPs, parents and young people. Community awareness initiatives should be designed to ensure that any factors, such as age, disability, sexual orientation and gender are considered. For example, there is a need to recognise the role of specialist women's groups in collaborating with generic community organisations to ensure that women can access safe spaces for advice and to engage in a dialogue on harmful practices.
- **Outreach:** Outreach services are particularly important as women may experience greater levels of isolation and multiple risks. These services provide opportunities for reaching and supporting women in other environments – home, community, education, health – that may be more safe and accessible, especially for women who may not have accessed any type of formal support.
- **Services for children and young people:** This study highlighted a gap in age-appropriate provision for young women experiencing harmful practices. For example, support services for female genital mutilation are mainly geared towards maternity services and other generic youth-based services are not appropriate spaces for engagement. A report by FORWARD highlighted that young people need to be trained in order to assist with the engagement process; young people are more likely to participate in discussions provided they are given a safe space to talk as well (Options & FORWARD 2009; FORWARD 2010).

## Partnership approaches

As well as investing in the development of organisations that predominantly work on HPs, it is important for HPs to be mainstreamed within other organisations that offer support to women and girls. 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. This would also help to build the capacity and expertise of both organisations on sexual violence and harmful practices.
- A specialist on VAWG and harmful practices could be co-located at a female genital mutilation clinic to improve access to other services including refuge provision, advice and advocacy.
- A partnership between a learning disabilities service and an advocate specialising in 'honour'-based violence and forced marriage would enhance support for this particularly vulnerable group.

## Outcomes

**Projects working to address HPs will be working towards achieving a range of outcomes. Expected outcomes are likely to include:**

- 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

It is important to recognise that specialist HPs services will also have their own systems that identify the additional benefits and outcomes of their specific interventions on harmful practices. Other models are being piloted to better reflect the impact of specialist VAWG services for women and girls. For example, the recent guidance from the Department of Health for commissioners refers to the value of other models in demonstrating the efficacy of services, such as the Social Return on Investment model which is being piloted by the Women's Resource Centre from April 2009 until February 2011 (Department of Health 2011). The project will explore the financial benefits of VAWG services and is being piloted with a range of organisations, including Ashiana Network and the Sudan Women's Association, both of which are specialists in harmful practices.

### **AN EXAMPLE OF PREVENTATIVE WORK IN SCHOOLS**

Ashiana Network, a specialist on forced marriage and VAWG, runs a schools-based programme for young women aged 13 to 21. Culturally specific counselling and awareness-raising workshops are available to girls experiencing family pressure, forced marriage, 'honour'-based violence and female genital mutilation. Ashiana's staff are all trained in identifying risk and responding to potential cases of forced marriage and 'honour'-based violence and the project has enormous benefits for the school. School staff have reported an increased confidence in flagging cases, following appropriate protocols, contacting Ashiana for support, as well as an increased understanding of harmful practices, "We can now provide support that we [otherwise] wouldn't have had expertise on" (Head of Sixth Form, Ilford Ursuline High School). **Cases of forced marriage have been identified as a result of the project, and in 2010 three forced marriages were directly prevented.**

Students now also have a better understanding of the definition and impact of violence. Young women also report that the project has helped them in a number of ways – they have been given a voice, increased confidence, practical coping strategies and choices and are less likely to have feelings of self blame. They also highlighted the importance of receiving culturally specific support

## 7. CONCLUSIONS 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.

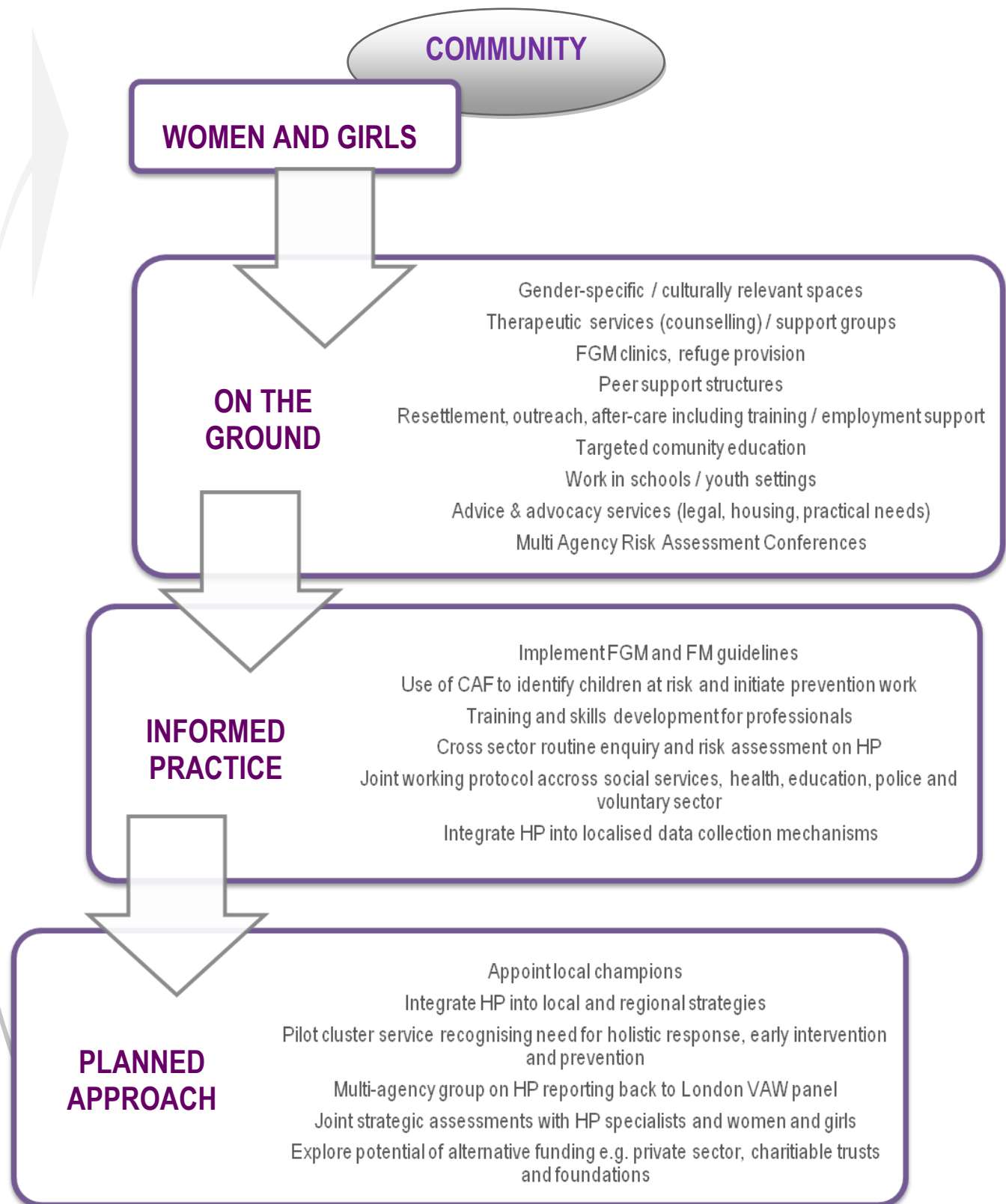
Current responses to HPs prevention and protection could improve through better integration of the issues into local policy, strategies and commissioning on VAWG, safeguarding of children and adults, reproductive, sexual and mental health services. Local Joint Strategic Needs Assessments provide an important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

# A CONNECTED APPROACH TO ADDRESSING HARMFUL PRACTICES



## 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

**KEY LEAD AGENCIES: GLA, LAs, CJS, HPs and VAWG specialists, health, education, commissioners.**

### **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.

**KEY LEAD AGENCIES: Midwives, health visitors (under-5's), GPs, school nurses, teachers, A & E nurses, paediatricians, social workers, police, HPs VAWG specialists, safeguarding leads.**

### **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.

Exploration of service models (using existing good practice) that are most effective for addressing HP's including service gaps in relation to children, young women including refugee and asylum-seeking communities experiencing HPs.

Funding bodies/ Trusts to explore the potential of funding HPs work, to include the funding of services that are no longer supported through statutory funds i.e. core costs, support within refuge services

Funding bodies should recognise the need for long-term funding (3-5years) that allows for full-cost recovery, and support for infra-structure development and evaluation

**Key leads: Commissioners, Directors of Public Health, HPs VAWG specialists, trusts and other funders**

### **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.

Awareness raising work should be delivered in partnership with HP voluntary sector specialists

Further research to increase knowledge in attitudes, perceptions and motivations of women and families from HPs practicing communities.

Integrate early intervention and prevention on HPs into commissioning strategies, service specifications and budgetary allocations on VAWG

**Key leads: Commissioners, LAs, GLA, HPs VAWG specialists, DFE, schools, colleges**

### **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 children and adults, VAWG, reproductive and sexual health.

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.

**Key leads: Health, LAs, education, Police, CPS, commissioners, other organisations working with women, children and families.**

## 8: APPENDICES

### Appendix 1: Definitions

The following definitions were used in gathering data during the study.

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#### **Customary beliefs and traditions and their links to violence**

Too often, concepts of tradition have been narrowly defined within the context of different types of mainstream religious beliefs and interpretations. However, there are whole plethora of belief systems and practices that operate globally which are fundamental aspects of different cultural norms. These belief systems can also be used as tools to control, maintain an inflict violence on women. For example, in a number of trafficking cases, 'witchcraft' has been used to promote fear and ensure subservience and compliance in victims.

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#### **Witchcraft**

The exercise or invocation of alleged supernatural powers to control people or events, typically involving sorcery or magic.

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#### **Dowry Abuse**

A dowry is "an amount of wealth handed over by a woman's family to her husband on marriage".<sup>22</sup> Dowry abuse usually occurs in an attempt to extort more dowries from a bride's family and includes but is not limited to threats, harassment, and acid throwing. This can lead to murder or suicide.

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#### **Female Genital Mutilation (FGM)**

Also known as female circumcision or female genital cutting, involves the complete or partial removal or alteration of external female 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.

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#### **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 HBV.

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#### **Honour-based violence (HBV)**

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

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#### **Adult**

'Adult' means a person aged 18 years or over.

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<sup>22</sup> Chambers Online Reference. <http://www.chambersharrap.co.uk/chambers/features/chref/chref.py/main?query=dowry&title=21st>

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## **Asylum dispersal policy**

Asylum seekers who have no other source of accommodation are allocated accommodation in dispersal areas around the UK.

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## **BMER**

Black minority ethnic and refugee communities

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## **British Crime Survey**

The British Crime Survey or BCS is a systematic victim study, currently carried out by BMRB Limited on behalf of the Home Office.

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## **CAF**

The Common Assessment Framework provides a standardised shared approach to carrying out an assessment of a child's additional needs and deciding how those needs should be met. The CAF aims to help the early identification of such needs and promote a coordinated service provision to meet them.

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## **Child, children and young people**

As defined in the Children Acts 1989 and 2004, 'child' means a person who has not reached their 18th birthday. This includes young people aged 16 and 17 who are living independently; their status and entitlement to services and protection under the *Children Act 1989* is not altered by the fact that they are living independently.

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## **Child in need**

Children who are defined as being 'in need' under section 17 of the *Children Act 1989* are those whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development, or their health or development will be significantly impaired, without the provision of services, plus those who are disabled. Local authorities and other bodies have a duty to safeguard and promote the welfare of children in need.

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## **CPS**

The Crown Prosecution Service, or CPS, is a non-ministerial department of the Government of the United Kingdom responsible for public prosecutions of people charged with criminal offences in England and Wales.

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## **De-infibulation**

The procedure to 're-open' a vaginal opening.

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## **Diaspora communities**

People who have migrated from countries outside of the UK who are now living in British society. By virtue of the fact that the diaspora share a common language or culture means that they potentially belong in a group – the community.

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## **Domestic Violence (DV) or intimate partner violence**

Involves a pattern of coercive control, and includes combinations of physical, sexual, psychological and financial abuse by a current or former partner. In extreme cases this includes murder.

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## **Early or child marriage**

Refers to any marriage of a child younger than 18 years old – see Article 1 of the Convention on the Rights of the Child. Girls are the majority of the victims and hence are disproportionately affected.

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## **FMU**

The Forced Marriage Unit (**FMU**) is a joint initiative of the Foreign and Commonwealth Office and the Home Office. Within the UK, the FMU assists actual and potential victims of forced marriage and professionals who work in the social, educational and health sectors. The FMU also works with embassy staff in other countries to assist victims.

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## **Hospital Episode Statistics (HES)**

The national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere. HES is the data source for a wide range of healthcare analysis for the NHS, Government and many other organisations and individuals.

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## **IDVA**

The main purpose of independent domestic violence advisors (**IDVA**) is to address the safety of victims at **high risk** of harm from intimate partners, ex-partners or family members to secure their safety and the safety of their children. Serving as a victim's primary point of contact, IDVAs normally work with their clients **from the point of crisis** to assess the level of risk, discuss the range of suitable options and develop safety plans.

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## **Infibulation**

Infibulation (Type 3 FGM) is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia.

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## **Multi Agency Risk Assessment Conferences (MARACs)**

Multi-agency meetings which focus on the victims of domestic violence where there is a high or very high risk. They aim to provide a co-ordinated response to support. The MARAC is a monthly meeting and it is intended to share information about Very High Risk clients in order to prevent homicide, develop a safety plan, put all possible support in place and lower the risk as soon as possible.

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## **Metropolitan Police Service (MPS)**

The main police service that operates in greater London (and includes the Royal Parks Constabulary).

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## **Metropolitan Police Authority (MPA)**

Scrutinises and supports the work of the MPS. The MPA has a strategic role and works with the MPS and its partners, 32 London borough councils, crime disorder reduction partnerships and other agencies in the criminal justice system.

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## **Primary Care Trust (PCT)**

Manages the initial care provided by GPs, dentists, opticians, on a local basis, which includes NHS walk-in centres and the NHS Direct telephone service. PCTs work with local authorities and other agencies that provide health and social care locally and currently control 80 per cent of the NHS budget.

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**Re-infibulation** (also known as re-suturing)

The procedure to narrow a vaginal opening after it has been deinfibulated for childbirth, for example. Re-infibulation is illegal in the UK.

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**Safeguarding adults' procedures**

A National Framework of Standards which refers to the local area-based, multi-agency response which is made to every adult *"who is or may be eligible for community care services"* (National Health Service & Community Care Act 1990) and whose independence and wellbeing is at risk due to abuse or neglect the victim and to link into relevant groups (e.g. Multi-Agency Public Protection Arrangements – MAPPA).

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**Safeguarding children**

A National Framework of Standards which refers to the local area-based, multi-agency response with children, young people and their families taking all reasonable measures to ensure that the risks of harm to children's welfare are minimised (Working Together to Safeguard Children, 2005, 2010).

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**Sexual Violence (SV) including rape**

Sexual contact without the consent of the woman/girl. Perpetrators range from total strangers to relatives and intimate partners, but most are known in some way. It can happen anywhere – in the family/ household, workplace, public spaces, social settings, during war/conflict situations.

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## Appendix 2: International and regional human rights treaties and consensus documents providing protection against gender related harmful practices

### International Treaties

- Universal Declaration of Human Rights, adopted 10 December 1948. General Assembly Resolution 217. UN Doc. A/810
- Convention relating to the Status of Refugees, adopted 28 July 1951 (entry into force, 22 April 1954)
- Protocol relating to the Status of Refugees, adopted 31 January 1967 (entry into force, 4 October 1967)
- International Covenant on Civil and Political Rights, adopted 16 December 1966 (entry into force, 23 March 1976)
- International Covenant on Economic, Social and Cultural Rights, adopted 16 December 1966 (entry into force, 3 January 1976)
- Convention on the Elimination of all Forms of Discrimination against Women, adopted 18 December 1979 (entry into force, 3 September (1981)
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted and opened for signature, ratification and accession by General Assembly resolution 39/46 of 10 December 1984 (entry into force, 26 June 1987)
- Convention on the Rights of the Child, adopted 20 November 1989. General Assembly Resolution 44/25. UN GAOR 44th session, Supp.No. 49. UN Doc. A/44/49 (entry into force, 2 September 1990)
- Committee on the Elimination of All Forms of Discrimination against Women. General Recommendation No. 14, 1990, Female circumcision; General Recommendation No. 19, 1992, Violence against women; and General Recommendation No. 24, 1999, Women and health
- Human Rights Committee. General Comment No. 20, 1992. Prohibition of torture and cruel treatment or punishment
- Human Rights Committee. General Comment No.28, 2000. Equality of rights between men and women CCPR/C/21/rev.1/Add.10
- Committee on Economic, Social and Cultural Rights. General Comment No. 14, 2000. The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4
- Committee on the Rights of the Child. General Comment No. 4, 2003. Adolescent health and development in the context of the Convention on the Rights of the Child. CRC/GC/2003/4

### Regional Treaties

- European Convention for the Protection of Human Rights and Fundamental Freedoms, adopted 4 November 1950 (entry into force, 3 September 1953)
- Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence, including HPs was adopted on 7 April 2011. The Convention is also open to accession by non-member States of the Council of Europe, EU member States and the non-member States which participated in its drafting. So far, 13 states have signed up since the treaty has been open for signature on 11 May 2011, although the UK is currently not a signatory party.<sup>23</sup>

### Consensus Documents

- United Nations General Assembly, Declaration on the Elimination of Violence against Women, UN Doc. A/RES/48/104 (1993)

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<sup>23</sup> Council of Europe Website:

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

- World Conference on Human Rights, Vienna Declaration and Plan of Action, June 1993
- UN Doc. DPI/ 1394-39399 (August 1993)
- Programme of Action of the International Conference on Population and Development, Cairo, Egypt, 5–13 September 1994. UN Doc.A/CONF.171/13/Rev. 1 (1995)
- Beijing Declaration and Platform for Action of the Fourth World Conference on Women, Beijing, China, 4–15 September 1995. UN Doc. A/CONF.177/20
- UNESCO Universal Declaration on Cultural Diversity, adopted 2 November 2001
- Convention on the Protection and Promotion of the Diversity of Cultural Expressions, adopted October 2005 (entry into force March 2007)
- United Nations Economic and Social Council (ECOSOC), Commission on the Status of Women. Resolution on the Ending of Female Genital Mutilation. March 2007
- E/CN.6/2007/L.3/Rev.1

### Appendix 3: Statistical analysis of harmful practices against women (Professor Alison Macfarlane, City University London)

Estimating the prevalence of 'harmful practices', including forced marriage, female genital mutilation and 'honour'-based violence is beset with problems. Women experiencing these will not be counted unless they seek help from one or more statutory or voluntary agencies, all of which keep their records separately and therefore count their clients in different ways. This report represents an attempt to collate information and data from variety of sources, supplemented by a 'snapshot survey', in which a number of organisations provided data about new clients seeking help in one week, in response to a request from Imkaan. This report starts by describing information about the three specific practices mentioned above and then goes on to consider a wider range of data about violence against women.

#### Female genital mutilation

Female genital mutilation (FGM) is not routinely recorded in maternity information systems and it is not included as a data item in the new Maternity Dataset proposed for England, so there are no robust data about the numbers of births to women with FGM. For example, a recent audit by midwives at Barts and the London Trust found that in many cases the presence of FGM was not identified antenatally and for 43 per cent of women with FGM, its presence was not detected until they were in labour, meaning that plans had not been made in advance to provide them with appropriate care. There was therefore a mismatch between mentions of FGM in antenatal notes and on the birth register.<sup>1</sup> Steps are being taken at Barts and the London Trust to improve this situation.

Estimates prepared for a report published by FORWARD in 2007, suggested that in 2001, 4.5 per cent of maternities in Greater London were to women who were born in FGM practising countries and were likely to have had some form of FGM.<sup>2</sup> It was estimated that this had risen to 5.3 per cent in 2004. There were many caveats about these estimates and they were spelled out in the report which recommended a survey and routine data collection by health and social services to collect more reliable data. This has not happened. In its absence, the estimates have been updated, applying a simplified method to data which are more readily available from the Office for National Statistics and which produces marginally lower estimates. These suggested that the proportion rose to 5.7 per cent in 2005, stayed at that level and then tailed off slightly to 5.4 per cent in 2009. Because of increases in the birth rate, this has led to an increase in estimated numbers from 4,238 women giving birth in 2000 to around 7,000 in each of the years 2007 to 2009.

These estimates do not include women and girls with FGM born in the UK or in other countries to which they may have migrated. There are no data available about the extent to which they have FGM and those born outside the UK cannot be identified. It is likely that the combination of legislation combined with changes in attitudes after migration to the UK will have reduced the prevalence of FGM, there is evidence from anecdotal accounts and reports that it still occurs. Although the report for FORWARD made some very speculative estimates of numbers of women and girls affected, further data and evidence would be needed to update these. No prosecutions have been brought under the legislation prohibiting FGM, but the Metropolitan Police's Project Azure investigates allegations of FGM.<sup>3</sup> In 2008/09 there were 46 such investigations and in 2009/10 there were 58.

Some data are available about the special clinics for women with FGM, although data are not compiled routinely or consistently from all of them. The clinic at University College London Hospital has seen a total of 169 women over the past two years, 2009 and 2010. Of these, 97 were new referrals and 72 were follow-up patients. About half of them are pregnant at the time of referral and the rest are referred mainly for sexual and psychosexual difficulties, notably being unable to have sex, experiencing pain when having sex or an inability to enjoy sex. Approximately 25 women a year undergo a de-infibulation procedure and about 95 per cent of these are done under a local anaesthetic in the clinics.<sup>4</sup>

The Whittington Hospital's level of activity has 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 in women who were pregnant.<sup>5</sup>

Imkaan's snapshot survey covered collected data of about a week's new referrals in participating agencies. Information was received about 18 new clients, six from UCLH, six from the Whittington, five from the Acton Well Women's Clinic and one from the clinic at Guy's and St Thomas'. The numbers were too small to be reliably extrapolated, but the information given gives a useful picture. **Ten of them were under the age of eight when they had FGM, six were eight or older and two did not give an age.** Among the problems they reported were painful periods, pain at intercourse and inability to have intercourse. Fourteen said they needed de-infibulation, but three did not. One from the Whittington had a major problem and needed referral to UCLH for surgery under a general anaesthetic. Five needed language support. On the whole, they did not answer questions about migration status but one was an asylum seeker, one a refugee, one was trafficked and one was a student.

All in all, the information available was patchy and incomplete. This supports the earlier recommendations for a survey and consistent routine data collection, both in clinics and during pregnancy and birth.

### Forced marriage and 'honour'-based violence

Both the Foreign and Commonwealth Office's Forced Marriage Unit and local organisations provide help for people threatened with forced marriage. In both 2009 and 2010, over a fifth of all contacts from women stating a region of residence came from London. In 2010, over two fifths of all contacts from people who gave their age were from people aged under 18.

**Table 1 Numbers of reports of forced marriage from residents of London**

Year	Total	Sex			Age		
		Female	Male	Not stated	Under 18	18 and over	Not stated
2009	365	317	48		88	265	12
2010	375	330	44	1	106	262	7

Source: Foreign and Commonwealth Office Forced Marriage Unit

Data from the Metropolitan Police's MetMIS system showed 366 forced marriage incidents and 110 forced marriage offences recorded during the 17 month period December 2008 to April 2010.<sup>6</sup> There were no time trends apparent over this period. There were wide differences between boroughs in the numbers of incidents and offences recorded. In the calendar year 2009, the numbers of incidents ranged from 37 in Newham and 23 in Ealing to one in each of the boroughs of Islington and Sutton. The numbers of offences ranged less widely from none in some boroughs to six in Newham and seven in Ealing. Data were provided about the nature of the 'honour'-based violence offences, showing that over half the offences involved assault and nearly a third involved rape.

Over the same period, 414 honour-based violence incidents and 228 offences were recorded. Again there were wide differences between boroughs with the number of incidents recorded in the calendar year 2009 ranging from one in Havering and Tower Hamlets to 20 in Ealing and Southwark. The numbers of offences reported ranged from none in some boroughs to 12 in Merton and 15 in Southwark. Overall, after rising from

a low level in the first few months, the overall numbers of offences oscillated widely with no clear trend. Just under half of these involved assault, 18 per cent harassment and four per cent were described as rape.

A report by the Metropolitan Police Authority showed combined numbers of recorded cases of forced marriage and 'honour'-based violence in London boroughs in 2008/09 and 2009/2010 and showed an increase from 127 in 2008/09 cases to 237 in 2009/10.<sup>7</sup> It attributed this major rise to increased police activity on this subject and acknowledged that there was major under-reporting in this area.

The numbers of prosecutions through the Crown Prosecution Services was much lower. Over a six month period from April to September 2010, there were 23 prosecutions for forced marriage and 38 for 'honour'-based violence.

**Table 2 Prosecutions for forced marriage and 'honour'-based violence, London, April – September 2010**

	<b>Total prosecutions</b>	<b>Successful prosecutions</b>
Forced marriage	23	4
'Honour'-based violence	38	13

Source: Crown Prosecution Service

Data from voluntary organisations reflected the categories of client for whom their services were designed. Over a recent year, the Newham Asian Women's project had between 16 and 21 new referrals per quarter and saw between 45 and 70 existing clients per quarter. The majority were South Asians aged between 11 and 15 and were either self-referred or referred by schools. About six women each quarter reported attempted forced marriage while the numbers reporting emotional abuse fluctuated widely from none to nine per quarter.

Data for the year 2010 from the Ashiana Network, based in Waltham Forest and providing refuges as well as working with schools, illustrated the extent to which the same women were subjected to a combination of these harmful practices, with domestic violence following forced marriages and 'honour'-based violence accompanying threats of forced marriage.

Women's Aid reported that in 2009/10, its national helpline supported 137 women giving an address in London in relation to a forced marriage and 136 women in relation to 'honour'-based violence.

## **Rape**

Rape was involved in a proportion of the offences described above, but they involved only a small proportion of rapes recorded in London. Reports of rape recorded by the Metropolitan Police and the City of London Police increased over the two year period 2008/09 and 2009/10, in all age groups. This could reflect fuller reporting.

**Table 3 Rape of a female offences, recorded by the Metropolitan and City of London police**

<b>Offence description</b>	<b>2008/09</b>	<b>2009/10</b>
Rape of a female aged 16 and over	1,448	1,979
Rape of a female child under 13	244	274
Rape of a female child under 16	338	443
<b>Grand Total</b>	<b>2,030</b>	<b>2,696</b>

Source: Home Office

### **Data from the snapshot survey**

Seven organisations providing care and support to women in London who were experiencing forced marriage and 'honour'-based violence contributed information about a total of 81 new referrals to Imkaan's snapshot survey. These data could not be readily aggregated in numerical terms, but the information gives useful examples of what was happening to the women concerned. Some of the organisations provided care to women from specific ethnic groups while others were more general. Most were voluntary and two had a helpline.

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. Apart from clients of two organisations, most spoke English and did not require language support. Some had problems as a result of their migration status, but they were in the minority.

The women who were captured in the snapshot survey experienced a considerable amount of violence, with most reporting emotional and psychological attacks along with physical attacks and threats and harassment. A number also reported isolation and entrapment and 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 her 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.

The organisations helped the women in a number of ways. A considerable proportion received help with accommodation, legal information or support and advocacy. It is clear that the organisations were playing a key role in supporting women who sought help from them after experiencing desperate circumstances. A more detailed study is needed to examine in greater depth how these problems interact and the support needed, as well as whether it is necessary to intervene at an earlier stage to prevent these problems before they become as acute as those described in the snapshot survey.

## Violence to women in general

The overall numbers of incidents of domestic violence recorded in London are very much larger than those cited above.<sup>7</sup> In the financial year 2009-10, the Metropolitan Police Service recorded 119,878 incidents of domestic violence in London, 51,809 of which were recorded as offences, compared with 52,910 in the previous year. This means a fall from 46 to 43 per cent of incidents being recorded as crimes, but this percentage varied widely by borough within each year. Overall, 175,039 offences of violent crime were recorded in 2009/10 and domestic violence accounted for 29 per cent of all reported crime in London.

**Table 4 Homicides where the victim was female, by apparent circumstance of offence, recorded by the Metropolitan and City of London police**

Apparent circumstances of the offence	2008/09	2009/10
1 - Quarrel, revenge or loss of temper	23	15
2 - In furtherance of theft or gain	1	1
3 - Attributed to acts of terrorism	0	0
4 - While attempting to restrain or arrest individual	0	0
5 - Arson	0	0
6 - Other circumstances	3	3
7 - Irrational act	5	2
8 - Not known	9	3
<b>Grand Total</b>	<b>41</b>	<b>24</b>

Source Home Office

The data about domestic violence were reported in an article by the Metropolitan Police Authority which pointed out that only one per cent of serious sexual offences are reported as domestic violence.<sup>7</sup> It also commented that these offences are under-reported, as victims are reluctant to report them. In addition, the Home Office definition of domestic violence excludes people under the age of 18; this means that so many women at risk of forced marriage would be excluded.

Although many of these women may have sustained repeated injuries, the numbers of homicides, as reported by the Metropolitan Police, are relatively low, as Table 4 above shows. The numbers contrast with the 5,585 London women and children who were referred by Women's Aid to a refuge or other safe accommodation.

## Other sources of data

The British Crime Survey, a major source of data, was not used in preparing this report, as it is based on a sample and is compiled in a way that the victims of the practices described here may not have been interviewed. In addition, it does not routinely provide regional data, so data for London were not readily available.

The Hospital Episode Statistics is a potentially useful source of data and the Home Office commissions tables about knife crime from this source. The data routinely available on the Information Centre web site

for provider units are not tabulated by area of residence or sex and the categories used are too broad to be useful in this context. There is, however, a potential for commissioning focussed analyses on these subject, but more time and additional funding would have been required.

## Conclusions

### Female genital mutilation

1. Data about numbers of women born in FGM-practising countries living in London suggest that numbers of birth to women with FGM have risen from 2000 to 2009. The information available is inadequate for estimating the extent to which girls born in England and Wales have been subjected to FGM in contravention to the legislation
2. A survey and routine data collection are needed to obtain better information and monitor the impact of the new guideline.

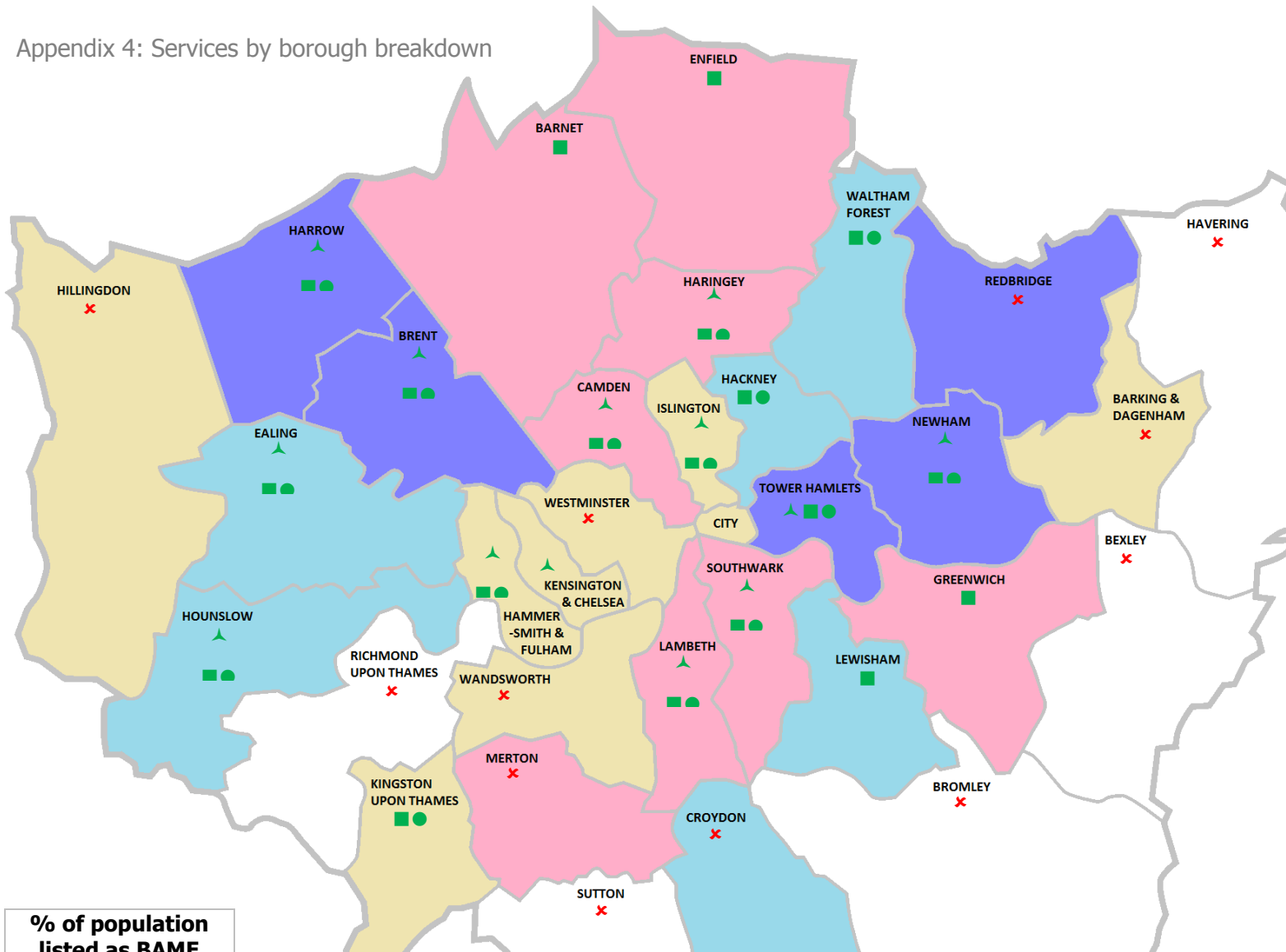
### 'Honour'-based violence forced marriage and rape

The data available are very patchy and likely to represent substantial underestimates because of the victims' reluctance to report these offences.

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## Appendix 4: Services by borough breakdown



% of population listed as BAME	
48.1% and over	
40.0% - 48.0%	
30.0% - 39.9%	
20.0% - 29.9%	
Less than 20%	

### 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 (×).

### 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 a short-term basis for singular posts or specific projects.

Some services are 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.

There are **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 infibulations (narrowing of the vaginal orifice with creation of a covering seal) and **1** offers health advocacy and counselling. Most are based in inner London.

	<b>NAME</b>	<b>FOCUS</b>	<b>SERVICES</b>	<b>COVERAGE/REFERRALS</b>	<b>LANGUAGES</b>	<b>SPECIALIST POSTS/SERVICE</b>	<b>EXTERNAL WORK</b>
<b>BARNET</b>	JEWISH WOMEN'S AID	DV / FM / "Spiritual Abuse" (see report)	Advocacy, counselling, helpline, information, outreach, resettlement	London	Hebrew		
<b>BRENT</b>	ASIAN WOMEN'S RESOURCE CENTRE (AWRC)	DV / FM / HBV / SV	Advocacy, children's service, health service, outreach, therapeutic, training	Barnet, Brent, Hammersmith and Fulham, Hillingdon, Hounslow, Kensington and Chelsea, Richmond upon Thames	Arabic, Bengali, Gujurati, Hindi, Punjabi, Urdu		Delivers training and to statutory and voluntary agencies.
	AFRICAN WELL WOMEN'S CLINIC [CENTRAL MIDDLESEX HOSPITAL]	FGM					
	HESTIA BRENT WOMEN'S AID	DV / FM / Trafficking / Prostitution	Refuge, outreach, resettlement, children's service. Specialist outreach service for African and Caribbean women.	Brent. Accept local women only in outreach service.			
	LHA – ASRA GROUP	DV / FM / HBV	Refuge, floating support. Specialist service for South Asian women.				

<b>CAMDEN</b>	AFRICAN WOMEN'S CLINIC [UNIVERSITY COLLEGE HOSPITAL]	FGM		Camden and Islington (referrals taken nationally). Also runs the service at another location in Camden.	Consultant Gynaecologist, Clinical Nurse Specialist
	HOPSCOTCH ASIAN WOMEN'S CENTRE	DV, FM, HBV	Advice drop-in, advocacy, information, floating support service	South Asian women in Camden.	Bengali, Sylheti, Hindi, Urdu, Nepali DV service runs in partnership with Solace Women's Aid. Runs programmes in schools for young people, giving them advice and support and creating awareness of opportunities.
	SUDAN WOMEN ASSOCIATION	FGM	Community-based preventative work with women and girls – workshops, seminars, confidence-building	Sudanese, Eritrean and Ethiopian women in Camden.	
	BRITISH SOMALI COMMUNITY (BSC)	FGM	Runs women's health sessions with a Somali doctor providing health advice and seminars, counselling, referrals to hospitals, medicinal massages, workshop on healthy eating and exercises with interpreting service.	Camden	Part-time outreach and advocacy worker to establish the Himilo (tackling) FGM Project. A significant element of the work is empowering young people to speak out against the practice.

<b>EALING</b>	ACTON AFRICAN WELL WOMAN SERVICE [MILL HILL SURGERY]	FGM	Advice, advocacy, children's service, de-infibulation, health service, outreach, therapeutic, training	Ealing. Outreach in other boroughs occasionally. Referrals taken nationally.	2 FGM Midwives, 1 Specialist Counsellor, 1 Somali and Arabic speaking Health Advocate.	Regularly delivers training and presentations to safeguarding / child protection teams. Member of National FGM forum. Group work in local community settings.
	SOUTHALL BLACK SISTERS	Dowry Abuse / DV / FM / HBV	Advice, advocacy, campaigning, development, educational, health service, outreach, policy and research, therapeutic, training	London	4 (advice and advocacy only)	Involved in a range of operational and strategic partnerships.
	SOUTHALL COMMUNITY ALLIANCE	FGM	Training and awareness raising, information, support, outreach	Ealing	FGM Project Officer	
<b>ENFIELD</b>	ENFIELD MUSLIM WOMEN'S AID	DV / FM	Refuge, resettlement	London (referrals taken nationally)	Bengali, Gujurati, Hindi, Punjabi, Sylheti, Urdu	
<b>GREENWICH</b>	LHA – ASRA GROUP	DV / FM / HBV	Refuge, floating support			

<b>GREENWICH</b>	DV / FM	Specialist refuge for African and African Caribbean women and children. Advice, advocacy, floating support, outreach, refuge.	Non-refuge services for women from Greenwich only. Refuge for women from outside of Greenwich only.	Creole, Fullah, Mende, Timini, Yoruba. Also, Gujurati, Portuguese, Punjabi, Somali, Turkish, Urdu and Vietnamese spoken for outreach and floating support.		
	DV / FM / HBV	Refuge, advice, support, information. Women with or without children from ethnic minority groups, predominantly Asian women. Refuge accepts women from outside of local authority only.	Wandsworth and Merton	Hindi, Punjabi, Urdu.		
<b>HACKNEY</b>	DV / FM / HBV	Advice, children and young people's services, counselling, health advocacy, information, mental health support and outreach, support group, liaison with other services	Kurdish and Turkish women in Hackney	Kurdish, Turkish	This is a one-year pilot, it runs out this year	They work in GP Surgeries, a couple of Children Centres and Hospitals in Hackney.

<b>HACKNEY</b>	HACKNEY ASIAN WOMEN'S AID [PART OF GATEWAY HOUSING]	DV / FM	Advocacy, children's service, counselling, information, outreach, refuge, resettlement	London, though local connection prioritised	Bengali, Hindi, Punjabi, Urdu
<b>HAMMERSMITH &amp; FULHAM</b>	FORWARD (Foundation for Women's Health Research and Development)	Child Marriage / FGM / HBV	Advice, advocacy, campaigning, information, health service, outreach, research, training, women's service	National	FORWARD works with individuals, communities and organisations to transform harmful practices and improve the quality of life of vulnerable girls and women.
<b>HARINGEY</b>	NEWHAM ASIAN WOMEN'S PROJECT (NAWP) - HARINGEY	DV / FGM / FM / HBV / SV	Advice, advocacy, children's services, health service, outreach, resettlement, refuge, therapeutic	Refuge, outside local area only. Non-refuge services give priority to women with local connection	Bengali, Gujarati, Hindi, Punjabi, Urdu
<b>HARROW</b>	HESTIA WOMEN'S AID, HARROW	DV, FGM, FM, HBV	Information, floating support, outreach, resettlement		French, Gujarati. Swahili for non-refuge services.
	AFRICAN WELL WOMEN'S CLINIC [ANTENATAL CLINIC, NORTHWICK PARK & ST. MARKS HOSPITAL]	FGM			
<b>HOUNSLOW</b>	EACH (ETHNIC ALCOHOL COUNSELLING IN HOUNSLOW)	DV / FGM / FM / HBV	Therapeutic service	Hounslow, Ealing, Barnet, Hillingdon, Brent and Harrow	EACH runs a service called Pukaar, a specialist counselling and support service for Asian women and young girls experiencing violence and abuse; and mental health problems.

<b>ISLINGTON</b>	AFRICAN WELL WOMEN'S CLINIC [WHITTINGTON HOSPITAL]	DV / FGM	Advice, advocacy, health service, outreach, therapeutic, training	Camden, Hackney, Haringey, Islington		2 Midwives
	AFRUCA	Child protection / Witchcraft / Trafficking / DV / Slavery	Advisory services, advocacy, awareness raising, community and international development, information, education, policy development	National and International		–
	IKWRO (Iranian and Kurdish Womens Rights Organisation)	Child Marriage / DV / FGM / FM / HBV / SV / Trafficking	Advice, advocacy, campaigning and raising awareness, outreach, therapeutic (counselling)	London	Arabic, Dari, Farsi, Kurdish, Turkish	<ul style="list-style-type: none"> <li>– 2x PT Advice (funding ends Nov '11)</li> <li>– 1xFT Advice and Outreach worker (Arabic and Farsi speaking, funding ends April '11)</li> <li>– 1xPT Outreach</li> <li>– 1xFT Training and Development Officer</li> </ul>
	IMECE	DV	Advice, advocacy, children's service, health service, outreach, therapeutic, training, women's service	London	Kurdish, Turkish	
	SOLACE WOMEN'S AID – COMMUNITY BASED SERVICES	DV / FGM / FM / HBV / Prostitution / SV / Trafficking	Floating support, project based, outreach, IDVA, dedicated sexual violence service, children's service	Barnet, Brent, Camden, Enfield, Haringey, Islington, Lambeth and Westminster	Bngali, Croatian, Dutch, Farsi, French, German, Gujurati, Hindi, Kikuyu, Konkani, Punjabi, Somali, Swahili, Turkish, Urdu, Yoruba	

<b>ISLINGTON</b>	HEALTH ADVOCACY PROJECT [PART OF MANOR GARDENS WELFARE TRUST]	FGM	'The FGM Initiative' does preventative work within schools, community organisation and healthcare services targeting specifically communities from Horn of Africa and the Middle East.	Target boroughs are Islington, Haringey and Hackney – also works across other parts of London		
	SOLAS ANOIS [PART OF SOLACE WOMEN'S AID]	Early Marriage / DV / FM / HBV / Prostitution / SV / Trafficking	Specialist refuge primarily for Irish Traveller women and children. Advice, advocacy, children's service, health service, outreach, refuge, therapeutic, training.	London	Floating support: Hindi, Punjabi, Urdu and Yoruba)	Irish Traveller Outreach/ Resettlement Worker. Staff at Solas Anois: – 2xFT Refuge workers – 1xFT Children's Worker – 1xFT Project Manager
<b>KENSINGTON AND CHELSEA</b>	GYNAECOLOGY & MIDWIFERY DEPARTMENTS [CHELSEA AND WESTMINSTER HOSPITAL]	FGM				
	AL-HASANIYA MOROCCAN WOMEN'S CENTRE	DV / FM	Advice, advocacy, referral.		Arabic, French	

<b>KINGSTON UPON THAMES</b>	BHAVAN (KINGSTON ASIAN WOMEN'S AID, PART OF HESTIA)	DV / FM / HBV	Advocacy (inc. health), information, refuge, support	Outside local area only	Basic Hindi, Gujarati, Punjabi, Basic Urdu
<b>LAMBETH</b>	AFRICAN WELL WOMEN'S CLINIC	FGM		Lambeth, Slough, Waltham Forest	FGM / Public Health Specialist
	ASHA PROJECTS	FM / HBV	Advice, advocacy, information, refuge	Resource Centre is for Lambeth women. Advice and information may be given to women from outside the borough. Refuge referral outside borough only	Bengali, Gujarati, Hindi, Punjabi, Sylheti, Urdu
	REFUGE (DOMESTIC VIOLENCE HELP   DOMESTIC ABUSE CHARITY) – LAMBETH	DV / FM / Prostitution / SV / Trafficking	Specialist refuge for African and African Caribbean women and children. Advice, advocacy, floating support, outreach, refuge.	Refuge accepts women from outside of Lambeth only. Non-refuge services accept women from Lambeth only.	Benin, Hausa, Ibo, Yoruba
<b>LEWISHAM</b>	REFUGE (DOMESTIC VIOLENCE HELP   DOMESTIC ABUSE CHARITY) – LEWISHAM	DV / FM / Trafficking / Prostitution	Advocacy, information support, refuge, floating support, outreach, resettlement, IDVA, children's service	Lewisham. Community outreach project for Vietnamese, Asian, Somali, Portuguese and Turkish women. Floating support for women from local area only.	Vietnamese, Somali, Portuguese, Turkish, a range of Asian languages.

<b>NEWHAM</b>	NEWHAM ASIAN WOMEN'S PROJECT (NAWP)	DV / FGM / FM / HBV / SV	Advice, advocacy, children's services, health service, outreach, resettlement, refuge, therapeutic	Refuge, outside local area only. Non-refuge services give priority to women with local connection	Bengali, Gujarati, Hindi, Punjabi, Urdu
<b>RICHMOND</b>	REFUGE (DOMESTIC VIOLENCE HELP   DOMESTIC ABUSE CHARITY) – RICHMOND	DV / FM / Prostitution	Advocacy, information support, refuge, floating support, outreach, resettlement, IDVA, children's service. Specialist service for South Asian women.	Richmond upon Thames. Community outreach project for Vietnamese, Asian, Somali, Portuguese and Turkish women. Floating support for women from local area only.	Hindi, Punjabi and Urdu.
<b>SOUTHWARK</b>	AFRICAN ADVOCACY FOUNDATION	DV / FGM / SV	Advice, advocacy, counselling, health service, outreach, training, women's service	Lambeth, Southwark, Lewisham, Newham, Tower Hamlets	Schools: Mediation for parents and mentoring for young people. Does partnership work.
	LHA – ASRA GROUP	DV / FM / HBV	Refuge, floating support	Barking & Dagenham, Newham, Tower Hamlets	
<b>TOWER HAMLETS</b>	WOMEN'S AND YOUNG PEOPLE'S SERVICES [SYLVIA PANKHURST HEALTH CENTRE, MILE END HOSPITAL]	FGM			

<b>TOWER HAMLETS</b>	OCEAN SOMALI COMMUNITY ASSOCIATION	FGM		Somali and other BME groups across Tower Hamlets and Newham	
	BLACK WOMEN'S HEALTH & FAMILY SUPPORT	FGM	Conferences and events, counselling, health sessions, older women's project, outreach and development, research, young people's services	Works in east London with newly arrived children and vulnerable adults as well as relevant professionals.	The project will build on its work with young people through the Peer Education Project to raises awareness of FGM amongst young people and with the older community. It will also offer training for health professionals, schools, social workers, community organisations and youth workers. They have also identified a need to tap into existing networks to reach newly arrived families.
	TOWER HAMLETS ASIAN WOMEN'S AID	DV / FM / HBV / FGM / Trafficking / Prostitution	Refuge, floating support, children's service. Specialist service for South Asian women.	Refuge accepts women from outside the local area only. Non-refuge services for local women only.	Bengali, Punjabi and Urdu.
	THE HAVENS - WHITECHAPEL	SV	Specialist service for people who have been raped or sexually assaulted. Advocacy, counselling, sexual health service, support and crisis intervention. Community based outreach work.	London-wide (for Asian Development Worker, Referrals can be made for clients attending The Havens Camberwell / Paddington)	Female South Asian Development Worker, provides cultural sensitivity. Sees/speaks to clients by appointment, also does outreach work and awareness raising. She is based at Whitechapel but works across all 3 Havens.

<b>WALTHAM FOREST</b>	KAWA (KIRAN ASIAN WOMEN'S AID)	DV / FM / HBV / Prostitution / SV	Advice, advocacy, counselling, information, refuge and outreach	Bengali, Hindi, Punjabi and Urdu.
	ASHIANA NETWORK	DV / FM / HBV / Prostitution / Trafficking	For women aged 16 -30. Advice, advocacy, counselling, information, refuge and outreach. Specialist support services for Asian, Turkish and Iranian women	Farsi, Hindi, Punjabi, Turkish, Malayalam, Urdu
<b>NO OFFICE</b>	DAUGHTERS OF EVE	FGM	Advocacy, campaigning, events to raise awareness on FGM, support groups for young women	National and International

# 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](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.)
<b>Barking and Dagenham</b>	173,300	50,000	28.90%	21
<b>Barnet</b>	328,200	107,100	32.60%	16
<b>Bexley</b>	218,200	27,600	12.70%	30
<b>Brent</b>	277,600	162,400	58.50%	2
<b>Bromley</b>	301,000	36,200	12.00%	31
<b>Camden</b>	208,100	61,600	29.60%	18
<b>City of London</b>	9,300	2,100	22.80%	25
<b>Croydon</b>	338,900	135,700	40.00%	11
<b>Ealing</b>	316,900	146,800	46.30%	6
<b>Enfield</b>	292,300	89,200	30.50%	17
<b>Greenwich</b>	232,300	76,200	32.80%	15
<b>Hackney</b>	226,600	93,400	41.20%	9
<b>Hammersmith and Fulham</b>	178,200	43,400	24.40%	24
<b>Haringey</b>	235,300	83,600	35.50%	14
<b>Harrow</b>	219,000	114,600	52.30%	3
<b>Havering</b>	230,500	17,100	7.40%	33
<b>Hillingdon</b>	255,000	75,200	29.50%	20
<b>Hounslow</b>	231,200	99,200	42.90%	7
<b>Islington</b>	202,300	51,900	25.60%	23
<b>Kensington and Chelsea</b>	167,300	37,900	22.60%	26
<b>Kingston upon Thames</b>	154,100	33,900	22.00%	27
<b>Lambeth</b>	292,700	109,800	37.50%	13
<b>Lewisham</b>	268,400	107,800	40.20%	10
<b>Merton</b>	197,500	58,300	29.50%	19
<b>Newham</b>	263,400	185,800	70.50%	1
<b>Redbridge</b>	253,300	121,900	48.10%	5
<b>Richmond upon Thames</b>	184,500	21,300	11.50%	32

BOROUGH	ALL ETHNICITIES	BAME POPULATION	% (BAME POP.)	RANK (BAME POP.)
<b>Southwark</b>	277,500	106,300	38.30%	12
<b>Sutton</b>	185,000	29,300	15.90%	29
<b>Tower Hamlets</b>	235,400	117,100	49.80%	4
<b>Waltham Forest</b>	227,100	94,200	41.50%	8
<b>Wandsworth</b>	290,300	63,600	21.90%	28
<b>Westminster</b>	213,100	61,100	28.70%	22

## APPENDIX 5: LIST OF PARTICIPANTS

<b>1. AGNES BAZIWE, CHIEF EXECUTIVE, AFRICAN ADVOCACY FOUNDATION</b>
<b>2. ALAN WEBSTER, CROSS GOVERNMENT FGM CO-ORDINATOR, FOREIGN AND COMMONWEALTH OFFICE</b>
<b>3. ALLISON BUCHANAN, DOMESTIC VIOLENCE &amp; HATE CRIME MANAGER, LONDON BOROUGH OF BARKING &amp; DAGENHAM COUNCIL</b>
<b>4. AMY NICHOLAS, STAKEHOLDER &amp; PARTNERSHIP TEAM, SOCIAL CARE, LOCAL GOVERNMENT AND CARE PARTNERSHIPS, DEPARTMENT OF HEALTH</b>
<b>5. ANASTASIA LUNGU-MULANGA, POLICY &amp; PROJECTS OFFICER, LONDON COUNCILS</b>
<b>6. ANGELA LAMBILLION, SENIOR COMMUNITY SAFETY OFFICER, LONDON BOROUGH OF WALTHAM FOREST</b>
<b>7. ANNIE HOWELL, DEVELOPMENT LEAD, IDENTIFICATION &amp; REFERRAL TO IMPROVE SAFETY PROJECT</b>
<b>8. ASHA-KIN DUALE, COMMUNITY PARTNERSHIP ADVISOR, CAMDEN VOLUNTARY ACTION</b>
<b>9. BALJIT BANGA, DIRECTOR, NEWHAM ASIAN WOMEN'S PROJECT</b>
<b>10. BEN RAWLINGS, JOINT HEAD OF UNIT, FORCED MARRIAGE UNIT, FOREIGN AND COMMONWEALTH OFFICE</b>
<b>11. BERNIE O'ROARKE, IRISH TRAVELLER &amp; RESETTLEMENT WORKER, SOLACE WOMEN'S AID</b>
<b>12. DCI CAROLINE GOODE, METROPOLITAN POLICE SERVICE HOMICIDE &amp; SERIOUS CRIME COMMAND</b>
<b>13. DR CATHERINE HEFFERNAN, JOINT CONSULTANT IN CHILDREN'S PUBLIC HEALTH, LONDON BOROUGH OF HOUNSLOW COUNCIL</b>
<b>14. DR COMFORT MOMOH, MBE, FGM/ PUBLIC HEALTH SPECIALIST, GUY'S &amp; ST THOMAS' HOSPITAL NHS TRUST</b>
<b>15. CRISTIANA SCOPPA, AIDOS – ASSOCIAZIONE ITALIANA DONNE PER SVILUPPO (ITALIAN ASSOCIATION FOR WOMEN AND DEVELOPMENT)</b>
<b>16. DEBBIE ARIYO, EXECUTIVE DIRECTOR, AFRICANS UNITE AGAINST CHILD ABUSE [AFRUCA]</b>
<b>17. DIANA NAMMI, DIRECTOR, IRANIAN AND KURDISH WOMEN'S RIGHTS ORGANISATION [IKWRO]</b>
<b>18. DIANNA BARREN, CHIEF EXECUTIVE, CAADA</b>
<b>19. ELIZABETH AJITH, COORDINATOR, SUDAN WOMEN'S ASSOCIATION</b>

20. DR ELLIS FRIEDMAN, DIRECTOR OF PUBLIC HEALTH, LONDON BOROUGH OF HILLINGDON COUNCIL
21. EMMA SCOTT , DIRECTOR, RIGHTS OF WOMEN
22. ERICA ROLLE, DOMESTIC VIOLENCE STRATEGIC CO-ORDINATOR, LONDON BOROUGH OF HILLINGDON COUNCIL
23. GAENOR BRUCE, IMMIGRATION JUDGE
24. HONG TAN, LONDON SEXUAL HEALTH PROGRAMME PROJECT DIRECTOR, LONDON SPECIALIST COMMISSIONING GROUP, NHS, ALSO DEPARTMENT OF HEALTH
25. HANNANA SIDDIQUI , POLICY AND RESEARCH, SOUTHALL BLACK SISTERS
26. HOWAIDA HASSAN, FGM WORKER, SUDAN WOMEN'S ASSOCIATION
27. ILA PATEL, DIRECTOR, ASHA PROJECTS
28. JENNA MARSH, INTERPERSONAL VIOLENCE TEAM, VIOLENT CRIME UNIT, HOME OFFICE
29. DCI JOHN CARROLL , ASSISTANT COMMISSIONER SPECIALIST CRIME, PROJECT AZURE, METROPOLITAN POLICE SERVICE
30. JOY CLARKE, LEAD SPECIALIST MIDWIFE, TEAM LEADER, AFRICAN WOMEN'S HEALTH CLINIC, WHITTINGTON HOSPITAL
31. JUDE WATSON, JOINT VIOLENCE AGAINST WOMEN STRATEGY MANAGER, CROWN PROSECUTION SERVICE
32. JULIET ALBERT, QUEEN CHARLOTTE'S HOSPITAL SPECIALIST FGM MIDWIFE, SOUTH ACTON CHILDREN CENTRE/ SURE START MIDWIFE, ACTON AFRICAN WELL WOMEN SERVICE, IMPERIAL COLLEGE HEALTHCARE NHS TRUST
33. KATHRYN SMALE, DOMESTIC VIOLENCE CO-ORDINATOR, LONDON BOROUGH OF TOWER HAMLETS COUNCIL
34. KATY RENSTEN, BARRISTER SPECIALISING IN FAMILY LAW, CORAM CHAMBERS
35. LEYLA HUSSEIN, CO-FOUNDER, OUTREACH, TRAINING, PROJECT DELIVERY, PROGRAMME DEVELOPMENT, DAUGHTERS OF EVE
36. LEETHEN BARTHOLOMEW, COMMUNITY PARTNERSHIP ADVISOR, CITY & HACKNEY SAFEGUARDING CHILDREN BOARD, HACKNEY
37. DR LIH-MEI LIAO, PSYCHOLOGIST, AFRICAN WOMEN'S CLINIC, UCLH
38. LOUISE ROUND, DIRECTOR OF CORPORATE RESOURCES, LONDON BOROUGH OF ISLINGTON
39. LYNNE ABRAMS, PUBLIC PROTECTION POLICY OFFICER, METROPOLITAN POLICE AUTHORITY

40. MANJULA NAYEE, SENIOR POLICY ADVISOR, STRATEGY & POLICY DIRECTORATE, CROWN PROSECUTION SERVICE
41. MARGARET WARREN, HEAD OF SIXTH FORM, ILFORD URSULINE HIGH SCHOOL
42. MARLIES DE JAGER, CENTRE OF EXPERTISE ON HEALTH FOR MIGRANTS AND REFUGEES
43. MEUTHIA ENDROJONO-ELLIS, INTERIM JOINT ASSISTANT DIRECTOR OF PERFORMANCE & COMMISSIONING, NEWHAM PCT
44. MIRIYAM BELL, VIOLENCE AGAINST WOMEN SUPPORT & PREVENTION WORKER, LATIN AMERICAN WOMEN'S RIGHTS SERVICE
45. MULKAHT ZUBAIR, FGM WORKER, AFRICAN ADVOCACY FOUNDATION
46. NAANA OTOO-OYORTEY, MBE, EXECUTIVE DIRECTOR, FORWARD
47. NAEMA CHOUDHURY, STUDENT ADVISOR, TOWER HAMLETS COLLEGE
48. NICKI NORMAN, DEPUTY DIRECTOR, WOMEN'S AID
49. NICOLA SHARP, HEAD OF POLICY & PARLIAMENTARY AFFAIRS, REFUGE
50. NICOLE BIROS, IMPLEMENTATION DOMESTIC VIOLENCE ADVOCATE, MOZAIC ADVOCACY SERVICE FOR WOMEN EXPERIENCING VIOLENCE
51. NIGEL CHAPELLE, CLINICAL NURSE SPECIALIST, VICTIMS OF VIOLENCE PROJECT, THE WHITTINGTON HOSPITAL
52. NIMCO ALI, CO-FOUNDER, PROJECT DEVELOPMENT, COMMUNICATION, FUNDING, DAUGHTERS OF EVE
53. POPPY BANERJEE, SENIOR COUNSELLOR, TOWER HAMLETS COLLEGE
54. RACHEL BILLET, UK GRANTS TEAM – VIOLENCE AGAINST WOMEN, COMIC RELIEF
55. PC ROGER GRIMES, SAFER SCHOOLS POLICE OFFICE, MET POLICE, TOWER HAMLETS COLLEGE
56. ROSALIND BRAGG, DIRECTOR, MATERNITY ACTION
57. ROSEMARY MAIN, STATISTICIAN, HEALTH INEQUALITIES & PARTNERSHIPS DIVISION ANALYTICAL HUB SOCIAL CARE, LOCAL GOVERNMENT & CARE PARTNERSHIPS DIRECTORATE, DEPARTMENT OF HEALTH
58. SARAH CREIGHTON, CONSULTANT GYNAECOLOGIST, UNIVERSITY COLLEGE LONDON HOSPITAL
59. SATVEERA SINGH, ASIAN DEVELOPMENT WORKER, WHITECHAPEL HAVEN
60. SELMA ALTUN, ADVOCACY & ADVICE SERVICES MANAGER, DERMAN
61. SHAMINDER UBHI, DIRECTOR, ASHIANA NETWORK

- 62. SHARON STRATTON, ACTING DETECTIVE INSPECTOR, VIOLENT CRIMES INSPECTORATE, DOMESTIC & HBV SERVICE DELIVERY**
- 63. SIMON MERCER, LONDON SEXUAL HEALTH PROGRAMME PROJECT MANAGER, LONDON SPECIALIST COMMISSIONING GROUP, NHS**
- 64. SIONED CHURCHILL, DIRECTOR OF SPECIAL INITIATIVES & EVALUATION, TRUST FOR LONDON**
- 65. SUE HAILE, NATIONAL HELPLINE MANAGER, WOMEN'S AID**
- 66. SUZELLE DICKSON, JOINT HEAD OF UNIT, FORCED MARRIAGE UNIT, FOREIGN AND COMMONWEALTH OFFICE**
- 67. TANIA CELANI, VIOLENCE AND SOCIAL EXCLUSION TEAM, POLICY & STRATEGY DIRECTORATE, DEPARTMENT OF HEALTH**
- 68. DS VICKY WASHINGTON, CONTINUOUS IMPROVEMENT TEAM (PARTNERSHIP), CHILD ABUSE INVESTIGATION COMMAND**
- 69. VICTORIA HILL, DOMESTIC VIOLENCE LEAD, BARKING & DAGENHAM NHS**
- 70. YACCUB ENUM, HEAD OF PUBLIC HEALTH PARTNERSHIP, WALTHAM FOREST**
- 71. YVONNE TOMMS, HEAD OF SUPPORT AND DISABILITIES, ADULT AND COMMUNITY SERVICES, LONDON BOROUGH OF WALTHAM FOREST COUNCIL**

## Appendix 6: References

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