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An Evaluation of the Support Our Sisters Programme: Introduced across Greater Manchester

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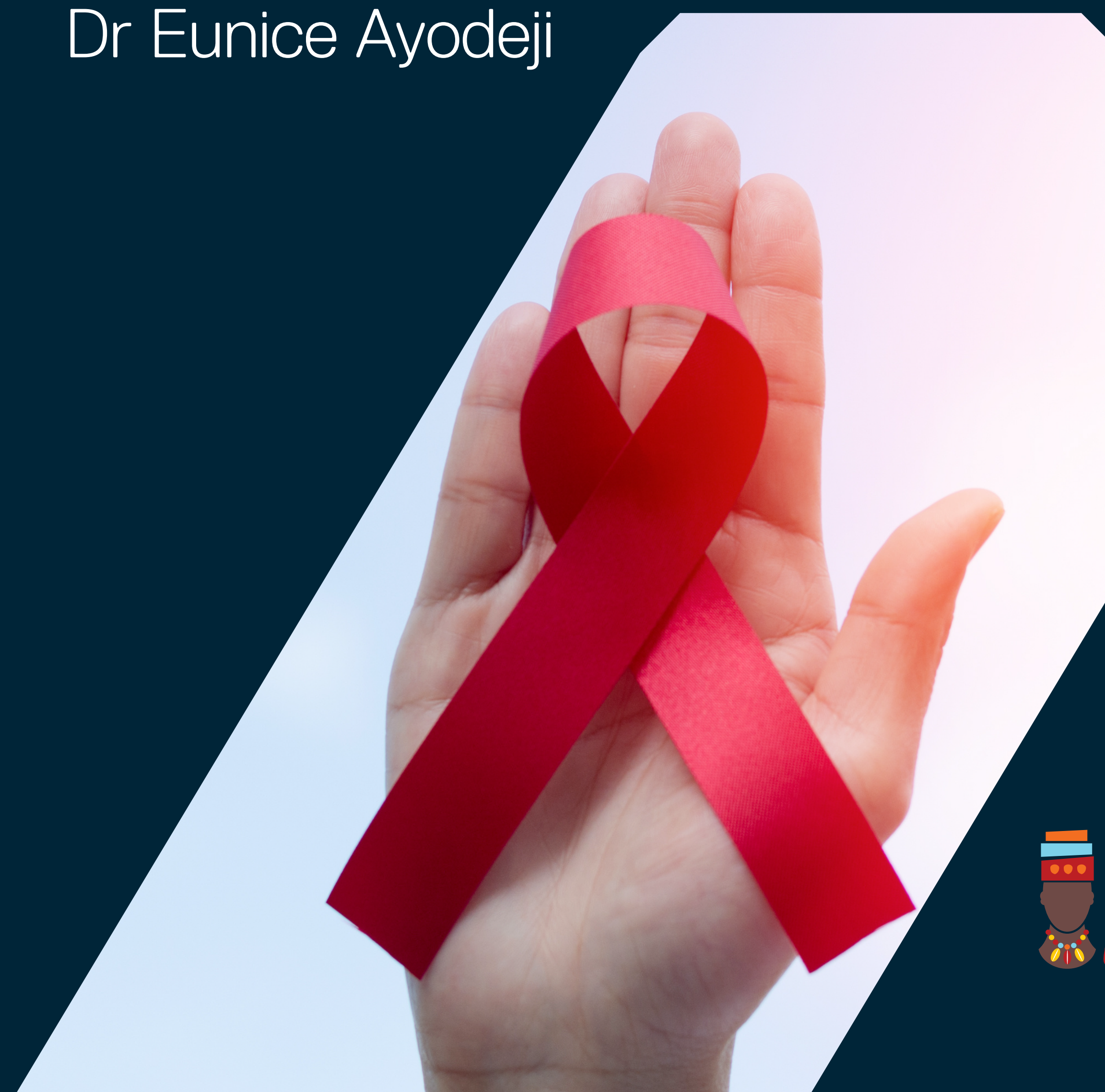

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This report aims to contribute to the already existing evidence on psychosocial interventions for those who have experienced FGM. We are continuously learning from others to improve our work; knowledge is never stagnant. Success is gained through perseverance and teamwork. I believe that together, we are progressing towards the successful route of abolishing FGM forever in our communities.

Peggy Mulongo
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Cross-cultural Mental Health Practitioner (CMHP)
NESTAC Charity

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Introduction

This report presents an evaluation of a number of projects that have been developed under the auspices of the 'Support Our Sisters' (SOS) programme, initially funded in 2012 by the Henry Smith Charity and hosted by New Steps for African Communities (NESTAC), a third sector organisation based in Rochdale, Greater Manchester. While the initial SOS project was funded by the Henry Smith Charity, subsequent funding was secured from Comic Relief, Greater Manchester Combined Authority (GMCA) and Manchester City Council to continue and expand the initial work. This work continues to date. The evaluation has been carried out by two researchers at the University of Salford; Professor Sue McAndrew and Dr Eunice Ayodeji.

The evaluation takes account of six projects; (1) The SOS Clinic (adult service); (2) The Guardian Project (a service aimed at children and young girls); (3) Peer Mentoring Project; (4) Youth Peer Mentoring Project; (5) FGM Education; (6) FGM Community Engagement Initiatives; a Health Advocacy Project. The evaluation provides statistical information and qualitative data regarding the experiences of a number of people involved in the projects: women who have received counselling for FGM and its implications; female peer support workers (peer mentors), male peer support workers (peer mentors) and those staff who have been managing the various projects.

This evaluative report is divided into eight sections; section 1 offers the reader an overview of FGM; section 2 gives a brief outline of how the evaluation was conducted; section 3 reports on the statistical evidence emerging from the six projects; section 4 presents vignettes of four of the women who, through the project, have received counselling; section 5 focuses on the experiences of two male peer mentors; section 6 reports the experiences of a groups of female peer mentors, and section 7 offers the lived experience of staff managing the projects. The final section, 8, offers a summary of the strengths of the projects, makes recommendations based on the evidence presented and considers what the future holds in terms of building on what has already been achieved.

Section 1: Overview of FGM

1.1. The Extent of the Problem

Based on 2011 census data (Office for National Statistics (ONS), 2011) birth statistics in England and Wales identified 170,000 women aged 15 and over having experienced FGM, with a further 63,000 girls aged 0-13 being at risk of exposure to the practice (Bindel, 2014; MacFarlane & Dorkenoo, 2015). In England and Wales, FGM is recognised as a 'hidden crime', and justifying the difficulties in evaluating the prevalence of FGM in these countries (MacFarlane & Dorkenoo, 2015; HM Government, 2016; Greater Manchester Combined Authority (GMCA), 2019). However, estimates suggested approximately 60,000 girls aged 0-14 were at risk of exposure to FGM and 103,000 women aged 15-49 and 24,000 women aged 50 plus, all residing in England and Wales, live with the consequences of FGM. Moreover, it is estimated 10,000 girls under the age of 15 years, who migrated in England and Wales, are likely to have undergone FGM (MacFarlane & Dorkenoo, 2015).

A recent report indicated Greater Manchester as being a major hotspot for FGM in England, specifically within the female asylum seeker population, as approximately 16% of this group are relocated in this region (GMCA, 2019). According to the GMCA (2019) report, there has been a significant increase of female asylum seekers from FGM practicing countries recorded in the last few years in nearly all the ten local authorities constituting Greater Manchester (GMCA, 2019). Such an increase was justified by the rise in asylum applications from women originating from FGM practising countries; Somalia, Sudan, Eritrea, Ethiopia and Nigeria. In 2018 21% of asylum seekers were resettled in the North West of England, compared to 11% in 2011 (GMCA, 2019). Nevertheless, whilst it is difficult to establish the prevalence of FGM locally, it is estimated that within Greater Manchester there are around 6,200 women aged 15 and over who have undergone FGM and a further 380 girls under the age of 15 who are at risk of the practice (GMCA, 2019).

FGM has been outlawed in England and Wales under the Female Genital Mutilation Act (2003) (parts of the FGM Act 2003 also apply in Northern Ireland). In 2015 the FGM Act (2003) was amended to accommodate further provision under the Serious Crime Act (2015) (HM Government, 2016). However, small scale academic studies and local authorities' casework interventions on girls deemed at risk of undergoing FGM, have suggested it is a continuing traditional practice in specific African communities (Mulongo et al., 2014a). The unwillingness on the part of communities to speak out about the practice and its implications can lead to a lack of emotional and physical support for those exposed to the practice. Such evidence is indicative, not only of the hidden nature of FGM in the UK, but it also compromises the level of responsibility required on the part of professionals in safeguarding those at risk and in supporting those who have undergone FGM. Subsequently, there is an ongoing need for community and health and social care organisations to work extensively with families originating from FGM practicing communities, with a focus on awareness-raising and education regarding, not only the physical, but the inherent emotionality and wider implications of such practice.

1.2. Origins of FGM

Primarily FGM is a deeply rooted practice associated with the African continent, where it is practiced in approximately 30 countries (WHO, 1996; UNICEF, 2016). However, it is also practiced amongst specific ethnic populations in the Middle East and Asia, and it has been identified amongst migrant groups in parts of Europe (Norway, Denmark, Netherlands, Sweden, UK, and France), North America

and Australia (Fisaha, 2016; UNICEF, 2016). While the origin of FGM is uncertain due to the absence of tangible evidence determining when and where this practice started, some researchers advised that FGM used to happen in ancient Egypt nearly 5000 years ago BC (Hosken, 1993; Smith, 1995; Elchalal et al., 1997). In ancient Rome, this practice was used with women slaves, whose labia minora was sealed with metal rings to prevent procreation (Reichert, 2006). Similar practice was observed in Greece, Pre-Islamic Arabia and the Tsarist Russian Federation (Reichert, 2006). Further evidence demonstrates the practice of FGM in Britain, Canada and the USA in the 18th century to prevent masturbation, and to cure hysteria and some other psychiatric conditions (Ng, 2000). In Africa and the Middle East, FGM is thought to have taken root centuries ago (WHO, 2006).

FGM encompasses several socio-cultural factors thought to be crucial for a girl best interest, in becoming a proper woman, ready for marriage (HM Government, 2016). A number of socio-cultural factors impacting on the practice of FGM include; beliefs, behavioural norms, customs, rituals and social hierarchies inherent in religious, political and economic systems (Momoh, 2005). For example, in Somalia there is a strong belief that FGM is a religious requirement (Keizer, 2003; Nienhuis et al., 2008), although there is no description of the practice in the Quran or the Bible (WHO, 2006; HM Government, 2016). In some practicing countries, girls and women who have not undergone FGM are not welcome in their society. The Masai of Tanzania refuse to call a woman "mother" if she has children and has not been circumcised (Mulongo et al., 2014a). A more common reason for FGM, particularly within communities living in Western Society, is that of preserving a female's virginity (Gruenbaum, 2006; Talle, 2007). For women and girls brought up in western society, and possibly still at risk of FGM, the effects of acculturation may impact further on their mental wellbeing given the mix of prevailing cultural norms (Whitehorn et al., 2002). The stigma inherent in the above is likely to further compromise a woman's mental wellbeing, particularly those who are opposed to FGM, yet reside in communities where it is part of their culture.

1.3. FGM and Human Rights

FGM of any type is both a harmful practice and a violation of the human rights of girls and women (WHO, 2008). Globally, the migrant population is strongly represented by vulnerable groups of refugee and asylum seeker families, among which girls and women experience various forms of gender oppression (Correa-Velez et al., 2005). In 2012 the United Nations General Assembly's Human Rights Committee placed FGM in a human rights framework, highlighting the need for a holistic approach that includes; recognising the importance of empowering women; promotion and protection of sexual and reproductive health and breaking the cycle of discrimination and violence (Diaz, 2012). In considering FGM as a serious breach of human rights, the United Nations High Commissioner for Refugees (UNHCR) and other associated agencies have stated that refugee status should be granted to women and girls fleeing their country to escape the practice; a statement reiterated by the British Medical Association (BMA) (2008). However, globally there are very few records of girls and women granted refugee status on the ground of FGM. The UK, has been criticised for rejecting women seeking asylum based on FGM, due to an unfounded belief on the part of the UK Visas and Immigration Department that it could open the 'floodgates' and lead to unmanageable numbers of female asylum seekers arriving at the UK boarders (Burrage, 2014). While Article 3 of the European Convention on Human Rights (1984) defends the right to be free from torture and inhumane or degrading treatment (Home Office Immigration & Nationality Directorate, 2001), in the UK, statistical evidence reporting

successful asylum applications on the basis of FGM is limited. In 2011 the Refugee Agency of the Human Rights Council reported of a total 8,795 women claiming asylum, only 2,410 (27.4%) were doing so on the grounds of FGM. Of these women on 640 (26.5%) were granted asylum (HRC, 2011). The Female Genital Mutilation Act (2003) made it an offence for UK nationals or permanent residents to carry out FGM, or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where the practice may be legal. More recently, the Serious Crime Act (2015), which incorporates the FGM Act (2003), introduced extra-territoriality for FGM, whereby the asylum context can be considered. Prior to this evidence presented by the Bar Human Rights Council (BHRC, 2014) before the Home Affairs Committee suggested insufficient protection in the area of FGM and asylum constituted a breach of the UK's international obligations, particularly, for asylum seeker children who are at risk of FGM if returned to their home countries. There is anecdotal evidence to suggest that it is common for girls to be taken abroad to undergo FGM (Home Affairs Committee, 2014) and therefore addressing the possibility of extra-territorial offences is crucial in order to adequately protect girls at risk of FGM, including children from asylum seeker families.

1.4. The Impact of FGM on Mental Wellbeing

Whilst the physical health consequences of FGM are well documented (Dare et al., 2004; Behrendt & Moritz, 2005; WHO, 2006; Royal College of Obstetricians and Gynaecologists [RCOG], Green-top guidelines, 2009), knowledge regarding the impact it has on emotional wellbeing has been slow to develop. When undertaking a review of the literature, WHO (2000) found that only 15% of studies focusing on the health effects of FGM considered mental health, and most of these were case reports. Since the turn of the millennium, studies that have identified the emotional consequences of FGM have identified depression, posttraumatic stress (PTS) and symptoms of impaired cognition comprising of insomnia, recurring nightmares, loss of appetite, weight loss or excessive weight gain, panic attacks and low self-esteem as being widespread within this population (Osinowo & Taiwo, 2003; Behrendt & Moritz, 2005; Elnashar & Abdelhady, 2007; Kizilhan, 2011; Vloeberghs et al, 2011). Factors thought to impact on the severity of the distress include; severe forms of FGM, immediate post-FGM complications, chronic health problems and/or loss of fertility secondary to FGM, non-consensual circumcision in adolescence or adulthood, and FGM as being used as punishment (Mulongo et al., 2014b). Likewise, in the UK, young women receiving counselling for FGM have reported feelings of betrayal by parents, incompleteness, regret and anger (Mulongo et al., 2014a). In a systematic review of the literature Berg et al., (2010) indicated a high probability of women who have been subjected to FGM being at greater risk of psychiatric diagnosis. These findings are re-iterated in a number of post-2000 studies from a variety of countries including; Israel, Northern Iraq, Norway, and the Netherland, with participants originating from Somalia, Ethiopia, Sudan, Eritrea, Sierra Leone, Egypt, Nigeria and Senegal.

A number of the studies have provided prevalence data relating to PTSD and/or other mental illnesses (Behrendt & Morritz, 2005; Applebaum et al., 2008; Chibber et al., 2011; Kizilhan, 2011; Vloeberghs et al., 2011; Zayed & Ali, 2012). For example, Behrendt and Morritz (2005) and Kizilhan (2011) reported a significantly higher prevalence of PTSD; 30.4% and 44.3% respectively, amongst women who had been subjected to FGM than women who had not been circumcised. In Senegal, Behrendt and Moritz's (2005) controlled study compared the mental status of 23 circumcised and 24 uncircumcised females. Results of the study showed that almost 80% of circumcised females met criteria for psychiatric

disorders, with 90% of the circumcised women describing severe pain and feelings of intense fear, helplessness and horror at the time of the traumatic event. Likewise, more than 80% of the women experienced flashbacks, a common phenomenon of PTS (Behrendt & Moritz, 2005). Chibber et al. (2011) also found 80% of circumcised women continued to have flashbacks of the circumcision event, with 58% experiencing affective disorders and 38% anxiety disorders. Such results indicate a link between psychological distress and Female Genital Mutilation, however, the practice of FGM is culturally embedded and perhaps consideration has to be given to available evidence related to not being circumcised and its effect on mental wellbeing.

1.4.1. The other side of the story

Whilst FGM is condemned within western society, the psychosocial implications of not undergoing FGM could adversely impact on females living in practicing communities. Not undergoing the practice could lead to a loss of cultural identity or anomie, resulting in mental distress, manifesting as anxiety due to fear of becoming socially excluded from the community. A number of studies report that women who have been subjected to FGM have minimal psychological morbidity, often feeling proud and believing that they are a better person for having undergone the procedure (Mwangi-Powell, 1999; Chalmers & Hashi, 2000). For example, in a study of 432 Somali women living in Canada, memories of FGM including; intense fear, severe pain, and being seriously ill at the time of mutilation, appeared to be outweighed by the participants' sense of pride, happiness and enhanced purity and beauty (Chalmers & Hashi, 2000). The complexity of FGM in a cultural context is demonstrated in a pre and post intervention study of 100 women undertaken by Ekwueme et al. (2010). Knowledge, attitude and behaviour pre and post FGM was explored with women recruited by systematic sampling from the General Outpatient Department at the University of Nigeria Teaching Hospital. After the women had been circumcised, results showed 85% of the respondents had a better understanding regarding the meaning of FGM, 71.3% knew the complications, 11% supported FGM, but 83% were against the practice. The stigmatizing attitudes held against uncircumcised women decreased significantly post-intervention; beliefs of promiscuity fell from74% to 22%, shameful 49% to 12%, outcast/cursed 14% to 2%, and not good for marriage from 66% to 19% (Ekwueme et al., 2010). The strong belief that a woman needs to be circumcised to be seen as 'good' and 'acceptable' is often inherent within the culture and passed from one generation to another without question (Mulongo et al., 2014b), presenting a challenge for those in Western society whose concern is that of FGM in the context of human rights and mental wellbeing.

1.4.2 Addressing the emotional consequences of FGM

A number of studies (Osinowo & Taiwo, 2003; Behrendt & Moritz, 2005; Elnashar & Abdelhady, 2007; Kizilhan, 2011) have made recommendations for psychological interventions to be adapted as a way of providing culturally sensitive therapy. However, studies reporting on the implementation and evaluation of psychological interventions specifically addressing the needs of women who have experienced or who are at risk of FGM are, at best, limited and perhaps reflect the paucity of studies relating to FGM and mental health (Mulongo et al. 2014b).

The limited research relating to the psychological consequences of FGM, coupled with the nuanced context of tradition and cultural beliefs, will impact on the way in which mental health services might provide support for women exposed to the practice. When developing therapeutic interventions for women exposed to FGM, account needs to be taken of the deep-rooted belief in the practice of FGM, as well as the cultural and social pressures women from practising communities are likely to experience. To promote healing, cognisance needs to be taken of the emotional and physical consequences of FGM and the cultural issues surrounding it in order to provide sensitive care (Mulongo et al., 2014a). A number of countries, such as the UK, Germany, Belgium and Sweden, have established guidelines on FGM for medical providers (Nour, 2004; BMA, 2011), however little attention has been paid to effective interventions addressing psychological needs (Mind, 2009). In the Netherlands, Vloeberghs et al. (2011) looked at participants' experiences of mental health provision, the results indicating both positive and negative experiences. Positive experiences included; interactions with mental health services, practitioners being better informed about circumcision and an increased awareness of its existence in the Netherlands, positive interaction with doctors and nurses when in the Reception Centre for asylum seekers and refugees; the latter providing appropriate referral of women to services able to address specific problems (Vloeberghs et al., 2011).

Drawing on an evaluation of the impact of the introduction of a community psychiatric nurse in a large refugee camp, Kamau et al., (2004) established that even a small amount of mental health care can have a dramatic impact on the mental well-being of refugees. In the UK current mental health provision for asylum seekers and refugees include: a limited number of specialist services for asylum seekers located in Trusts or run by independent bodies; trauma services that include survivors of torture or violent conflicts in their patient population; Freedom from Torture, formerly the Medical Foundation for the Care of Victims of Torture; inter-agency partnerships developed specifically to provide services for this group; and specialist general practices of in-house sessions with community mental health nurses or counsellors (Aspinall & Watters, 2010). Regardless of such services there appears to be a general lack of awareness that refugees and asylum seekers are a group that have distinct needs which are multiple, complex and require specialist knowledge. In such circumstances the effectiveness of psychological interventions for mental health difficulties can be compromised, and especially for those at risk of FGM whose cultural beliefs are at odds with the legal system of the country they are now residing in (Mulongo et al., 2014b).

1.5. Events leading to the development of the SOS Model

In the early 2000s, the borough of Rochdale became a dispersal area for asylum seekers, leading to a steady increase in the number of refugees, asylum seekers and later on EU migrants entering the area. Between May 2006 and March 2010, 750 refugees who resettled in the area through the Government Gateway Protection Programme (GPP) were referred to NESTAC by the local Asylum Team, with the majority of them originating from FGM practicing countries. These statistics did not include refugee and asylum seeker families living in this area, who were not part of the Gateway Protection Programme. By September 2010, approximately 1,200 families of refugees, asylum seekers and EU migrants were registered with NESTAC, 50% of who were locally based in Rochdale, whilst the remainder came from other local authorities in Greater Manchester, particularly from Manchester and Salford. NESTAC's work on FGM initially started in 2008 with adult female refugees who resettled locally under the GPP, and has gradually developed over time. In 2008, NESTAC also partnered with

the Rochdale Law Centre, as they started a two-year funded 'Female Asylum Seeker Programme'. Since the inception of this partnership there has been a 5-fold increase in the number of women exposed to FGM coming forward.

Initially, the majority of initiatives to address FGM had been concentrated in Southern regions of England, a number being initiated by the Foundation for Women's Health, Research and Development (FORWARD), a national women's rights charity based in London. In April 2010, FORWARD offered financial support to NESTAC to set up a three-year FGM project in Greater Manchester, called 'Young People Speak Out' (YPSO). YPSO ran from April 2010 and was completed in December 2012, the objective being to engage and consult with members of African communities, particularly young people, regarding the practice of FGM. This project successfully recruited 42 young people, including a small number of young boys, all of whom voluntarily chose to participate. The most pertinent outcome from the YPSO project identified the need for more emotional support for young girls and women who had experienced FGM, this being one of the main issues within asylum seeker and refugee communities in Greater Manchester. Although there are a great number of counselling centres for women, including services for domestic violence, sexual assault and torture, most were unfamiliar with FGM, and did not address this issue within their programmes of support. At the time of the project's inception, the Gynae-obstetric Department at St. Mary's Hospital in Manchester was the only place offering physical assessment for adult women who had experienced FGM, but in the main any physical health complications related to FGM were ante-natal orientated, that I mainly for pregnant women. The department had no specific service providing emotional support and counselling for this particular group of women, nor was there any other service in the area offering such provision. As a result, NESTAC was the only organization in the Greater Manchester area, to offer emotional support to women who had been subjected to FGM.

During the life of the aforementioned project one GP Surgery in Rochdale, who were registering a high level of Black, Minority, Ethnic (BME) patients, expressed a need for counselling and support services tailored to meet the needs of those who have experienced FGM and were keen to be involved in a project. Health professionals from this and other GP surgeries have sought advice and support from NESTAC in terms of how to effectively support the specific emotional and cultural needs of women who have undergone FGM, and also with regard to widening access to appropriate information and services for this particular group. Such a need was reiterated by other professionals attending FGM workshops that NESTAC were providing for statutory and non-statutory organisations across Greater Manchester. By September 2011 the demand from professional agencies in Greater Manchester had significantly increased, with the main requests including, but not limited to; raising awareness on FGM and providing emotional support to women and girls.

Following the YPSO project, the partnership work with the local Law Centre, the collaboration with GP surgeries and health professionals across Greater Manchester, and further consultation with members from FGM practicing communities, an urgent demand in terms of providing a drop-in clinic where women, age18 and above, could address some of the emotional and wider issues inherent in FGM was evident. Recognition of such a demand resulted in the inception of the Support Our Sisters (SOS) pilot project.

1.6 The Pilot Project (2012 – 2015)

This was a three-year pilot project funded by the Henry Smith Charity, delivered through NESTAC and evaluated by the University of Salford. The project adopted a community-based participatory research (CBPR) approach, bringing together the expertise of the University of Salford and NESTAC. Whilst NESTAC had extensive experience of working with women exposed to FGM, Mental Health mental health specialist at the University of Salford worked with NESTAC in the development of the SOS Clinics as a pilot project, ensured that the pilot project was conducted to appropriate ethical and governance standards as defined by the University of Salford, provided advice and assisted NESTAC in collating information and data that could be incorporated into health policy and practice.

The project objectives included:

- Establishing three drop-in clinics within Greater Manchester, to offer emotional support to those who had or were likely to experience FGM.
- Measuring the effects of such support on a woman's emotional wellbeing.
- Building capacity through training peer mentors to help sustain the work of providing basic emotional support to their peers.
- Evaluating the effectiveness of the model for those attending the drop-in clinics and those undertaking training as peer mentors.

The pilot project had two phases: phase one was to determine the effects of drop-in clinics on the emotional wellbeing of women who have had FGM; phase two involved developing and evaluating peer support as a way of continuing the service once the project had finished. Qualitative and quantitative data was collected for phase 1, while phase 2 collected statistical and evaluative data. Phase 1 involved 30 women who had received counselling (30 completed the Warwick-Edinburgh Well Being Scale, while 27 also agreed to be interviewed). Phase 2 involved 27 people completing the peer mentoring training.

The pilot project ended in March 2015, and it successfully achieved its objectives. The project potentially led to further funding that helped develop the SOS Model, providing wider benefits for participants who took part in the pilot project and beyond.

1.7 The SOS Model (2015 – Ongoing)

The primary focus of the SOS Model is to support women, young girls and families who are either at risk of, or affected by FGM. There are numerous strands by which this is has, and continues to be, achieved following the three-year pilot.

Since 2015, and the end of the pilot project, six FGM projects have been initiated by NESTAC in response to clients' needs. All six projects are; inter-related, have been ongoing since 2015, and constitute the SOS Model. These six projects are: (1) The SOS Clinic (adult service); (2) The Guardian Project (children and young girls' service); (3) Peer Mentoring Project; (4) Youth Peer Mentoring Project; (5) FGM Education; (6) FGM Community Engagement Initiatives; namely the Health Advocacy Project. With the exception of the first two projects which are led by mental health specialists, the remaining four projects aim to feed into the SOS Clinic and the Guardian Project. The overall aim of the four latter projects is to educate professionals and to engage and empower members from FGM

communities who want to play a role in the eradication of FGM. An overview of the six projects constituting the SOS Model can be seen in Table 1.

Table 1: Outline of the six FGM projects constituting the SOS Model

	Project	Timeframe	Outcome
1	SOS Clinics: Psycho-social therapeutic service for adults	2012 - ongoing	Individual & Group Therapy offered to adult women to women exposed to FGM. Also men's therapeutic group.
2	The Guardian Project – Psychosocial Therapeutic service for girls and young women (under the age of 21)	2016 - ongoing	Providing support for young females at risk/affected by FGM and their families.
3	Wellbeing Peer mentoring project	2014 - ongoing	Building capacity by training peer mentors (from FGM practicing communities) to assist in providing basic emotional support to their peers.
4	Community Engagement Initiatives: Health Advocacy - 'Aspire, Inspire	2017 - ongoing	Capacity building initiative to train women to effectively raise general awareness on FGM within practicing communities and amongst professionals.
5	Youth Advocacy project	2012 - ongoing	This initiative is based on the long-term partnership work with FORWARD, resulting in three distinct strands developed by youths in Greater Manchester: Skills-building and youth-led initiatives Volunteering Creative workshops
6	FGM Education	2015 - 2019	NESTAC work in schools/colleges and universities across Greater Manchester**.** This is part of a national consortium led by FORWARD, using quality assured youth-friendly materials in primary and secondary schools. It also encompasses education to college and university students. FGM Training for professionals**.** A standardised training for multi-agency professionals, covering a variety of FGM topics, as well as tailored training packages highlighting key FGM subjects to suit the needs of relevant agencies.

Section 2: Methods used for evaluation

The evaluation adopted a mixed methods approach. Descriptive statistical data was collated using information from a variety of sources, including reports and training programmes provided under the NESTAC umbrella. Data was collated from the two main FGM services across Greater Manchester; the SOS project (adult focused) and the Guardian project (Children & young people focused). Referral data was collated from the three specialist therapeutic clinics across Greater Manchester. Data in relation to training, support groups, campaigns and overall numbers of individuals reached during the period of the projects was also collated. Quantitative findings are presented in section 3 of this report.

Qualitative data was attained through 1:1 interviews and focus groups. Focus groups were used to collect data from (1) those responsible for delivering and managing the projects, three participants in total and (2) women who had undergone training and now work as peer mentors, six in total. One to one interviews were conducted with six people in total; four women who had received counselling for FGM and two male peer mentors. All focus groups and interviews were carried out at the University of Salford, in a private room in the counselling suite, and each lasted between 35 to 90 minutes. All focus groups and interviews were audio-recorded with permission of the participants.

Ethical approval was provided by the University of Salford for the original project [HSCR 12/84], this also covered an evaluation with women who had used the counselling service and those who had trained and worked as peer mentors. A further amendment to that approval was sought and achieved on 3rd August 2018, allowing the evaluation to include staff who facilitated the projects.

Analysis of the qualitative data was undertaken after recordings were transcribed by OUTSEC, a company offering confidential transcription. Analysis led to the generation of themes for each of the four women who received counselling and across the four interviews; across the two male peer mentor interviews, and for each of the focus groups. Findings from each group of people are presented in sections 4, 5, 6 and 7 of this report.

Section 3: Statistical Data

This section presents the demographics of participants involved in the six FGM projects constituting the SOS Model, covering the overall period of 2010 – March 2019.

3.1 Project 1 – The SOS Clinics (2016 – 2019)

Table 2 below shows data collected between 2016 and 2019 of all direct and indirect beneficiaries who were involved with the SOS Therapeutic Clinics across Greater Manchester.

Table 2: Direct and indirect beneficiaries of SOS clinics

Direct beneficiaries	Number		
	Year 1	**Year 2**	**Year 3**
Individual psychosocial support – (women 18+)	87	163	215
Individual psychosocial support – (young girls under 18)	22	12	0
Internal referral to the Guardian Project (girls under 18)	0	10	22
Women's Group therapy	151	115	150
Men's Group therapy	0	44	65
Total of Direct beneficiaries	***260***	***344***	***452***
Indirect beneficiaries			
Partners living in the same household (FGM awareness and basic counselling support)	82	127	55
Other relatives, children and adolescents living in the same household (FGM awareness and basic counselling support)	29	72	107
Total Indirect beneficiaries	***111***	***199***	***162***
Total of direct and indirect beneficiaries	**371**	**543**	**614**
Overall Total across the 3 years	**1528 beneficiaries**		

Diagram 1: Direct Beneficiaries of SOS Clinic

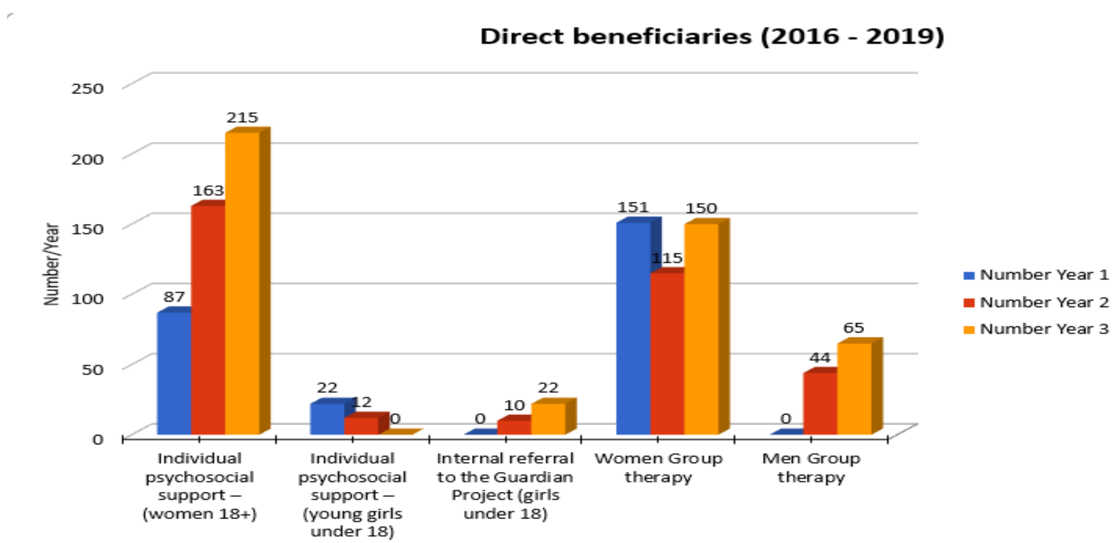


Diagram 2: Indirect Beneficiaries of SOS Clinic

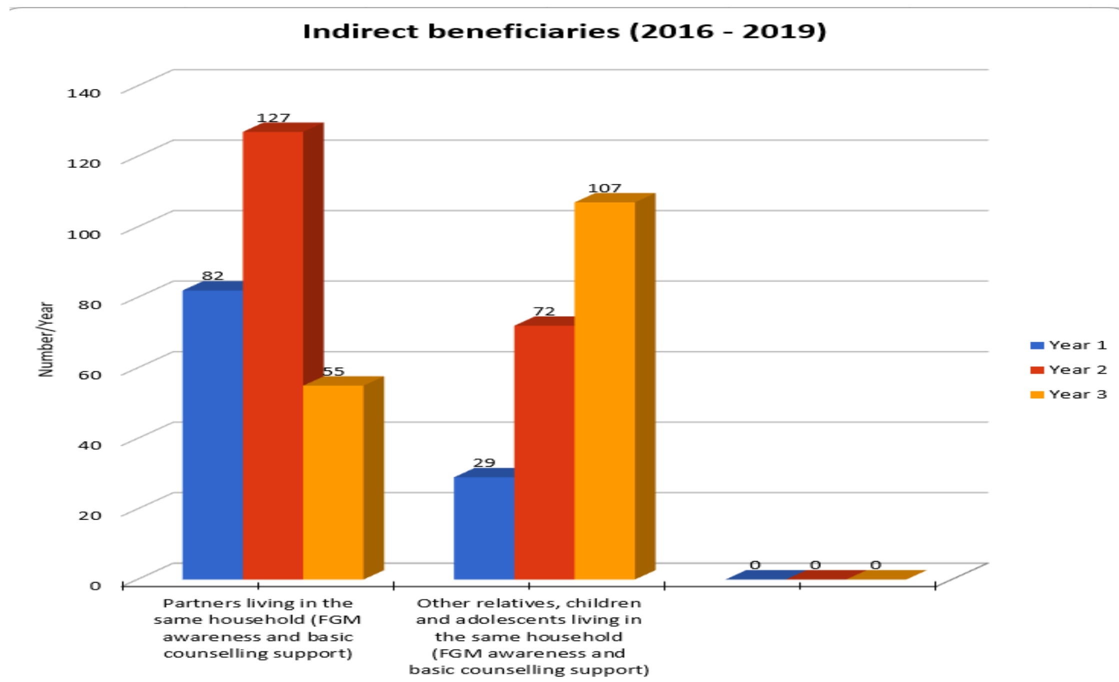
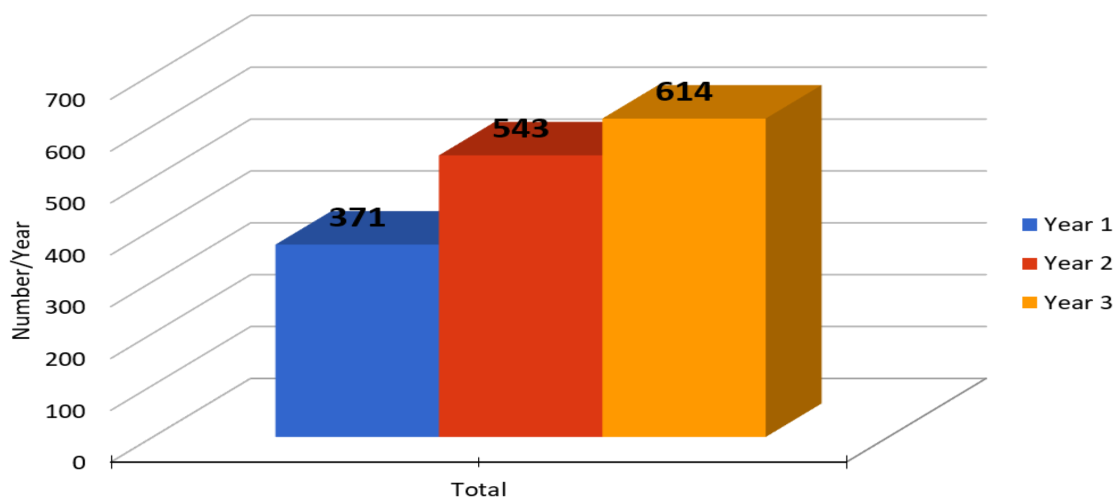


Diagram 3: Direct and Indirect Beneficiaries of SOS Clinic (2016 – 2019)



Results show an annual increase in the number of adult clients who directly benefited from individual psychosocial therapeutic support and in the men's group therapy. The number of clients attending the women group therapy remained stable, except in the second year where a slight decrease was observed. Individual therapeutic support provided to young girls under the age of 21 years at the SOS

Clinic in the same period decreased over the three years. This is in contrast to the increase in number of referrals made to the Guardian Project (under 21) during the same period.

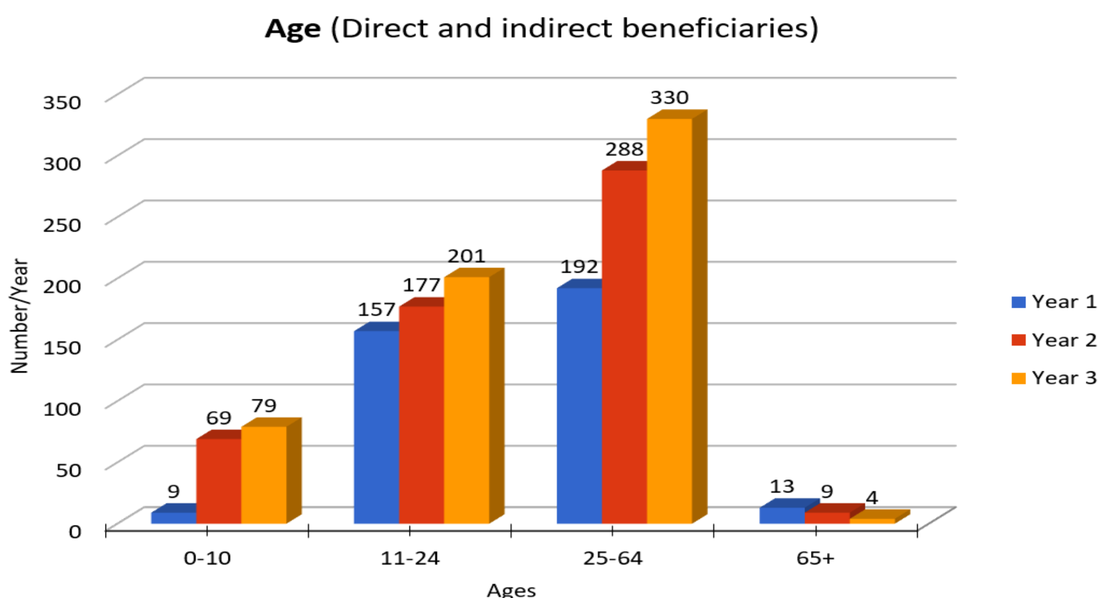
The number of partners living in the same household who indirectly received either emotional support and/or FGM awareness fluctuated during the three years; a higher number being recorded in the second year, and the third year showing a lower number of partners supported. However, it was interesting to observe that indirect support provided to siblings and other relatives increased over the three years. The evidence presented shows an increase in number each year between 2016 and 2019 in the overall total of direct and indirect beneficiaries.

Table 3 presents demographic data related to the age of direct and indirect beneficiaries of the SOS Clinics across Greater Manchester over the three years.

Table 3: Age of direct and indirect beneficiaries of the SOS Clinics

Age (Direct and indirect beneficiaries)	**Number**		
0-10	9	69	79
11-24	157	177	201
25-64	192	288	330
65+	13	9	4
Total for each year	**371**	**543**	**614**
Overall Total	**1528**		

Diagram 4: Age Range of Direct and Indirect Beneficiaries



The most common age group for women and girls directly and indirectly supported at the SOS Clinics is 25-64, followed by the 11-24 age group, and then the 0-10 year olds, with those 65+ being the least supported.

Table 4 shows the gender of the direct and indirect beneficiaries involved in the SOS Clinics, most of whom are female. The data also shows an increase in females each year over the three year period. The number of males supported is low, with the last two year showing an increase compared to the first year.

Table 4: Gender of the direct and indirect beneficiaries involved in the SOS Clinics

Gender (Direct and indirect beneficiaries)			
Female	289	416	493
Male	82	127	121
Total for each year	**371**	**543**	**614**
Overall Total	**1528**		

Diagram 5: Gender of Direct and Indirect Beneficiaries

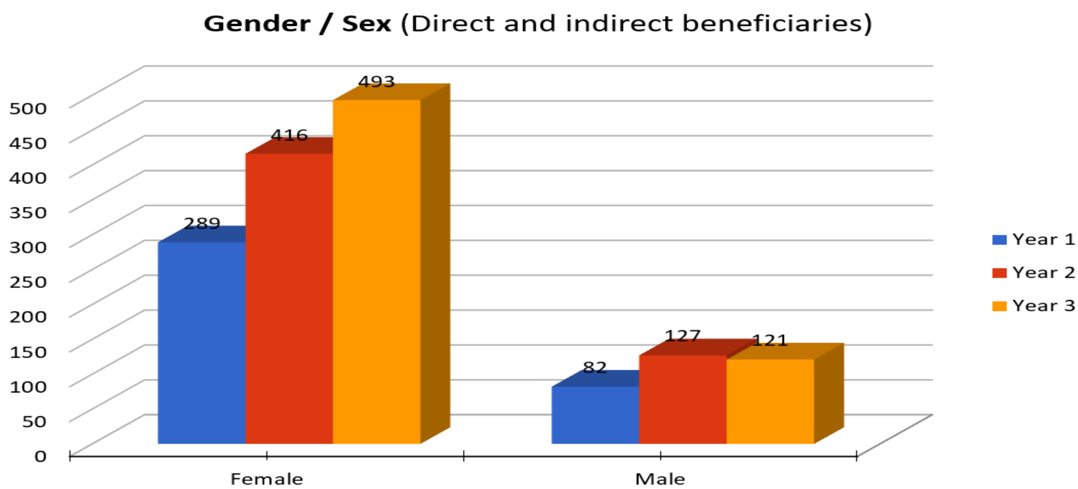


Table 5 below shows the ethnic origins of clients supported in the SOS Clinics, over a three year period. The countries of origin are also the places where FGM took place.

Table 5 Ethnicity and place where FGM took place

Ethnicity	Year 1 (11 countries)	Year 2 (15 countries)	Year 3 (13 countries)
Year 1 – 11 countries			
Cameroun	3		
D. R. Congo			5
Egypt		16	
Eritrea	9	24	
Ethiopia	8		42
Gambia	33	59	30
Guinea Bissau	9	22	29
Guinea Conakry	5	11	18
India		6	24
Indonesia		4	
Iran			16
Ivory Coast	3		
Kenya		16	
Kurdish - Iraqi			26
Malaysia		3	
Nigeria	87	119	148
Senegal		40	
Sierra Leone	25		
Somalia	107	114	111
Sudan	82	92	105
Uganda		8	
Yemen		9	
Zambia			4
No disclosure of ethnicity or where FGM took place			43
Total	**371**	**543**	**614**

In total 24 nationalities were recorded. The most common ethnicity and places where FGM took place for those attending the SOS Clinics is the African continent, with Nigeria, Somalia and Sudan being the most prevalent. A small number of clients were of Asian ethnicity (India-Bohra, Indonesia, Iran, Iraqi-Kurdistan, Malaysia and Yemen), with India-Bohra and Iraqi-Kurdish being most prominent. A small group of clients did not disclose their ethnic background or country where FGM took place. Table 6 below shows the religions of beneficiaries.

Table 6 Religion of those benefitting directly and indirectly from the SOS clinics

Religion – year 1	**Year 1**	**Year 2**	**Year 3**
Christianity		65	148
Islam	371	462	436
Other –			
Unknown		16	30
Total	**371**	**543**	**614**

Over the three years, Islam has been the dominant religion of those directly or indirectly benefitting from the SOS clinics, representing 83% of the beneficiaries, while only 14% identified as Christian, and 3% did not disclose their religion.

Table 7 shows the immigration status of those benefitting directly and indirectly from the SOS clinics. The SOS team only started collecting statistics regarding immigration status in the year 2018 – 2019, showing that majority of clients supported were naturalized British, followed by citizens from the European Union. Clients with refugee and asylum seeker status were also equally proportionate in number.

Table 7. Immigration status

Immigration status – year 3	**Number**
Asylum seeker families	118
British	208
EEA (European Union) citizens	141
Refugee status	123
Unknown	24
Total	**614**

3.2 Project 2 – The Guardian Project (under 21s) (November 2016 –March 2019)

Data related to children and young girls referred to the Guardian project are presented in this section (see table 8). In total 218 children and young girls were referred to the project. The tables presented below highlight significant data relating to the referring districts, source of referrals, reasons for referrals, types of FGM the young girls encountered, identified FGM risks, country of origin, age, gender, religion and immigration status.

Table 8: Referring Districts to the Guardian Projects

Year 1 (17-18)		**Year 2 (18 – March 19)**	**Total Across 2 Years**	
Borough	**Number**		**Number**	**%**
Bury	8	4	12	5%
Bolton	8	8	16	7%
Manchester	39	77	116	53%
Oldham	3	7	10	5%
Rochdale	0	12	12	5%
Salford	11	19	30	14%
Stockport	2	2	4	2%
Tameside	5	1	6	3%
Trafford	7	3	10	5%
Wigan	0	1	1	1%
Total	**84**	**134**	**218**	**100%**

Manchester is the area in Greater Manchester with the highest number of young girls referred to the Guardian Project, representing 53% of those referred over the two years. Salford is where the second highest number of referrals came from. Both of these local authorities have shown an increased

number of referrals in the second year. Bolton had the third highest number of referrals, followed by Bury, Oldham, Rochdale and Trafford. In the remaining local authorities, a very low percentage of young females were referred to the project. Table 9 presents information relating to the source of referrals to the project. Please note, one referral may include more than one client, for example three members of a family would be included as one referral.

Table 9 Source of referrals

	YEAR 1		YEAR 2	
Referral Source	**No. of referrals**	**No. of clients referred** (including unborn babies)	**No. of Referrals**	**No. of clients referred** (including unborn babies)
Children's Social Services	**36**	56	31	47
Health	10	13	5	8
Police	3	4	1	2
School	0	0	1	2
SOS Clinic (Internal referral)	4	10	22	31
Third sector organisations	1	1	24	42
Other – (legal, adult SS	0	0	2	2
Total	***54**	****84**	***86**	****134**

Diagram 6: *Total number of referrals over two years: 140

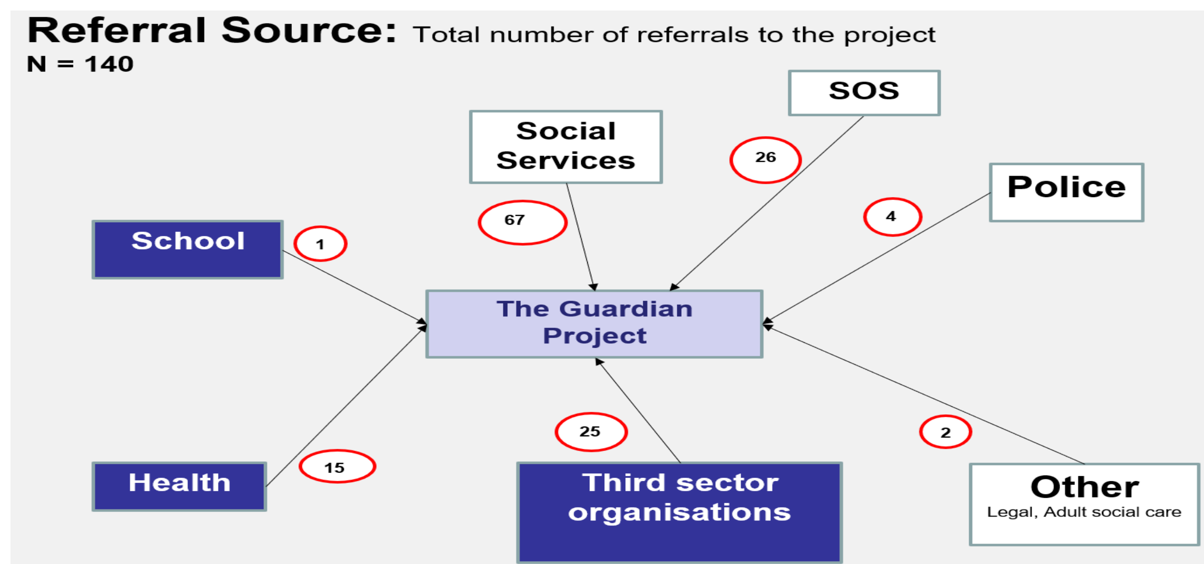


Diagram 7: Breakdown of Diagram 6 for Year 1

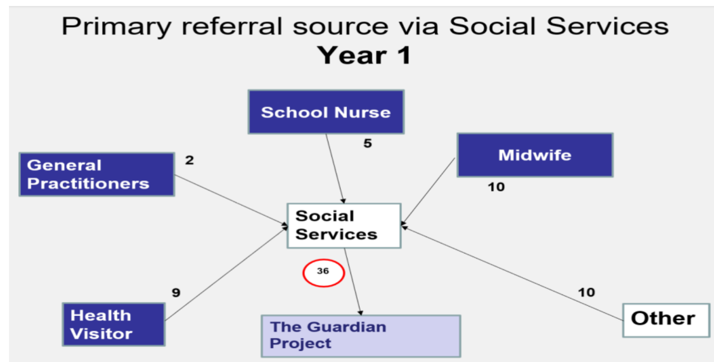


Diagram 8: Breakdown of Diagram 6 for Year 2

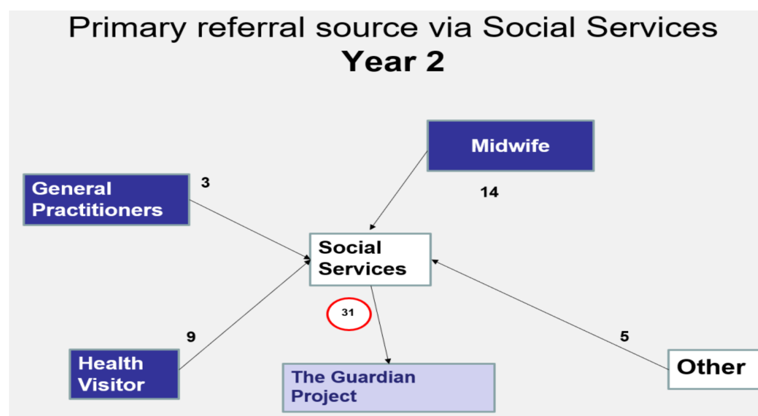
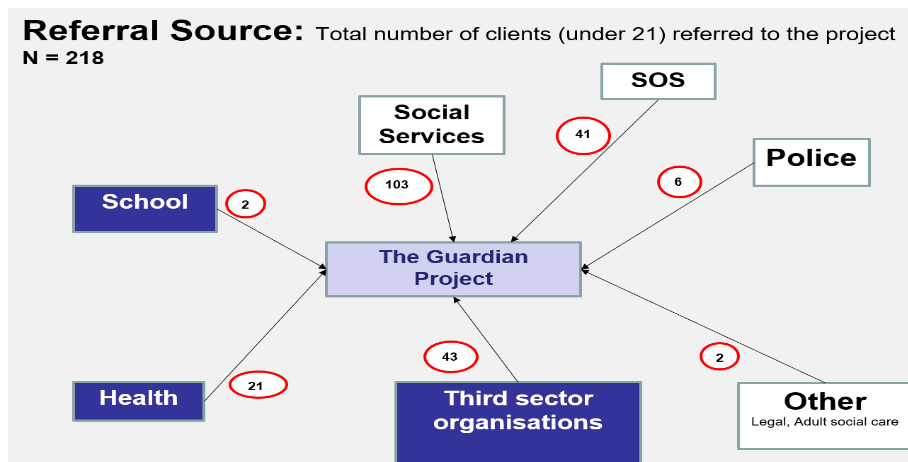


Diagram 9: Total number of clients referred over two years: 218 (Under 21)**



It is noted that the main source of referral is from Children's Social Services, followed by internal referrals via the SOS Clinics (adult service), third sector organisations across Greater Manchester and local health agencies. However, a breakdown of referrals received from the Children Social Services reveals that the primary source is mainly health agencies, as shown in Diagrams 7 and 8 above.

Reasons for referral

Safeguarding young girls at risk of FGM is the main reason for referral to the project, especially where work is conducted with mothers and young girls. This is followed by the provision of emotional support, particularly for young girls aged 7 to 21. Within the second year of the project there was almost a 5-fold increase in the demand for therapeutic work with those in the 7 – 21 age range. Other reasons for referral include preparation for FGM medical examination, with a noticeable decrease in the second year of the project, as well as working with fathers in the household. See Table 10.

Table 10. Reasons for Referral

Year 1

Reasons for referral	Number
Direct FGM safeguarding work with clients (under 6) and mother	66
Direct FGM/emotional support with client (7-21)	6
Other (as instructed by referrer) – (i.e. medical examination; working with fathers…)	12
Total	**84**

Year 2

Reasons for referral	Number
Direct FGM safeguarding work with clients (under 6) and mother	95
Direct FGM/emotional support with client (7-21)	28
Other (as instructed by referrer) – (i.e. medical examination; working with fathers…)	11
Total	**134**

Cases by type of FGM

It is clear from the findings that the highest number of clients (under 21) referred to the project are those at risk of FGM due to family history or disclosure. Most of those supported in this project underwent Type 1 FGM, followed by Type 4 (pricking), Type 2 and Type 3 respectively. Where FGM Type was recorded as unknown, the young women were uncertain of the Type they had been subjected to is identified in Table 11.

Table 11 Types of FGM

Year 1

FGM Type	Number
Type I	20
Type II	3
Type III	0
Type IV	8
Unknown	7
No FGM but at risk	46
Total	**84**

Year 2

FGM Type	Number
Type I	19
Type II	3
Type III	1
Type IV	3
Unknown	21
No FGM but at risk	87
Total	**134**

FGM support for identified cases at risk

The main risk identified through the project related to young girls (under 6 years of age). To reduce risk it was essential to work with mothers and older siblings who have already experienced FGM by providing emotional support and education. The second risk identified is the necessity to directly support young girls (7-21) at risk of FGM, followed by the need to provide emotional support to young girls who have experienced FGM. There was a number of ongoing cases who were at risk and where the need for support was identified (See Table 12 below).

Table 12 FGM support for identified cases at risk

Year 1

Risks Identified	**Number**
(0 – 6-year-old): Emotional support provided as Mum and/or siblings been through FGM	52
Medical Exam	1
((7-21): Support for young person at risk	6
(7-21): Support for young victims of FGM	25
Total	**84**

Year 2

Risks Identified	**Number**
(0 – 6-year-old): Emotional support provided as Mum and/or siblings been through FGM	32
Medical Exam	4
(7-21): Support for young person at risk	49
(7-21): Support for young victims of FGM	49
Total	**134**

Country of origin

Nigeria, Somalia, Sudan are the top three countries where clients referred to the project originate from. See table 13 for the list of clients' countries of origin over the last two years.

Table 13 Country of origin

Year 1

Country of origin	**Number**
Somalia	28
Nigeria	22
Sudan	4
Senegal	4
Yemen	4
Gambia	3
India	3
Guinea Bissau	3
Guinea	2
Ethiopia	2
Eritrea	2
Sao Tome	2
Sierra Leone	1
Guinea Conakry	1
Indonesia	2
Malaysia	1
Total: 16	**84**

Year 2

Country of origin	Number
Kurdish-Iraqi	5
Sudan	22
Somalia	19
Gambia	3
Nigeria	33
British /African (Country of origin not provided)	27
Indian/British Indian	4
Ethiopia	5
Kenya	4
Iran	3
Guinea	7
Liberia	2
Total: 12	**134**

Age, Gender, Religion and Immigration status

The most common age-range of young girls supported by the project is the under 5s, followed by those 6-12 years and 13-18 years respectively. Only two clients in the age-range of 19-21 were supported through the project. All individuals supported were female, with Islam being the main religion recorded. In the majority of cases those supported were children of asylum-seekers, followed by British Citizens, European Economic Area (EEA) Citizens and refugee children respectively. In the second year, the immigration status of four girls was recorded as unknown. (See Table 14).

Table 14 Age, Gender, Religion and Immigration status

Year 1

Age	**Number**
Under 5	35
6-12	30
13-18	19
19-21	0
Total	**84**
Gender	
Female	84
Male	0
Total	**84**
Religion	
Christianity	28
Islam	56
Other	0
Unknown	0
Total	**84**
Immigration status	
Asylum seeker families	19
British	23
EEA Citizens	18
Refugee status	24
Unknown	0
Total	**84**

Year 2

Age	**Number**
Under 5	64
6-12	47
13-18	21
19-21	2
Total	**134**
Gender	
Female	134
Male	0
Total	**134**
Religion	
Christianity	24
Islam	98
Other	0
Unknown	12
Total	**134**
Immigration status	
Asylum seeker families	61
British	34
EEA Citizens	11
Refugee status	24
Unknown	4
Total	**134**

3.3. Project 3 – Peer Mentoring Project

An average of 10 to 15 people per year was the target number to train as Wellbeing Peer Mentors, who would help sustain the SOS Clinics. However, an increase in the number of trained Peer Mentors was observed during the last two years (See Table 15).

Table 15 Wellbeing Peer Mentoring (2014 – 2019)

Wellbeing Peer Mentoring (2014 – 2019)	**Number**				
	Year 1 2014	**Year 2** 2015	**Year 3** 2016	**Year 4** 2017	**Year 5** 2018/19
Female Peer Mentors successfully completed the training	12	15	12	18	16
Male Peer Mentors successfully completed the training	0	0	3	2	4
Total number of Trained Peer Mentors	***12***	***15***	***15***	***20***	***20***
Female Peer Mentors actively involved with FGM cases	3	5	7	7	9
Male Peer Mentors actively involved with FGM cases	0	0	2	2	4
Total number of Active Peer Mentors	***3***	***5***	***9***	***9***	***13***
Ad hoc Peer Mentors involved with FGM cases	2	2	5	5	5
Peer Mentors empowered to further their education	2	2	4	7	6
Overall Total of Trained Peer Mentors (5 years)	**82 (9 male and 73 female)**				

This particular project was recognized for its excellence following a visit in October 2014 from the International Development Minister Lynne Featherstone at NESTAC: http://www.rochdaleonline.co.uk/news-features/2/news-headlines/91921/government-minister-lynne-featherstone-praises-female-genital-mutilation-charity-on-visit-to-rochdale

3.4. Project 4 – Community Health Advocacy – 'Aspire, Inspire'

This project aimed to train an average of 15 to 20 Health Advocates per year; however, the second year registered an increase in the number of participants. All participants were female.

Table 16 Community Health Advocacy Project (2017 – 2019)

Community Health Advocacy Project (2017 – 2019)	**Number**	
	Year 1 2017-2018	**Year 2** 2018-2019
Health Advocates (HA) successfully completed the training	20	25
Health Advocates (HA) actively involved in the community	17	21
Total number of Health Advocates (HA)	**20**	**25**
Overall Total (2 years)	**45**	

3.5. Project 5 – FGM Youth Advocacy (2010 – 2019)

On average each year15 young people have undertaken 3-days training. Between 2010 – 2019 a total of 102 young people (17 males and 85 females) have been trained as FGM youth advocates.

3.6. Project 6 – FGM Education

NESTAC work in schools across Greater Manchester (2015 – 2018)
Figures shown in this section reflect NESTAC's work in schools across Greater Manchester between 2015 and 2018.

- 490 teachers education re FGM through staff training
- 2,455 students received FGM awareness sessions
- 260 parents engaged through FGM outreach sessions
- 17 schools across Greater Manchester took part (most schools visited during the three consecutive years)

Training for professionals directly or indirectly involved with FGM (2015 – March 2019)
FGM training and presentations were delivered to professionals working across Greater Manchester, with a total of **2,574** professionals reached. A further breakdown is presented below.

2018 – March 2019:

- 45 FGM sessions delivered across Greater Manchester, reaching **875** professionals who received awareness sessions on FGM via trainings and workshops.
- 1 SOS (February 2019) event reached **175** professionals (multi-agency)

2017 – 2018:

- 41 FGM sessions delivered across Greater Manchester, reaching **711** professionals
- 1 SOS (February 2018) event reached **80** professionals (multi-agency)

2016 – 2017:
33 FGM sessions delivered across Greater Manchester, reaching **733** professionals

FGM training for community members (2015 – March 2019):

In the last 3 years a total of **2,437** community members were reached via outreach sessions, SOS events and community workshops delivered by Peer Mentors and Health Advocates.

2014: 2 publications on FGM and its psychological impacts:

- International Journal of Mental health Nursing (February 2014) – http://onlinelibrary.wiley.com/doi/10.1111/inm.12060/full

- Journal of Reproductive and Infant Psychology (October 2014) – http://dx.doi.org/10.1080/02646838.2014.949641

Section 4: Experiencing the FGM Counselling Service – Four vignettes

Please note for confidentiality purpose, pseudonyms have been used for each participant and the Mental Health Specialist who worked with them.

4.1: Maimouna's story

This is Maimouna's story, a lady who originates from the Gambia and came into contact with the counselling service through *Imani*'s involvement with 'Women Asylum Seekers Together', where she offers 1:1 counselling. Maimouna told of how she;

"Was having a lot of complication, a lot of menstruation, bleeding, and then I went to have an operation twice, but before that, I was a member and am still a member of Women Asylum Seeker together, so through my operation Imani was there helping, and then, when I came out, I lost a lot of blood, and then I started explaining to Imani, none of us knew, it's because of the FGM, I went through."

Maimouna goes on to explain;

"I went for this operation …. only a day operation, but I ended up being in the hospital for one month. They have to donate me with the blood and then I was having the operation and then the infection started …… so, through that investigation, the Doctor knew that it's because of the FGM I went through, that's why I've been having these complications…..but through Imani I get to know a lot of the FGM."

"Imani it helped me emotionally, but already, it can't replace what's have…what they've removed from me."

"Before [talking to *Imani*], *I was scared to discuss about FGM…. it's a taboo from the country I came, you don't have to discuss about it. Through counselling with Imani, I didn't know that they were playing with our minds, saying this is taboo this is, it's cultural, and everything, then talking through it helps me a lot. A very, very lot."*

Maimouna originates from Gambia, where she believes 99% of females experience FGM. She goes on to describe how the practice is tribal;

"My dad is a Wolof and my mum came from a strong individual who believes in FGM, called the Jola's, so, my dad didn't have… my dad didn't want us to do it, but, he didn't have upper hand on this, because of my mum, my aunt, some of my uncles, my gran, they're all Jola's, so they tell my mum like, you cannot destroy the culture, this is what it has to be."

Although Maimouna had been educated and described herself as the, "*sharpest among the family"* at around the age of 19, the participant was forced to marry a relative, but unable to stay in the marriage she decided to flee to the UK, where she continued her studies in [named university course].

For this participant the cultural nature of FGM reinforces its secrecy.

"It's a shame, even no one tell you not to talk about it, but you can't talk about it, I mean who you going to tell, this is where they cut? I mean all the girls are similar, we're all just similar, we all went through the same thing, so none of them dare to say."

Perhaps it was the secrecy surrounding the FGM that attracted feelings of shame. The participant stated,

"Since I was a child no one's seen my private parts, when I had it done until when I got married, I was even ashamed of myself, for my husband to see me and for the way they tighten it …. men are men, you would still be their wife, or they will go outside and satisfy themselves."

This appears to be a catch 22, having been exposed to FGM as a child and not being able to share the trauma, made her feel shameful, questioning what she looked like in terms of her vagina and the pain experienced when embarking on a sexual relationship. However, there was also an expectation of her engaging in sex with her husband or risk being further humiliated if he sought a sexual relationship elsewhere.

Being able to talk about the FGM seemed pivotal in this women's healing process.

"It was a bit of challenging, seeing her [*Imani] and then talking… She helps me to understand more. Back home and here is different, you are free to talk about it, we're here to help you and we're here to listen to you. So, obviously don't think like you are back home, not to share what you've been through. So, seeing Imani, it makes me another person, in life. I can stand up in front of so many people and talk about FGM."* She goes on to state *"it gave me confidence, but to myself, the life I missed since I was ten."*

Maimouna went on to explain why, in her culture, FGM is a continuing threat.

"But it's not done, finished, back home….. if I go back home, I'm young, I'm 40, next year…. I wouldn't be able to get any man or to get married [to someone] *at my age, it would be the older one, and that one wouldn't be my choice even, it would be their choice. And before getting into that marriage, because of my mum's side, the Jola tribe, they need to re-do me again. Yeah, so my mum's tribe, they have it done twice."*

An outcome of her relationship with *Imani* has resulted in her own volunteering.

"But talking it through with Imani, really, because I was having one to one with her for like six weeks, so from there, I go with her to the schools, here we do the campaigning, and I do other volunteering, to other organisation as well."

Being able to engage in voluntary work has increased her confidence.

"That confidence is in me now. … Imani's one to one thingy, it gives me the confidence. We went to the University in Manchester. I'm not going to stop. So, many girls, people don't know, they are not aware, awareness is very, very good, because, I heard they even smuggle children from here to other places, back home to do them. So, many girls can be covered not to go through, what we went through."

Maimouna found coming to '*a foreign country hard'.* Originally, she was invited to England by a female '*classmate*', a '*friend*', but one who she chose not to tell about her forced marriage and fleeing to get away from her husband. However, her friend contacted people from their home and discovered what had happened and '*kicked* [her] *out of the house. '* This undermined her confidence and made her question who she could trust.

Maimouna talked about furthering a sense of community. She was clear that this did not refer to her working in what might be termed her own community, but rather '*communities*'. Such communities included schools, drop-ins, fund raising, giving talks at local venues, libraries, and talking to the masses, black and white people alike, and including those who belong to practising FGM communities. She sees this is a way of '*building a community'* so '*people can know'*.

For her future, although still having asylum status, she would like to do more work around FGM, but is reluctant due to her precarious status.

"*Even now I can do some campaigning with Imani, but I have to hide my identity, because, I don't want to be handed back, even though I'm here, social media is everywhere, people will be reading, people will be seeing. I've already had the danger in me, which lives with me still now, so, I wouldn't want another danger to be on top of me. But, if my status is clear and everything, why not* **[**work closer with *Imani*]?"

For Maimouna, growing up in a culture where there is a strong belief of FGM being a necessity for girls, that same culture prohibited her from speaking about the traumatic experience she had been subjected to. In addition, she was forced into a marriage she did not want, in part due to the shame of her FGM, and 'escaped' to the UK to achieve respite. Maimouna is also aware that if she returns to the Gambia, she faces the threat of further FGM and another forced marriage to an older man. In her healing process being free to talk about her FGM has been pivotal. Having had this positive experience, she now feels she is able to live a life that has not previously been accessible to her since the age of 10 years old. Her positive experience of the counselling service had led to her altruism, whereby she is now committed to helping others from practising communities in a variety of ways to ease the burden of FGM.

4.2: Amina's story

This second vignette relates to Amina, who originates from Sierra Leone, and who starts her story by explaining how FGM is inbred within the culture.

The secret society

"FGM's a secret society, sometimes people don't want to talk about it"

"I'm a victim of FGM, we don't know the signs, you don't know the reasons, these signs are, something else, if your grandparents do something to do and you think this is good for you and everybody does, you think it's good."

"I was really pro FGM, because this is my culture and my religion"

The above statements demonstrate the strength of the cultural beliefs relating to FGM.

"I had an argument with Imani that what you're saying is not true, I don't believe you because this is my culture and I've done it since I was five and all my family and friends, they did it and there's no problem."

"we don't talk about it …because I was told if you talk about it you're going to die, or you're going to have a bad luck forever, you can't sing the songs, because it's a very spiritual moment, it's a beautiful moment, but you don't feel that build up because you're in pain."

Migrating from one culture to another and being challenged over the legitimacy of FGM initially invoked resistance towards her 'new' culture, but after acquiring further knowledge (theoretical, tacit and experience knowledge) she has moved to a position of being 'brain washed'.

"So, it's psychologically it's, they, brain wash me and then now I realise that I've been brain washed and I can't enjoy my sex life"

"*My grandma yeah because they did it to me [laughter]…..wow, why would my grandma do that? …..If they loved me, how can she do that, but then it takes me my whole life to know all these things."*

Amina goes on to talk about how FGM has affected her sexual wellbeing

"I didn't know it was from the FGM, for me, I thought it was a normal woman thing, like, having a very, very painful period and sexual, having pain whilst you…did all that stuff. And sometimes, looking down there and thinking why is people different? That can be an emotional thing, but you just don't know why. I'm just thinking maybe it's a women thing, all women have pain when they have sex, that's not normal."

"I start talking to people who haven't had it, and then my friends haven't, they don't have it, they don't have that problem, but every friend that has been going, has gone through FGM, from one to three [types] *they have got problems. So, that used to upset me."*

"I've been going out with this guy for nine months which is very weird, and then I explain to him and he understands, because we came from the same culture."

The above statements are indicative of the improvement she has made in being able to talk about how FGM has impacted her sex life, but also him coming from the same culture he is aware of sexual intercourse being painful for women from that culture.

When asked about what accessing counselling has meant for her, Amina responded with the following;

"It feels relief, right now I feel relief, I'm talking about it [FGM]*."*

"Imani actually helped me a lot to come out of it, to say look you are beautiful …….. I was actually angry with my grandma [laughter], ……… why did they do this to me? And then now, I'm getting better and Imani, you know talking to me, telling don't worry you'll find a husband who really will take it easy with you. So, because of that, I can get positive about my campaign, but I'm also happy that I've been talking to Imani for almost two years. I've seen Imani for a long time, since that time, yeah, I'm not

kidding, I'm feeling better, much better in most of the ways….telling her all this thing that I've never told anyone."

"I feel like there's something wrong when I'm having a new relationship, ……. I feel very uncomfortable, this thing made me so unconfident, when it **[man's penis]** *comes there.* **…..** *So, I'm always talking, I have to call Imani and say why, Imani always says calm down, do this, do this, you'll be alright yeah."*

The above statements are testament to cultural counselling in as much as being able to empathise with a client's situation, being accepting of what is being told, remaining supportive and facilitating the development of a more positive differing insight.

"I learn so many things, and then from there, I became depressed, …you learn you should be happy, but then, I became depressed because yeah, I thought this is not a good thing that they did to me, so from that depression. Imani bring me out of that depression to have a passion to go around…this is because of what they did, I don't want it to happen to anybody else, not children that I'm going to have, if I'm going to have any."

For Amina, having counselling that was culturally sensitive appeared to have led to a position of altruism;

"To tell the story and I hope I can empower most women. …. I see women who know exactly what happened to them and they know all the side effect, you don't even have to tell them, but they can't talk about it."

"So, if we can get those women to talk about it and empower them, and then it will make them happy, ……… we will all start working together. I don't know 100 years, 200 years down the line, FGM will be no more, yeah. Thank you [laughter]."

"I would love to you know work with women in FGM.…… I would love to help, as much women as possible, if I can counsel any women… if I can give them confidence and …. understanding about, you know it's not their fault and it's not supposed to happen to them, …if I could help people like that, even one. If I can counsel one person and then that person gets better and becomes happy, like me…. happiness. **[*laughter*]."**

"If we have more places like Next Steps [NESTAC]*, more awareness, more empowerment, more women learning, more people like me, who think that they can't talk about it."*

"But we need more funding, we need to reach more women, especially in Manchester, yeah, we need to reach more."

When talking about addressing the problem of FGM in her own country of origin Amina talks of some of the challenges involved, not least and the multiple ethnicities who pass through Sierra Leone.

"It's hard to get through to them because most of them do not speak English, …if we have more funding and more ways of empowering women, we can go and empower most of those women. …… make them aware and before you know, we don't have to…rather than spending a little and not getting anywhere, it's good to spend what you can and then to get to as many women as you can and then

before you know it, 100 years' time, FGM will be abolished. But we can't just tell people that FGM is illegal, if we don't have them, we don't tell them why and we don't educate them, they don't know the side effects, so they'll be like, oh yeah, alright and they won't do anything about it."

The need to explain rather than threaten (the illegality of FGM) is an insightful observation. However, in the next quotation Amina talks of the appropriateness of using a legal framework in certain situations, in particular within the migrant population in the UK.

"Well, sometimes we have to tell them it's illegal for them to listen, because African people don't like to have problem with the police."

Towards the end of the interview we returned to her own life and the impact counselling has had on this.

"I know how to have sex and I can actually try and talk to the man and tell them. You know, before I wouldn't be, I would be like this is normal, but I would get angry you [the man] *were actually punishing me [laughter]. I have reason, to be thinking this man is always hurting me. They're not hurting me, it's me being sensitive there."*

"It's [FGM] *already in me, so I have to try to make it better, and that's what I do now. …… I know that I will definitely get a man one day because now I know how to go around and, and I can have…I'm not going to enjoy sex, but I can let the man, enjoy it yeah."*

In the next statement there seems to be an element of blame, in terms of both taking on and dispensing with the blame.

"I know now it's me, it's my fault so, if you know something is…just it's not my fault. What I mean is the pain is in me, not them doing anything bad."

"I don't want to hate my grandma anymore, because thousands of people…after seeing what other people have gone through. Mine is like, just tip of the ice block."

And Amina's final word;

"I know what happen yeah, and I know that it's not my fault and I know that it happens to loads of people, and I know that I can make it, control it and can make it better, at least with me. So, it's up to me how I deal with it, so I decide to deal with it happily and forget about all that and help all the other women."

Amina's story is akin to four of the five stages of grief; disbelief, anger, depression and acceptance. Not being allowed to talk about FGM within her own culture meant she was ignorant of the implications of the practice, blaming herself for some of the difficulties she encountered during her life. After migrating to the UK and having opportunity to talk about it and being challenged, she was initially defensive, but as she gained insight into the wider implications of FGM she started to question the morality of FGM. However, moving away from ingrained cultural beliefs was not a simple journey, but one that brought bouts of depression and the questioning of self. Being supported on this emotional journey provided the necessary time for her to process all this information and find a way

of moving forward that would enhance her life. This appears to have been achieved, partly through her acceptance of self and partly through her altruism in working with migrant women in the UK and for women in Sierra Leone.

4.3: Serena's story

Serena originated from Nigeria and has not returned to her country of origin since moving to the UK as she remains fearful of going back for her own safety and that of her children. When discovering she was pregnant with her daughter, she Serena started to worry about what would happen to her female child.

Remembering the past, fearing the future.

"Actually it was about my daughter that I have…. I thought they are going to do the same as when I went, I was really scared. I was really worried about her, it was bad, I don't know what happened to me, because I can't remember when they did everything to me, you know that fear was just coming to me."

Along with her pregnancy and knowing she was having a baby girl, memories of her own FGM experience were reignited. Serena reiterates her fear several times and when doing so it is palpable during the interview.

"When I was pregnant with her, when I found out I was having a baby girl that is when I felt worried that if they are going to – you know, what am I going to do? I don't want my daughter to have the same, but then I remember my midwife, I talked to her, you know, she said…… she didn't really know what to do…"

This was obviously a very worrying time for this lady, but Serena did find some hope when telling the midwife. During this period of time she turns to her midwife for help and support, but the midwife is at a loss as to what she can do. Serena also talks to her friend, as she also has a daughter, and it is her who tells her of the work *Imani* is doing with women who have experienced FGM.

"I talked to my friend, because my friend has a baby girl, she was naturally like oh this lady help me, she was the one, she has helped me, and now with her daughter. She just give me Imani's number, but I don't know if she [*Imani*] *was going to be there for me."*

Serena is unsure if she will be able to access counselling/support and she did have to wait approximately two months before she could actually get an appointment with Imani.

"Because she is really busy, you know, she is so busy because sometimes when I call, when I go there, calling, calling, she say xxxx I will call you back, because she is so busy, I don't think she has any extra time, you know. That is why I just have to share – I think it does feel like that – it was two months before she booked an appointment for me, because there was a lot of people, a lot of clients was with her, before I get to my time."

After waiting approximately two months, the sessions Serena was offered were limited in number. However, *Imani* was able to extend the boundaries of help. This appeared to act as a safety net for her;

"I had the six sessions. The most helpful thing? Oh my God, I think it's a lot. You know, because she helped me with the idea, because I was going through different things, they could not help me [local midwife]*, but when I went to Imani, yes, she helped me with everything. She sent me to* [name] *Hospital, yes, they really helped me there."*

"She [*Imani*] *will call me, even if I didn't book before, maybe like one week she didn't hear from me, she had to call me and check on me… [name] are you okay? Yes, she was really checking on me, she did not leave me you know."*

'*Checking on her*' was interpreted as a positive behaviour that *Imani* exhibited. The participant indicated she experienced it as a caring behaviour, *Imani* was interested in how she was and reinforced she was still there for her regardless of whether they have met face to face or not.

"I spoke to her for – I think it was a lot. When I am down, I was just going to say Imani, I don't feel like, you know, just for me to speak with her… yes, she would just book an appointment for me, she was okay with doing that…. it was a long time [receiving support from *Imani*]*, so yes….more than a year."*

"She really helped me a lot, because before I went to her, I was really down with everything."

Serena was keen to see the service extended.

"I would like to still be friends [with *Imani*], *as I said before, I told you she is very busy. She needs to get a lot of support you know, support so you don't have to be in the queue for long time, I think that would be very brilliant, yes, that would be good. Because I was worrying, are they going to get to my case because I can remember…. Imani, please, I want to speak to you. So, when I saw Imani I know,* she said '*don't worry, you will see me but there is a lot of people before you.' I wish she had maybe a lot of assistants or help, then everything will just be going good."*

Knowing help is available brought Serena a sense of relief but having then to wait perhaps initiated a new fear, that of being seen and heard, of being given the opportunity to talk about the things she had never before found the courage to say out loud. When asked about those providing help and what characteristics and skills she thought they might need, Serena said;

"I think you might have to talk to anybody, because like now, maybe talking to you like now, maybe…. maybe if I talk to you, look at what I have done, this is what I think. I want to be happy but you will say oh, you have to do that, you know, I think everybody can find maybe someone who has understanding of it [FGM] *and how bad it is*."

Serena's final thoughts about the counselling were;

"[The counselling] *it was really good, I said that the service was really good, because when I went to her* [*Imani*]*, just to put my mind to her*, *this is what I am feeling, she said to me [name], we are just here, tell me what you feel, what you are experiencing, everything…….. you feel good, it really help me a lot……. just speaking about it* [FGM]*."*

Serena's story is one of trauma, her own experience of FGM being reignited at a time in her life when she might expect to be happy, being pregnant with her daughter. These conflicted feelings compromise her mental health, she feels "*really down with everything."* While she finds the courage to speak to a professional about her concerns, this person is not able to help. She then speaks to a

friend who also has a daughter and it is at this point she given details of the counselling service NESTAC is providing. After what she perceives to be a long wait, she is finally able to access appropriate culturally sensitive counselling that is flexible enough to meet her needs. For Serena, being able to speak about her FGM and be listened too is a relief.

4. 4: Sasha's story

Sasha originally comes from the Sudan and had some difficulty expressing herself in English. She was very nervous when being interviewed and her husband was present and supportive during the interview, at times helping to interpret what she had difficulty expressing.

Getting help for trauma

Sasha was in hospital when she first accessed support, meeting the counsellor face to face and then accessing support by telephone. Sasha stated;

"Before talk to Imani, this thing not good, all times…. Crying…. and being crying for anything for all times. After seeing Imani, because crying – feeling crying all time…. and I follow Imani [advice]**,** *information about this* [FGM] *and how to talk with my family and my culture* [community]. *I feel happy."*

"When I made the first time, when I went there, I was a bit conscious to speak about my experience, Imani assured me that everything is confidential and this is a service that we provide and you are not the only woman whose culture is like this and you can feel free to talk. And then after I start to speak loudly about my trauma and the horrible days, they have done this to me, and how I was feeling. Mentally I was tortured and I faced difficulties mentally, and physically when I am passing [my] *period, is very hard for me and I know that is because of the FGM and the sexual intercourse was very hard, especially the first time, it was very hard for me. This makes me have a trauma and mentally I start to hate this."*

"Before I met Imani, before I met the organisation, I was feeling humiliated and I was not feeling good, mentally was sad. When I met her, she said there is another woman going through this experience and this is not only you and I started to change my mind and I started to accept my situation and I started to cope with it and I start to move forward, to prevent these horrible things to be repeated again."

Railing against the culture

Sasha explained to me how she was trying to educate her community in the Sudan about the unacceptability of FGM; *"me tell the community in Sudan and* [Sudanese] *community here, FGM is bad….and not kind for woman."* She goes on to stress how her communities, both here in the UK and in the Sudan believe;" it's *FGM…. it's not bad for woman."*

Sasha talked of;

"For me and my culture and my community, all time speak to me, this is good, not good……… And they, all of them, all time, say it is not good for this [support for FGM] *psychologists, is bad.* [In her community] *all females not good in reading…. in university, sometimes…. not good* [for them to be educated]*."*

The above statements give a context to the lives of women living in the Sudan. For Sasha, spreading the word and protecting the innocent are important facets of her life. She told me of how she used what she learnt during her counselling to inform her friend about the implications of FGM, and how together they embarked on trying to educate their community.

"All time information and how to do this service in culture, in community, is very nice for me and my friend…… I can understand this ……. tell my friend this habit is not good and after long time, this woman [friend] *is not good and pregnant... it is hard and sex is hard and like all the time tell my friend and community this habit is not good. I make slide for community, take out this* [FGM]*, not good."*

Sasha goes on the talk about the concern she has for her daughter;

"Talk to my daughter about this, this not good…. me – I am suffering for this. But I am not – I don't want you, my daughter….it's not good, all the time is not good, in culture, habit is not good, but for me it is education. It is – not to pass to my daughters – I don't want someone to suffer like me. I know how bad it is and how I feel and I don't want to repeat this trauma again through my kids."

Sasha then talks of how she is trying to educate women in her community and the challenges that she encounters;

"Sometimes woman in community, old woman, are not seeing this. Yes. But me and my friend, all the time repeat this habit is not good, this habit is not good, all the time. All the time we sat with women, three, four, and explain, sometimes they are not sure and it is not good. Sometime they listen, sometime no listening."

"All the time me and my friend is same age go out like this, repeating, repeating, repeating, and tell the small girls, 13, the consequence at the end. We are trying really, and we are trying to communicate the information that we have got to our communities. And sometimes the older women in the community say to us don't listen… but we trying to emphasise by repeating and repeating also, because we do believe this is the only way for us and for our kids, to relieve them from this bad trauma and we believe that this was wrong and we don't want it to be repeated and we don't want to do this [FGM]*."*

Sasha tries to explain the role older women have within the Sudanese culture and why her and her friend are working hard to change the practice of FGM within the culture, after they have received support and training from NESTAC.

"The old woman, because you know that sometimes they do have influence on their daughters, so we are trying to show our ideas using all the brochures and information that we get from NESTAC, information on how to advise a community, because NESTAC trained us… this [FGM] *is not good, and I am being driven from self-experience I have suffered. I was mentally tortured by this because this is very, very bad practice and I went through the consequence of this. So I realise this is a horrible experience and by any means I don't want this experience to be repeated again to the next generation, I am not going to have this happen to them. You can do this from the old women, because you know the old women sometimes they do have influence on their daughter, who are trying to save these ideas. Happily the women in my area, they were convinced this is a bad experience. But using all the information that we get from NESTAC… brochures and the sessions, trying to give evidence and not listening to what the old women that are saying."*

"I build up – start to organise sessions in my community…… [I talk about] *how horrible this is and how to cope with it…. sometimes women, they have been in danger, and even their child will be in danger, because the FGM and the period* [menstruation] *is horrible because of the FGM and they will be unhealthy, because of the FGM. And the only way out of this is to stop this. We* [participant and friend] *have organised lots of sessions within the community, using that – I am finding that this organisation help me and because when I get help, I pass this help on. We explain how it effects the women, she is not feeling anything while she is having this* [sexual intercourse], *they took all of her pride and it is not fair, someone to decide on your behalf …"*

Connecting the pieces

In the closing minutes of the interview Sasha was able to bring together her own experience of receiving counselling and how this had impacted her current commitment to eradicate the practice of FGM from the Sudanese community.

[Spoken by translator] *"I saw Imani, first time, when she said to me others have been through this, this developed the courage for me to speak loud. I was fully aware, through my personal experience, this* [FGM] *was not good practice, because I witness that in myself and through the pain that I have been through, through the risk I have been through while I am giving birth, through the hard time in my life, through the many, many times of the period that I get the pain before the period that I have been through. I knew there was something wrong and there was something wrong in this practice, and I realise this is a wrong practice, but after seeing one expert, I know how others, especially me, how I am feeling, because when I saw Imani she felt what I have been through, she knew what I have been through. That is why I felt very confident and she said to me this is a confidential service and I am here to help you out and I am here to link you with others that have been through this and you have help sessions and you are not the only one who has been through this."*

"All of this, mentally, gives me courage to speak loudly and to stand against this practice and to pass information, because it is unfair for me to get such wonderful service and not pass it to others. So I was keen to get my community benefiting, so I have introduced this service to my communities and we have run a session in our community house and we invite daughters, religious people, people from communities, all peoples from communities that do still believe this is good practice. And we brought all the information that you got from NESTAC to defeat what they are saying, because the religious people, we defeated, this is not a religious thing, I think that the religion is not asking for a woman to suffer. From the doctor, we provide all the things that defeat the myths that is saying that the area can grow like a penis and a woman will smell bad and the doctor defeats this, because this has nothing to do with FGM, it is a personal hygiene. If you take care of it, everything will be okay and I am happy, because I get relief from the women, the pain that I was in, and I am now happy because I pass this [information] *on. Sometimes you get resistance from the old women, but from this session, and we are planning to have another session, and as much as we can we raise awareness and I know and I believe that we are going to defeat it…. because this is the right thing."*

[Spoken by translator] *"Yes I am feeling confident and I am very, very happy and I am counting myself one of the happiest people, that I have come across this service, because it convince me that I am not alone and I am not suffering alone and it gives me the opportunity to speak loud and to get my courage, it gives me the chance to go and help others. I know I have been through a bad experience and I can do nothing for that, physically, to reverse it. But mentally I am happy that I have been given this*

opportunity to stop these habits, this makes me more happy because I am helping communities and I am helping people and I am raising awareness and all of this. It gives me the courage to stand and speak loudly and for the community and for my kids, so it gives me the chance and it is nothing to be ashamed about, because this is not me. I have been through this because of others. But now I am changing that I am happy. I am feeling very strong to speak about it, and what makes me the best is that some old women, they start to change their mind now."

While language was problematic, it was clear for Sasha the experience of FGM was traumatic, at time she described it as being '*tortured'*. She talked of the trauma being both physical and mental, the former often being related to menstruation and painful sexual intercourse, the latter being associated with her mental health, particularly feelings of sadness. Similar to the previous participant, Sasha was also committed to ensuring her daughters were not exposed to the same trauma she had experienced. A pivotal turning point for Sasha was meeting Imani and being made aware of the service NESTAC provide. In particular it was the realisation that she was not the only woman and others had also experienced FGM and that the service was confidential that appeared to be most meaningful. This learning appeared to boost her confidence and Sasha became highly motivated to change the practice of FGM within the Sudanese community, both in the UK and the Sudan. She believes a particular challenge is the elder women within the community as they are can be influential over their daughters and ant to maintain the practice. Again there is an indication of altruism in wanting to improve the lives of Sudanese women and Sasha is trying to do this by mobilising resources with a friend and providing educational sessions where FGM myths can be challenged.

4.5 Summary

The four participants were from four different African countries; Gambia, Nigeria, Sudan and Sierra Leone. In each of these countries the practice of FGM is embedded in the culture, but it is also something that is not spoken about. The secrecy surrounding FGM may perpetuate the practice, as women are unable to share their traumatic experiences of not only being circumcised, but also about its wider implications; painful periods, sexual intercourse being hurtful rather than pleasurable and fear for their daughters. For each of the women, being given the opportunity to talk about their experiences of FGM appeared to be pivotal to their healing process. In providing a platform for the culturally sensitive counselling delivered by NESTAC, the women found the courage and confidence to talk about their problems and were motivated to help others. All four women presented an altruistic attitude towards raising awareness, challenging an eradicating FGM.

Section 5: Peer Mentors – The Men's Story

Two male peer mentors came forward to talk about their experiences of what could, at a superficial level, be construed as a 'female orientated' project. The men were interviewed separately. For confidentiality purpose, pseudonyms have again been used for each of the participants; Omar and Ibrahim, and five themes emerging from their individual stories are merged within this section. The themes are: (1) Out of the ashes the phoenix rises, (2) Moving through a process of education, (3) Reflecting on self as a man, (4) Taking on a meaningful role, Facing the challenges, reaping the benefits, (5) Where next? Looking to the future.

5.1: Out of the ashes the phoenix rises

When asked what motivated him to undertake the training when he had already been working on the FGM initiative, Omar stated;

"Because firstly when we start, I guess trying to campaign against FGM, I used to be one of the person in the FGM mentor online, FGM online, FGM men forum, because we was trying to reach a lot of people, talking about FGM, trying to know what people think about FGM and the aim was to be able to get more information to be able to stop the issue or to discuss about FGM. But the thing is we tried but it didn't work, because most of the people didn't want to discuss it [FGM] *online, you know."* (P1)

Omar goes on to explain;

"It was just men. So it was like people didn't want to talk about it, some people were saying it's natural, why you guys want to talk about it and it's concerning our culture, and trying to challenge our culture. So you know people's thinking it was kind of – how to say – exaggeration – like we have – you want to deny your own culture. So it started, but it didn't really work, it wasn't really what I was looking for, so this is why when the SOS project started." (Omar)

Ibrahim also spoke of the cultural difficulties in talking about FGM;

"Because you know it's slow. From all cultures to speak about such issues with the woman it's a bit ashamed…….. you can't talk about it because it involves lots of, it's kind of offensive to talk about it [FGM] with the woman, but you can talk with the man because you can talk one language with the man." [Ibrahim]

Ibrahim goes on to explain where the need for male mentors came from;

"It [SOS] *started towards more woman,* [providing] *emotional support. And then at one point, because of the culture, men were trying to challenge our support workers….. it was like difficult for our females to be a mentor, for our support workers to go and starting to educate the men because of the culture, they didn't want to get any advice or information from a woman. This is when we start thinking about men being mentors. And then after that, because I was really keen for everything FGM and this opened all my mind. I knew a lot of things about FGM, but getting the course, giving me more idea of how we work with not only men, but even woman."* [Ibrahim]

5.2: Moving through a process of education

"The course firstly gave me a large vision of FGM and why FGM….. and talking about the emotional impact of the FGM on the woman and because when we took the course, it was men and women on the same [course] *…. I could hear women talking about FGM, talking about impact on their health and then trying to – even some women when they were talking about it and crying. This I say okay, there is lot of things to challenge there. So its impact, it's being like something people – even in a relationship, they couldn't even talk about it. So the woman are suffering by themselves and the men, they say okay, I feel a bit like guilty."* [Omar]

"During the course we had some kind of case studies, was trying to do some practice as a whole group, giving some kind of case link. It was really important. I could see our professional work, as a counsellor, and then the impact of the legislation, because what we see now, like it or not, there is a legislation, you need to respect it otherwise you get – I think it's opened my mind, really made a difference." [Omar]

"The course in January was a very nice course. It adds to me a new experience and it gives me the tools where I can use it to convince others because for me I totally understand this is a wrong practice. But to convince others you need some sort of tools. You need information, awareness, how to talk to people about what's going on, how to tackle the issues and how to sell your idea. And the course is fine but it's ….. but I believe the experience and the feedback of experience and if there is any chance for these courses to be running regularly you add experience. Now from the practice I can add to the others by telling my experience." (Ibrahim)

"I've started to experience.. demonstrate what I've been learning to practice and participating with many visits. And I've supported many families and……. I've been busy in the team to tackle some issues as well since we've got about six or seven families that we've helped." (Ibrahim)

5.3: Reflecting on self as a man

Both Omar and Ibrahim reflected on themselves as men and how engaging with the project had impacted upon them.

"So as a man, it is like we are in a relationship with someone, she's suffering and I don't care about it, I am just looking for my own interest… it needs to get men to be involved in that case. To get men to understand how a woman is suffering… – and this is part of my job, because I am also a community worker." [Omar]

"What has driven me is a personal experience. Because a man who is married to a woman that went through FGM, and I know how it feels. I was… I can't say I was in pain like her, but when you are in someone who is in pain, somehow this will affect you …… I don't know how she was suffering in the period of time, I know how she was suffering when she was giving birth. I know how she was feeling about that she can lose her child, which is my child as well. And on top of all of that it's the sexual intercourse …… It is very hard, for me as a man. Because when you are doing, have sex with a woman you can't give her the pleasure, the full pleasure. This is affecting me as a man ……… When the other partner is not feeling just like I'm feeling, it makes you…I can't explain how bad you feel like that. And it's, that's why I was eager to get involved in such issues. Again, I've got kids and I can't by any means

imagine that my kids can go through that experience. So I'm pleased that they will not go through that experience, then I decided to help others not to go through this." (Ibrahim)

"It's not only this. It's not only these issues. Because you know it's all about mental things. How mental torture, how they feel, it's a mental torture when you do this for a woman. It's against humanity. It's against humanity when you do that for a child, she don't know her rights at that time. She's so young. You go and you decide a decision that will turn her life into a nightmare. This is for me is totally unacceptable." (Ibrahim)

5.4: Taking on a meaningful role

"It's working, because I have been involved in more than four cases now and I can confirm that in all the cases, I felt the husband, at the first appointment, believed that FGM is a good thing, its our culture. I don't want anybody coming here and telling my wife this and this. But at the end of the session, we could see that he changed his mind and then he start even campaigning. There were some cases when you go there, already the husband say okay, me I am against FGM, but I didn't know exactly the consequence. But now I know, because they really don't talk about it. It is like something happen when she was younger, after that it's just let's leave it like that. And now, when you start giving some information, try to explain to them what is FGM, what is the issue, how it happens, the reason for FGM, we say it is not religion, it is not this, not spiritual. So there is a lot of information people don't know. I guess it's at the end we talk about legislation, we say to them okay, you know legislation in this country is like that, so you can't do that. So we are just trying not only to educate you about FGM, but we don't want you to be a victim of the law." (Omar)

"So this is the position, you know a families background, the man has the influence to direct this from me and for me I've tried to set the idea that if you convince the man then that means you convince all the family. Sorry to say that, but that's how it works back home. I know my community. I know it's a one man show which is not the ideal situation. I'm not agreeing with that, me personally, my family are not doing that. But I know how it works. So if you can convince the man that means you are almost 80% you've done your mission." (Ibrahim)

"Even sometimes you are involving some Imams from religious background to come in and speak in sessions you know? This is not what Islam is calling. Islam is not for torturing people, Islam is a peaceful religion. It's [FGM] *not good. Islam encourages us to respect a woman."* (Ibrahim)

The above describes the participants' role in educating men about FGM and its implications in terms of relationships. While Ibrahim relies on his cultural background and his position in his community to educate men, at times he invites an Imam to come along and speak to the men and reinforce FGM is not a religious requirement. Omar chooses to uses the law and the unacceptability of FGM to challenge thinking. Omar also presents himself as an ally, a buffer between professionals and the family from a practising culture;

"You know, we are working with professional like social workers, police and then health professionals. As a professional, their first aim is to protect children and you need to know exactly what they want and why they are doing it. And then we try to do it in the community, so try to get time [to speak with the professionals] *to explain* [the situation]*, because the police or this professional they come every*

day to see you and it is because they have a lot of cases and a lot of problems to deal with. So we just help them, advise them, and to give them some counselling about the FGM. It is bits like that." (Omar)

5.5: Facing the challenges, reaping the benefits

"I used to think before culture is culture, so because it's a culture, we couldn't think about going out of the culture. But now there is ….. something in the culture, it can be changed; because if it hurts, if it's not good, we need to change the culture. I start on that, telling people about the way people in that culture are treating children. Or when you start explaining to them now if it is a part of their culture, it is bad. The majority of people they change and people understand everything, it is changing, you know. It has opened my mind and this kind of thing, mentoring. And we see the impact of the local discussion." (Omar)

"Sometimes the communication ……. some families are shy to talk about it. It involves things that we've been taught back home is not allowed to speak loud about. He [the man] don't want to discuss this in front of his wife in my presence as a man you know....that's why when me and… sometimes me and social officers we go and visit families and try to sell the idea that you [female social worker] can stay with the woman and I can stay with the man outside. So this is one of the challenges." (Ibrahim)

"Sometimes you face some challenges and the most challenge is the religious background. When in sessions I say nothing in the Koran is telling us to…in fact the Koran is berating us for doing stuff like this because this harms humans the Koran is protecting. This is the main rule. Anything that is harming people, the Koran is not agreeing with…. because Koran is to make people's life easier and peaceful. There is nothing, no phrase, no anything saying that you have to go for FGM. It's a myth." (Ibrahim)

Ibrahim goes on to talk about people living in LMIC where FGM is practised and how, regardless of the law often prompted through countries signing up to the United Nations Treaty, those living in the villages rather than the cities continue to practise FGM. This appeared to frustrate Ibrahim. In contrast to this frustration, Omar talked of the benefits he has gained from working as a peer mentor;

"So it has opened my mind and another thing is I could understand, better understand the role of the social worker, the role of health visitor, and now the role of the police and it gave me the idea on all kinds of jobs they are doing. And I can even see the gap in these services and then we try to work with them and see how to fill the gap, just giving us, as a peer mentor, as a community worker, it give us a kind of, not dignity, but enough satisfaction to be involved and to help in the process of educating about FGM." (Omar)

"I feel very, very good …… I feel even confident when I go and visit the family, I know exactly how to start, what to say, I know to be patient, so it gives me some kind of – it is like doing some mediation, so you must be patient, you must listen before you starting talking. Just be kind and then going step on to become a peer mentor, if we see the guy is like a community leader or something like that. I think three or four of my clients become coaches too, so they become community peer mentor too. And they like it." (Omar)

5.6: Where next? Looking to the future

"I want to go back to university, I want to go and do social work, because I want to be more informed……. I want to get more skills and because I can see that we are helping people, but I want to do a bit more." [Omar]

Omar also talked about having the peer mentor course accredited.

"Trying firstly to accredit the course, or to do another – a second part of the course, to give people a more, I don't know, more skills. This kind of course can be, for example, is like level one and level two, can be like for all people who have already got some skills, can just go further, because for the level one, we just take people from the community, try to give them some basic level of skills, some basic awareness for doing it [peer mentoring]. *And then if we can go to level two and give them more – and people who have got already skills and then giving them more security ……. I know it is not like to do the job of social work, just stay in the community, being more active and doing the kind of job they can be recognised for, you can be paid for this kind of job."* [Omar]

"My vision now to get all men to be involved in campaigning. So as a peer mentor we are going to do awareness, we want to give advice, we are going to do everything, but at the end, the objective falls to get the men to start campaigning, everyone to campaign in his own community. Because different communities are different – Eritrean is different, Nigeria is different. So trying to get people from their community and going and campaigning in their own community." [Omar]

"I am feeling very, very confident when I am talking with family. But I think we need to extend our campaign, our training to some group of professional, for example the police or social worker. I think the approach they are taking, not all of them and– I don't know, to make this approach more human, you know, instead of doing like a military approach - going there, getting the passports. When we go there after that it's like doing a really, really hard job because you find a family whose children don't understand why police come in our house, they treat my parent like that, you know. They are really, really disappointed of the system. We talk about it in the project, we think about this, trying to see if there is a way to talk about this with professional, you know. And this is the only thing I can say, but the rest – like I said, this is just a small part, but I can say that just the way all these services are acting, it's fantastic, when a case is told to us, they give us possibility to go to the family, to talk to the family. And then we got some contracts to doing this kind of thing that was fantastic. Like I said, this is FGM peer monitoring." (Omar)

"This is what I'm dreaming about. You can find some sort of help for back home countries. Any sort of help can help. If you can just put information out and share it with them, website of the organisation to raise awareness. I believe if you can tackle this issue there then you will minimise the risk of getting this bad experience travelled between [African countries and UK] and you rest assured for those people that are going back. Sometimes you can't prevent people to go back to visit their relatives back home, but you can raise awareness…… Back home the mums are still the core influence. I know it's hard but if you can do something it will help." (Ibrahim)

"So for me it's the future. I have to look forward. I have to look forward and stop stuff like this to happen again and I feel that I'm responsible….. I feel that I've got a commitment towards my

community. This is what's driven me. And you do believe that you can help to stop stuff like this to happen to someone else. This is with me the steam engine to move forward." (Ibrahim)

"We do this voluntarily and sometimes you, sometimes there should be some resources of money to cover….. more funds this would be fine to support. But sometimes when we are visiting families and we are going there, although sometimes they say to me we need to reimburse you, and sometimes I'm not accepting because this is charity work for me. I don't want it. But if there is, if they invest more that would be fine." (Ibrahim)

5.7: Summary

Both men are committed to raising awareness about FGM in African communities. Although Omar had previous experience of support work through an online support for men who are likely to be affected by FGM this initial attempt at raising awareness and offering support was unsuccessful. However, after undertaking the peer mentor course both men were more confident in tackling the issue related to FGM and were keen to get involved at an interpersonal level with families and communities affected by FGM. Both men believed the course had broadened their knowledge and thinking re- FGM, and because of it being a mixed course (men and women) it enabled the men to hear the impact of FGM first hand. On a personal level perhaps undertaking the course prompted them to reflect on self as a man from a practicing community. They talked about sharing the pain, feeling bad as a man in not being able to give their partner the same sexual pleasure as they experienced within the relationship. They also wanted to protect their children and future generations from FGM, with Ibrahim describing it as '*against humanity*' and '*turning her* [daughter's] *life into a nightmare*'.

Both Omar and Ibrahim believed the future is positive. They saw their role of being meaningful, educating the men from differing cultures where it is the man who is regarded as head of the family and therefore able to exert influence. Both want more education and the opportunity to share their experiences with others, volunteers and professionals alike, and to receive feedback on the work they are engaged with, the latter perhaps being attainable through 'clinical' supervision. Finally, although both men undertake the work on a voluntary basis, they would like to see recognition of and accreditation for the course.

Section 6: Female Peer Mentors – Focus Group

Since the inception of the project 82 people have been trained as peer mentors, 9 males and 73 females. There have been 39 active peer mentors at any one time over the last five years, 13 of whom were active in 2018 – March 2019. Since the inception of the Health Advocates Programme two years ago, 38 women have been active; 21 being consistently involved between January 2018 – March 2019, delivering FGM coffee mornings in their own communities. In addition, a number of women undertook the role on a more ad hoc basis, fitting it in with their other commitments (see section 3.3. of this report for the statistics relating to this project). Again what is presented in this section is a compilation of the six participants' discussion focusing on their experiences of being a peer mentor. Common themes emerging from the focus group were; (1) Reasons for entering a world of peer mentorship, (2) Starting Early: Work in Schools, (3) An organised peer mentor service, (4) Investing for personal gain, (5) Facing the challenges, (6) Looking forward.

6.1: Reasons for entering a world of peer mentorship

"Well, we do it from good hearts."

"I have an FGM background, and after learning about all the side effects and everything that's happening……so I can help other women in my situation"

"My background is not from FGM, so I wanted to help other people and see what they're going through."

"I come from a community that practices FGM, and I wanted to raise awareness and reach other women so that they are able to understand me. Because they know I come from the same community, so it would be easy to speak to them."

Within the group there was a mix of women who came from practising and non-practising countries with the underlying motivation being to help other women. One way of achieving this was to align self, using their culture to help raise awareness. However, it was also accepted that it is not always possible to match those looking for support with someone from the same community;

"It depends on who has the problem and comes to us."

However, every effort is made to match people, particularly in light of there being a language barrier.

"I've been going to most of the people from the same background as me……we come from the same community, the same background, so it's very easy to speak to them, to communicate, to understand, and we all know where we're coming from."

At times of distress, using one's own language may be a relief, as it better facilitates emotional expression. There was also discussion about the women's own learning during the training course, particularly in relation to the different types of FGM which may be practised in different countries. For example, Samira told of what she had learnt during the training.

"Different parts of the vagina, and then how did you … sexual, like, type 1, type 2, type 3, type 4. So, these 3 types, and then the pulling one [type 4], it just does my head in…. because I never, ever knew about this. All I knew was just the cutting, like the one I went through, but the pulling bit of the lips

and then applying the special oil on it… and then there is how they sew it up, and when you're having a baby, they open it up and then stitch it back again. I was shocked, honestly, it hit me. But, coming here and then some ladies saying, 'Yes, I did this' now it wasn't bothering me……because to my head I was only thinking what I went through, that's the only thing about FGM, I didn't know all these things are happening. So, it made me eager to know more, and then to give more."

In the above statement there is evidence of egocentricity, Samira knowing about her own cultural practices regarding FGM without realising it is carried out differently in different communities.

6.2: Starting Early: Work in Schools

Jemima and Sabrina delivered sessions in schools in year 6, 10 and 11. They described their work as;

"Challenging, very challenging, especially with children….. especially, for example, when you're talking about the female genitalia. There is a lot of giggling in the room."

Jemima and Sabrina described their interventions as;

"The level of education is really low, so we don't go into detail, we have different Powerpoints [presentations] *for high school and for primary school. With primary school, we teach them the human rights, to look after their body. When you tell them to look after their body they'll understand. So, we have sets of levels for different ages."*

Regarding secondary education, Jemima and Sabrina described the students as;

"Laid back, but the younger ones, they kind of … they laugh it off. Some of them are really eager to understand, to learn, to hear what we tell them [year 6]. *But the high school, yeah, those ones are the challenging ones."*

6.3: An organised peer mentor service

From the women's perspective the development of a peer mentor service appears to be based on their strengths as identified by the manager of NESTAC. The women talked of "we all do the training, but she sees our strengths." An example they gave was;

"she's very good with the media, she's very good spokesperson to raise awareness……she will always take [Zizou] *to go to the families, and sometimes when it comes to schools she'll come and ask* [Jemima] *… she sees where you are able to go and fit in and do it. So, she can select us in that manner."*

Within the allocation of roles there also appeared to be room for negotiation.

"Imani doesn't force anyone. So, yes, she'll say, 'It's up to you to say yes, I want to do it or, no I don't want to do it'. Like me, now, when she says go to TV I'm running [laughter] So no, … Imani tells us what there is to do and then who wants to go and who is good at whatever you're good at."

There are three drop-in centres run by the peer mentors, in Salford, Rochdale and Manchester and they operate on a monthly basis. Because of restricted funding in Salford and Rochdale they can only

take 12 women at the drop-in centre, whereas Manchester can accommodate 50 women. The peer mentors talked of the attendees at the drop-in wanting to meet on a more regular basis;

"The ladies requested twice a week, because them being in that group talking to each other, they teach each other, and they help each other…., and we have new people all the time. So, sometimes they say, 'Why can't we do it twice a week, because I need to speak to that lady that was in the group, I need to know more."

Apart from the women supporting each other, the drop-in centre also offers the women education;

"We always arrange … sometimes we get speakers to come and talk to the women, and sometimes we will be passing on hygiene, empowerment, every day different topics. Like now, we are planning another training course [to increase the number of peer mentors]."

In addition to providing education, with children, young people and adults from practising communities, running drop-in centres, and supporting individual women that are perhaps in crisis or having specific problems, the women also said they work alongside social workers and midwives, act as advocates and contribute to professional education, often via workshops, with social workers, nurses, police, and doctors. They also said;

"We have the coffee mornings and we've invited men, because we know it's not a woman thing, because men also have a say in it. Because we've realised, in some communities, it's the men who actually initiate the FGM, so we involved the men and it has gone down very well. So, at least men also want some training."

Within the focus group discussion, the women appeared to be keen to have male peer mentors.

"That would be good, because some communities, when women and girls talk to the women [peer mentor] *and then the man normally comes and he's trying to talk too … they don't understand why is she talking about this* [FGM] *So, the men doing the peer mentoring, they can come along, and they can talk to the men as well."*

Safi told of how she approached men and how she explained the gravity of FGM.

"I've been talking to lots of men, the men from my country, they're like, 'Yeah, you're the woman who tells …' and I start explaining to them ……… I just send them the types - 1, 2, 3 - and how they do it, but by the time I get to [type] *3, they're like 'Whoa, no way!' They just give up, they're like, 'No way, really?' Because they are used to Type 1 … in the Gambia, they're not used to Type 2, Type 3 and all that. So, when I say the types and they say, 'No, shush, no', they just change their minds straight away."*

6.4: Investing for personal gain

Some of the women talk about what they gained personally from undertaking the training course and becoming a peer mentor.

"For me it's the confidence. … if she's telling you her life story, you're going to be like, 'Ah, okay, I'm sorry', you need to support them, but in a professional way. I've learned that a lot. Because I'm a very

sensitive person, I cannot see another person crying, but this taught me how to be strong and how to help someone else by not crying. So, it [the training] *did play a big role."*

Sabrina, who educates children in schools stated;

"From the schools, what I've learnt is when you go it's … because where I come from we don't talk about private parts, that is a taboo, so now, standing in front of the children, drawing a diagram of the vulva, the vagina, and then trying to tell the kids, 'Do you know what this means?' …..at the beginning, you're asking and it's like you don't want to ask loudly, it was very challenging. …..Now I am more confident, yeah. Now, I just put a different mask on and I'm just getting on with it."

In terms of their own emotionality resulting from their work there was no evidence of 'clinical' supervision, but the women appeared to develop what they perceived to be their own coping strategies.

"It's hard obviously, but it's part of your work, so when you're leaving work … I will say I will leave myself at home and transfer into professional. I am used to it so … even when I am home, I try not to switch … I'm getting there, I think, I'm getting there."

Zizou appears to use two personas; one of personal self and one of professional self, perhaps in order to protect the former from the traumas she is exposed to when the women tell their stories and the latter to enable her to be confident in her peer mentoring work.

6.5: Facing the challenges

Challenges for the women appeared to revolve around culture, and those they were visiting and/or working with did not believe anything was wrong with the practice of FGM.

"We said, 'Do you know it's against the law in this country?' and she said, 'Well, in Kenya it's allowed'. She was Somali, most Somalis live in Kenya, and in Kenya it's allowed, there's no law. We said, 'Really?' and she said, 'Yeah, I did it in Kenya', … And then, she was saying, 'I don't have a problem', because I was asking her, 'Don't you have a problem when you're having sex or childbirth?' She said, 'No, no, when I was in Kenya we go to the hospital, they open it, I have my child, then they sewed it back. To her it was like we were the ones that needed educating on how good it [FGM] *is, telling us, 'There is no problem about it, it's fine, I don't know why you're here'. I never forget [laughs]."*

"This is their culture. Their culture is really deep, so coming to somebody's house, like that lady, telling her about this, she will be like, 'What the hell are you talking about?' That's what she told me, they all did it. To them it's natural it's what they've been doing. Unless they become … they know the side effects and they've gone … otherwise it's very hard. I can't blame them anyway."

Whilst trying to address strong cultural beliefs, the lack of long term funding also troubled some of the women. A few of the women were aware the project money was coming to an end and this concerned them for how they might continue their work. Other women voiced their concern in terms of the women who sought help from them.

"We do use our own transport too. Like, when we have the … because in my group we cook, we do different things, we teach women how to cook, we do drumming, just to make them happy. Because some people are really, really … their light is gone because of this horrible thing that happened to them. They're very sensitive, so … Some women came all the way from Rochdale, so you have to … because some of them are asylum seekers, some people are single parents, but they are going, so they don't have money to be coming all the time. So yeah, that's it, money, travel and food."

6.6: Looking forward

All of the women in the group expressed a desire for more training, especially in relation to health advocacy, 1:1 counselling and recognition of other abuse issues.

"I don't know what different people have said in different ways, but even the psycho-sexual counselling training you can do, about sexual relationships and things like that."

"I want to carry on and I want other women also to be trained. Because FGM is not going away, because it's been there for how many years?"

"We need more interpreters too, because we don't have any trained interpreters and it's very hard."

6.7: Summary

Regardless of the female peer mentors sharing a common culture and language with many of the women and families they worked with, it appears that in undertaking the course they were able to gain further knowledge, develop their skills and grow in confidence. In addition, in observing the women while they undertook the training, *Imani* was able to recognise their personal strengths and utilise these to good effect in achieving the project aims. For example, those who worked well with children and young people, those who were happy to talk to social media, such as television reports. The activities the women engage in are far reaching and while such activities have facilitated the honing of skills and the furthering of confidence and competence, they have also had to develop coping strategies to protect the self from the traumatic stories they need to hear. The main challenges the female peer mentors face were identified as being trying to change entrenched cultural beliefs and the insecurity of the possibility of losing funding. Finally, all the women were optimistic about their work and the future, with a number of them identifying specific related courses that they would like to pursue.

Section 7: The Project Team

During this focus group interview, the three females who facilitated and managed the differing projects provided information about the overall running of it and discussed their experiences of being involved. All names and information that may compromise confidentiality has been omitted. Nine themes emerged; (1) Spaces and clientele (2) Working within the spaces (3) One of the same or differing roles? (4) Expanding the project (5) The therapeutic path to altruism (6) Measuring success (7) Making a difference: Grass roots to boardroom and back (8) The rocky road to success (9) The paradox.

7.1: Spaces and Clientele

The 'spaces' referred to above are physical spaces. In terms of the SOS programme, three different spaces have been identified to cover Greater Manchester; one based in Rochdale which is part of the NESTAC Community Centre, one in Salford, which is based within a children's centre hub and one in Manchester within a Black and Asian Minority Ethnic community centre. Each of the three spaces are well used, especially the one in Manchester, but financial and human resources need to be considered and at times this limits what the women can be offered.

There is a mix of women who engage with the project. Some women who might be young adults, born and raised in the UK, are British, to those who are now living in the UK, but came when they were much older, and for whom opportunities are less available to them. Some of the barriers they face include; language, understanding the system, they might not have had their immigration status determined, the latter limiting their access to specific opportunities. Additionally, some women who attend the project services have recently arrived in the UK, and time is needed for them to familiarise themselves to the 'new' culture and to build trust with those outside of their own cultural community. For those women who are coming in as asylum seekers, part of the Gateway Protection Programme, the question of FGM is flagged early on to them arriving in the UK, and they might be signposted or referred to the service. Furthermore, the service has also had a few foreign students referred.

7.2: Working within the spaces

The three workers talked about the work they do with those people who sought support via the project. In terms of a space for 'awareness' raising, one member of staff said;

"Yeah, its space for awareness on FGM, but I think it also related topics around women's rights, around their relationships, around other forms of violence. And then, the family work we do is primarily around girls who are identified by social services or other professionals with safeguarding responsibilities."

"In terms of space, sometimes we give the opportunity to women themselves to determine what type of support or activities on top of FGM they would like to start talking about, so as well we start discovering other issues that might be related to FGM. You know, women's issues that if we cannot ourselves look after, we'll get partners, organisations, to come and deliver awareness sessions, still using the same space."

"With the family work that would be girls either affected by or at risk of FGM, and we would work with the girls/young women, but also support their family. So, it might be about doing family work to decrease risk, getting parents to understand FGM is harmful and illegal. It might be about preparing girls for an examination. … Yeah, examination of the genitals to see if they've undergone FGM or not. So, that's the support/safeguarding aspect of the SOS."

"We would then have community work, we do general awareness raising, events targeted towards FGM affected communities. We also run two training sessions for a community member. We've got the peer mentoring which trains women, primarily from FGM affected communities, to offer low level emotional support, befriending, and they'd come alongside with ourselves to cases and do that family work. And then, we also deliver training for community health advocates. So, that's around enabling, again, women from primarily FGM communities to go out into their local community and raise awareness. This can be through coffee mornings or running a small event. The idea is that they'd have access that we as professionals outside of those communities would not be able to get."

7.3: One of the same or differing roles?

I asked the three participants if there was any difference in the roles of the peer mentors and community health advocates.

"Different and complementary [laughs] in a way, when we started, we started with only the peer mentoring. And by peer mentors visiting the women, we've noticed that it was mainly befriending and then following-up once their [women's] *emotions were quite stable. We realised when they are stable, they have other needs in terms of not only FGM. So, it could have been other cultural issues that they didn't know how to address, they wanted to discuss about. So, the peer mentors would becoming like advisors for them, sometimes helping them fill in forms, things like that. Then, there was a need, we noticed, even if we provided basic awareness … they were coming back with questions all the while, like 'Oh, I would like this … maybe my friends to know about this', things like that. That's when we decided to develop the health advocacy, so that the peer mentors would be empowered to be trained to be able not only to support one particular person - because the peer mentoring is quite individual - but to go beyond this and then offer support to the whole community."*

The above suggests peer mentors go on to receive further training to prepare them to deal with the wider issues related to FGM. In trying to clarify this one participant said;

"They are mostly calling themselves peer mentors, but some of them feel much more comfortable just with the peer mentoring [1:1 sessions with the women]*, but others would be feeling much more comfortable with the health advocacy side, so it's overlapping. But they are all able to do everything. We feel like, when we ask for a peer mentor, whether they want to do coffee mornings or something else, so now they have a bit more choice."*

While having the choice over the type of work you opt to engage in can be satisfying, there could also be concern about '*all being able to do everything'* as there is the danger of the old adage 'Jack of all trades, master of none'. Another participant tried to further clarify the roles of the peer mentors/health advocates.

"But they are both [roles] *quite intensive and busy, going to the community, having coffee mornings, sometimes just in a particular house, the house that she's supported first. The lady will be calling maybe four, five, six other ladies, and then we call it coffee mornings because it's going to be … and then they do it informally. And it's under supervision because they need to be accompanied by a senior peer mentor, to assess how they are doing it, and it is recorded so that they can learn about their progress … this one is quite successful at the moment."*

The above statement is indicative of a thoughtful thorough training programme, whereby the skills and knowledge acquired are observed in action to ascertain the quality of service being delivered. The statement also clearly demonstrates the snowballing aspect of the intervention, with the original client involving up to six other women in learning about FGM and its associated issues. However, the participant also raised the issue of a *'senior peer mentor'.* Again, one of the participants attempted to clarify what was meant by a '*senior peer mentor*';

"The senior peer mentor, to be honest, it's the ones who started the peer mentoring from the early stage, because we trained a lot, some went and others we kept. And then, those we kept first, they kept learning and learning and learning. Apart from the health advocacy, all the senior peer mentors we have trained at the moment, they are also delivering sessions in schools, for example, for pupils and staff. So, we keep training them, we keep developing those skills."

7.4: Expanding the project

When asked about their work in school, the three participants offered insight into what that involved.

"That's [work in schools] *the community engagement aspect, and then we've got an element that is around working with professionals. So, we deliver professional training, as well as briefings, and I guess that* [working with professionals] *then helps feed into the referrals. Because we're hoping that professionals will understand and identify FGM at a much earlier stage and recognise the importance of community engagement and having community-based organisations as part of the safeguarding process. Because I think that's been a bit of a difficult message to hammer home, but we're getting there."*

"And then we do youth work, we've historically trained up young people on FGM, they've done activities, or they created a poetry book in the past. And then we run schools work, so that's training for staff, delivering student sessions in both high schools, as well as year 6 in primary school. And then we were able to offer parent sessions, but that … there's been less of an uptake of that in Manchester. And then also outreach sessions, we're providing support within a school setting if needed. So that's part of the package, but we've found definitely the student sessions and the staff training is probably the most popular."

"On top of that, once we've delivered training to staff in school, they still have the opportunity to contact us at any time, in case they need advice, so we provide telephone advice as well. We have a phone where they can reach us for any advice, especially for example before the long school holiday, then you'll be having a high level of phone calls, because they can get stressed in terms of children travelling back home [to practising countries]. *So, just to make sure that they are not making the wrong*

decision or the right decision, they are making in terms of maybe contacting social services or doing internal meetings. So, they will be checking with us first and then getting our advice."

"I think, with the peer mentors as well, I've always found … because I pretty much do the groundwork, you know, like going out visiting families and doing some of the awareness sessions with professionals as well, but what I find with the peer mentors is, when they are involved it really does help to reinforce any kind of message that you're trying to deliver, and I've always found that the peer mentors have been really great for doing that for the organisation. You find that students … because I've been into universities as well, to raise awareness, and students will always sit up when they hear someone with personal experience or being able to talk quite openly about any experience that they've had. So, there's more work for the peer mentors."

"Peer mentors as well, they've got a unique ability to be able to really identify with the culture. Within the raising awareness in the university I think it's one thing me being stood there and delivering a presentation and providing some sort of statistics …. but there's nothing like hearing it from somebody who has been through the experience and has come out the other end and is now offering the advice and helping to raise awareness and end the practice."

7.5: The therapeutic path to altruism

As well as discussing what the project encompasses and the specific services it has been able to develop, the participants also discussed the benefits of receiving help and becoming a peer mentor.

"There's also an element of empowerment for these women, the peer mentors, especially if they've been shown emotional support before, and then they're willing to give back to their own community. We can more and more see it when … in the beginning we may have been struggling about who wants to talk about FGM openly, but now …. It's about, 'I'm not scared any more, I want to speak about it and I want to speak in my community. I want my community to know that they as well can speak about it openly'…. Another element, I think as well, is the way the society has been portraying FGM women as victims, and they don't want to be seen as victims they want to have a life beyond FGM. So, by doing the peer mentoring, it's just like, 'Okay, we've been through FGM, we've struggled, we've survived it, but now we are talking about it we also have a life, so stop looking at us as if …'. So, it's really … For example, you can see how social workers, as part of a family visit, if a peer mentor is there, you can see that the social worker is … not admiring, but there is a respect when they look at the peer mentor. And for them, it's important, for a topic which is kind of shameful, when people start looking at you with respect, I think it's a lot for them and it's a pride for them."

7.6: Measuring success

The three participants shared ideas on what they thought indicated success.

"It is key to have the ownership of the campaign. Because I think one of the things you get levelled at is the cultural relativism idea, like 'who are we in the UK to say women and girls should exist in a certain way and behave in a specific way?' And I think the more we have women from affected communities speaking out about it, there's a sense of … yeah, ownership of the campaign, it's not somebody on the outside saying, 'You need to do this'. I think also what's positive about it is that idea of empowerment. …. So, I think that idea of empowering them, enabling them to be … 'You can do anything you want,

you can build these skills', and I think it gives them that sense of … yeah, that increased sense of worth, challenging the different patriarchal norms that fuel FGM."

"For me, helping develop the project has been just like an amazing journey for me. And today…. when we talk about it at a strategic level….. when we talk about this particular project across Greater Manchester, seeing it recognised and embedded in most of the pathways, hospitals, social services, the police, seeing them part of the pathway…. when I see that strategy, it can be, 'Wait a minute, that's amazing, the work we are doing."

"Just thinking about the recognition, when locally you are recognised, but also more and more you start becoming recognised nationally. Being invited to places like London, where you'll be sitting with other organisations, and when you present on your project, organisations who are there for a long time say, 'Wait a minute, is this really happening in Greater Manchester?' Yes, it is. But it's just like pride, 'Oh, that means we are doing well', you know? … it gives you more motivation in how to get it even better."

"Emotional support, I think talking … I will say no matter what approach you are using, when you see the outcome of the woman…. I've always been amazed in seeing the result in terms of change in behaviour, emotion and how they accept things and … especially women who … cannot really talk about this, and at the end they come out …. asking questions around sex, around genitalia, and … it's like you've freed them from something."

"I think the peer mentoring has done a lot, that's another one. I know that we've talked a lot about the peer mentoring, talking about men being mentors as well. This was as well, I think, a big achievement for us, to get the men involved, even if there are not too many, but having men involved."

"I think, for me, the strength would be around, really, the staff and the peer mentors, in terms of their cultural competency. A lot of FGM organisations who don't really get FGM or don't have staff who fully get it, and it's kind of … you can tell it's very text book, the way that they're approaching it, and I think it's far too nuanced and complicated a subject to approach in that text book style. I hope people can learn from us… I think, also, one of the biggest things, are the staff and the peer mentors….. Clearly peer mentors are going above and beyond what they're resourced to do. I think, as NESTAC, I think it punches above its weight, because I think a lot of people get very surprised at actually how small it is, because there's a lot of work happening."

"The women who are there [women's group] *love being there and have sometimes so much else happening in their lives that it enables a space where they think, 'I am valued and I matter and someone is going to listen to what I am saying, someone wants to help me'. And I think there are not enough spaces like that, particularly for women with indeterminate immigration status, women who are BME, women who are otherwise marginalised. And, to keep having them come and want to seek that … just that space. It's not even sometimes about specific support needed, it's being part of that network and that collective and community. I think that's a strength to get people who want to keep coming."*

"From my point of view, I would say the way that our organisation has come across in Greater Manchester. When I walk into a strategy meeting, you can kind of see the sense of relief on some of the social workers' faces… I am so keen to help… It also feels great that, okay, I'm here to help

everybody else understand, and then they feel supported….. people are confident to pick up the phone or drop us an email, is a great strength of ours, and we've all worked hard in order for that, and we want to continue to work hard."

"Another strength, I guess, is the process… the 3 or 4 steps we all follow. … the organisation of it all and the way that we can access all our information has just been set up so well, it means that when new people come in or if anyone's leaving, there's a really nice, easy way to introduce it because we've been that detailed in keeping things up to date. … So, I feel that it's a great strength of the organisation."

7.7: Making a difference: Grass roots to boardroom and back

"I enjoy the project. I find it extremely rewarding. I find that meeting all the different people that I've met and being able to make a small change, a bit of a difference in some families' mind set is really empowering, for me and for them. I think that the project has taught me so much …… it's taught me to engage and provide awareness to families, not just parents but children, and also be part of change. I get to sit on strategy meetings and I get to work with different organisations, and also attend forums around Greater Manchester. So, in that aspect, for me, it's been incredible. But again, just from a grass roots point of view, just engaging with mums and children, providing them with up to date information about legislation in the UK, providing them with that education, and being in a position where that's been heard, knowing that the work's been completed, is always fantastic."

"A lot of the work that I do is … has been referred through social services or different organisations across Greater Manchester, so I'm working with these organisations and providing information to the families, but also ensuring that the work is done so that these organisations can close their files. That is a big part of it, but my main work is in actually ensuring that the families do understand, and that they're engaging and are aware of why I'm involved and why I am now walking away as well. So, that A-Z of work … it's completed."

"Well, at the beginning it was… I was really actually quite nervous, it was a little bit overwhelming, because everyone was talking about all these legislations and things like that, and I was having to speak to my supervisors and find out what on earth was going on. But, wow, it's … to be a part of it. Because we're able to change different pathways within greater Manchester, to include certain projects and have a say. And to have such an impact on how the police would, for example, now do things differently, and to have a little bit to do with that, is fantastic, it's great for my personal growth."

"My experience of the project, …. I come at it from a slightly different perspective to my colleagues, where prior to this role I was doing strategic and policy work on FGM. So, for me, it's been really exciting seeing national policy being implemented at a local level, So, that's been a nice shift to see that in practice. I think also … it's nice to be working on a project that actively addresses that [FGM at grass roots level] *and not just trying to speak to different policy makers or professionals. I think also, for a very long time, people forgot … FGM was happening to young people. So, you're getting lots of awareness raising with adult women, very little work around how you would talk to a nine-year-old about FGM. I felt that was a massive gap, … still is a very big gap across the UK. So, it's really pioneering to be part of a project that looked at that gap and thought, 'Okay, we'll find a solution for that', and for that to be taken seriously. Because I think a lot of pilots don't get off the ground, don't move past*

pilot period, and to then have funders saying, 'We not only believe in this pilot, but actually we can see all of the additional work you're doing, and we're going to fund that and resource that', I think is a massive accolade for the project."

7.8: The rocky road to success

[In the beginning] *"It was difficult to get into those places* [schools, hospitals]*. For example, in a local hospital here I think I've been pointed in the direction of a particular person, and I think it took me maybe three months since I sent emails after emails that I've never had answered. And it took … we had a community event, …… the manager from that particular service attended ………. she was the person I was emailing, and she didn't know me, and I didn't know her, only by name, but we met in the toilet [laughs] and she was like, 'I think we need to have a conversation, you need to come in and see me'. And then, when she gave me her name, I was like, 'I think I emailed you three months ago, and I sent you …', and it was,' Oh, it was you! ……. And then, from that lady, we had access to the Black and Asian Minority Ethnic Community (BAME) Centre, where we set up and then she came on board. So, it has been very, very difficult to get there, this was just one example."*

There was also a perception of rivalry between third sector organisations and statutory services;

"So, under the statutory services, you have school, children's services, education, health … so, all this versus third sector, I won't say it's a war but it's just like … in terms of power it's just like when you are third sector you're not really … part of the Department of Health for example……. I would say that in practice, we are seeing it differently today with NESTAC and SOS, but it was a long journey before we got that credibility."

"I think the challenge is that third sector organisations … there's very little standardisation across the board. So, you get some third sector organisations who are great, you get some who are really limited, and I think I can then appreciate … if you're a social worker, if you're a healthcare professional, you wouldn't have that knowledge of which organisation is good and which is not good, and if you have one bad experience you just say, 'Well, I'm not going to engage with the third sector at all. I think that's probably one of the biggest challenges."

7.9: The paradox

"One of the challenges with FGM is, you're constantly having to create the demand for the emotional support. So, you're almost … you're constantly having to do awareness training, promoting your service, to then be able to increase referrals to provide the emotional support. I don't think it's an issue that people individually, would come to the realisation that they should get some support around this. There's kind of a couple of steps before that of like, 'I need to know what FGM is, then I need to know why it's harmful or it's an issue, and then, 'Okay, where can I get support?' Community work, similarly, is for women to think, 'Oh, I didn't know I could talk about this'. So, it all ultimately, for me I think, feeds into this idea that you can get support. I don't think it would work if we just had one project or ran only a support group on its own."

7.10: Summary

For the project team there was recognition of the need to train people to deliver multiple aspects of the project. Ensuring those undertaking the training course were knowledgeable about differing aspects of FGM and developing their skills to work as peer mentors on a 1:1 basis with family members and as health advocates appeared integral to the success of the project. This was evident when project team members spoke of taking care to ensure trainees were using the appropriate skills through supervised practice and feedback. They also talked of 'senior peer mentor', creating a ladder of progression for the volunteers. All 3 team members articulated the importance of peer mentors and how, after being offered help, they were keen to put something back into the community and the respect they gained from others for doing this.

From the perspective of the project team it has not been without its challenges. The coming together of voluntary sector and a range of professional organisations they needed to work with has at times proved difficult. For example, people not answering their emails, professionals being despondent about third sector organisations due to lack of standardisation. However, the work being carried out under the auspices of the SOS programme is amazing in its diversity; within BME communities, in schools, with teachers and pupils, universities, hospitals, social services and the police. In addition, those delivering the project have been able to make a difference at both a grass roots level and at national policy level. Through the project, the project team have been able to achieve integration into the health and social care system as well as seeing positive results with families and having impact of the attitudes of professionals towards those affected by FGM.

The final section, 8, offers a summary of this report, presenting the strengths of the projects, making recommendations based on the evidence presented and considers what the future holds in terms of building on what has already been achieved.

Section 8: Conclusions and Recommendations

8.1: Conclusion

This report presents both statistical and qualitative data evaluating the SOS Model; a programme of cross-cultural education and psychosocial support introduced across Greater Manchester to address FGM and its wider implications. Between April 2017 and March 2018 the greatest number of women and girls exposed to FGM known to NHS services within the Northern Region of England resided in Greater Manchester, followed by Yorkshire and Humberside (NHS England, 2018). Women and men representing 24 FGM practicing countries, predominantly from the African continent, but also including; India-Bohra, Indonesia, Iran, Iraqi-Kurdistan, Malaysia and Yemen, have taken part in various aspects of the six projects that make up the SOS Model. They have benefited from services that include; 1:1 adapted counselling for adult women, as well as young girls, all exposed to FGM; therapeutic drop-in clinics for individuals and groups across the region; educational projects at primary, secondary and higher education levels; innovative and creative adult and youth specialist advocacy services, cross-generational empowering within communities; educating and supporting professionals mainly within health and social care, education, police and those with safeguarding responsibilities, helping them to increase their cultural competence. All of the people benefitting from the SOS model reside in Greater Manchester, demonstrating the ethnic diversity of the region and confirming a need for the work to continue here and beyond.

In summary, this report has presented an evaluation of six projects under the SOS umbrella, namely (1) The SOS Clinic; (2) The Guardian Project; (3) Peer Mentoring Project; (4) Youth Peer Mentoring Project; (5) FGM Education; (6) Community Engagement Initiatives – Health Advocacy Project. In total **2574** professionals and **2437** community members have either accessed training or attended events delivered under the SOS umbrella in the last three years. **82** Individuals have successfully completed peer mentor programmes (9 male and 73 female) over the last five years (2014 – March 2019); **45** women from different FGM practicing communities have completed the Community Health Advocacy programme over the last two years (2017 – March 2019). **218** girls under the age of 21 have been referred to the Guardian Project between January 2017 and March 2019, of which **133** are at risk of FGM and **85** have undergone the practice. In relation to education and youth peer mentoring, **102** youth Peer Mentors (17 male and 85 female) have been trained between April 2010 and March 2019 and **2455** students have received FGM awareness sessions between 2015 and 2018. In addition, **490** teachers across **17** schools in Greater Manchester have received FGM awareness training during the same period.

Four participants who received 1:1 counselling as part of the original project highlighted the importance of being able to talk about their FGM, as prior to having such opportunity the secrecy surrounding FGM had the potential to perpetuate the practice. Being able to share their traumatic experiences of not only the genital mutilation, but also about its wider implications appeared to be pivotal to their healing process. In providing such a platform, the women found the courage and confidence to talk about their problems and were motivated to become altruistic towards helping others by raising awareness, challenging cultural norms and pursuing the eradication of FGM.

Peer mentors, both male and female, offered a positive overview of their training experiences, recognising the importance of accessing a course that was of mixed gender and nationality and the

significance of learning from each other. All those undertaking the training course reported broadening their knowledge, developing their skills and growing in confidence in tackling issues related to FGM. All were keen to get involved at an interpersonal level with families and communities affected by FGM. In addition to them attending the course, the project lead (*Imani)* facilitating it, was able to recognise the personal strengths of the attendees and utilise these to good effect in achieving the project aims.

On a personal level, undertaking the course prompted the men and women to reflect on self as a person from a practicing community. They all talked about sharing the pain, particularly in relation to their sexual relationships and they also wanted to protect their children and future generations from FGM. The activities the peer mentors engage in are far reaching, and while this facilitates the honing of skills and the furthering of confidence and competence, it also requires the development of coping strategies to protect the self from the traumatic stories heard.

For the project team, some of what the peer mentors had said was reiterated by them. For the project team it was important to recognise the need to train people to deliver multiple aspects of the project and to ensure those undertaking the training course were knowledgeable about differing aspects of FGM, able to develop appropriate skills and to feel confident in delivering the service. This was evident in how the training course is organised and their commitment to providing supervised practice and feedback. They also talked of introducing 'senior peer mentors', creating a ladder of progression for the volunteers.

Becoming a peer mentor within a campaign against FGM is not without its challenges, the most obvious one being trying to change entrenched cultural beliefs. Perhaps this is where the male peer mentors could be most useful depending on the hierarchy within a family from a given culture. Where the man was considered head of the house, it appeared the male peer mentors would take it upon themselves to talk to him about FGM, as they had witnessed first-hand that their female counterparts had made little progress in this endeavour. The female peer mentors agreed with the accuracy of this situation and whilst it could be argued this could perpetuate the status quo, equally it is about using resources wisely to achieve the aims of the project. In this instance, it is not simply raising awareness, but rather knowing who is best placed to educate a specific group of people.

From the perspective of the project team, the challenge has been in the coming together of a voluntary sector organisation and a range of professional statutory organisations. At times, those organisations they were seeking to work with were suspicious of their work ethic and the standards they were or were not adhering to. The project team worked hard to prove their commitment to the work inherent within each of the six the projects and to develop positive relationships with statutory and other no-statutory organisations in order to be listened too, taken seriously and be respected.

All the peer mentors who engaged in this project evaluation believed the future is positive. They saw their role as being meaningful and aspired to making a better future for young people from practising communities both in the UK and their countries of origin. All participating mentors want more education, with some wanting to access specific courses, believing this would enable them to offer further help to FGM practising countries, and in adapting the SOS Model in situations where there is Violence Against Women and Girls. All wanted the opportunity to share their experiences with others, volunteers and professionals alike, and to receive feedback on the work they are engaged with. Finally,

although currently all peer mentors undertake the course and their subsequent work on a voluntary basis they would like to see recognition of, and accreditation for the course.

Another challenge reported by the female peer mentors and the project team was the threat of funding being lost. For the peer mentors, this is perhaps akin to one losing a job and although the work they do is all on a voluntary unpaid basis, they have made a personal commitment to improve the future for women, developing a sense of altruism through becoming aware of the importance of the work they are undertaking.

The work being carried out under the auspices of the SOS Model is amazing in its diversity, providing an exclusive personalised psychosocial care package to those who have been directly and indirectly exposed to FGM. The Model uses thorough psychosocial needs and safeguarding risk assessments, constantly adapted and reviewed at the early, mid- and final stages of the holistic care package provided to clients and their families. Likewise, the significance of educating community members and young people via schools and universities using creative methods; and educating and supporting multi-agency professionals across the region cannot be underestimated in tackling FGM and safeguard women and young girls at risk, thus aiding the process of ending violence towards women and girls.

8.2: Strengths of the projects in terms of local and national policy

This report highlighted several outcomes resulting from the SOS Model, and which have contributed to enhance the different aspects of the projects involved in this programme, such as the standardisation of the SOS Model across Greater Manchester, partnership work with statutory and non-statutory services, adult and young peoples' cross-cultural therapeutic support, peer mentoring, community engagement and awareness raising in communities, schools, or amongst professionals.

The findings that emerged from the six projects comprising the SOS Model contribute to inform similar programmes developed at national and international levels. Further, significance of the findings in this report contributed to meet FGM objectives set by UK national standards and quality assurance processes, namely; FGM Multi-Agency Guideline (2016); Violence Against Women and Girls (VAWG) Strategy (2016); Home Office Mandatory Reporting (2015); Department of Health Guidance – Safeguarding against FGM (2015) and The Royal College of Obstetricians and Gynaecologist Female Genital Mutilation and its Management (Green-top Guideline 53) (2015).This is demonstrated throughout the work conducted under the umbrella of the SOS Model, where the curricula around early intervention, peer support, community engagement and empowerment, and multi-agency partnership work are constantly considered and effectively connected with relevant pathways specific in meeting the priority needs of families from FGM practicing communities. Moreover, women and young girls are provided with adequate and long-lasting psychosocial therapeutic support service throughout their healing process, contributing to meeting the standard requirement established by the department of health.

8.2.1: Greater Manchester FGM standards

One of the key strengths of this Programme is the 'Logic Model' developed by the Guardian Project (see appendix 1) and standardised to; coordinate FGM services across Greater Manchester and to provide psychosocial therapeutic support to young girls under the age of 21, a gap identified in the **Greater Manchester Multi-agency protocol (2014)**, and backed by the Department of Health guidance

(2014) (See appendix 2). The SOS Clinics (see appendix 3 for adult referral pathway) and the Guardian Project (appendices 4 for 0 – 18 referral pathway) are clearly embedded within the Greater Manchester FGM referral pathways.

The Greater Manchester Police (GMP) and Crime Plan – Standing Together (2018) highlights the importance of multi-agency work in tackling crime and making Greater Manchester a safer place. The plan outlines the need to protect the most vulnerable people, including children and young people, with an emphasis on violence against women and girls. Within the GMP and Crime Plan the Guardian Project was recognised as an initiative that needs to be built on, the document stating; *"partnership approach to work with the NHS to improve access to counselling services across Greater Manchester and with police and criminal justice partners to progress FGM protection orders and prosecutions"* (Page 37).

The above reveals the constant need for partnership work between the health and the criminal justice system. Similarly, this initiative meets the objectives set by the Public Health Outcomes Framework for England (2013), which encourages multi-agency partnership work to develop outcomes linked to local Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWBSs). In light of this, the SOS Model has been championed as a model of good practice in Greater Manchester by its partnering with Manchester Foundation Trust (MFT), since January 2015.

8.2.2: The SOS Model – A valuable partner to local health services

The Department of Health publication Commissioning services (2015) and the NHS England FGM Recommendations for Commissioners (2018) to support women and girls with FGM outlined the need to develop specialist/dedicated services, highlighting particularly the availability of psychological and psychosexual services. The SOS Model has been essential in demonstrating valuable multi-agency partnership working and in developing evidence-based practice of specialist FGM therapeutic services delivered by a third sector organisation.

The SOS Model has been promoted within the MFT since late 2014, leading in January 2015 to the appointment of the Cross-cultural Mental Health Specialist from NESTAC to the MFT, through an Honorary Contract. The contracted mental health professional aimed to inform, safeguard and address the health care of women, girls and families affected by FGM using a holistic approach and is bi-directional:

- Providing insight psychosocial care for women affected by FGM
- Addressing Safeguarding through Mandatory Reporting and Recording. The MFT FGM e-recording tool was developed and included a clear referral pathway embedding SOS Clinics, and collects data contributing to the reporting of statistics to the Department of Health.
- Working towards compliance with the NHS quality assurance standards and Clinical Governance.
- Sexual Assault Referral Centre (SARC) refers girls (under 18) undergoing FGM physical examination to NESTAC (Guardian Project) for emotional support and preparation prior to the physical examination
- St Marys Uro-gynaecology service refers adult patients who went through physical examination to the SOS Clinic for emotional support.

The partnership outlined above has been nationally recognised on three occasions:

- March 2015 NESTAC in partnership with MFT won British Journal of Midwifery (BJM) National Award for tackling FGM initiatives
- September 2015 NESTAC in partnership with MFT was finalist for the Nursing Standard Award.
- 2018 NESTAC has promoted the partnership model in London to the Home Office FGM Unit

8.3: Recommendations

Based on the evidence presented and findings discussed in this report, and considering what the future holds in terms of building on what has already been achieved, the following recommendations are made:

1) Based on the findings of this report, the SOS Model has demonstrated its practicality and significance as an intervention framework essential in supporting families affected by FGM in Greater Manchester. The Model has further shown its flexibility and ability in working effectively with relevant stakeholders and key statutory agencies involved in tackling FGM. Consideration should be given in regulating and sustaining this holistic specialist service and transferring knowledge to areas with high prevalence of FGM locally and nationally.
2) Findings of this report revealed an increase in the number of direct and indirect clients benefiting from emotional support in the SOS Clinics (adult service) and the Guardian Project (children and young girl's service), leading to the need to expand human resources in the SOS team as the project grows.
3) The fear of losing funding resources was further reported by Volunteer Peer Mentors and paid staff, stressing the significance of securing a long-standing and consistent funding source to sustain the developing work built by the SOS Model.
4) It was noted that the main referral sources to the project was from Children's Social Services, from which breakdown of referrals revealed health agencies as their main primary source of referrals. This evidence should be considered by clinical commissioners in the region, to contribute towards the sustainability of the SOS Programme.
5) Male and Female Peer Mentors participating in this evaluation stressed the significance of seeing recognition of their role and accreditation (the latter is now in the process of being achieved) for the Peer Mentoring course. Although the Peer Mentoring training package was very well evaluated by the University of Salford as part of the three-year SOS Pilot project, consideration should be given to obtaining a national accreditation and in reinforcing and evaluating the role of 'Senior Peer Mentor' (male and female), progressing it from an informal role to a more formal role, where remuneration is implicit.
6) Findings in this study clearly demonstrated the need to increase the current provision of clinical supervision for Volunteer Peer Mentors who actively provide basic counselling support to their peers. This is fundamental in order to protect them from any form of re-traumatisation and ensure their mental wellbeing needs are met.
7) Based on the findings from the SOS staff, a pro-active multi-agency partnership with effective communication between partner agencies and the SOS team is pivotal in strengthening and enhancing the relationship. An advisory group might be essential for discussing potential problem-based challenges affecting each agency and establish an effective mechanism to overcome those challenges.

8) Where similar FGM psychosocial intervention programmes are already delivered nationally and internationally, a specialist therapeutic steering group bringing relevant agencies together would help ensure a sharing and transferring of knowledge exclusive to the emotional and psychosocial care provided to women and young girls at risk or who have experienced FGM. This could be an opportunity for authors to further develop a national or international standard therapeutic intervention model on FGM. The literature demonstrates a scarcity of FGM therapeutic interventions globally.
9) A high number of asylum-seeking children and young girls have been supported through the Guardian Project. There is a need to further identify, acknowledge and document the psychological needs of asylum-seeking women and young girls affected by FGM, to ensure that documentary evidence is available in support of their asylum claims, accessibility to appropriate health and social care, and safeguarding those at risk of FGM, as recommended under article 3 of the UN Convention.

The above recommendations should be considered by UK policy makers, to promote social justice, inclusion-based specialised services, as well as the health and wellbeing of the vulnerable women and girls at risk and affected by FGM. This report evidenced the positive impact of the SOS Model on individuals affected by FGM, their families, practicing communities, multi-agency professionals, and to the wider public. Those delivering the projects have been able to make a difference at both a grass roots and at national policy-making level.

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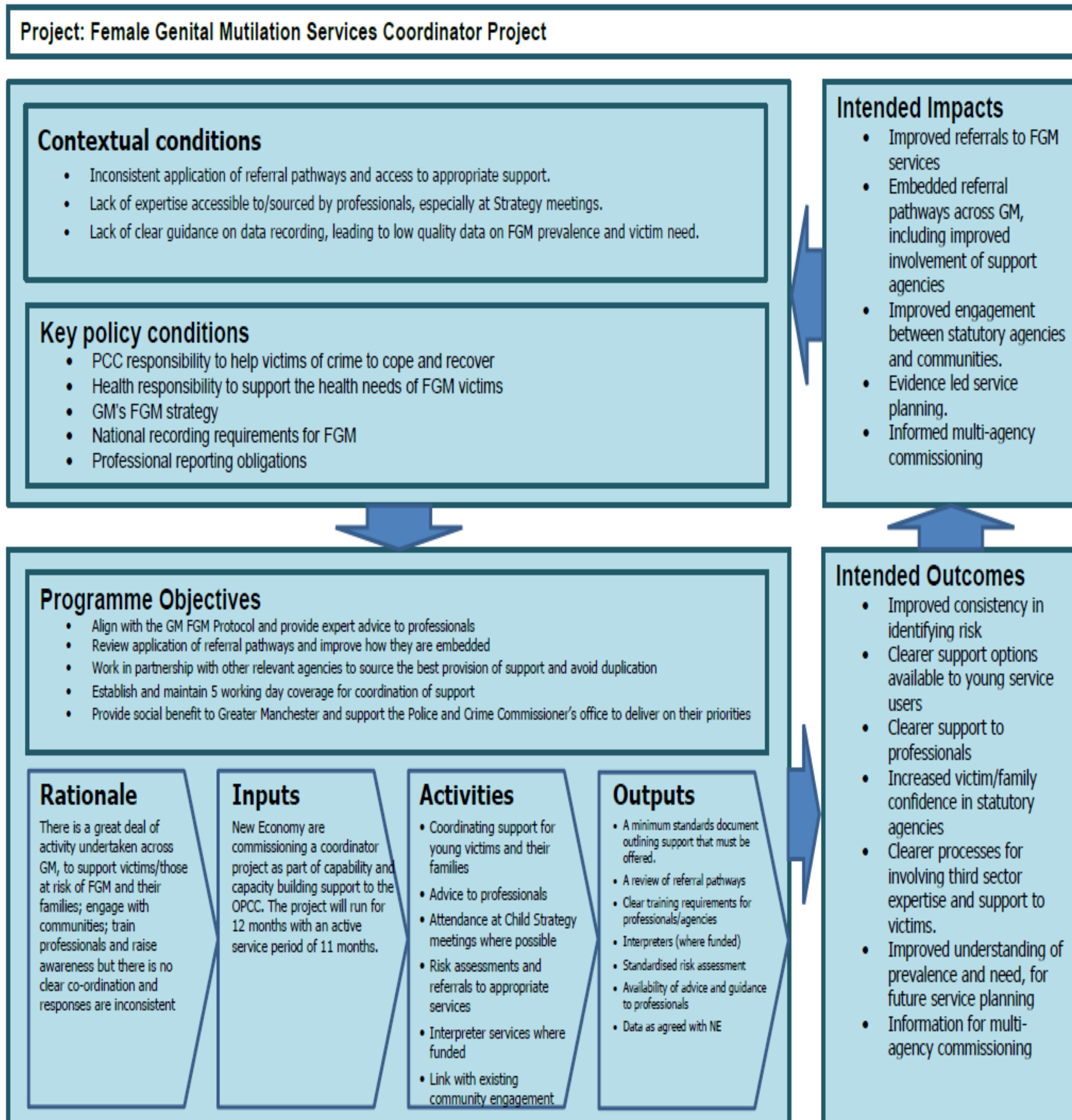
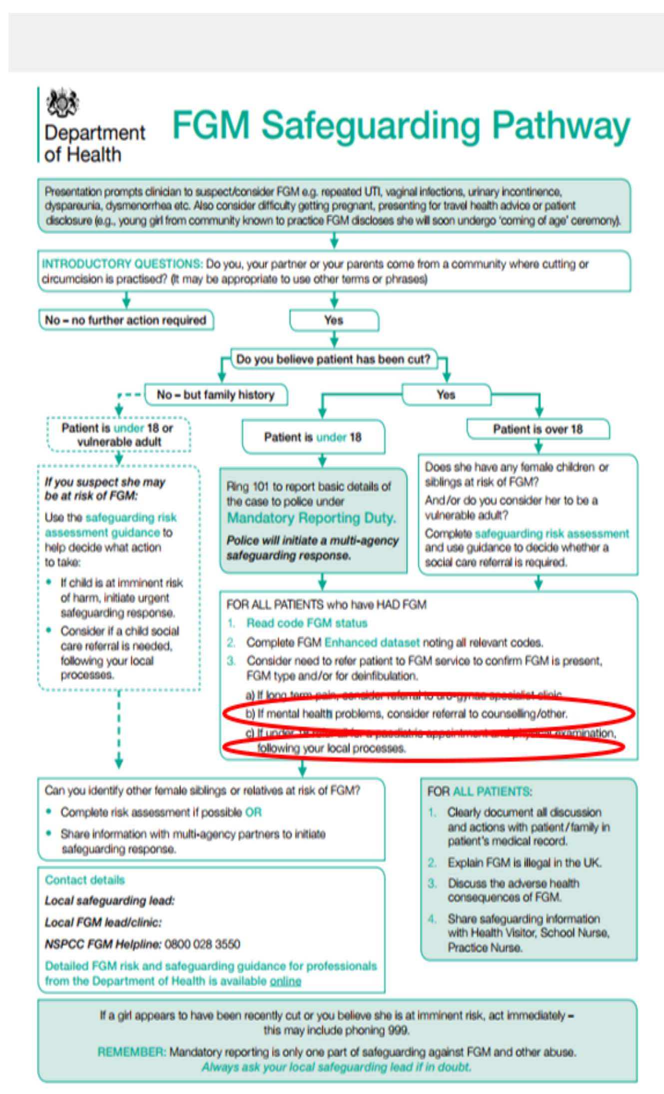
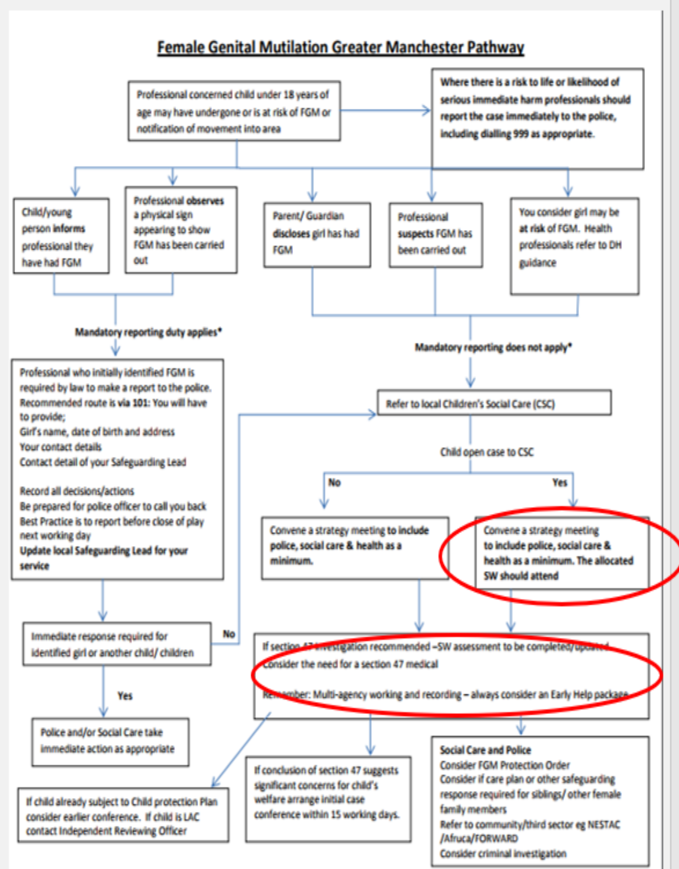
Appendix 1: The Guardian Project: FGM Coordinator Logic Model



Appendix 2: National / local FGM Safeguarding Pathways



The SOS Model supports the national and local referral pathways and their involvement is required for local FGM examinations.



***** Circled above (DoH FGM Pathway):**

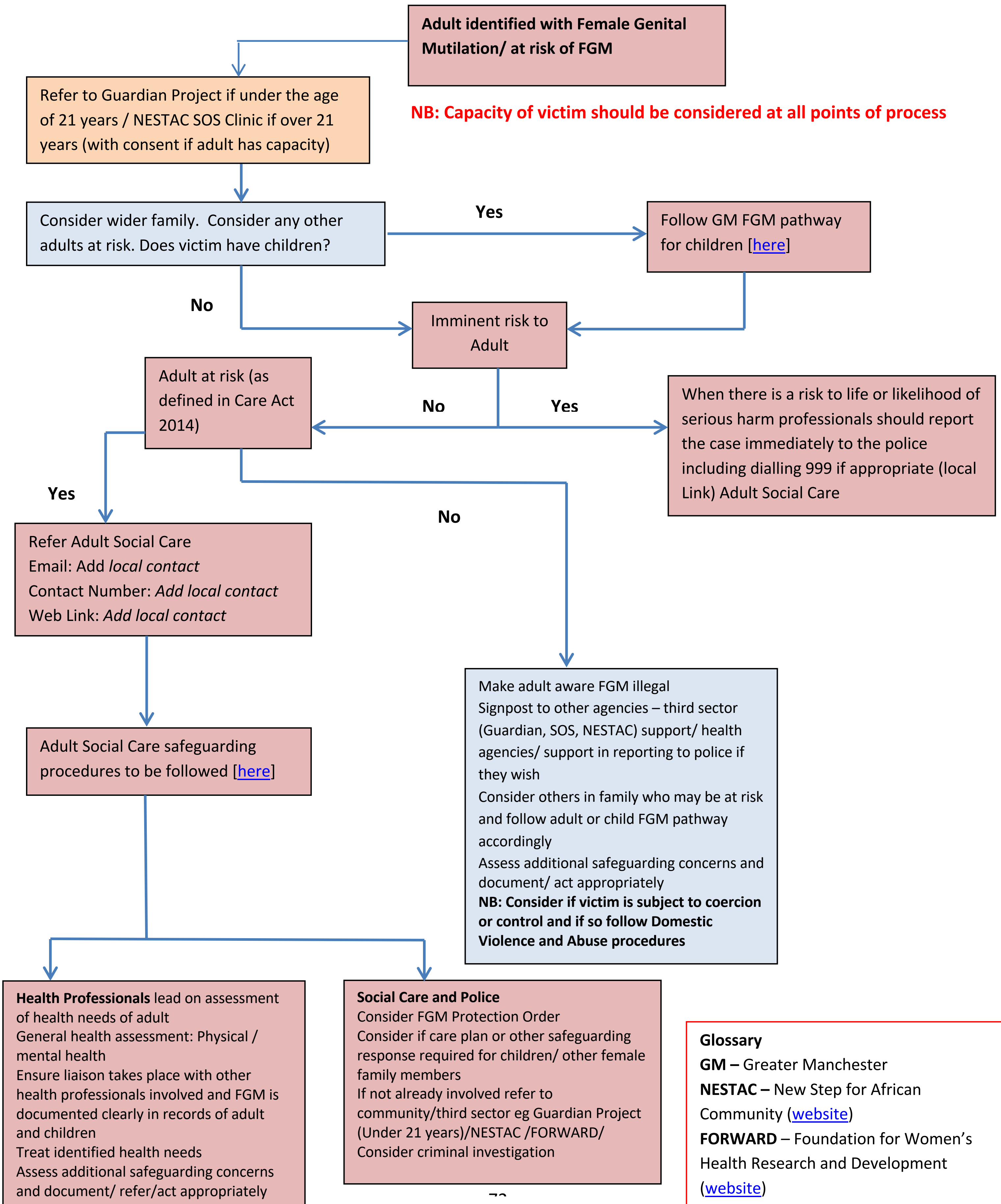
3. b) If mental health problems, consider referral to counselling/other.

c) If under 18 refer all for a paediatric appointment and physical exAmination, following your local process.

***** Circled above (FGM Greater Manchester Pathway):**

- Convene a strategy meeting to include police, social care & health as a minimum. Allocated Social worker should attend.
- If Section 47 recommended – Social Work Assessment to be completed/ updated. Consider the need for a section 47 medical
  Remember: Multi agency working and recording – Always consider the Guardian Project, always consider an Early Help package

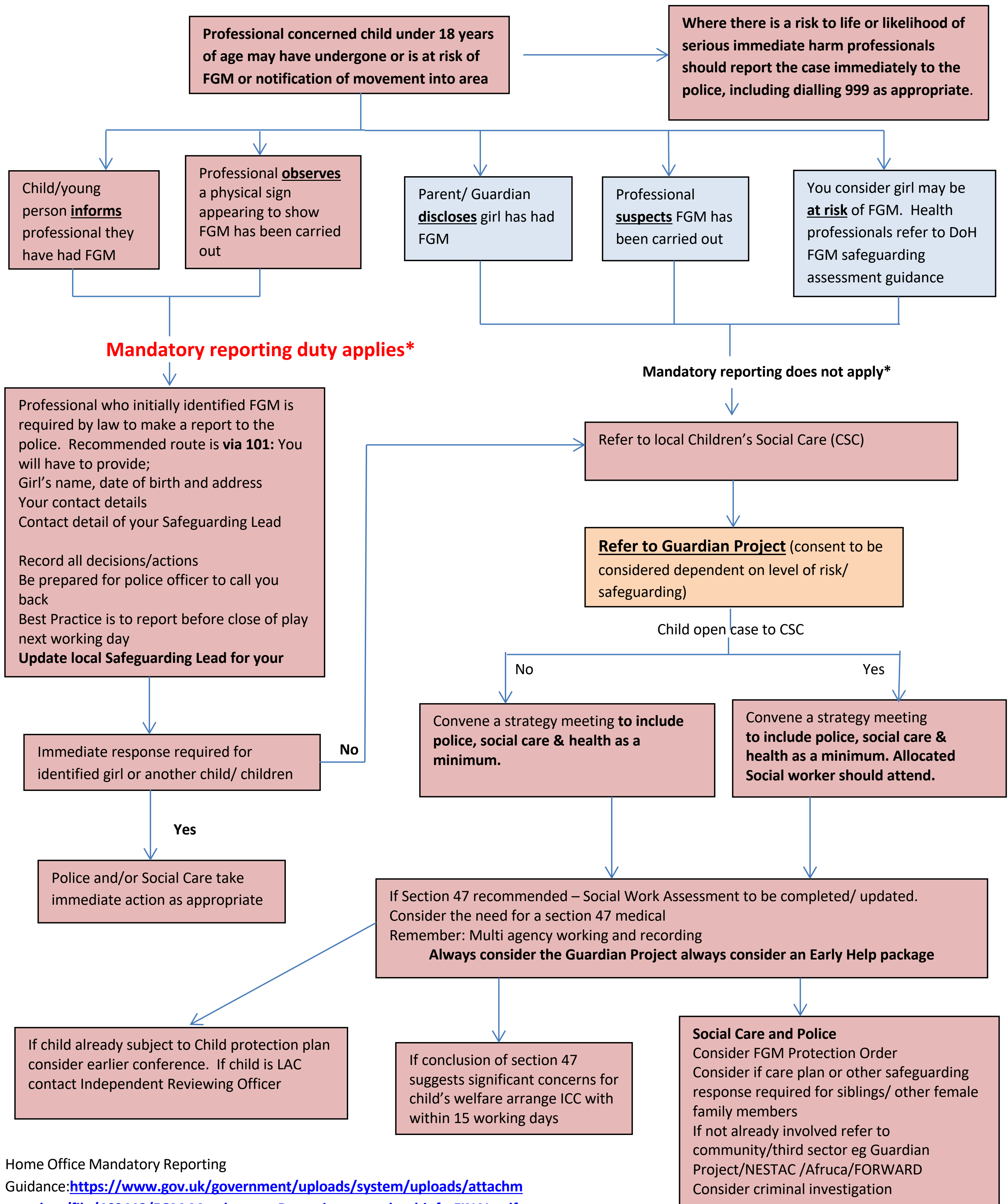
Appendix3: Female Genital Mutilation Greater Manchester Pathway for Adults



DH Guidance: **https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/418564/2903800_DH_FGM_Accessible_v0.1.pdf**

Governments Multi-agency guidance: https://www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation

Appendix 4: Female Genital Mutilation Greater Manchester Pathway (0-18yrs)



Home Office Mandatory Reporting Guidance:**https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/469448/FGM-Mandatory- Reporting-procedural-info-FINAL.pdf**

DH Guidance:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/418564/2903800_DH_FGM_Accessible_v0. 1.pdf