January 2020

Community Consultation: Barnet Harmful Practices Strategy

Findings

NATIONAL FGM CENTRE

Developing excellence in response to FGM and other harmful practices

Barnet Safeguarding Children Partnership

Acknowledgements

This study was undertaken by The National FGM Centre (NFGMC) with the focus group discussions facilitated by NFGMC staff. The report was compiled by The National FGM Centre with technical support from Katy Newell-Jones, who we are very grateful to.

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Abbreviations

CCG	Clinical Commissioning Group
CiN	Child in Need
DoH	Department of Health
FGM	Female Genital Mutilation
NEL	North East London
NHS	National Health Service

1. Executive Summary

Female Genital Mutilation, forced marriage, "honour"-based abuse and abuse linked to faith and belief are harmful practices and a violation of the human rights of victims/survivors. These harmful practices can have a deleterious short and long term impact on the health and wellbeing of survivors/victims. Harmful practices can occur in any community, so any approach to tackle the issues needs a broad approach that engages the citizenry.

The National FGM Centre was commissioned by Barnet Safeguarding Children Partnership to obtain community member's views and attitudes about a range of harmful practices. The data collection method involved the use of focus groups. Barnet Safeguarding Children Partnership's plan is to use the findings of the focus groups to inform their violence against women and girls strategy. Therefore this report gives voice to the participants and by extension communities. It should be viewed as a starting point to build on developing pathways for change.

Key findings:

Male and Female participants generally had divergent views on whether or not harmful practices are an issue affecting their communities in the UK. All participants in the female focus groups concurred that harmful practices exist in communities in Barnet as people 'migrate with their cultures' whilst male participants held an opposite view.

- Female participants were more likely than male participants to share personal experiences regarding harmful practices and also knew someone who was also a victim/survivor. Male participants had never openly discussed the issue of harmful practices and spoke about these practices as being historical.

- Female participants had better understanding and knowledge of harmful practices than male participants. For example, the male participants were unaware of breast flattening and lacked knowledge in the different types of FGM.

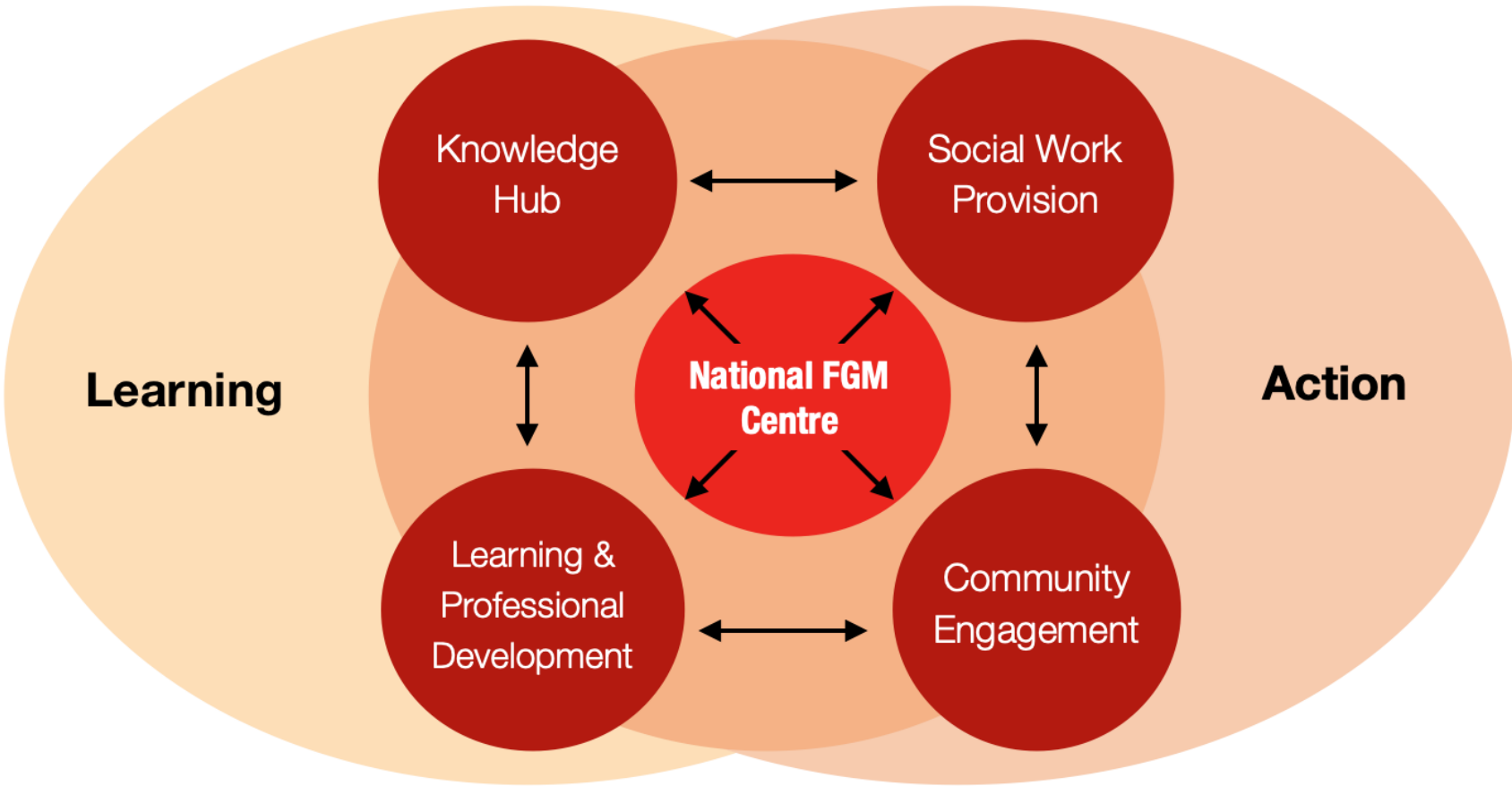
- There was a fear that communities would be further stigmatised if FGM, "honour"-based abuse and forced marriage are taught at schools. The fear of stigmatisation is "real" for mainly the Somali participants.

- Both female and male participants felt communities in Barnet should be given the opportunity to consult on the final harmful practices strategy prior to ratification by the Council.

- Both female and male participants felt that a third party, such as an organisation like the NFGMC would be an ideal and safe bridge to relay key messaging between communities and statutory organisations in Barnet.

- All participants approved of the Council's approach to seek communities' views and welcomed the opportunity to shape the future for Barnet's approach to tackle harmful practices

2. Background to the National FGM Centre



The NFGMC, a partnership between Barnardo's and the Local Government Association (LGA), was established in 2015 as a Department for Education's Children's Social Care Innovation Programme project initially set up to develop a systems change in the social work response to female genital mutilation (FGM) and to help end all new cases of female genital mutilation (FGM) in England by 2030. In 2017, the Centre's remit was extended to include other harmful practices including child abuse linked to faith or belief and breast flattening. It has developed a unique model of service delivery which it believes is most suited to addressing harmful practices. This combines social work, community engagement, professional development and a digital response (www.nationalfgmcentre.org.uk). The Centre now works in eleven local authorities in four English regions and has provided training to multi-agency professional staff across the UK to over 15,000 professionals.

The National FGM Centre's Vision is to keep children and young people safe from FGM and other harmful practices. Through our work we aim to:

- ***Prevent*** new cases
- ***Support*** those affected by FGM and other Harmful Practices
- ***Protect*** children and young people
- ***Partner*** to deliver services and learn

The Centre's independently evaluated intervention model is different, unique and innovative. The Centre works across the UK, with a diverse group of service users and partners to deliver expert services, ensuring children and young people have safer childhoods, stronger families and positive futures. The Centre's authority on FGM, breast ironing and child abuse linked to faith or belief is rooted in the fact that the model has been shown to achieve positive outcomes for children. The volume of cases worked on gives the Centre and it's partners a unique insight into what works to safeguard children from harmful practices, and the work is influenced by those the Centre seeks to protect. Since 2015, the Centre has worked on over 615 referrals in 11 local authorities , including with over 214 survivors of FGM including 24 under 18, prevented girls from undergoing FGM by supporting applications for 37 FGM Protection Orders and launched a ground-breaking FGM Assessment Tool for social workers. Through the work of the Centre, communities are given a voice, and are heard and professionals know how to respond effectively to safeguarding concerns.

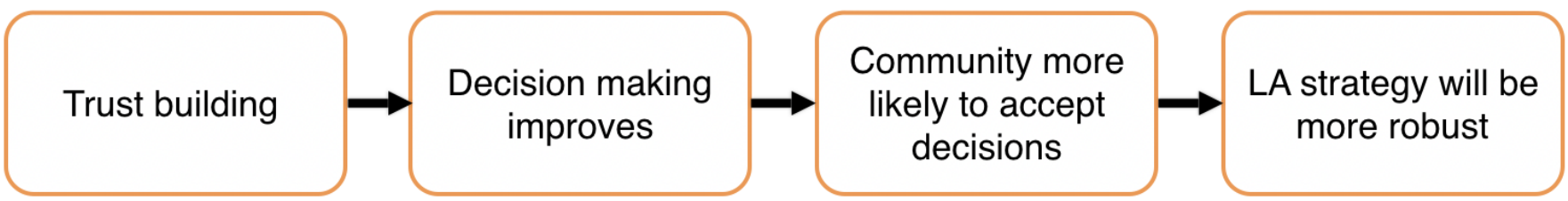
3. Background to the consultation

The NFGMC was commissioned by Barnet Safeguarding Children's Partnership to design and deliver a consultation exercise with women in men in Barnet communities to explore views and attitudes on various harmful practices. For the purposes of the consultation the 'harmful practices' focused on included FGM, forced marriage, "honou"-based abuse, child abuse linked to faith or belief and breast flattening.

The purpose of the consultation is to have an increased understanding of:

- Perspectives on the issues around harmful practices
- Practices influenced by culture or tradition, preferences and values
- An honest discussion of views and values
- How well the priorities within the harmful practices strategy reflect this discussion

The outcome of the consultation is to increase professionals' understanding of harmful practices by listening to those affected, in turn helping to ensure that Barnet's Harmful Practices Strategy reflects the needs outlined, and that services and outcomes are improved as a result of being better aligned to service user needs.



Demographics of Barnet – data and trends

The population of Barnet is estimated to be 394,000, the largest of all the London boroughs, and it is becoming increasingly diverse. 52% of the children and young people in the borough are from Black, Asian and Minority Ethnic groups, and 182 languages other than English spoken as a first language in primary schools. The Black, Asian and Minority Ethnic population is projected to increase from 39%, to 43% of the total Barnet population, between 2017 and 2032.

The data which exists indicates that Barnet is an area of relatively high prevalence for the occurrence of female genital mutilation (FGM). FGM and other harmful practices are hidden forms of mainly intra-familial child abuse, and as such difficult to identify and record accurately. However such data for Barnet does exist and includes the following:

- The study by City University in 2015 (Prevalence of Female Genital Mutilation in England and Wales, Macfarlane and Dorkenoo) which estimates that between 2005-2013 there were 945 girls born to women with FGM in Barnet, and that in 2011 there were 141 girls between the ages of 0-14 years with FGM living in the borough.[1]

- The same study estimated that there were 2,739 women over the age of 15 years living in Barnet with FGM. Population changes and growth since that time are likely to have increased this number.

- Modelling by North East London (NEL) Commissioning support on behalf of NHS England estimates that in 2016 there are 149 girls aged 0-14 years in the NHS Barnet CCG with FGM. In 2021 it is estimated that this figure will be 151. This places Barnet as the local authority which is 20th out of 32 local authorities in Greater London according to the number of girls 0-14 years with FGM.

- NHS Digital collects data on FGM within the NHS in England on behalf of the Department of Health (DH). From 2015 – 2019 there were 215 newly recorded cases in Barnet primarily recorded through maternity services.

There is very limited data on other harmful practices, although it is noted that the Children in Need census for 2016/17 did for the first time require data to be provided on FGM and abuse linked to faith or belief as factors identified at the end of a Child in Need (CiN) assessment. In the years 2016-2019 Barnet recorded 54 for child abuse linked to faith or belief and approximately 28 cases for FGM.

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[1] Macfarlane, Alison, Dorkenoo, Efua, *Prevalence of FGM in England and Wales: National and Local Estimates*, https://www.city.ac.uk/__data/assets/pdf_file/0004/282388/FGM-statistics-final-report-21-07-15-released-text.pdf, 2015

4. Methodology

The research team contacted a range of community organisations working in Barnet who come into direct contact with service users. Three key players who became integral to the consultation and assisted in the recruitment of participants were:

Community Barnet	Community Barnet supports, promotes and coordinates an effective voluntary and community sector in the London Borough of Barnet to enhance the quality of life for all. Community Barnet also provided a safe place for the women's FGD's
Healthwatch Barnet	Healthwatch is an independent local organisation that gathers and champions the views of the public who use health and social care services.
The Somali Collective	Is a non-profit and non-political organisation striving to assist Somali people living in Barnet and neighbouring boroughs.

Further to this, Horn of Africa Women's and Children's association provided a venue for the male focus group.

Participants

Participants were Barnet residents, and were recruited via advertisement through each organisation as listed above and were offered a £20 love to shop voucher for participating. A total of 21 participants attended two focus groups with female participants and 12 attended the focus group with male participants.

Countries represented in the female focus groups included:

- Nigeria
- Ghana
- India
- Iran
- Cameroon
- Colombia
- Romania
- Sierra Leone
- East African Asian
- Pakistan/Saudi Arabia
- Trinidad
- Gambia

Countries represented in the male focus groups included:

- Somali
- Djibouti
- Gambia/Sierra Leone

Facilitators

The Centre allocated a female worker, who has a range of expertise in working with communities, to facilitate the female focus groups, and a male worker, who too has a range of expertise working with communities, to the male focus group. Focus group discussions were also information giving sessions on harmful practices with facilitators explaining details of some of the practices being explored, such as breast flattening.

Leethen Bartholomew	Leethen Bartholomew, expert in FGM and child abuse linked to faith or belief is a social worker by background and current Head of the National FGM Centre , bringing with him over 20 years of experience in child protection and community engagement
Rohma Ullah	With a background in human rights including refugees and child trafficking, Rohma has worked at the NFGMC as both a specialist in direct work with children, families and communities, and currently as training and professional development lead

Method

The evidence was collected via focus groups using an adapted version of the 'REPLACE 2 approach'.[2] The REPLACE 2 approach recognises that FGM is a social norm and that each community has different belief systems and enforcement mechanisms supporting its continuation. Therefore, to address this requires individualistic and community focussed theories of behaviour change to fully capture the

[2] REPLACE 2, a new approach to end female genital mutilation (FGM) in the EU, http://www.replacefgm2.eu/

complexity of the practice of FGM and also other harmful practices in an approach to end them. Using the REPLACE 2 approach achieves this outcome by:

- Engaging with affected communities and ensuring they are active participants in the development and implementation of an intervention in order to gain their trust and commitment
- Drawing on community readiness theory to assess where the whole community sits in relation to addressing FGM and other harmful practices.
- Working with communities and in particular with community peer group champions to develop interventions aimed at moving the community towards ending FGM and other harmful practices.
- Monitoring and evaluation, both quantitative and qualitative, to capture community as well as individual responses

Transcription

Focus group recordings, totalling 6.5 hours, were transcribed over a period of 17 hours, and subsequently analysed for themes and sub-themes.

Consent and safeguarding

Consent was obtained verbally prior to the recording of the discussion, and participants were assured that anything they said during the discussion would be kept confidential unless there it involved a safeguarding concern. Anonymity was also assured i.e. their names would be anonymised should they be quoted and no one would be able to identify them.

Limitations

Whilst focus groups are a good way to garner collective views and allows for participants to reconsider and reevaluate their views there are limits to using the approach. For example, the male focus group was largely a heterogenous group in terms of ethnicity and this could have provided only the positioning of one community. Discussing such a sensitive issue as harmful practices in an open forum could have resulted in a less open discussion, as some participants may not wish to share personal experiences in a group setting. Additionally the sample size (n33) is small and represents the participants' views and this may not entirely reflect their community's views.

5. Findings from the Focus Group Discussions

For the purposes of the consultation, the harmful practices focused on include FGM, “honour”-based abuse, forced marriage, child abuse linked to faith or belief and breast flattening.

Level of awareness in relation to harmful practices

All focus group discussion (FGD) participants, both women and men, were familiar with the terms forced marriage and female genital mutilation (FGM). Most were also aware of the complex interplay between witchcraft, faith or beliefs and child abuse in their culture. However, few were aware of breast flattening. Facilitators spent some time explaining this practice, which sparked a debate around why it happens. Most female participants argued patriarchy had a key role to play, with one participant arguing “it’s the male psyche."

Forced marriage

The concept of forced marriage was understood by both male and female FGD participants. The men initially described it as something which can happen to young women, then agreed that young men could also be victims.

Most felt that it used to take place in their communities, with accounts being shared of young women being forced to marry older men against their will and the prospect of divorce bringing unacceptable shame on the family. Most felt that forced marriage rarely occurs nowadays in Britain in their communities. As explained by one man,

> ‘the mother or the father say they rather be more happier to find their girl or their son somebody they are very happy for it and will be treated well’.

Another man suggested that girls are less likely to be coerced into forced marriage nowadays saying:

> ‘within the Somali community to be honest, girls are more educated than boys at this point in time, and therefore more aware about their rights than even the boys…..the girls are more educated’.

Although the men’s views in the FGD pointed in the direction of this being an historic practice, outside of the FGD, one male participant disclosed to the facilitator that he had what he thought was an arranged marriage, but later found out that his wife was forced into the marriage by her family and this

was unbeknown to him. This participant went on to disclose that when his wife left the marriage, she was accused of being a witch by relatives, and that they have subsequently divorced and based on this experience he's unable to trust others, so he has decided not to marry again.

The women saw forced marriage as something which is still taking place in their community, although infrequently. One woman talked about British girls being subject to forced marriage overseas saying:

> 'there's a lot of criss-crossing with these things, going out there and coming back……somebody being taken for forced marriages, children being taken to Pakistan…..You are going on holiday, the man is ready for you to get married and when you are there….they are not Britain, they don't care, because that is what they believe in.'

Female genital mutilation (FGM)

All were familiar with the practice of FGM and were strongly opposed to it. Most men felt that FGM is not practiced in Barnet, one describing it as "barbaric". The men were less informed about the different types of FGM, thought that it is not an issue "back home" and acknowledged that they have never openly discussed FGM with others. The men also describe FGM as taboo and a tradition in their culture and called for the need for parent education. This perhaps suggests that they think it might still be taking place in their community.

The men were aware of the UK law against FGM and saw the law as positive, with one man saying 'The law is made, it's a deterrent. Therefore, that law is good'. Another goes further saying, 'The law is enforcing already. So, it's not against us. The law is supporting us.' There was a strong feeling among the men that knowledge of the law on FGM would prevent FGM being practiced, saying,

> 'you explain to them what you do is wrong, and it becomes the law if you cross that, everybody will respect the law'

The women in the FGDs were more aware of cases of FGM in their own communities than the men. One woman explained that, *'the parent cannot explain why they are doing, it's just what they believe in'*. All of the examples mentioned involved the girl being taken overseas to be cut, with one woman saying:

> '…..it's become like a transatlantic thing……where people are criss-crossing'.

She goes on to explain that a midwife friend of hers in Sierra Leone had been approached to perform FGM on a girl who had been taken there during the holiday. The women talked about secrecy being a strong feature of FGM. For example, in Sierra Leone, when girls are cut they join the Bondo society, a

secret society, and fear that if they tell anyone that they have been cut then they will be subject to witchcraft.

There are reports of girls, including the niece of one FGD participant, being stopped and questioned at Heathrow and Gatwick airports about harmful practices, especially forced marriage and FGM when returning from visiting relatives overseas; it is likely participants are referring to 'operation limelight' - a project run by Project Azure of the MET Police to raise awareness around harmful practices in airports. Some parents are reported to be taking indirect flights to avoid the questioning, *'Where are you flying from today? And I say Brussels. I'm not telling you I'm flying from Cameroon, Nigeria or the Gambia but I flew from Brussels this morning'*. Some talk of girls not wanting to let their mothers down and so not being willing to talk to authorities about being cut when they travel home. This is summed up by one woman who said:

> 'Do you think that in her right sense of mind, she will say, this is what my mum or dad did to me? ....a child always believes whatever mum is doing to her is right. There is no way they will readily incriminate, you know, their mum'.

Others say that girls who have learnt about FGM at school are more aware of their rights and more assertive and would not keep quiet.

Breast flattening

Many participants in the FGDs were hearing about breast flattening for the first time and asked questions about what it is, why it is done and who does it. Two men had heard of breast flattening as a means of stopping a young woman's breasts from developing.

One of the female participants from Cameroon, where it is practiced, knew more so about breast flattening. She was able to describe the practice to the other women in some detail explaining that there have been reports of cases of breast flattening in the Midlands. She suggested that in cultures where breast flattening is practised large breasts can be seen as an indication that a young girl may is no longer a virgin, saying:

> 'Well you have to suppress the breasts from growing because once the breasts are coming out….their friends mock them saying….'the breasts are coming out because she is very sexually active'.'

Other female participants were surprised by this, arguing that they thought for most, the development of the breasts was a good thing and that societally made women look more attractive. None of the participants were aware of any specific incidences of breast flattening taking place in their community

in the UK. There was a strong call for further research into breast flattening in the UK from one female participant.

Proof of virginity

Being able to provide evidence of the virginity of a girl was raised by several FGD participants and appears to be one of the driving factors behind some of the harmful practices, including breast flattening,"honour"-based abuse, forced marriage and checking the tightness of the entrance to the vagina. As one of the women explained:

> 'virginity affects the bride price, it affects the honour of the family and then the girl's education'.

One female participant from Gambia explained what was in her words 'an old practice' whereby girls would be asked to insert hard boiled eggs into the vagina to prove virginity - if the egg could not enter, "it meant she was a virgin". When asked whether this practice of virginity testing still happens, she argued 'not that I know. It was years ago.' Some of the women were shocked to hear this. There was a general consensus amongst the female participants that proof of virginity is still important and charts the course on how girls and women manoeuvre the world. This invariably determines how parents choose to raise their daughters and is intertwined with how a girl and women's perception of self.

Child abuse linked to faith or belief

Witchcraft as a faith or belief is a highly complex issue which many FGD participants, both men and women, felt remains embedded in some communities in Barnet. There were differing opinions about the interactions between spiritual, religious and medical conditions and the most appropriate ways of protecting and supporting vulnerable people. The terminology around witchcraft itself, is contested. One participant from Trinidad said *'terms like black magic and witchcraft are no longer used, it's gotten status, so it has a faith on its own'.*

Some participants know of women who describe themselves as witches. One woman explained a recent exchange at a gym club, '*Honey, in England today, I go to the gym and now, being a witch is something of status……and that's why we have to be very careful not to offend others, and people would say that it's my choice to believe… I am working out with her all the time next to me and we are talking and …she said, 'I am a witch'… just as you would say, 'I'm a Christian'. …she didn't have any issues with telling me. So, no longer is it dirty and dark… so, now when we talking to people we now have to respect*

rights, because people are saying, 'I chose to be a witch', 'So what, you Christians have Christmas, we have Halloween, what is the problem? We equal'.

Another woman explains that:

> 'some mothers actually initiate their children [into witchcraft], so it continues to run in the family. It's like a legacy they don't want to lose, so they initiate their male children and their female children, so it continues.'

One woman sees witchcraft and Christianity as alternative belief systems and felt strongly that people have the right to choose the religion of witchcraft, saying, *'… let's be fair and let's be clear… we live in a world where everything is acceptable, everything… People might say: I am a Christian, I chose to bring my children up as Christians, so from very young I offer them up to the Lord, I christen them, I baptise them and every day our faith is our lifestyle and I teach them the principles of the faith. Who is someone to come and tell me that I cannot be a Christian or I cannot bring my children up in that faith? Now, this woman who comes to me and says, 'I am a witch'. So she brings her children and says this is my faith, I chose to believe in witchery or sorcery, or whatever, so my children will be part of this thing. So, I just want to know, I mean, with all the conversations going around the table, what is the aim? Are we going to be telling guys that, 'You can't be [believe in witchcraft]' or 'beware of this one' because nobody will be free unless they want to be free.'*

Other women see witchcraft as a negative curse and talk of the power of Christian prayer to break the curse and set people free from witchcraft, saying:

> 'if they want to be free, then what they do, they ask her for a prayer, a strong prayer. I'm not talking about witchcraft, I am talking about prayer from the spirit of God. Some of them break because the curse will break them, and that's it because they no longer have it, it's just gone, whatever was inside them, with the prayer it just walked away… The prayer always works, I believe in that. I'm a Catholic'.

Although there were differences in how participants viewed witchcraft, all were in agreement that there are cases where it has resulted in child abuse and that vulnerable people need to be protected from harm.

When talking about witchcraft, FGD participants said that in their culture people might say of someone who might have mental health challenges that they have 'been *possessed by a Djinn'*. This person might then not be taken to a medical facility and instead the community would accept their behaviour as evidence of them being possessed and take measures to drive out the Djinn. Some participants thought that a child possessed by a Djinn could perform hypnosis, with one woman saying:

> 'they do kind of like hypnosis…..well this child has these powers where they are able to do things like that. And you are sitting there and looking at the child and they start doing some kind of funny faces, turning the eyes…and you are like why are they doing this kind of behaviour'.

Some participants felt that an evil spirit can be countered effectively through Christian prayer. In the male FGD, all of the participants agreed that mental health rarely occurs and instead believed that it is possession. Once it is possession they believe that intervention should be provided by a faith leader and this included children.

Stigmatisation of communities

The men in the FGDs were more likely than the women to see harmful practices as having ceased in their communities with one man saying:

> 'mutilation and forced marriage, those two things are not exist anymore, and if they do exist, it's very minute, and they are getting shamed every day and whoever carried out these actions are getting victimised and they have no power in the community.

Men, particularly from the Somali community, felt that the government did not recognise the efforts being made by communities against harmful practices and that inaccurate assumptions are sometimes made which result in their community being unfairly stigmatised. One participant explained that FGM no longer takes place in their community and the whole community:

> 'stand against it….. FGM is not something part of our culture anymore……we categorically refuse anything associated with Somali community and FGM as a connotation'.

Another man felt that care should be taken when talking about FGM in schools as classes will include people from different communities and *'those kids can use those kinds of allegations and these particular students can be victimised……. can be used as small banter and that can be turned into bullying and everything else'*.

There was also a feeling from some of the men that cultural practices like FGM were being demonised whilst other practices which are carried out by surgeons, like cosmetic surgery (both genital remodelling and breast enlargement) are accepted in British society as social norms.

When the men were asked what the three highest priorities were in their communities, they listed gangs, drugs, knife crime and mental health as the highest need, with FGM being considered of lesser importance.

Knowledge of the law and awareness of initiatives to end harmful practices in Barnet

Most FGD participants knew that harmful practices, in particular FGM, are illegal in Britain. However, some women felt that the community, '*know about the practice but not the law*'.

Some men reported that FGM was against their religion. Several had seen information about FGM on the government website. None was aware of work in Barnet to end harmful practices and were not aware of any local organisations involved in such work. One man said he thought the community would need to phone NHS Direct to find out more or to report abuse.

Some women and some were aware of the work of the NSPCC, however, they were not aware of many other organisations working locally on harmful practices.

Both male and female FGD participants were keen to see improved communication channels between the authorities of Barnet and the local communities and greater dialogue about harmful practices and initiatives to end them. Any implementation of policy should first involve their input.

6. Recommendations

There were four different types of interventions suggested by FGD participants to end harmful practices in communities in Barnet.

(a) Robust responses to actual cases of harmful practices being practiced

A small minority of participants would like to see robust, punitive approaches adopted, including checking whether girls are cut as they leave the UK to visit their families overseas, then re-inspecting and questioning them on their return. One woman felt a strong deterrent was needed and suggested, 'if you are going to do it [FGM], you will not be able to have your children'.

(b) Increased education and awareness raising about harmful practices

Most participants were not aware of leaflets on harmful practices being available in Barnet, or of places where community members could go for further information, advice or guidance.

There were calls for publications with information on harmful practices, for handouts being available, including the information provided by the FGD facilitators, which participants clearly found useful. It was suggested that this information should be circulated to health centres, psychologists and health professionals and disseminated to patients. A comparison was made with the Ebola outbreak, where information was readily available and widely shared.

Education of parents was seen to be key to ending harmful practices with schools being seen as the most appropriate place for this to take place. One man enthusiastically said, 'Yeah, yeah in primary and secondary school…asking parents 'Are you aware about this? What can you do about it? It's harmful to your kids'.

Most participants felt that children should be aware of harmful practices and that knowledge by girls could lead to girls avoiding harmful practices. One woman said, 'The children can read, then they know that, so publicity's important. Leaflets, sensitisation and reaching out to communities, churches and schools.' However, others were keen that the focus should be on educating parents, rather than children and some felt that primary schools were inappropriate places for these conversations to be taking place.

When informed that as from September 2020 FGM, forced marriage, domestic abuse and honour-based abuse will be taught in secondary schools, the response from men was mixed. Some welcomed

this initiative, others were more reserved saying, 'From September, let's not go there, as there are some other things coming with it……we should not open Pandora's box, but yeah, the FGM we support it and everything else'.

The men generally feared that their community would be stigmatised, so any educational work in schools must be mindful of adopting an approach that does not disadvantage communities. The issues discussed raised further questions about parental rights verse child rights; how teaching will be delivered; age at when it should be taught and the need to provide factual information.

(c) A consultative, community engagement approach drawing on the knowledge within the community of harmful practices

It was clear from the FGDs that even though the participants were informed and educated members of their communities, they felt there was a lack of communication between the authorities and the community in relation to harmful practices.

The concept behind this approach is the need for key people to be identified from within the community to work with the authorities to develop initiatives which will work in their community. Then for these link people to act as role models and to promote dialogue within each community in order to engage fully with the different stakeholders, as described by some of the women, as follows:

> 'You really need to work with the communities because when you are dealing with long held traditions, tribal loyalties and things, …you need to get the communities involved to bridge that gap and get the community involved. Because if you are just a social worker from Yorkshire, goes to talk to a tribe, they really will feel offended… an African approaching and African… you are making one step of respect for that culture'.

> '…we are all from different communities and the only way we are able to reach out to those communities is, we need to now form a group and say okay… if we can actually identify one person from each of the communities I think we can say, 'Yes, together a team together, we will achieve more', because I cannot just move and jump into the Ghanaian community and start trying to tell them things - we need somebody from that community. And when we come in as that kind of a team, we can create a great impact because we are now saying that this is what we think, we want to talk to them and say, 'Look, can we change our way of thinking?'. I can't take my Cameroonian way of thinking or doing things and impose them on a Ghanaian or Nigerian… or Romanian or Colombian or from Gambia or from Sierra Leone…'

> 'you need someone who is more understanding… it's a wider societal thing, it is not just the FGM, there are other things going on. So be respectful of cultures, so that you are not just saying, 'Well don't be part of your society',

because they are all intertwined, they are intertwined'.

The men describe a similar approach with a specific focus on community leaders;

> 'So, the best way is to go through the communities and in every community, you have people who other people will listen more and are respected more. So…when you are coming in, find out who is the community leader or the person who is respected, it could be a lady or it could be a man. So, when you meet them, you with this person, they will take you well and they will spread that news.'

'

> I think the community leaders could also be put in touch with children who they think might be at risk from a forced marriage or FGM, for example, because sometimes as a child, when you are going through an issue with your parents you don't always want to go to the social services. Sometimes, sometimes it could be more comfortable to talk about the issue with someone from your own community, as in somebody who understands the culture and from there they can find the right solution. So, I think that that could be a role for the community leaders too'.

(d) Avoiding re-traumatisation and providing support for survivors

Whilst most FGD participants were in favour of greater dialogue around harmful practices, one man expressed concern that raising FGM might re-traumatise girls and women, saying, 'My worry a little bit now…is that some people have passed that stage…they've done FGM, they've healed…. are we not opening a wound, a fresh wound by asking about FGM?... we might re-traumatise again'.

Other men were keen to see support provided for survivors of harmful practices, saying, 'council giving them some kind of comfort for them to get over the traumatic that they've come through'.

(e) Adequate resourcing

Finally, FGD participants, both women and men, were keen to point out that initiatives to tackle harmful practices in their communities require adequate resourcing in order to be effective, as explained by one woman who said:

> '…one thing you always have to understand is that these things come with a cost because once we don't have that cost to work with we will not be able to proceed… so we have to be honest upfront to say that those things will have to come into play before we can actually make an impact'.

(f) Recommendations by the facilitators

Discussions on proof of virginity showed that there are deep-rooted views linked to "honour" within some communities. Such views will have wider implications for the experiences of women and girls that are beyond concerns associated with harmful practices. These are highly sensitive issues and therefore require careful consideration. The snapshot of views provided in the FGDs should be used as a springboard for further discussions and policy change. So, a key focus of the council's work going forward should be to create stronger links with communities and groups.

The discrepancy in the views and knowledge between the male and female participants glaringly suggests that work needs to be done with men to provide them with the right information about gender based violence. Based on the views of the male participants this must be done at a community level in settings where they are accessible and with faith and community leaders driving this change.

Men should be given an opportunity to discuss such issues on an individual basis as there are challenges to discussing such sensitive issues in a group setting with other men.

With harmful practices being a mainly gendered issue, it is inevitable that women would have more insight into the matter. The women participating in the FGDs had either experienced or knew someone who experienced a harmful practice. Therefore, they are a strong source of information and can play a role in co-producing an effective approach to raising awareness. Opportunities should be carved out to provide them with a voice, and to work alongside the council and to educate men.

It was evident that some women in the FGD had information about girls at risk, but this information was not passed onto the authorities. Taboos around discussing these issues within communities, and the emotional pressures placed on girls to adhere to cultural norms and not to dishonour the family are barriers to disclosure. Addressing this requires a preventative educational approach based on behaviour change at an individual, family and community level.

Parents and communities need to be informed of the approach being taken by schools to educate students about harmful practices. Students, parents and communities should play a part in informing the content of lesson plans and developing the best approach to use to teach students to ensure communities are not stigmatised.

FGDs suggests that there is a disconnect between communities and statutory services and participants were overwhelmingly open to overcoming this. Therefore work should be done to bridge this gap by developing an effective community engagement approach.

Child abuse linked to faith or belief and how it intersects with mental health needs to attention as some communities may not consider seeking medical intervention. Communities may believe that mental health does not exist and could interpret symptoms as spirit possession or witchcraft. Therefore engagement with faith leaders and communities about this issue requires attention. Awareness of this issue as a safeguarding issue is at an embryonic stage, so a good starting point would be to create dialogue with communities and faith leaders about the issue, and when and why it would be considered a safeguarding concern.

Development of a community resource pack is needed. This could include information about harmful practice, but could essentially include a range of other issues and must include a list of support services.

7. Conclusion

This study indicates that those selected to participate in the FGDs are opposed to harmful practices, including female genital mutilation, forced marriage, breast flattening, "honour"-based abuse, and child abuse linked to faith or belief in their communities. In addition, they are committed to working with local authorities to inform and educate as well as to engage the community in dialogue around these issues.

The level of awareness of harmful practices is higher among women than men, however, both men and women see the ending of harmful practices as the shared responsibility of both men and women in their communities.

Local authorities are urged to avoid the stigmatisation of affected communities and instead to allocate appropriate resources to develop a consultative, community engagement approach drawing on the knowledge within the community. It is recommended that this approach avoids re-traumatisation of survivors and instead provides them with appropriate support, provides a programme of education and awareness-raising about harmful practices, whilst also develops robust responses to actual cases of harmful practices in the community.

Local authorities should also seek the views of communities present in the area on issues which may affect them to strengthen trust in statutory agencies; not only to increase the identification of those at risk of harmful practices, but also to provide stronger services through robust policies which have been informed by information on the ground.

Appendix A: Framework of questions for the focus group discussions

THEME 1: *KNOWLEDGE ABOUT HARMFUL PRACTICES*

1. Tell me what you know about FGM/FM/BF/CALFB
2. Do you know the scale of the issue in Barnet
3. Do you think these are issues that affect people in Barnet? Do they happen a lot? Do you personally know anyone affected?
4. Do you think these issues require more attention in Barnet?

THEME 2: *COMMUNITY EFFORTS*

1. Are you aware of any work being done in your community or Barnet to address these issues?
2. (Follow up question) How long have these efforts to address female circumcision been going on in your community?
3. What is going well and what else needs to be done?
4. Which people in the community do you think these actions or programmes are not reaching? (Prompt: For example, individuals of a certain age group, sex or ethnicity)
5. Are you aware of any laws or policies on these issues in the UK?
6. How does the community view these policies and laws?
7. Who would you feel safe communicating your concerns with?
8. What the barriers to reporting abuse in communities?

THEME 3: *COMMUNITY LEADERSHIP*

1. Are there any community leaders involved in any effort to tackle FGM in your community?
2. Are community leaders concerned about these issues?
3. Who are other community leaders or stakeholders who should be involved in any effort to tackle FGM in your community? (Probe to identify critical players?)

THEME 4: *COMMUNITY WILLINGNESS CHANGE*

1. Do you think that there are any reasons for some members of your community to still want to continue the practice of female circumcision in the UK? Probe
2. Based on the answers that you have provided so far, what do you think is the overall feeling among community members regarding this issue?
3. How do you think communities in the UK are influenced by what happens back home? In what ways?

THEME 5: *PREVENTION (time, money, people, space, etc.)*

1. How do you think we could best raise awareness of harmful practices in Barnet?
2. How best do you think we could protect children and adults from harmful practices?
3. Are you aware of any community based organisations or groups that are working at the community level to provide services or programme to tackle female circumcision?
4. What role do you play in preventing these issues?

THEME 6: *ENDING HARMFUL PRACTICES*

1. What do you think are the solutions to ending harmful practices in Barnet?
1. Do you think you could help to end harmful practices in Barnet?