UK Female Genital Mutilation Network Meeting – 15th February 2006

Present –

Gladys Meka – Mothers Union,
Rimberria Mukeria – RAINBO,
Comfort Momah – GISTT,
Dorcas Akejuobe – LWH,
Jennifer Bourne – WF African Well Women's Service,
Leila Hussein – WF African Well Women's Service,
Chloe Adams – FCO,
Francis Feeley – Francis Feeley Fundraising Services,
Sarah McCulloch – ACCM,
Efua Dorkenoo OBE,
Anna Aguma – Health First,
Martha Jean Baker – WILPF,
Josephine Fael – ACCM,
Karen Renshaw – ACCM,
Rahima Farah – Central Liverpool PCT,
Barbara Clark – Home Office,
William Gale – Home Office IND,
Robin Titchener – Home Office IND,
Eushrah Ahmed – FORWARD,
Amina Ahmed – ACCM

Sarah McCulloch - This is a follow-up on last year's meeting. We're still campaigning and doing research, to come together to share good practice and also who is coordinating the work that is going around the UK. We seem to not to know what is going on and even if there is work that is going on in other cities we all seem to assume that it is only London, Sheffield, Liverpool doing the work but each city has some work that is going on. Also supported to involve Government departments who make the rules and they provide services to users. So, today's meeting is to follow up on last year's meeting, but there is also an issue about asylum which has been concerning me for the last year and I have invited guests from the Home Office to come and talk to us about the work they are doing and how they make those decisions and is up to us to share our concerns with them.

The meeting is going to be chaired by D Efua Dorkenoo she was originally the pioneer of the FGM campaign in the UK, she is an international expert on FGM and she has been working with the World Health Organisation in Geneva and she has come back to the UK to continue the strong, hard work. She is now working as a consultant with Forward and I would like to welcome her to take over the meeting.

Chair -Thank you very much Sarah, I'm just looking at the time, so I am going to be a very strict chair. We are a bit late, and according to Sarah, we are not going to have a break and we are going to go straight through. But just to add a bit to what Sarah was saying about me. I wanted to share with you that I am doing a study to look at the prevalence of genital mutilation in the UK, in England and Wales. I am doing the study in conjunction with the London School of Hygiene and Tropical Medicine and the City University Medical School. It's a Department of Health funded study and hopefully by the end of March we would have some robust figures to give us a baseline on where we are in terms of estimates of women and girls possibly affected. Right, the first item on the agenda is introductions and so we would like to move that on, it's twenty five past ten, to give us as much time as possible, if each of you could introduce yourself and tell us what you are doing and make it quite plain, not too long.

Sorry it's my first time of coming so I don't really know much about it. My name is Gladys Meka; I am representing Mother's Union London Nurses. I am their social policy officer, and they have asked me to come along and find out what is going on here.

It's my first meeting as well, my name is Leila Hussein I'm the youth outreach worker for African Women's Service, Waltham Forest.

My name is Jennifer Bourne; I am the specialist nurse, the lead for the African Women's Service, Waltham Forest. We work with women, who are affected by FGM, and we also do a lot of training, we work with other agencies and we work with a lot of other groups in Waltham Forest and across London and recently we've put together a multi-agency child protection policy in the borough which thanks to our colleagues in Cardiff they allowed us to have and copy their original policy, and I understand that that policy might now be used across London.

I'm Chloe Adams; I'm from the Consulate Directorate of Foreign and Commonwealth Office, I'm responsible for assistance policy which is about what assistance we provide to British nationals overseas. So one of my responsibilities is to look at policy on FGM and what more we can do proactively to prevent British National from being taken overseas to have FGM and how we can help if they have been taken overseas and what we can do afterwards. My predecessor Phillippa came to the meeting last year.

Hello ?? it's my first meeting as well, I'm an advocacy worker, working in Liverpool and my role is I work with parents of children who don't know much about the law, and educate them about the new law and working with them and working with the Women's Hospital as well.

I'm Martha Jean Baker, I am very interested in women's human rights issues and a number of years ago I was involved with planning in a side event for CSW commission in state on this topic. I knew about it before then but I became very involved and engaged in that and realised the importance and attended a conference that was held at a friend's house discussing new legislations and issues around it and the issues around the need for asylum and other kinds of issues. So this is an issue that I've remained personally and professionally interested in.

My name is Eushrah Ahmed and I work for Forward Foundation for???? . I am the community development officer. Forward works with community groups the Government on the issue of FGM in terms of campaigning and advocacy. We have some projects in Africa, so it is the first time for me to attend this meeting for FGM Network.

My name is Rimberria Mukeria – I work for RAINBO.

I'm Karen, who a lot of you might have spoken to on the phone, I joined ACCM in October '04 as Sarah's admin officer and it's been quite exciting really to see what's been happening since then.

I'm Josephine, I've recently started working with ACCM, and my role actually is to work with young girls, I'm a service development worker. The thing that we are hoping to do is running a formal session, and half of the time will be devoted in to thing based on discussing a formal training session such as assertiveness and esteem and health as well.

My name is Amina Ahmed; I am working at Agency for Change Management based at London under Sarah McCullough. I work with parents for community practice, FGM.I give them encouragement, educate them and give them information and bring back their confidence and self esteem and introduce them to other agencies.

My name is Anna Aguma, I work for Health First which is the health promotion agency for ??? Commission. I work mainly with African communities round, particularly HIV, but obviously because I work with African communities FGM is a particular issue. I suppose at the moment what we really try to do is to try to raise awareness, not just within the communities but within the Primary Care Trust as well with regards to FGM and to make sure that people also know new legislation and where they can go and stuff like that.

My name is Dorcas Akejuobe OBE, I'm a specialist working with FGM, I'm equality and diversity lead for Prose Liverpool Rules. I'm a member of the FGM group for Liverpool which is Multi??? Community Group, and it was set up in 1996 and has been going for a while now. We more or less support the community, encourage the community to come to us and we use the advocacy, we do the ground work, as you all know it is a silent thing and what we have done in our Trust I will share the good practice. We've set up a clinic for the pregnant mothers; we are looking to set up a clinic for the younger girls as well.

I'm, Barbara Clark, I work for the Home Office, I'm a senior case worker, I think Bill is going to be a further explanation of what we do, so I think I might leave it to him, but my particular area is asylum applications for Somalis.

Hello I'm (cough) Robinson, I also work in the Home Office, I work in the Asylum Policy Unit, advising in policy areas, one of which is gender issues and within that are FGM is relevant to me.

Hello I'm William Gale, commonly known as Bill, I'm called the chief case worker in Asylum Casework Directorate, which roughly equates to senior casework advisor, I think. I've been working in the Home Office for 30 odd years and in asylum for 14 years and I've just started as chief case worker after my successor moved at very short notice.

Well, I suppose it's my turn to talk, I'm Francis Feeley and I work with ACCM and other clients as a technical writer. My duties are to help with the technical writing, and for the last 6 years I've been the independent evaluator for ACCM. My duty being to do the roughly equivalent of "yes your bum does look too big in it" to give a critical friend's assessment of how things are going, so I have some very good friends in this room.

Thank you very much, that was very quick, we now are getting to the meat of meeting which I think where all of us want o share good practice and ideas. So this session is basically for the sharing of information and good practice so I will say that putting on my researcher's hat it will be very interesting to find how we've sort of evaluated the different aspects of FGM work in this country. So, I am looking back to over 20 years of work in the community in terms of child protection, in terms of rehabilitation issues and in the last decade ??? asylum, so there are different areas, and I would say that if I look back FGM went into the policy in the 80s. It went either first legislation and then it was brought in through child protection with the new children's' act and there is already a document on inter-agency collaboration in terms of child protection so that's brought it into the work of all the professionals involved in child protection. And then in recent times FGM has been written into the policy of sexual and reproductive health. So it would be interesting to see where we are with the same activity, because there's been activity, there's been training policy on all levels for many, many, many years so I myself have been away and since I came back everywhere I went people have said, there is no policy, which is quite interesting too, I would like to open the floor fro sharing of information on good practice.

We are very concerned on child protection in our borough which is why we have brought together a multi-agency group. We work a lot with the metropolitan police to raise

awareness. We do a lot of training with professionals, and also Leila and my colleague Fatima? do a lot of work community groups. So we are very concerned because the London child protection procedures were based on the old law, on the prohibition of female circumcision act and also there is very little really that's robust in the London procedures about child protection. So we were very concerned, and I spoke to my colleague Caroline Jones in Cardiff? And they have a policy on child protection that she very kindly let us have. We've adapted it a lot because we work with the police, with social services, with education, and with health to look at this policy, because we've had a number of child protection cases coming through following the ??? So we're very worried about this and so that policy now is at the point of being agreed by the local Safeguarding Children board and it will be launched in he next few months. I spoke with my colleagues in the strategic health authority so the policy has now gone to the strategic health authority. They've told us they want to incorporate it into the London child protection procedures, because what it doe sis it gives a lot more information, it's also got good practice guidelines at the back written by health, written by social services, written by the police and education and voluntary sector. So it's a good, robust policy, because when you're a practitioner, and I've been a practice nurse you don't want to be reading through reams of documents, you want to have something to lock at that clearly shows you how to go forward. But, really underlying this policy is the need to have community advacates to work with social services, with all the agencies and the communities, and also training. So that underpins the policy, the use of advocates and training.

What we have done is to have conferences like that every year in Liverpool and we will be invited to speak this, but this conference we opened it up to professional colleagues and professionals and social services, midwives, anybody that is interested. The last one we had was last year and (rustling). The issue of FGM is so complex that a lot of people don't know much about it. It's about reasonableness? And training about three in a year just for the midwives want sat and talk about the law. And in our group when we do the ??/ what we've done with the community, we have the community come for an FGM day because you wont get them to come, you have to provide lunch to get them to come. They will look at the time from 10 to 3 because they have to collect the kids from school. So we have the community there, 3 sessions, a 5 minute video as well and I've been into the Somali group of which I took a video in the Somali language and I have a Somali help leaflet before me, though that is a way of making the awareness to start with for the professionals and the community. What we've done, starting in 1999 we asked for the guidelines and now we've got the link link? The link link? Is a clinic for women who no speak English. So what we've done, we bring every woman back whose got a problem and we look at other needs like FGM and we've got a booking computer and it asks them have you been closed, and if they have been closed the midwife asks them to see the consultant. If girl have type 2, type 4 they need to be defibrillated or opened up and the consultant see them and we see to that, and it is done on a labour ward. And the consultant is teaching other consultant. So in a path of racial awareness we need to the service need of the pregnant mother. When we started we wanted to target the younger ones we set up the clinic and nobody was coming and I was talking to Rahima. That would be the best thing that I should talk to the gynaecologist but the gyny doctors did not want to see the young girls who were not pregnant the consultant obstetrician does pregnant so we got some politics there. What I've need to do is to see why can't our younger girls can just walk in so that they can be defibrillated, so that's the way we have

done it in the past 10 to 15 years working with the community and it's no easy. I've invited people from London to speak to our community, so I just tell everyone I am an African from Nigeria and it's not just a Somali issue, it's an African issue. So that's what we've done so far.

I just want add something because I'm working with young people myself and I understand why they wouldn't just stroll in like you just said, especially the girls who really need to build up their confidence. We had girls who come in for sessions because what I do, I have like health awareness sessions not just about FGM, they wont just come for FGM, because when it comes to young people they have other issues they are dealing with at the same time and after them sessions we had young girls who came in under cover. The had to sort of phone in and you have to make sure it's really like nobody knows who they are really. We just notice that recently we had a lot of young coming through, because it's deduction again really because they think they only need to be opened up when they are buoy to get married and it's building their confidence and saying you don't have to be married to be opened up, you know, it's as a human you really need it.

I just wanted to give some anecdotal feedback, the effectiveness of this kind of outreach; I mean one story that I think that says something. At the time that I was working on this programme for the WNC the CSW it was raining hard and I missed a bus. The bus was there and he wouldn't open the door and there were 3 of us at this bus stop and we had a long time to wait for the bus and 2 of the people were Somali women who were clearly mother and daughter and they started talking. And somehow or other when you are waiting for a bus you talk about things that you might not otherwise, and I was telling them that I was working on this particular project and they were asking me questions and we were talking about, and at one point the mother sort of leaned over to me and said "It's important, keep doing it". And I'm not working in that field so it was interesting to me that this mother leaned over and sort of confided this in me and said "Do it! Keep doing it".

Because the mothers want to do it, it's the culture they have a long, long time. I work with parents, I educate them because it's too hard to tell them that we want to stop this thing, because of the culture, they want to hold it, and they want to believe it. So they need to educate the parents, they need to educate the grandparents, all mothers and all dads. And explain to them the law and give them conferences and give them time to speak in a good and comprehensive way. And nurses and midwives will bring it to woman, talk to her and if they are not educated and they have the words from the other

family members and practice FGM. And if they get educated and come to that forum they understand everything and they want to keep that and do it and do it.

That's a very good contribution; you know most of the women will not be speaking English.

A lot of people, they listen and she will tell her and next lot and next lot and the other one and that's the way they listen.

Word by mouth.

I wanted to look at sort of systems, that would continue which goes back to good practice, like Dorcas, you have said that through the maternity clinic and the outreach work is it (text message came in).

We work for the PCT central and it's a partnership, I'm based within the Liverpool Med? And when we have a clinic on a Monday morning we have like 6 lady workers of FGM of time to find out between them. So Rahima is ??? advocacy worker and she's based in the community.

Where is her salary coming from?

From the ??? Centre.

From the PCT, that is very important.

We have got a partnership with PCT.

?? in April 2004, and a lot of this work is based at central PCT.

Are you on the public health core?

Social Inclusion team.

So what we are picking up here, we are trying to look at, in terms of the good practice, how the system which we could build on and it is sustainable, because one of the major problems with the work on FGM is lack of funding. And it is mainly because in the past it is sort of left for NGOs to do the activities and NGOs are very under funded. So what perhaps as we talk, since we have the statutory sectors here let's look at it. Now Dorcus although you have link workers, my first question is, when you deliver a mother who had already undergone genital mutilation, can we just tentatively say that risk factor that perhaps if you delivered baby girl, it could happen, so I want to find out from you how for example when she leaves from the midwife's care and is now is based around health visitors.

What happen, within our group that we set up is we go to PCT Central ?? in the group. I'm on the group, and you got community and you got the ??? so you got people there working as a group. So we use Rahima because she is out there, so when the mother is

going home, 2 days, 3 days we don't say anything. We use Dorothy because she's based, you know, within the community and she's got new room now. They both got commissioning? And Rahima is there and sadly that something that happen. I went to give a report to a group of women in the community, they are mostly ??? The Sure Start midwife invited me so I thought this an opportunity to mention FGM, so I mentioned it, and this young girl said "You shouldn't be telling us what do" and I could see she was a bit agitated. But I told her I'm not the only ??? worker here. So talked to Rahima "Do you know this ??" so she said "I know her, I'm going to speak to her" . That's the way we work.

So I know the parents and if there is a problem with the parents, you know, you are just giving them advice, so if the health visitor approaches me and says she has been to the house, she's not happy with the outcome, she feels the mother is still thinking of taking the child abroad to have female genital mutilation then she will ring me and I'll go round and speak to the family and then ask questions and tell them about the new law. And if she does take her out of the country, I have given her a copy of the new law and that's 14 year's imprisonment, just letting her know that the health visitor had some concerns as well. So we work together as a team as she was saying we are multi-agencies, we all work together, it could be a social worker, like I got a phone call from a lady who come to our conference that we did last year in Warrington. She didn't have, there's no-one in Warrington, no-one had a clue on FGM. She had a case brought to her where a child, was a lady converted to Islam and she married, I think, an Iraqi man, and he said that they had a 3 month-old daughter and wanted to do FGM on the little girl and because she was a new convert to Islam, he was trying to say "Look, at the end of the day you have to do it" And because she had just converter she was really, really scared so she approached the health visitor and moved out with the child because she didn't want it to happen and the husband went to see the Imam of the mosque to ask, and he said "You don't have to do it, it's not compulsory". And they went back together again, but at that point she was literally thinking "Oh why did I turn to Islam, because this is what my daughter's going to get".

I'm very new to this group, this what we are talking about, is being done yet?

Already women and girls who have been affected, who have come, they have already undergone it, and there are also people who are living here who are continuing, but we still don't have the good evidence. The only evidence, there's quite a few child protection interventions and it's very confidential. Welcome Comfort, I see you are at the back there, could you introduce yourself.

Hi, I'm Comfort and I run the African Well Women's Clinic and I'm the FGM specialist. Can I just stay here, because I have been on call and I am tired and I have to be here because my eyes are red.

Sarah, you wanted to say something.

Just a brief about what we have been doing in Sheffield. When we started 7 years ago there was hardly any work done in Sheffield. So I set up an FGM strategy group with a group of professionals from Social Services. There was a health visitor who was in

charge of health visitors in South Yorkshire and it was started and there was a police officer on it and members of the community and I provided them with training with support of CAFOD. Since then we have had protocol for midwives in the sense that if a woman comes to us pregnant we talk to her because they have been trained to give advise about how she's going to manage her pregnancy if she's been infibrilated. They also give information, necessary to the consultant what to record on her notes, on what kind of FGM she's been through. Those notes will be able to go the midwife who will look after the woman when she gives birth in order to go to the health visitor so she follows up if the woman still has health problems the health visitor will advise her to go and see her GP. The problem is the high turnover of midwives means that (agreement from somebody else blocked this part of the sentence) is from 70% to now 20/30%, because we keep having to go back to do the training. The non-professionals within the strategy group, one of them is child protection ?? communication is now taking on the education and training with teachers and liaison officer's health and school classes she trains them in FGM issues. The problem is fear of dealing with the issues. They can see that children are at risk but they don't want to report it because they are fearful being, getting the community against the school or the teachers. And I was in Bristol on Thursday doing a training session for session workers and about 20 of them turned up, never heard of the new act and 2 of them didn't think that FGM even existed and didn't see it a problem in Bristol in the Somali community in Bristol. It just goes to show what sort of information is available.

Sarah, can you pick up on this, Sarah has brought in GPs and school nurses and, you know, I wanted to highlight, perhaps a problem that we meet. Because the department of health is developing a CD ROM for professionals, so that will be quite useful and they will take the responsibility of getting it to all the authorities. So this meeting is very important and we want to pick on your brains on what is happening, because it seems to me that as far as I can recall, training and all this has been done since the 1980s. So as Sarah is saying it looks as if, because of high turnover of staff and others, as soon as staff move that's the end of it. I recall in the '80s even Waltham Forest, actually in terms of policy development giving, presenting something to the consul, to kick start, this was in the '80s.

That was ?? Boot.

The number of training, in fact the director doesn't stay in the office because there is training to do and Comfort is doing also training, but we still are, after all, along the line come back to, people don't know about it, professionals don't know what to do, it seems to me we have to ??? into the system.

Its also very difficult because we do a lot of training within our borough for multi-agency professionals and we do training in other boroughs, but the difficulty is practice nurses who could be some of the first people who see a woman with a child at risk and not often able to access that training because of getting away from the practice. GPS are reluctant; GPs are the ones who really don't come to the training. So you've got the GPs who've got the practice nurses, we've trained health visitors, we've trained school nurses, we've trained social workers. But in Waltham Forest the social workers are changing constantly. In the maternity department it's really, really difficult to get into maternity, there's a great

deal of resistance. And in the steering group, the Maternal and Child health steering group keep raising this issue of FGM. They're not taking it as a priority, even with the need for public health they are not taking it as a priority, even though every time we state it in the meeting, they've done a needs-assessment for African women because our stats in public health were so poor, around African women. They did not have they did not have the question about FGM on the questionnaire to start with until we got is changed. And they're not asking routinely in maternity if a woman's been circumcised, so her care cannot be planned (question over statement). I've been trying to do that but there's so much resistance. You're a midwife, our service is in the community, we have a clinical service and we have the other service where we work with the community and the professional, but there's a lot of resistance from the staff. We keep records of the people who come through our service and we keep records of the amount of people we train, but there's still a lot of people out there who don't access the training.

(Talking, but noise of vehicle going past obliterated it) Because I've been training these different groups, but I agree that if there's any concerted effort within a specific location, a borough or PCT to involve all these different groups then health professionals and social services. (Contribution inaudible, audible movement in room cover most of this, only some words heard) we ar monitoring what is really happening, the changes ??? of knowing and the ??? risk, within the health sector . Many girls within this borough at risk. Five years later ??? so many have survived ?? they've been cut, there to monitor the population groups how the different sectors feed in to each other ???? geographical area because, we don't really know if its existing at all. Also the health service will be used because the girl go to the GP or the clinic. Is there a guideline about violating the privacy of the person who want examine they been cut, ???

How do you raise awareness?

You're a Christian ???from different sectors. How do you know ??? cut, ??? different sectors. ?????? but we don't know.

There are two issues here, the data and evidence baseline which we need to have, which is missing, and has the reason why right now we are doing the first prevalence study, sponsored by the department of health so, in this particular study it is going to map for even the local authorities how many women are affected. But I do agree with you that this effort has come from the NGO sector. So one of the problems is how the government sector is so aware of where FGM is lodged and who is responsible for that monitoring because if that doesn't happen from the NGO sector. As far as I know from Forward there have been two surveys to look at local authorities, whether they have policies on it, whether they do case work on it, what are they doing on it. But again it's outside the sector so I think it's something go and see where is FGM going. As far as I knew in the early '90s it was supposed to be lodged with Social Services and therefore there is the need of identifying a sector who has that responsibility. All the other sectors say it has to come not just on the fault line, it has to come from the Government so that it's taken more seriously to the ground, local authorities, and taken seriously and which is the sector which is actually going to do the coordination and be able for us as a network to be able to ask them what is the situation.

(Many people talking together).

I've talked to different Government departments and every time the Home Office will pass it on to the Department of Health and the Department of Health will pass it on to Department of Education and Skills because it’s an issue with children in schools. The Home Office will say it’s a criminal issue and the public policy (somebody coughed) and they have a minister in charge of it as well. But the Government departments will pass is on from one department to the other, because of the sensitive issue of FGM. But then they don’t do much else and they will say go to the Home Office, the Home Office will say, go to the DFES, the Department of Health, so we need one department to go to.

Maybe it is time to say enough is enough, maybe this is the time to move things forward.

Joined up Government!

Because we have had enough of “this is not my department”, this is the time we have to do something and move forward and mobilise them. It’s good that the Department of Health are now looking to the media, then maybe from her we can take it to them and say “look these are the issues”. We need some group, or whatever monitor what is happening, and there needs to be good collaboration between NGOs who are doing fantastic work without money, along with the Government sectors as well.

The only thing is, if you’ve got the policies there, it’s no use unless you’ve got something underpinning that policy, and you’re asking “How do you monitor the health whether you’re being successful”. The only way you can do that is if everybody in health is asking the questions and is finding out whether the girls are circumcised, whether they’ve been cut, whether they’ve been stopped from going out of the country. Everybody has to be aware of it right across the board from Health, Social Services, the Education, the voluntary sector, everyone has to be on board and asking the questions. And that has to be down again to, you’ve got the policy, but you need the training and the awareness raising. It’s no good bringing in policies and having one organisation (statutory organisation) would monitor it. Because you’re not going to get accurate figures if people aren’t, you know, monitoring it locally.

There are all sorts of issues, for example, if we had the baseline prevalence we could do it every five years. In Africa which is much easier than here (it’s more complex), what they’ve done, 18 countries, attached to the health and demographic surveys a module on genital mutilation. So each five years they do the demographic and health survey. There’s some questions on FGM, and some of the countries have even done two or three studies. And so we are seeing the differences between the ages, whether it’s going down between mothers and daughters, so on and so forth. Sarah has reminded me of the time, but this has been very good, and we have picked up several things.

It’s time to go to the guest speaker.

At this point, I think we would like to ask Bill Gale, who will talk about FGM and asylum.

Bill Gale's Contribution

Thank you very much every one, first of all, I had better make it clear that I am not Bill Gates; I have sometimes been called that, for the record. Two things, first of all thank you for inviting us. I met Sarah at a meeting of the Women's National Commission FGM sub-group back min January wasn't it and I spoke at a meeting that they were holding then and she was kind enough to ask me back to this meeting. I wasn't quite prepared for an open public meeting and I haven't, I'm afraid come with a prepared speech but I hope what we say, and it won't just be me talking, I hope it will be Barbara and Robin as well. It's your questions that I want to answer, if I possibly can, rather than deliver a speech and then wait for the outcome. So I'm sorry if that disappoints you but I'm hope that it will be helpful all the same.

Sarah's invitation arrived just after I returned from vacation in Florida so I haven't had terribly long to prepare something for this, as most of your time when you return is taken up with reading your emails, of which we have hundreds in a matter of weeks. So with those apologies let me start by introducing ourselves a little bit more than we were able to at the start.

I've worked in asylum now, for some 14 years, I started out working in the section which dealt with mainly the Democratic Republic or Congo and I had no previous knowledge of the DRC or Zaire as it was then. But you rapidly learn, and in those days we had huge numbers of applicants from Zaire, and so I was luck enough to go across to Kinshasa in 1994 and spend a week there talking to various NGOs, churches, other countries embassies, the Government minister responsible for human rights, and that sort of thing. So I've had minimal experience of Africa directly, but I hope some experience over all those years of, and increasingly of FGM. But of course, asylum isn't just about protection from FGM; it's about protection from all sorts of other things such as political and religious persecution. So FGM does form a part of our work, but I have to say, a fairly small part of it, and perhaps we'll come on to that in a minute.

First of all, what we do, I lead a team of some 20 or so senior case workers, and we are not actually involved in decision making ourselves. We advise case workers on how to prepare for their interviews, how best to look at the information, what research they might want to do and anything that arises from those cases, and of course, every single case is different. Every single case has its own individual features, as we are all human beings. So, it's a cliché perhaps, but it is true that every case is judged on its own merits.

So we are organised in regional teams. I used to work in the team which was responsible for Central Africa, Southern Africa and parts of West Africa. Centring on the Great Lakes region we are seeing Rwanda, Burundi, Southern Africa and now more recently, West

Africa. Whereas, Barbara's team works more on the East African countries, Somalia being her main subject, Robin was working with me on the DRC, particularly, so between us we've, I suppose, become increasingly aware of the significance of FGM in the cases that come to us.

So what we do as senior case workers is help case workers who do the interviews and make the decisions. Our operations are based in Croydon and in Liverpool. We also deal with a lot of other issues, particularly when there's a high profile case which comes to notice, which hits the media. We would advise ministers of what that case is about, what's been happening on it, what's going to happen next. We are responsible, not for the whole range of decisions; we are responsible, if you like for the very start of it, at the initial decision stage. So the decisions that case workers make are then, by and large, subject to appeal, and then they go forward to the appeal-hearing, and then there may well be other representations following that. So in a sense we are in at the start of it all, rather than the end. But of course, the very initial decision sets the tone for happens later on.

So, we stand between the case worker and the current information, we help the case worker interpret the current information, of which there is a huge amount of information available. We work to guidelines, and the first thing I want to draw your attention to is the availability of the Home Office web-site and gender related persecution which were last renewed in October 2005. They are available for inspection, I have a copy with me, but only one copy, but if anyone wants to look at the web-site and can get access to it you will find them there. But, if you want to take a copy, there is a facility for that, that's fine.

(Aside) I have got a few copies if anyone wants one.

So, I think generally speaking, let me make one statement, and that's very important, that nobody who has a well-founded fear of returning to a country where they may be facing FGM will be returned. It is accepted that somebody with a reasonable likelihood of being forced to undergo FGM will not be required to leave and return home. Now there are two ways this might happen, first of all, under the '51 convention for refugees a person has to establish well-founded fear of persecution for one of the five main reasons, race, religion, nationality, membership of a particular social group or political opinion. So, there are five main categories for the granting of asylum to applicants from other countries, and of course, an applicant may have one or more of any of those features in their reason for seeking asylum here.

Also, if they do not fit under the convention there is also Article 3 of the European Convention on Human Rights, and Article 3 as you know forbids us from returning anybody to a country where they have a fear of inhuman and degrading treatment. So, it is common ground between us all that a reasonable likelihood of FGM will require protection, and that's what asylum is about, protection. It requires protection when there is, a) no protection, on very little protection in the country of origin and where the threat to the individual is not just local but national. Now this is where country information comes in, how important it is that case-workers are adequately briefed on country situations.

So, we look to a huge variety of sources of information on that. From the Foreign and Commonwealth Office, to Amnesty International, Human Rights Watch, a whole range of organisations who can give us reliable, on the ground information on what things are actually like in the countries of origin. It is not our privilege to go abroad and do our own research, we rely upon other researchers to tell us, in a sense, what conditions apply I particular countries. So, armed with that information a case-worker will go into an interview with a claimant, ask questions about why the individual is seeking asylum and build on that information. There may be information already available in the form of a written statement. That's normally very helpful because it gives us a clear list of where to direct the questions.

So, an individual will come to us in Croydon or Liverpool, and in various other locations across the country to set out their reason for seeking asylum. Now I think its accepted generally that not every individual necessarily will tell us everything in one go, and particularly in this area, because it may be that the individual is reluctant to speak openly about that, unless and until its really necessarily.

So, they might start by telling us about persecution for other reasons such politics or religion and it may not emerge until much later on that they have other reasons as well for seeking asylum. So, it's not the only opportunity before the initial decision is reached, there is another opportunity at appeal hearing and even beyond that for individuals to tell us why they are seeking asylum. So, I think this is particularly the case in FGM, Sarah and I know of one particular case because we wrote to each other about it, where a Sudanese lady made her claim on the basis of political involvement in Sudan. And it wasn't until the appeal hearing that, in fact, the issue of FGM to her daughters was raised at all, and the adjudicator had to look at therefore, not only the original reasons for seeking asylum, politics, but also there was a reasonable likelihood of that particular girl, or daughters. Now, the appeal was dismissed, as it happens, the adjudicator's decision was promulgated but of course there is maybe scope for further evidence to be considered before the individual is returned to Sudan.

As I said earlier, nobody who themselves faces FGM or maybe whose daughter faces FGM would be returned to the country. I think there are other claims where perhaps somebody has undergone FGM already and comes to us for asylum, but bear in mind what we are talking about is the need for future protection, a need for protection against a future risk, not necessarily something that has happened in the past and has scarred the individual, but the need for future protection, so that's what we are about.

Now, in a sense that's a very brief overview of where we are, I'm not sure if Barbara can add to that from her own experience, but it's true I'm relieved to tell you that the number of cases where FGM is an issue are very, very small actually. The great majority of claimants are asking for asylum foe political reasons, or religious reasons. Those are the two main features in our work. FGM would normally arise where it doesn't normally arise in politics as membership of a particular social group. Now that may arise because the individual or the women from a particular country are treated as second-class citizens with very few rights, and can be identified as a particular social group in that particular country.

The other issue that needs to be remembered is some times, in some countries, in some states there is perhaps a tradition of FGM, in certain areas, for certain ethnic backgrounds, but not necessarily nationally. So that somebody seeking asylum because of a threat of FGM in a particular area in that country, what the question will be if you moved away from that particular area what would happen. Would you be, in a sense, OK if you were not required to live in that particular part? What stops you, for example from moving into say, Lagos in Nigeria if particular areas of Nigeria are traditionally FGM areas? Are there other areas where you could live reasonably, we don't insist on this unreasonably, but where it is reasonable to expect you to go to avoid the persecution that you're afraid of?

I think I'll stop there and relieve you of the burden of hearing my voice and everything and maybe turn to Barbara to give you a flavour from the Somali point of view.

Barbara Clark

Actually the thing I find strangest about dealing with Somalis is that we know that FGM is something that goes on all the time, but it is something that I very rarely see. I've got one on my desk at the moment which is actually raising FGM, and I'm in the process of reversing the original decision. I mean, however much guidance we give to case-workers I'm afraid this particular case is a prime example where the information is there, and the case-worker clearly, either hasn't understood it or followed it, because she's made reference to " if you don't want to be re-stitched following the birth of your child, go to a private maternity clinic". I have sat down with the person concerned, the idea of a private maternity clinic anywhere in Somalia just beggars belief. I don't even know where she's got it from, maybe from a web-site? I mean, I've tried to find it, and I couldn't find reference to it. So, I think however much guidance is available there are going to be cases, which do, at the initial stage go wrong, but hopefully, they'll get picked up at appeal. This particular one, actually the representatives have written in complaining, so it's actually ended up with me, and I will now be reversing the decision.

But it isn't something I see a lot of, mainly, I think, because we all know that Somali is such an appalling place for a lot of people, women especially, that there are plenty of other issues that they find much easier to talk about, that they will raise at the initial stage. They tend to only bring this up at a later stage or even appeal rights are exhausted, because it is such a difficult subject to talk about.

One of the things, I'm listening to your debate, from what you talk about and what you do, one of my concerns is anecdotally we're hearing that people from Holland with refugee status are now sending their children into the UK for FGM. Now, I find that an appalling idea to think that……

Input – it's actually the other way round.

Well, I'm sure we do get it the other way round, anecdotally we're getting a lot of people who show a fingerprint match, who show they have actually got refugee status somewhere else in Europe. So we look at behind the scenes why this happening, why are people choosing to come here. Now obviously the size of the Somali community is a big

pull, but also we are being told that it is because it is easier to get it done in the UK than it is, certainly, in Holland.

Input – I don't know much about this, but my predecessor, I don't really know the background, but know that we did make some representation to the Dutch.

Input 2 – I think an MP from a Somali background in Holland also thinks that people should be routinely examined, from Somali background by health visitors of health personnel to find out if they have undergone FGM or not.

I've found it quite interesting listening to your frustrations, because we get frustrated as well. I mean, the number of cases I get through that, you know, I could get a four year-old that's claimed asylum who the agent has delivered to some unknown relative in the United Kingdom. Now, I've got no way of getting any story out of a four year-old, I've got no idea what this four year-olds basis of claim is and it's very difficult. We will always a child, certainly a level of protection, certainly until their eighteenth birthday, I mean, by that stage they've been here so long that we would give them permanent residency. But the bit that concerns me, is that we will notify social services but we get a letter back saying, "yes we're sure they're fine".

Input – it could be private fostering.

I'm sure it happens because I understand enough about how the clan and the family system works to know that somebody that you've been sent to may not actually be a blood relative, it may be a distant cousin or whatever, or a close friend, but it does concern me.

I mean, I've just said to Bill today, I've had a case referred to me, a Somali gentleman has been put in prison having raped a child who was in his custody, and there's a lot of issues about this that concern me. I have no right to anything more than notify social services.

Input – If a female is applying for asylum from a country where this could be a risk factor could you actually ask about it or do you wait for them to raise the issue?

No, we do on occasion have the guardians actually attend the interview but it is difficult because an asylum issue is a private issue between us and the applicant. We cannot discuss this reason for claiming with any outside agency.

Input – are you saying (movement in room) we know that there are possible other issues.

Chair – Have we finished with this presentation? Then I will open the floor formally for different interventions.

Bill – shall we just respond to Barbara's question? We rely upon the applicant telling us, we don't really go fishing for possible other reasons for seeking asylum, it's really risky to do that because it may put ideas there that were not there in the first place into a person's mind. Obviously we wouldn't just ignore clues that were in the statement at all,

but we wouldn't normally go further than what was before us or what the applicants chose to tell us. Well we don't do it and I think there's a respect for the individual that we will not pursue anything that's not there to be pursued. We should not explore things which may not be there at all; if they are presented to us then we must respond to them.

Chair – But I would have thought in the case of children you would refer them to social services.

Barbara – We do, and we have to hope social services take that information forward. We would always, certainly, certify social services if there is a concern for a child's welfare.

Input – we also face similar problems of how staff might be able to with problems overseas, because of the age of the potential victims, because our staff can't simply take children away from their parents. We could be accused of child abduction; we might be able to repatriate them if they are under sixteen.

Chair – OK so we have got up to 11.50 for questions and Aisha you are wanting to…..

We had a meeting with Forward and we asked some questions of some refugee women who was working on FGM and then we had a meeting with a senior case worker. We selected some reports and looked at it and we wrote back to the Home Office saying that the issue of FGM was covered in this report. People involved with refugees asked us to write expert reports with relation to FGM, which we did. What has actually happened is that we haven't had any feedback.

Bill – Our country researchers are a separately organised, so they come under research and statistics. So the country information office would rely on whatever expert evidence was available on particular country practice, and would be very grateful for that, if that was made available to them. I can provide the name of the head of the unit and the address if you need that. So, in a sense obviously none of us here are experts on country, we are here to interpret the evidence and to receive it, obviously applicants are welcome to put forward expert evidence in support of their claim. Sometimes, it may be medical reports, sometimes; its reports prepared an academic expert on that particular country, which will be taken into account when the decision is reached.

OK, I have done quite a lot of work for advocates on this. We provoked a meeting with Jeremy Oppenheimer, I think it kick-started some kind of working group meeting and there was one in January. But at the first meeting we had a discussion about the quality of the staff they are using, because they are all going to the site and some of them may not reflect the reality on the ground. One suggestion was that they would have a look at some

of the information. But my main question to you is there is a problem with categorisation of FGM and the Geneva Convention of ‘51, on the different categories, particularly the issue on a particular social group. And, I don’t want to go into individual cases; there was one case which was in the papers, here you have Sierra Leone. Even the Government politicians openly support the campaign on FGM to support it happening. If you were to look at the prevalence there, it is over 90%, and yet some of the cases which I recall, they said you can move and live somewhere else. I think there is a problem with the categorisation of women fleeing persecution, it may not just be just FGM it may be other forms of gender violence and the understanding is not there. I am not saying that every case should be allowed to stay but they have a right to have a fair hearing. In the former case for example, it did say that FGM does not constitute torture.

Sarah – I have got four cases that have gone through the court system where the judges or adjudicators have said FGM does not constitute harm.

(People all talking at once).

Bill - If you look at our gender guidelines on this particular area there is no doubt that FGM forms persecution and requires protection. I wasn’t aware of the Forni?? Case until Sarah’s group mentioned it in January, but I want to emphasise that although asylum as defined under the ’51 convention was refused, humanitarian protection allowed the individual to stay here. It did not meet our requirements on asylum as defined in the convention, but it certainly did meet the need for protection

That is the point; I think in this country, we need to actually contest and get it accepted that women are fleeing FGM, within those categories it’s properly stated.

Bill – I think in those cases, it will be, I think in most cases, assuming that there’s no connection with politics, which sometimes may be the case, more often the case that the woman would form part of a particular social group and thus bring herself under the ’51 convention. But that is very much defined by the conditions in the country; it is not necessarily the case that in countries where FGM is performed women would be mainly from a particular social group. As I say, if they fall outside the convention then there is the secondary, and these days, very little difference from the protection of Article 3.

In some places it’s happening, and to a certain extent here it’s happening to interpret the convention more broadly and to look at the history of the convention, when it was written, how it was written and the fact that it is basically male.

To add to that, in Canada, in the United States it has actually had test cases which have gone through using the categorisation of the convention, but I think it has not happened here. And, maybe the information you have given us is very good, but it is something we need to reflect because to get more lawyers to look at it much more closely. Why everybody is being put on the humanitarian category.

Bill - I didn’t say that they would be, I think there will be a minority of cases where the person from that particular country her particular circumstances does not fall within that

country within a certain social group. But the next move would be to bring up the Article 3 protection.

Can I just point out that Canada and USA asylum systems are not the quite the same. We have ?? section, Canada doesn't have that, it's a sort off fall back supplementary looking at an individuals case, so they might interpret things and their time-frames may be different to our system. So it's not quite a synonymous system.

Bill – But I don't think the 51 system is a dead document, but it was drafted, OK, after the Second World War, but in fact case-law and the courts have interpreted it well beyond the way it was originally envisioned a protection.

And I'm saying it's time to continue interpret it in a changing world based on circumstances in a living world and changing world.

Bill - Well you may regard it as being slow in that but in our own experience of working with asylum, things have changed.

Yes, I recognise that, but for a key change.

Yes, but for most of the case-work on FGM they all fall. The other thing I wanted to pick up with you is, you are looking just at protection in relation to FGM, and people are fleeing from it, but there are also instances where it had actually occurred but this is just an example of one case which came to my attention. This was one girl who was being trained, she had undergone this against her will and had really undergone some horrendous situation, but I will agree with you that you are not counsellors to counsel people who have been through it. But she comes from a clan in her part of the world, the women who actually do the mutilation, they come from a particular clan, and she was being trained after having been through it, having been traumatised, she was being trained as a circumciser. And, so she was seeking asylum on the basis that she does not want to do that, and that her situation is something from which she cannot escape. She comes from the blacksmith caste and there is no understanding, and as I said this is a very complex issue and to have that much broader understanding, and she was fleeing from that situation.

Bill – I am sure we come across that sort of situation in West Africa and Sierra Leone and Liberia where it's the threat of being forced to be the person she doesn't want to be, and of course, what we have to take into account is what would happen if she did return, what would happen to her. Would she be faced with persecutory behaviour and is there any way in which she could avoid that within her own country. Now, each case is treated individually and obviously we would have to look at what you are saying. Would that be the case in hand?

And it's that sort of information that can go into the young information base, where the case-workers have to understand that this is possible.

Bill – Yes, it's a bit like conscientious objection in wartime in countries where conscription is compulsory and you could be required to go and do things that you are in

conscience not able to do. But that doesn't necessarily bring you within the convention; it depends entirely on the threat or the punishment if you refuse to do it.

Death! In this case, the punishment is death.

Bill – Obviously somebody facing death is not required to return.

She will be killed, and that understanding was not there. The other thing I wanted to pick, in court I have seen a case-worker where an interpreter was brought in from that country and I could see that the girl was shaking. Because it is also the situation where if the person is coming from the same country, they will go back to the community and tell them what has happened. We need to have a lot of in-depth consultation to broaden our understanding on the situation of women which is quite different from political prisoners who, 99% are males; the state has committed the crime. As opposed to family for women the human-rights abuse to the woman, the culture which is condoned by the family members and also in the developing countries it's more the extended family set-up and in many places women do not even have a right to move. Male authority can track you down, even if you are moving through a non FGM practicing country, and we would like to have much more technical consultation. Then finally before we move on I feel you need to bring in experts from these areas who really understand it, because I feel that within the Eurocentric thinking it's not possible for something like this to happen. But we are talking about a different set-up which makes it more difficult for people here to understand and if you just go to some university professor they will not have really understood. They could write nice gender papers and all the context of women's lives and there is a need for you to look at bringing experts who can give in-depth information for your data-bases and be understanding of people work with us.

What concerns me is that you said women have already had it done. But maybe the women who have found their way here who've already had it done want to go to one of the well-women clinics and have themselves opened up and, if you are sending them back. First of all if they have managed to have that done they are going to be re-done when they go back or they going to be deprived of the opportunity of their health benefits and their rights benefits.

Not only that, when they have a baby and the child is a female the child has the tendency of being circumcised again and so history will be repeating itself.

Bill – sorry, one more response from me, is that new have difficult cases to decide here and one that I can remember. There was a lady from the Gambia who gave birth to a child here and whose husband was back in the Gambia who said to us, "If I go back, his family will force me to have the child circumcised". Now what do we do then, well the Gambia is a very small country and is the person from that kind of background where she would be vulnerable to that threat, so these are difficult cases on which we have to make decisions on. The Gambia differs from other countries which are much bigger, so there are all different cases which we can talk to you about. Obviously, we can't name names but we are aware of the difficult sort of issues that are around.

I’ve noticed we’ve been discussing ?? health professionals, it’s a grey area and it’d been going on for years and nothing’s changing. I feel there wasn’t a lot of awareness in the community, and I think a lot of work needs to be done, if you don’t empower the community itself. Especially with FGM people who are victims are from communities where nothing is ever said, it’s a practice that’s never talked about. So I think that first we have to work with the communities themselves, to empower the community first before moving on to anything else. I feel there is a lack of information for the community itself. Going back to the Somali community some of them can’t read, so tapes would be a good idea, but I feel a lot of work needs to be done with the community before anything else, because if these women don’t know that this is actually wrong.

I've got two young girls myself and it’s all about educating the new generation as well because the older generation, like my mother she turned around and ??? Alright, so it’s 2005 I’m going to look after my son and my daughter in future. And, I do a lot of work with young women who’ve got young children and we’re the new generation today, there’s a lot of them who are just saying no.

(Many people talking at once).

It’s not just that because I’ve met young people who’ve just come from Somalia, 25 or 26, they know it’s wrong and I’ve seen a child born and raised in this country this is my culture, because when you come from another country and you come to a western country you feel you need to be holding onto your culture. Because people who have been here a while, they are still stuck in 1975, you know what I mean.

(Many people talking at once).

Chair - Just one more question, which we promised, and then we will finish.

One reason we are having this meeting is all the policies, all the ??? If the people ???

(Many people talking at once).

….. gender issue, because we need to do all the different ??? if fact the policies in place assure the mechanisms are there….(more interruptions) With out that, all these laws are passed and they still don’t want to listen.

(Many people talking at once).

We are from different cities, Leeds are doing their bit, Liverpool are doing their bit, London are doing a lot. You know, we have been doing that for years.

It’s changing!

(Many people talking at once).

Fatima is standing here, she is a new generation, she’s telling her mother, she’s not doing her daughter. It is changing but without the policy, people like us on the front-line

without guidelines, I can't do anything with my mothers when they come to the unit. Without a policy from PCT to go out, on child protection we can't, and the Home Office, they need the guidelines. Can I just ask one question, do you get training for your case-workers, because that's important clearly?

Bill - Two things, every single case-worker gets quite a long period of training, not only in how to conduct an asylum claim, but haw to interview, and gender comes into that. It is not the majority of that, but it is a large part of the training. Secondly, there has been refresher-type coaching where in think Refugee Women's Legal Group came in to do some presentations to our senior case-workers last year in intensive formats to inform the case-workers, we couldn't do it with everybody. But there is an awareness of the need to keep up with developments.

Chair – If we can have people raising their hands and it's really nice that we are moving into the way forward, so it has just moved nicely to it, so if we can just have people raising their hands and not all talking at once.

I do a lot of work with the youth, we work with professionals and with community, and it is more harder because we have still got to get a reputation. I can't just say, well FGM today Monday, because nobody will talk to me, nobody will be there and it's OK for me call on professional, because I can talk to the professionals on a professional level. But when I'm talking to the community, it's like two different jobs.

When it comes to young people, young people are not going to come on a Monday morning I had to go to a Somali concert, 2,500 young people but taking the risk, again stuck in the middle of the stage, I might get stoned for giving that information. So you get on that stage and you mention the law and people, OK they stop, but as I came down people were going, oh! Great, you know like we said earlier on, whispering to you, saying thank you for doing this job, I am glad that it is you that is doing it.

Chair – Just to add to what both of you are saying, I think so far we have been, sort of focussing on the idea that the issue is just the Somali community and I am just wondering if in our work the Somali community is very important because of the prevalence, at least in Somalia is about 98%. But there are other communities also, and there is a lot of silence in that area and in fact most of the casework which is coming to the asylum probably comes from West Africa, and Kenya ???and these communities if you look at casework interventions which have been coming up, they are cutting across the board. Recently I came across a case from an Iraq Kurd which was quite interesting.

(Many people talking at once).
… don't actually need the full reversal. I have seen a lot of people from Sudan, I've seen Iraqis, they didn't need the full reversal, obviously they needed some cultural understanding, but they did not need a full reversal like in the Somali community.

I think that because everyone in school only talks about Somali kids that another child could be neglected, people think only Somali kids have this done.

Chair – So we need to be informed about the rang, and there is a range of it, and the different countries, and thanks to UNICEF, the United Nations, there is a lot of data which has come up and in fact if Sarah gives me your email, I will give you a site where new data has come up. The DHS data has come up. So we need to look at all the relative ratios if we are in a key position to provide services and education and see to it so that it is getting to all the communities that need it. There are some communities that are much more vulnerable, particularly because of thee child birth and there is the type too and there is something for you to look at.

(Many people talking at once).

But it would be pity for women in need of protection for you to send a woman back home because she didn't bring up FGM as an issue. I simply wanted to volunteer the reason why they should stay, I think it is important that this is explored either from inland but also sticking outside help input in those cases. But to be able to get a whole sense of awareness, just because she has a political stance that is her right, what is she subjected to when she goes back home. What is the circumstances and back home that make her life not enjoyable as a human being, so what would be the situation back home.

Bill – Yes, I think that we must expect that some of the applicants who come to us are quite content for it to happen when the go back home, but it is not always the case that everybody is afraid to go back for that reason. So I think it is a very delicate balance here between intruding into a person's thought processes and asking them to tell us to please be open with us and to give them the opportunity tell us, right up to the last minute of why it is that they do not want to return home. And after all most claimants are legally represented and these days, I'm glad to say, most legal representatives are authorised, because they are able make the best of the individual's claim. Now it does depend on the individual, and I think this is right, to tell us. It may be the case that it is not a problem for them, and we have to respect that, but we do have to respect that individual raising it at some stage in some form or other. It may not be at the interview, it may not even be at the appeal hearing, it may that the individual does not feel comfortable with any of that, but at the end of the day, it does depend on her or whoever it is saying what it is that they are fearing. And I don't think we can go beyond that, we can be alert to it, and I agree that we informed very much better about individual countries and practice there, and to be aware that this may very well be an issue, and in a sense be alert to that and encourage the individual if there is a glimmer of that being an issue for the person concerned.

(Unclear input)

You are looking at just one stage in the whole procedure, the initial determination. There are also the immigration judges, there are also the lawyers, and not all of us know everything there is to know about the different countries.

It's just that there was a report that funnily enough the legal team told me two days ago that she won her case and it was on FGM. She had the FGM done back in West Africa and she was going to be forced to marry an old man, and then she was seeking asylum here, and on the basis that when she go back she will be re-circumcised because they didn't do it properly, initially. And I assessed her and the case was refused initially and then had to go back again, and the team called me in and she won her case just recently. But maybe we need to inform the legal team as well.

Chair – I am just going to spill the beans a little bit because there is that fear that if women fleeing FGM are given asylum then the whole place is going to be flooded with them. The number of women affected is quite staggering, but the other thing for me in terms of the government agencies taking the issue forward is also to look at where is ??? is supporting countries in terms of its work with countries to eliminate FGM. And I'm not sure Sarah whether its ?? or you we should take it to, because most of the countries were at least in the African region. There is a lot of good work from governments in the sub-Saharan African region, and I think another way of looking at the work is to look at how we are supporting the governments to deal with the problem over there.

…… supporting some local NGOs in some countries with mainly educational work, but I'm not sure of the extent of this or what more could be done.

Chair – Just to say that, it is actually an interesting development because its only recently that African women will come out and talk about FGM, let alone go out and actually seek asylum on the basis, because most of them are frightened, they are petrified about talking about it. If you come from Sierra Leone and you went a sought asylum and you came up in the press you are a target for being killed. So you have to have that in find that really people are going to flood the place, it's really the process and what will happen is so staggering many women would not come forward. It's quite interesting that people actually have the courage to come forward with it, but if you can follow that aspect as well so that it is integrated more involved sources goes to this kind of activity to prevent it from the source.

If I can say at this point that ??? is doing some work through their programmes, obviously they need some training.

I reproductive health, OK, is it Dorcus first?

OK, I just wanted to mention one thing, I think we have already talked about it, that I think it is very important for this meeting to come out (rustling). And also mentioned the importance of the campaign on FGM is needed right now. We want to move on, for example talking about certain society community groups which practice FGM. We have to have enough information about that group, its not enough to say we are working with that community, why was this social, cultural, maternal, practice FGM for example. ??? or Sudanese, or Somalian, why and we have already done some work on that, for

example, targeting the Muslim community who practice FGM. For example, through the centre for Muslim women, but I think the community organisations and national organisations work on FGM is to define why these groups are doing FGM. Eventually we need to tailor some sort of policies and practice to try to tackle the issues of FGM.

Chair – So what you are actually saying is that the work here, so far lacks the evidence and we need to have such cultural research targeted at specific communities in order to understand where each community is coming from in order to target the campaign. And I think in terms of the wider discussion and lack resources; the lack of seriousness which is given to the subject in terms of in government for example, where is the money from research on FGM. The research that I'm working on, it's a tiny bit of money, which had to be fought for over three years to come to that decision. Yet we need all this if we are working with the communities we need qualitative research to understand, where people stand. So Government officials, I think that the need for building the evidence….

Often you if say you are dealing with FGM issues you are told, give me the data, the statistics, where is the information. So you say give me the money to get the information if you want it.

Build it into the budgets.

If this is UK network, right, FGM network UK, I think there is a lot of fragmentation out there. There are so many groups, so if you want to take leadership making it more effective you want to go from here, correct me if I'm wrong.

(Several people talking at once)

I talked to a professor, Professor Lavender; they've got a group called Clinicians. And I challenged her, I said I will work with you, I know about this, I said, I'm a practitioner and I've worked with that group as well. Just let me finish, I just want forward me as practitioner all the clinicians, the professors, for us to come together as one group and taking forward a united stand, divided fall.

Chair – Dorcus this is a very good intervention and first we have to thank ACCM for persevering for this network even to have the second meeting. I have told Sarah that we need to structure this and then make it an umbrella kind of thing where all the new groups, everybody working on it will come and affiliate into this umbrella because there is enough experience for us to point out where the gaps are.

Sorry, can I raise something there, we've been in place since 1999, we were set up as a needs-led service and we have expanded since then. The PCT has gone through major restructuring and there is no commitment from the top, to continue our service. This will leave a great big gap within the services in North-East London and what I want to bring to this group is, we need some support to take to our chief executive, even if it's a letter saying this service needs to continue. Because, for seven years we've been there and we assessed the need for a youth outreach worker who is in post, we just need some support to keep this service going with the PCT.

Maybe you need you need to take it to the Department of Health.

Well I do, and the Strategic Health Authority. And the evidence of the areas that the women come from are right across London.

It would be a shame if you lose that.

Can I just say something, I'm sitting here listening to all this, and I'm looking at the name of Diana up there and I'm thinking how a number of years ago she got involved with what was then a taboo subject, HIV/Aids and she made it acceptable to talk about it, and she made it no longer taboo. And, what really needs to be done is a public campaign, not just in this community or that community but the broader UK community about this issue so that the students of mine who threw-up when somebody from Forward came and explained what it was about, people will know about it, it's horrible and people should know about it. Everybody should know about it, not just the Somali community, or the Sudanese community, or the, this community, and once it becomes something it becomes talked about so it's less taboo that something will be done.

I think there's been a process, because initially it was difficult to oppose this because people used to pick on one element of it and it became much more difficult. We have moved to a stage where it is much, much easier to talk about. And what you are saying, for example, one of the sections of the Government is coming up with a campaign on gender violence. They are going to put ??? The Government is serious about gender violence, I am sure it covers the forced marriages and beating women and FGM is to be part of it. Before we actually close we need to crystallise what Dorcas has actually said.

First of all, you know the CD ROM which we sent for was doing it that is important to us to make sure it is accurate, it's good. They are going to send it out to all professionals, from the Home Office to clinical practice nurse. It needs to be good and then that is in your audit that you're doing to help us to know where we are. Plus the UNICEF you say is already there, I gather there will be conference in 2007, a big conference ??? and I thought we had a big conference, and that's for a long time, maybe the time has come to have a two day national conference, so fragmentation, CD ROM, audit of where we are.

There's a special ?? on violence against women has just been invited by us, and has agreed to come to the UK, I think in October to conduct a European-wide consultation on violence against women. And I think that this is an issue that obviously needs to be brought up.

I would like to find out if the Embassies of the countries this will happen will be involved.

So, we have agreed on a national conference, is it a conference or a consultation. We haven't had a national conference for a long time.

We are all fragmenting, we need an umbrella, and we have so much to take away from today.

(Many people talking at once).

Sarah was asking, last year people were not quite clear whether to continue with the network, so we agree that we are going to support the network.

- General agreement.

We need somebody like Comfort here in London or the Liverpool group to write to all the other groups to come to the meeting here next year. So I think it would be nice to work with the Home Office and ?? as well.

So where do you think the conference should be?

Well Anwar was the first one to suggest it to me, some time ago, I thought she would be here today, and she was thinking about two-days conference. I've got to see a doctor in France and he's doing ?? we can invite the Somali ??. And that was the idea, she said two days next year, it needs a lot of planning.

When we have a conference we should be able to have all the sectors.

(Many people talking at once).

In Liverpool there was a very good outcome, there was lot of consultants a lot of nurses, a lot of social services.

(Many people talking at once).

Francis – I am aware that Sarah is not here and this network had a period of funding which has ended.

We have to first agree to take it forward and Sarah, you are here. We are in agreement for taking the network and we understand that there is no resources.

There is recourses now, because I've got some new funding.

- Laughter!

So, for the next three years I can continue doing this, my only concern is that people need to make commitment. For me to organise and get people together I need to see commitment, and want to see this rivalry, oh! I'm doing this, I'm doing this, and we are all doing the same thing. We're trying to work with the Home Office and other professionals you make sure ??? children.

- General agreement.

Now, I think there is need to structure it.

Sarah – I cannot do it alone so (Many people talking at once)…. as a team, not as an individual. May I suggest that we get Afwar get this together, transport to meetings and things so we can then structure it.

Chair – I suggest that a few of us come together and think about fleshing out the network properly and send it out to everybody for comment.

May I suggest in planning this thing, this conference that you try to get at least one major high profile press person involved, perhaps as a chair.

Chair – we are very good at that. We have put FGM on the agenda in this country, we put it on policy, we set up the framework, African women did it for the Government to work on it. What we need to do, a couple of years we have been working very well, we need to scale it up and mainstream it so it's properly constituted (other voice) then - . … every September. We are going to take it forward.

Can I suggest that aside from Sarah and Comfort you come into the core?

We don't want a very big group.

Sarah – Dorcas.
And Jennifer.

Anwar should at least be invited.

So, we will get together a structure and flesh something out under the auspices of ACCM. Or I can take it if it's a problem, but we will do under the auspices of Forward, one team working all that, is that OK

I have a lot of work to do with Jennifer's (client group) somebody needs to write a letter.

I'll take it forward to; we need a commitment from the PCT. I have a permanent position, and there's not the level of commitment.

The PCTs are being disbanded and are being replaced.

In theory by commissioning but we have statistics, we have post codes so we details of Muslim women from all over London so need support the network so we can take (to the PCT).

What sort of support did you want?

A letter from the network, from other organisations. Just to there's a need to continue the work, you know, the child protection policy is in place and the services pulled out and it's crazy.

Chair – Can we draft a letter and the different organisations could sign?

That would be great! I have a meeting with the PCT next week.

Sarah – Maybe you could draft a letter how you want it to be stated and then send it to me and I will email the others.

Chair – I think we have rounded up everything.

Sarah – Any other business?

Chair – Any other business (firmly).

There's just one other thing if the conference happens can we include a lot of youth-worker because I think that is very important.

Chair – When it comes to the planning stage (noise in room) we will have a planning stage where everyone will get a chance, in terms of the different actors.

(General discussion in support, many voices overlapping.)

Chair - The other thing that the Government gave Forward a lot of money which has to be used for dissemination and I think, I looked into the budget, a meeting in Cardiff or Birmingham or somewhere, London perhaps and use them to report on the key issues. Some of the3 key nothings we want, we can bring the PCT all the different actors together. I have been ordered to set a date, something which we can do that, I will do that. Now, I will be in touch with all of you, we should finish at the end of March, but we have the small amount of money, £3,000 so we can let all of you know.

Sarah – I think Josephine has something to say.

Of course we want more youth-workers but we need more funding (general laughter and agreement).

Chair – It would be good if we had a project proposal, a joint project proposal for all the groups, for example – this year we want to in for monies for community work, go jointly to get the resource and each group gets its bit.

There are so many groups involved and they don't want anything boring, we need something exiting here, something that will draw their attention (general discussion – many voices).

Sarah – and the other thing we are doing, we are trying to get a T-shirt and we need to decide who will make it and the design, have you brought a sample?

I'm sorry it should have been posted.

Sarah – This T-shirt will have on the back FGM Act 2003 STOP and the different words in French. On the front it reads 'Stop Cutting Girls'.

Can I just make a practical suggestion I noticed in the report from last that Maggie Baxter of Womankind was involved and there's a funder called Seagram Banking Trust? You can't go to them, they have to invite you, but Maggie Baxter has had funding from them and has been very good at introducing (people). So they might be able to come up with something for this kind of work, because this is the kind of thing they are interested in.

Chair – Let's get together the core and we will flesh something up and we will see how we can work on this, but Sarah has just gone out, but I wanted to take the opportunity, on behalf of ACCM to thank everybody who came. Thank you very much (applause).

Meeting finished.