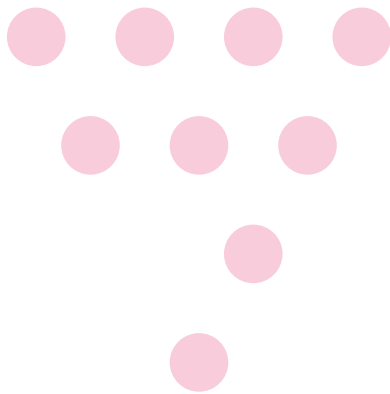


Female Genital Mutilation

Affected Communities
in Birmingham



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Dedication

This report is dedicated to the brave survivors of female genital mutilation / cutting (FGM / C) who helped us with our research. Despite their painful memories these survivors had the courage to share their experiences with us. We thank them for their participation because without their support, the research would not have been possible.

Their accounts and their views will hopefully contribute towards changing attitudes in FGM / C affected communities and to diminish and eventually eliminate the practice of FGM / C. Together we look forward to a future free of FGM/ C not just in the UK, but also across the world.

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About Muslim Women's Network UK

Muslim Women's Network UK (MWNUK) is a national Muslim women's organisation in Britain (www.mwnuk.co.uk). We are a small national charity (no. 1155092) that works to improve the social justice and equality for Muslim women and girls. Our membership also includes men and women of other faiths / no faith who support our work. We find out about the experiences of Muslim women and girls through research and helpline enquiries. We identify policy and practice gaps and use this information to inform decision makers in government as well as informing our community campaigns. We also develop resources and train women so they are better aware of their rights. We have a separate website for our national helpline (www.mwnhelpline.co.uk) that provides advice and support on a range of issues some of which include: domestic violence, forced marriage, female genital mutilation, sexual abuse and discrimination.

The impact of our work is particularly felt in reducing the vulnerability of Muslim women and girls, decreasing the prejudice they face, and giving them a greater access to rights and services - all of which allow them to contribute to society like any other citizen. We are also creating a critical mass of voices to influence change with more women being confident to challenge discriminatory practices within their communities and in society and to influence policy makers.



1. Introduction

1.1 Main Aim and Objectives of the Research

The aim of this research was to increase the understanding of the issue of female genital mutilation (FGM) in Birmingham by finding out the views of women, children and men from FGM affected communities and use the insights to be able to better challenge tolerance of this practice and build awareness. Another objective was to understand the impact on survivors and what support was needed for them or those at risk and whether there were issues being overlooked by current service provision.

1.2 What is Female Genital Mutilation?

Female Genital Mutilation (FGM) is sometimes referred to as ‘female genital cutting’ (FGC). Some people also refer to FGM/C as ‘female circumcision’ - but ‘circumcision’ is an inappropriate term as it implies that it is the equivalent to male circumcision suggesting that consequences are far less severe than is the actual case. However, the term FGM is not always understood by individuals in practicing communities; they are more likely to use the term ‘circumcision’ or relevant terms in their own language e.g. the Somali term for FGM is gudnin, the Sudanese term is tahir and the Arabic term is khitan (FORWARD, 2013).

FGM is defined by the World Health Organisation (WHO) as the range of procedures which involve “the partial or complete removal of the external female genitalia or other injury to the female genital organs whether for cultural or any other non-therapeutic reason”. WHO has classified FGM into four types (WHO, 2014):

Type 1

Clitoridectomy

Partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).

Type 2

Excision

Partial or total removal of the clitoris and the labia minora (the ‘inner lips’ that surround the vagina), with or without excision of the labia majora (the ‘outer lips’ that surround the vagina).

Type 3

Infibulation

Where the clitoris and labia minora are completely removed and the vaginal opening is stitched or narrowed leaving only a small opening (1 - 2 cm) for the passage of urine and menstrual blood.

Type 4

Other

All other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, pinching, piercing, incising, scraping and cauterising the genital area.

1.3 Prevalence of FGM

Some statistics are given below to highlight the extent of the problem in terms of women and girls who are living with FGM or at risk of it in the UK, Europe and worldwide

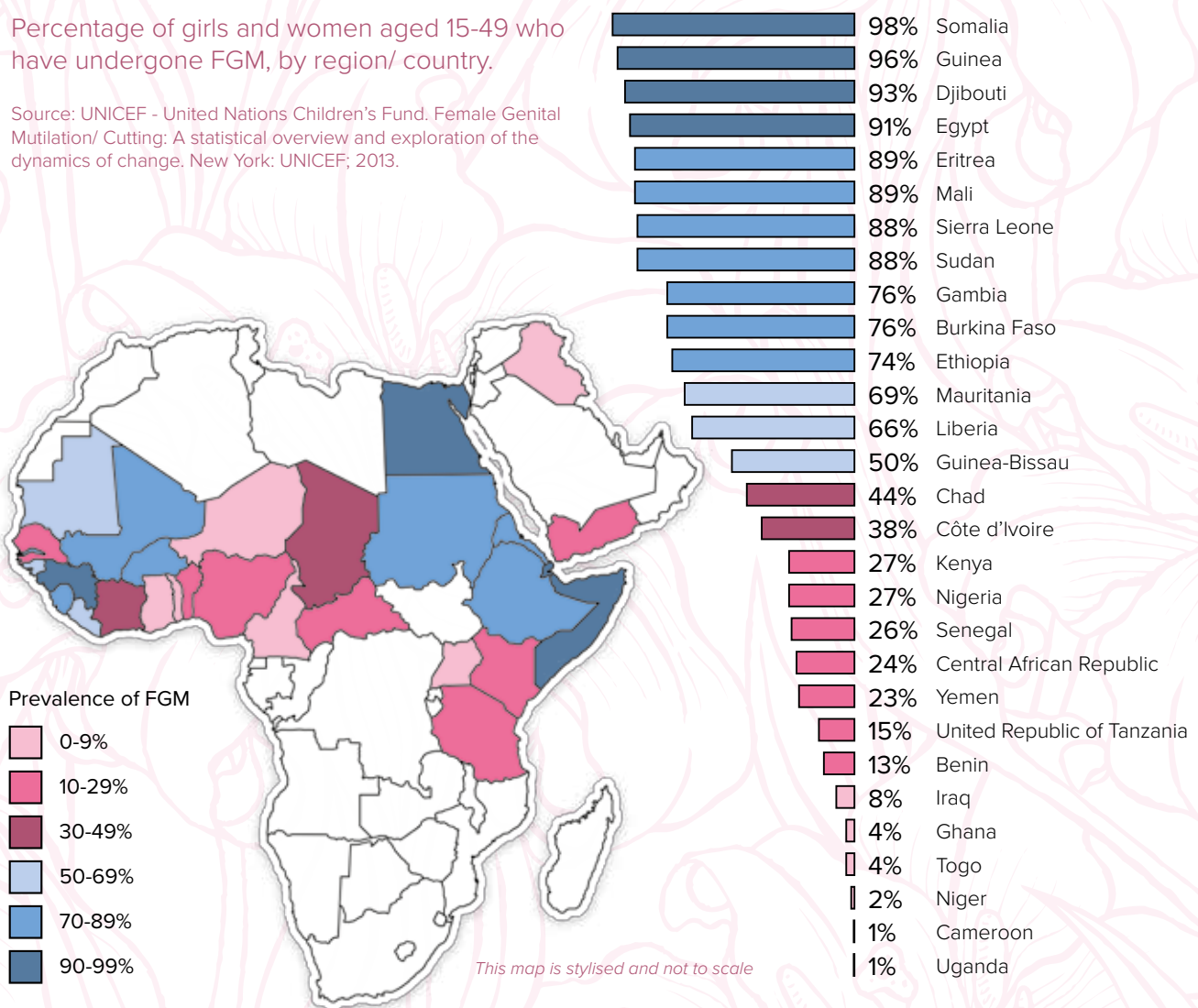
a. Global Statistics

The United Nations Children's Fund (UNICEF), estimates that more than 125 million women and girls worldwide have undergone FGM, the majority living in 29 countries in Africa and the Middle East. The list of these 29 countries with their prevalence rates can be found in Figure 1). Although no national representative data on FGM are available for countries including Colombia, Jordan, Oman, Saudi Arabia and parts of Indonesia and Malaysia, evidence suggests that FGM is being carried out there too. It is also practised in pockets of Europe and North America, which, for the last several decades, have been destinations for migrants from countries where the cutting of girls is an age-old tradition (UNICEF, 2013).

Figure 1

Percentage of girls and women aged 15-49 who have undergone FGM, by region/ country.

Source: UNICEF - United Nations Children's Fund. Female Genital Mutilation/ Cutting: A statistical overview and exploration of the dynamics of change. New York: UNICEF; 2013.



b. European Statistics

European Parliament estimates that 500,000 women and girls are living with FGM in Europe with another 180,000 at risk each year (European Parliament, 2009).

c. UK Statistics

An estimated 137,000 women and girls with FGM, born in countries where FGM is practised, were permanent residents in England and Wales in 2011. From 1996 to 2010, 144,000 girls were born in England and Wales to mothers from FGM practising countries. It was estimated that 60,000 of these girls aged 0-14 in 2011 were born to mothers who had FGM (Macfarlane and Dorkenoo, 2014). The Health and Social Care Information Centre (HSCIC) is collecting data on FGM within England on behalf of the Department of Health (DH) and NHS England (NHSE). According to the October to December 2015 statistics, there were 1,316 newly recorded cases of FGM reported, with 2,238 total attendances where FGM was identified or a procedure for FGM was undertaken (HSCIC, 2016). No reliable estimate of prevalence of FGM in Scotland is available. A preliminary analysis of 2011 census data by the Scottish Government noted the number of residents born in Africa had doubled and estimated that from 1997-2011, 2403 girls were born in Scotland to parents from FGM practising countries (Scottish Refugee Council, 2014).

1.4 FGM and the Law

FGM is a form of child abuse and violence against women. It was made illegal over 30 years ago by the Female Circumcision Act in 1985. However families were bypassing the law by taking girls abroad to have the procedure. The Act was therefore replaced by the Female Mutilation Act 2003, which made it illegal to take women and girls overseas for the purpose of FGM. As the law only applied to UK nationals or permanent UK residents, it was strengthened by the Serious Crime Act 2015 to also include people who are also habitually resident in the UK (but are not UK nationals or permanent UK residents). FGM has also been unlawful in Scotland since 1985 and a conviction can also result in a prison sentence of up to 14 years.

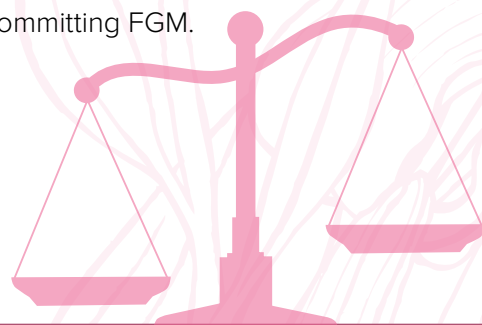
FGM Protection Orders

The Female Genital Mutilation Act was amended by section 73 of the Serious Crime Act 2015 to include FGM Protection Orders, which offers the means of protecting actual or potential victims from FGM under the civil law. The Orders came into force on 17 July 2015 and apply to England, Northern Ireland and Wales. Breach of an FGM Protection Order is a criminal offence carrying a sentence of up to five years in prison. As an alternative to criminal prosecution, a breach could be dealt with in the family court as a contempt of court, carrying a maximum of two years imprisonment.

FGM Protection Orders contain legally binding conditions, prohibitions and restrictions to protect the person at risk of FGM and may include:

- Confiscating passports or travel documents of the girl at risk and/or family members or other named individuals to prevent girls from being taken abroad.
- Ordering that family members (or other named individuals) should not aid another person in any way to commit or attempt to commit an FGM offence, such as prohibiting bringing a 'cutter' to the UK for the purpose of committing FGM.

Bedfordshire Police obtained the first FGM order in the same month the orders came into force. They seized the passports of two girls to prevent them from being taken abroad to undergo FGM (Rawlinson, 2015).



Mandatory Reporting of FGM

The Female Genital Mutilation Act 2003, was amended by section 74 of the Serious Crime Act 2015, to include mandatory reporting to police by regulated health and social care professionals and teachers if:

- They are informed by a girl under the age of 18 that she has undergone an act of FGM.
- They observe physical signs that an act of FGM may have been carried out on a girl under the age of 18.

The legal duty came into force on 31 October 2015.

Note: NHS clinical staff must also record in patient healthcare records when it is identified that a patient (even if they are over 18 years of age) has undergone FGM.

1.5 FGM Affected Communities in Birmingham

Birmingham is the most ethnically diverse city in the UK with people of White, Asian and Black ethnicity representing 68%, 20% and 7% respectively (Birmingham Health and Wellbeing Board, 2012) and includes significant populations of FGM affected communities:

- According to the 2013-2015 Birmingham Violence Against Women Strategy (Birmingham Violence Against Women Board, 2013) five years data up to 2013 showed National Insurance Number registrations in Birmingham for people from 17 different countries where FGM is practiced.
- The information currently in the local Joint Strategic Needs Assessment (JSNA) shows that there are a number of Birmingham residents born outside of the UK in countries where FGM is practiced such as Somalia, Kenya and Nigeria where FGM prevalence rates are 98%, 27% and 27% respectively (UNICEF 2013).
- According to the Office for National Statistics of the estimated 103 000 Somali-born migrants residing in the UK, approximately 7765 live in Birmingham. This is the second largest population after London. The prevalence rate for FGM in Somalia is 98%.
- The 2011 census also indicated that there are over 10, 000 people in Birmingham described their ethnic group as Arab most of whom are of Yemeni background (given their long established history in the city). The prevalence rates for FGM in Yemen are over 19%.

Although ethnicity alone does not indicate that girls born in these communities have had or will undergo FGM, health data does raise concerns because women suffering from FGM are presenting themselves at hospitals in Birmingham. For example, in 2011, Birmingham's African Well Women's Clinic (Heart of England Foundation Trust) treated women who had undergone FGM who were from 12 countries of origin. The largest groups came from Somalia, followed by the Gambia, Eritrea and Sudan. According to their data they had 318 FGM referrals and the women had undergone types 1, 2 and 3 FGM.

The numbers of babies born to mothers who have undergone FGM is also continuing to rise across the city. For example, Birmingham Women's Hospital NHS Trust reported between June and December 2011 that there were 63 births by women who had experienced FGM; 21 women were Somali, 13 Yemeni, 5 Sudanese, 4 Eritrean, plus nine other ethnicities in smaller numbers. According to Heart of Birmingham PCT an estimated 916 girls born in Birmingham between 2003 and 2009 were at risk of FGM. However these figures did not include newly arrived children (Birmingham Violence Against Women Board, 2013). Also new research conducted by City University London and Equality Now shows that Birmingham has one of the highest rates of FGM outside London with prevalence rates ranging from 12 to 16 in every 1000 women having been cut (Macfarlane and Dorkenoo, 2014).

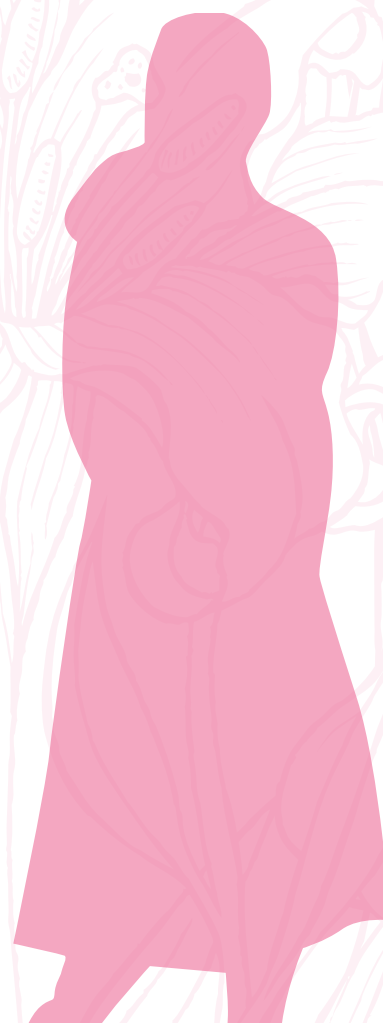
Collectively such data does indicate that FGM is a concern in Birmingham and girls born to mothers who have undergone FGM may be at significant risk of FGM. Even girls who are born to mothers from FGM affected communities who have not had FGM could also be at risk from extended family e.g. aunts and grandparents who may support the practice. Birmingham City Council data locally indicates that in Birmingham upwards of 5,000 girls enrolled in school between the ages of 5 and 18 come from FGM practicing countries (West Midlands Police and Crime Panel, 2015). It is therefore very important to understand the attitudes of children, men and women from these communities, particularly the Birmingham Somali community (given its size and the fact it is a deeply entrenched practice in Somalia with its extremely high prevalence rates). Findings can help to understand the challenges to abandoning the practice of FGM. Insights to experiences of survivors and community attitudes could also provide guidance to community organisations and front line professionals / agencies working to prevent FGM.

1.6 Police Investigations and the Birmingham Context

Despite the fact that FGM is illegal in the UK, no one has been convicted for the practice. The first landmark prosecution took place in January 2015 against two men, one of whom was a doctor, but they were found not guilty (Laville, 2015).

In 2012 West Midlands Police arrested one doctor and one dentist in Birmingham after an article in the Sunday Times claimed they had caught the men offering FGM for two girls aged 10 and 13 (Mahmood and Mills, 2012). Although the charges were dropped Ali Mao-Aweys was struck off the medical register in 2014 (BBC News, 2014) and the General Dental Council struck off Omar Sheikh Mohamed Addow the previous year (Dowling, 2013).

It is alarming that there may be a tiny minority of medical professionals from FGM affected communities who could be willing to perform FGM. Not only is it against the law but they are also giving the false perception that medicalising the practice makes it acceptable. Local police statistics also indicate the occurrence of FGM. West Midlands Police have revealed they dealt with 70 cases between January and July 2015, which has included the arrest of a man for arranging for his 15-year-old daughter to undergo FGM (West Midlands Police, 2015). This is higher than in previous years where it had investigated 49 suspected offences between January and June 2014. For example, 41 cases were recorded in 2013, 25 cases in 2012 and 8 in 2011. Given these statistics and the fact that some girls in Birmingham are clearly at risk of FGM, we also attempted to find out about people's attitudes to reporting concerns during our research.



The West Midlands Police Crime Panel

The West Midlands Police Crime Panel launched an inquiry in 2014 to find out what the Police and Crime Commissioner can do to facilitate integrated working between agencies to prevent and respond to FGM in the West Midlands. A range of organisations were invited to give evidence between 24 November 2014 and 19 January 2015.

The inquiry highlighted that according to official statistics from acute hospitals in the seven West Midlands districts (Birmingham, Coventry, Dudley, Sandwell, Solihull, Walsall and Wolverhampton), between September 2014 and March 2015 there were 632 newly identified cases of women and girls who had undergone FGM. However, they had not been cut recently and it is likely that they were cut before they lived in the UK and were seeking medical support, such as for childbirth. This is important information because it is usually the girls whose mothers have been cut who are felt to be at any risk.

The West Midlands Police Crime Panel Report made 5 key recommendations that were shared widely such as with NHS Trusts, Clinical Commissioning Groups, Safeguarding Children Boards and Directors of Children's Services and Public Health. These were:

1. Educating Communities

Change the mindset of communities through an educational campaign by working with parents through schools and supporting those already speaking out on the issue. Also ensure when a girl is born to a mother who has undergone FGM that appropriate steps are taken to ensure the family is made aware that it is both illegal to perform FGM and its consequences.

2. Educating Practitioners

Ensure good quality training for practitioners so they understand risk and the role they need to play in protecting girls.

3. Having Consistency Across the Region

Ensure agencies across the region learn from each other and that regional best practice is developed.

4. Prosecuting

Gather intelligence and detect practice of FGM locally and identify those who may be practicing FGM and take action such as civil remedies (e.g. FGM Protection Orders) and take steps to protect girls at risk.

5. Providing Therapy

Ensure therapeutic needs of survivors of FGM are met, as currently there is little evidence of such support being made available.

2. Methodology

2.1 Data Collection

Given the size of their populations, the two largest FGM affected communities in Birmingham are Somalis and Yemenis (see Introduction). During the research we therefore tried to reach out and particularly seek survivors from these two communities. Table 1 shows the ethnic groups of the survivors who we spoke to together with prevalence of FGM in their countries of origin. Of the 16 survivors we interviewed, almost half (i.e. 7 participants) were of Somali background. The other women who shared their stories were of the following ethnicities: Eritrean, Djiboutian, Sierra Leonean, Egyptian, Nigerian, Sudanese, Gambian and Yemeni. Their case studies can be found in Appendix 1.

Table 1: Ethnicity of survivors interviewed and prevalence and type of FGM practiced in their countries of origin / birth

Ethnic Group of Interviewees practicing communities in Birmingham	Percentage of women aged 45-49 who have had FGM in country of origin *	Percentage of girls aged 15-19 who have had FGM in country of origin *
Egypt x 1	96	81
Eritrea x 1	95	78
Djibouti x 1	94	90
Gambia x 1	79	77
Nigeria x 1	38	19
Sierra Leone x 2	96	80
Somalia x 7	99	97
Sudan x 1	89	86
Yemen x 1	25	19

* Source : http://www.unicef.org/media/files/FGCM_Brochure_Lo_res.pdf and DHS and MICS, 1997-2011

Despite the significant size of the Birmingham Yemeni population, we found it difficult to speak to women from this community. Although one young woman shared her story, it was extremely difficult to find women willing to speak about FGM. We eventually managed to speak to small group of six women (of Egyptian and Yemeni heritage) through an Arabic speaking interpreter. However, we were only able to do this because the women were attending a separate gathering. We persuaded a few of them to speak to us afterwards in a focus group. The women were in their 50s, 60s and 70s. Some acknowledged that they had also undergone FGM but disclosed very limited details given the presence of other women.

We targeted the following groups for our research:

- Survivors of FGM
- Women who did not have FGM
- Men from FGM affected communities
- School pupils (boys and girls)

We conducted the research through one to one interviews, a focus group and questionnaires and managed to gather data through the following:

- 30 one to one interviews - 16 survivors, 8 women who did not have FGM and 6 men from FGM affected communities
- 1 focus group with Egyptian and Yemeni women
- 560 Questionnaires aimed at girls aged 16 years and under of which 77 were identified as being filled in girls from FGM affected communities (based on their ethnicities)
- Workshops with 120 boys aged 16 and under of which approximately 40 were identified from FGM affected communities (based on their ethnicities)

During the research interviews and awareness raising sessions the participants were informed of the legal status of FGM; where to get further support and help; limits of confidentiality (duty to report risk of harm and disclosures); and that FGM is not sanctioned by religion.

One to One Interviews

As the lead researcher (who was checked through the Disclosure and Barring Service) working on this project was herself not from a FGM practicing community, we were aware this could be a barrier for engagement and trust. She therefore spent the first two months attending training courses to gain knowledge of the issue and local community events to build links with women and men from FGM affected communities to identify individuals for one to one interviews.

During networking at events and meetings, individuals were asked if they were willing to participate in our research. A snowball approach was adopted where preliminary research interviewees were asked for other contacts that may be able to assist with the research. Evidence was gathered either by speaking to people face to face or via telephone interview.

As the subject matter was very sensitive and personal, a number of the interviewees felt apprehensive sharing their identity and provided interviews anonymously. The interviews were conducted alone unless the participant wanted someone present. The interviews were also semi-structured because it was evident that many would find it difficult to share their views openly. We tried to find out the following during the interviews:

- Background information - ethnicity, age, faith, how long they had been living in the UK
- FGM procedure practiced - type, location, age etc.
- Consequences of FGM
- Reasons used to justify the practice including role of religion
- Instigators / facilitators of the practice
- Attitudes towards the practice including willingness to challenge and report it

The level of details provided by participants varied considerably depending on how comfortable they felt sharing information. For many this was the first time they had spoken about their experiences of FGM in such depth. In this report not all details associated with each interview have therefore been provided both to protect identities and also to ensure the accounts were not too lengthy.

Data Collection Through Survey Questionnaires

We also wanted to speak to children from FGM affected communities. However, this is a difficult group to reach particularly for one to one interviews. So we sought their views through anonymised questionnaires after delivering FGM awareness raising workshops conducted in three secondary schools (two girls schools and one mixed gender school). These workshops and surveys were not specifically aimed at children from FGM affected communities but to entire classes to avoid stigmatisation and bullying. Basic demographic information that was collected through the survey (and information from school staff) helped us to identify children from FGM communities and only their questionnaires were analysed for the research.

We asked the children to give us feedback on the workshops and their views on whether: they were willing to ask for help if they or someone they knew was at risk of FGM; if they knew someone that had FGM or whether they themselves had it; if they were willing to disclose or report concerns and who they would speak to. After the workshops information on reporting and where to get help was given and any safeguarding concerns raised with the safeguarding lead. The anonymous surveys were also shared with West Midlands Police so they could use the findings for their research.

Focus Groups

The focus group was used to primarily target Yemeni women because they are a hard to reach group. The discussion consisted of introducing the topic and facilitating an open discussion, which included probing questions. The most significant comments they made are listed in Appendix 3.

2.2 Safeguarding

The research posed a number of risks so we put measures into place to mitigate them as follows:

- Anyone taking part in the research could be stigmatised as a result. We ensured that their interviews were conducted in a safe space agreed with them and their interviews were anonymised.
 - Survivors of FGM being re-traumatised by recalling their experiences. We informed them how to access counselling services. However, these were not specialist FGM ones but generic ones. We also encouraged them to only disclose what they felt comfortable with.
 - Identifying children at risk of significant harm or who had undergone FGM. When such risks were identified, child safeguarding procedures were followed.
-

2.3 Limitations of the Research

This qualitative research was conducted on only a limited budget; we only had resources for a researcher to spend one day a week on the collecting data. Some of the research had to be conducted during additional voluntary time while the report was written completely in voluntary time. This meant limitations in terms of applying a systematic methodology and having to use a multiplicity of methods.

The research was also affected by the following limitations:

- The reach of the investigation was limited to the networks and connections we made during the research, as links to FGM communities prior to the starting the study was minimal.
- All the participants for the one to one interviews identified as being Muslim, which means we did not have representation from other faiths.
- Despite the significant Yemeni population in Birmingham we struggled to reach them.



3. Research Findings - Procedure for FGM

3.1 Primary Instigators of FGM

It was evident from the interviews that women, (particularly the elder generation) were the main instigators of FGM (see table 2). Even in one case where the young woman did not have FGM, she explained that her mother did try and bribe her and her sisters to have it done (**Case Study 8 - Appendix 2**).

Table 2

Appendix 1	Comments Regarding the Instigators of FGM
Case Study 1	The survivor explained that an old woman and her grandmother came to the house and her grandmother told her that she would be cleaned.
Case Study 2	The survivor said that if she had daughters then the elders would pressure her into getting the girls to have FGM
Case Study 3	The survivor described how her mother, her aunties and the the cutter lady gathered around her and that she remembered there were 8-10 ladies.
Case Study 4	The survivor recalled how her mother took her to the village and then the women took her and the other girls to the bush to get cut.
Case Study 5	The survivor described how she was taken to a room by her mother and held down by ladies.
Case Study 6	The survivor explained it was women who led her (along with other girls) to the ceremony (for transition from childhood to womanhood) by women.
Case Study 7	The survivor said that her father was against the cutting so her mother carried it out while he was away.
Case Study 10	The women told the survivor that she was going to become a woman.
Case Study 11	The mother of a survivor explained how her mother in law persuaded her husband to take their daughter back to Gambia. During the visit the mother in law subjected her daughter to FGM (without permission).
Case Study 12	The survivor's step mother and grandmother wanted her to be cut and arranged it despite her dad being against it.
Case Study 13	The survivor now resents her mother for putting her through FGM.

Although we did not find any evidence in the case studies to suggest that men were the main instigators, there were indications that some men are supportive of the practice. For example, in **Case Study 8 (Appendix 1)** the survivor's mother had decided with her father that it was going to happen. In **Case Study 11 (Appendix 1)**, the interviewee's husband had taken their daughter to Gambia (against her wishes) where she was cut because of the grandmother.

The research showed that the men considered FGM a woman's business and it appears that they are often not involved in the decision to have it carried out or the actual procedure itself. In fact there was significant evidence that many men in the study opposed it. For example, 6 men who were against FGM were willing to be interviewed for our research (Appendix 4). Also the survivor in **Case Study 7 (Appendix 1)**, said her father was against it so her mother carried it out while he was out for most of the day. She said when he found out, he nearly divorced her mother over it. Another two women said they had not been cut because of their fathers who were against the practice (**Case Study 1 and 3 - Appendix 2**). Women therefore need to be equipped to be more resilient to pressure from their own peer group particularly the older generation who are often highly respected and men can play a role in challenging the practice (as discussed further in Chapter 7).



3.2 Location and Method

The women gave differing levels of details about the procedure because they generally felt awkward and embarrassed to talk about it. From the various accounts given, it was generally an older woman from the community who performed the procedure without any anaesthetic. Prior to the procedure some described being asked to have a bath to ensure they were clean and given new clothes and presents. Some recalled singing and dancing too. When the time came they were held down by a number of other women and then cut. Many said they screamed because the pain was so severe and some recalled seeing lots of blood and being terrified. Afterwards the legs were bound and the pain would last for days and they were given little food or water for about a week. One survivor recalled having the procedure done three times (**Case Study 7 - Appendix 1**) because she kept opening up as it was not done properly in the first place, which prolonged her agony.

15 of the survivors interviewed directly had the procedure performed in their countries of origin before arriving and settling in the UK. However, the Yemeni girl who was aged 17 (**Case Study 15 - Appendix 1**) had her FGM procedure in Saudi Arabia as her family lived there for a number of years before moving to the UK.

Although most of the survivors had their FGM performed by older women in their countries of origin without anesthetic, some evidence emerged there may be a trend towards medicalisation of the procedure by those who may be continuing the practice in the UK. Families may be involving health professionals because they may believe it makes FGM less harmful to health or to that it makes it less detectable. Evidence included interviewees being aware of involvement of medical professionals and families taking children to hospitals in the Middle East to have it done

- One participant had heard that girls used to be taken to other UK cities such as Sheffield and Hull to get it done but now girls are being taken to Dubai or Egypt so it can be done under anesthetic. She also remembered one childhood friend being taken to Oman to have FGM.
(Case Study 9 - Appendix 1)
- One participant said: “There is some private clinic in London owned by an Arab that was doing it. I even heard about a relative, who was in her 20s and had not had it done but wanted it. She went to a GP that was also from the same background and asked him if he would do it for her.” This was in another city outside of Birmingham but she did not disclose location nor whether this relative managed to have FGM. She herself had a medical procedure in Saudi Arabia before her family settled in the UK.
(Case Study 15 - Appendix 1)
- One participant explained how she and her sisters were bribed by her mother with money to agree to have FGM in Dubai. However, upon arrival at the clinic the appointment had to be rescheduled and they had to return to the UK without having the procedure carried out
(Case Study 8 - Appendix 2)
- One Yemeni lady in her 50s from the focus group thought that that FGM was acceptable providing it was medicalised and said that she was aware of the practice continuing in certain parts of Yemen.
- One participant believes some families may be taking girls to have FGM done in Middle Eastern countries because it is carried out in a sterile environment such as in a hospital or clinic.
(Case Study 1 - Appendix 1)

It appears that there may therefore be a very small minority of medical practitioners such as doctors from FGM affected communities who may be illegally offering FGM services. Perhaps the two medical professionals arrested in 2013 in the city of Birmingham (as highlighted in Chapter 1) was not surprising. The identity of such health professionals who provide illegal services is likely to be passed around by word of mouth. This means there will be people in the FGM affected communities with an awareness of who these professionals are. It is therefore important that people are encouraged to whistle blow and report any medical practitioners they suspect of cooperating in the practice of FGM. As people will be reluctant to report, they should be made aware of how they can report anonymously.

Those who want to continue practicing FGM will not just be taking girls to their country of origin. The research has highlighted that operations are also being performed in the Middle East. However, the police initiatives at airports that include distributing information on legal and health impacts of FGM currently tend to focus on outbound flights to ‘countries of prevalence’ in Africa. Perhaps awareness raising targeting outbound flights to Dubai and Saudi Arabia should also be considered given that they are popular travel destinations (for holiday and religious purposes respectively) and also provide medicalised FGM services.

3.3 Type of FGM

Almost half of the survivors either did not know, were unsure or did not want to disclose which type of FGM they had undergone. However, about one third (6 survivors) had the most invasive form of FGM, type 3 (see table 3). This indicates that significant number of girls in Britain may be at risk of this severest form of FGM and also living with its consequences.

Table 3: Number of Survivors by FGM type

FGM TYPE	Number of Survivors
1	2
2	1
3	6
4	1
Unsure / Not disclosed / Did not know	6

A couple of the survivors (**Case Studies 7 and 9 - Appendix 1**) mentioned that some families were encouraging their daughters to 'pinch' themselves as an alternative to types 1,2 and 3 FGM. Pinching is used as a method to elongate the girl's labia minora, which would be classified as type 4 FGM. Families may be resorting to pinching because they may be worried about being caught carrying out the more severe types 1, 2 and 3. This may be viewed as an alternative method or families may also wrongly believe that this form of FGM is acceptable because it is the least severe (and harder to detect by health professionals). Some may not even regard it as FGM as no cutting is involved. However, it is important to highlight the different practices that fall under type 4 and that these are also illegal. Type 4 FGM is often given little attention during awareness raising in communities and training of frontline professionals.

3.4 Age When FGM Performed

Of the 16 survivors interviewed directly, 14 of the survivors had FGM performed on them before puberty between the ages of 4 to 10 years before arriving in the UK. Two survivors (**Case Studies 11 and 16**) did not disclose the age at which it was done. In fact the lady in **Case Study 11** shared the story on behalf of her daughter. Although she did not disclose her exact age, she confirmed that her daughter was under the age of 16. She shared her story anonymously via telephone because she feared being reported.

For those who want to continue this practice in the UK, it is plausible to assume that it is prepubescent girls that are most at risk of FGM. What is also worrying is that although the age of cutting has remained fairly stable in most countries where FGM is practiced, where change has occurred, the most common trend is towards younger ages (UNICEF, 2013). Also the data in Table 1 shows that although in some countries the practice of FGM has declined because fewer girls under the age of 19 have had it done, in other countries the practice remains strong. For example, FGM is a deeply entrenched practice in Somalia with a prevalence rate is over 97% and in the countries where the prevalence of FGM is high the most common age for the FGM procedure is between 6 and 8 years (FORWARD, 2007). Due to the close ties between diaspora communities and relatives from countries of origin, this trend (age of cutting and strong support for the practice) is likely to be reflected here in Birmingham (and in the UK more generally).

Although prevalence of FGM may be lower in the Yemeni communities of Birmingham reflecting the lower prevalence rate in Yemen (compared with rates in Somalia), it is important to engage with this community and raise awareness of the health and legal consequences of FGM. Considering some evidence was uncovered about Yemeni girls having had FGM (**Case Study 15 - Appendix 1**), and women of Yemeni background presenting with FGM at maternity clinics, it is important to do specific awareness raising in this community in the future and must not be overlooked (in favour of the Somali community).

Given the age of the girls at risk, schools are essential in safeguarding them from FGM. Although all schools should have FGM awareness raising workshops, staff and pupils in primary and junior schools (as well as early year settings) should be prioritised; by the time girls reach secondary school, the likelihood is that FGM has already been carried out. However, from our experience at MWNUK, it has been very difficult and almost impossible at times to get into schools due to the sensitivity of the issue.

Due to the publicity about FGM in the media, MWNUK have found that secondary schools are now more receptive to workshops and we have been working in partnership with FORWARD (through a Department of Education Grant) to deliver workshops in secondary schools. However, delivery in primary and junior schools remains a substantial gap in Birmingham as well as in other cities in the UK where FGM practising communities have settled in significant numbers. To get schools to be more receptive to tackling this issue, school governors and head teachers need to be targeted for training first on this issue and given assurances that the workshops can be delivered using age appropriate and sensitive language so as not to stigmatise communities.



3.5 Evidence of Girls Undergoing FGM

During outreach in schools, we have uncovered some evidence that there are girls attending school that have had FGM. For example, in one school a 13-year-old girl of Somali background disclosed that she had FGM before arriving and settling in the UK. Another girl of Yemeni background had FGM before arriving in the UK. Although no legal offences had been committed because the girls had FGM before arriving in the UK, these cases highlight that girls are attending schools who have had FGM and are not receiving any support. Spotting the signs and awareness raising should not just be focussed on obtaining disclosures for the purposes of a prosecution but also to provide medical and psychological support too. To date we have not had any disclosures from girls who have had FGM while being resident in the UK. This is not surprising because children will not want to get their parents into trouble. However, our research revealed some evidence to suggest that girls have had FGM while living in the UK (whether they have had it carried out here or taken abroad for the procedure).

Examples of evidence include:

- One woman disclosed anonymously (**Case Study 11 - Appendix 1**) that her daughter had FGM. She was upset because her mother in law had done it against her wishes when her husband took their daughter abroad for a holiday. This is unlikely to be an isolated case given the pressures exerted by family members abroad as highlighted by some of the survivors.
- One young woman (**Case Study 8 - Appendix 2**) said that although she had not had FGM, she recalled her mother bribing her and her sisters to have it done during a trip to Dubai. As the appointment had to be rescheduled, it was not carried out and the girls returned to the UK without having FGM. This is also unlikely to be an isolated case.
- One 15-year-old girl purposefully did not want to listen to the FGM talk in school and became disengaged. She appeared very upset and left the room. Once she calmed down, she repeatedly asked if FGM was against the law and against Islam. From her responses and behaviour we suspected she may have had FGM but she did not disclose, which may have been due to the fear of getting family members into trouble. There were another couple of occasions when other girls exhibited similar behaviour but did not disclose either.
- In one survey, a 15-year-old girl revealed that she knew a friend at school who had FGM but would not disclose further details.
- In other surveys a few girls would not answer whether they had FGM even though the responses were anonymised.

4. Research Findings

- Consequences Of FGM

Table 4: Summary of consequences that emerged from the research

Consequences	Physical	Psychological	Sexual	Social
Short Term	<ul style="list-style-type: none"> ■ Severe pain ■ Bleeding / haemorrhage ■ Fever ■ Unable to walk for days ■ Wound opening up ■ Violence 	<ul style="list-style-type: none"> ■ Shock ■ Fear ■ Nightmares ■ Flashbacks 		
Long Term	<ul style="list-style-type: none"> ■ Menstrual blood retention ■ Urinating more frequently ■ Urine retention ■ Recurring infections ■ Severe pain due to being cut open before the wedding night ■ Complications during child birth ■ Caesarian ■ Domestic Violence 	<ul style="list-style-type: none"> ■ Nightmares ■ Flashbacks ■ Depression ■ Anxiety 	<ul style="list-style-type: none"> ■ Pain during sex ■ Lack of sexual pleasure ■ Lack of sexual desire ■ Problems with intimacy 	<ul style="list-style-type: none"> ■ When periods are prolonged not being able to pray or fast - resulting in religiosity being questioned and accused of making excuses ■ Embarrassment when being medically examined ■ Marriage breakdown / divorce

4.1 Effects on Physical Health

The health impact and the severity varied amongst most of the survivors, which may have depended on the type of the FGM. The following short-term physical impacts were reported: severe pain, bleeding / haemorrhage, fever, unable to walk for days and the wound opening up. Examples of long-term effects reported included: menstrual blood retention resulting in prolonged periods, urinating more frequently, urine retention, recurring infections, further severe pain due to being cut open before the wedding night, pain during sex, complications during child birth and delivery by caesarian. Domestic violence was also reported, which resulted from women not wanting to have sex because it was too painful. There are other physical health implications of FGM that were not mentioned by the survivors we interviewed but it does not mean they were not suffering from them. Some of these included infertility and being prone to cysts and keloid formations, which can result in unintended cuts into the urethra and rectum that may cause fistulas.

It can be hypothesised that the health consequences related to FGM will become more severe if women and girls do not ask for help or when they do, don't indicate the underlying reasons for their problems. Young girls (and their parents) may be reluctant to ask for help due to the fear of getting into trouble with the law. Even where girls have already been cut before settling in the UK and no legal offence has been committed, they may still not ask for help due to the fear of being stigmatised and being scrutinised with regards to other girls in the family. From 31 October 2015 frontline practitioners such as those working in the health care service have statutory duty to report known FGM for under 18 year olds. These new rules will make it harder for children and their parents to ask for help over health concerns. It is therefore vital that doctors and nurses are trained to be vigilant in identifying medical problems that may be linked to FGM, identifying risk of FGM and speaking with patients sensitively. Some good practice is listed below (British Medical Association, 2011):

Good Practices For Health Professionals

- Ensure that care is taken not to make affected girls and women feel stigmatised - for example not using the term female genital mutilation as it may be considered offensive or inappropriate and trying instead to use neutral terms such as female genital cutting (or even circumcision).
- Address concerns sensitively so as not to exhibit signs of shock, horror or revulsion.
- Consider other girls and women in the family who may be at risk of FGM or suffering from the consequences of it when dealing with particular cases.
- When taking routine patient history from girls and women from communities that practice FGM, ask about FGM e.g. this could be done when registering new patients.
- When vaccinations are requested for overseas trips to countries of origin that practice FGM, consider risk of FGM and ask questions and raise awareness about the law and health consequences.

Medical professionals such as doctors are often viewed as authority figures and highly respected and therefore could also play an important role in efforts to support communities to abandon FGM by raising awareness of its harmful effects and health risks by speaking at community events and to influencers in the community such as religious leaders.

4.2 Psychological Effects

From the accounts given by the survivors, it was clear that the cutting was a traumatic experience for most of them and the psychological impact had lasted into adulthood. Many continued to have nightmares and flashbacks, which are likely to be undiagnosed symptoms of posttraumatic stress. Some examples of experiences are:

- Survivor still gets frightened thinking about the experience and gets nervous when she sees sharp tool or blade.
(Case Study 4 - Appendix 1)
- Survivor says she cannot forget what happened and keeps having nightmares about the cutting and even thought she could see the ‘cutter’ when she was giving birth.
(Case Study 5 - Appendix 1)
- Survivor remembers what happened in the ‘bush’ every time she has fever.
(Case Study 6 - Appendix 1)
- Memories are triggered now by the smell of Dettol.
(Case Study 9 - Appendix 1)
- When the survivor sees her husband’s razor, it reminds her of that time.
(Case Study 14 - Appendix 1)

It also appears that most have been suffering in silence because they have not shared their trauma with others let alone receive a therapeutic intervention for it. For some talking to the researcher was the first time they had shared their experiences and feelings in detail **(e.g. Case Studies 1 and 14 - Appendix 1)**. Others found it difficult to talk about FGM and its impact. For example one survivor said *‘it was embarrassing to talk about intimate matters and that women don’t talk about these things’* **(Case Study 1 - Appendix 1)**.

As most women are not telling anyone about their symptoms nor speaking about their experiences, they are not receiving any counselling which could help them deal with their anxiety, depression and post-traumatic stress. Although one woman did go to her doctor for her anxiety, she says that the doctor did not attempt to ask her about her childhood or underlying reasons for her feelings and recommended exercise and going for walks. The survivor said she had not mentioned the cutting either **(Case Study 6 - Appendix 1)**.

GPs are now receiving training on FGM from a safeguarding point of view so they can better protect children. However, they also need to be made aware (particularly those situated in communities where significant numbers are from countries with high FGM prevalence rates) that some of their clients may be adult survivors of FGM and suffering from mental health issues because of it. They also need to be able to identify health problems that may be associated with FGM and be able to ask appropriate questions so women feel they are able to disclose and be referred for counselling.

Counselling is not only essential for women to improve their mental health, but can also help play a crucial part in eliminating the practice of FGM. Only when women are able to deal with and process the anger, resentment and feelings of loss and betrayal by their parents, will they fully understand what happened and why it happened. This in turn can give them the confidence to challenge the practice so others do not have to go through what they have endured.

4.3 Sexual and Relationship Effects

Mental health of survivors can deteriorate further if the FGM has resulted in relationship problems and domestic violence including breakdown of marriages. Examples of experiences provided by survivors include:

- One survivor explained that sex with her husband is very painful and was beaten at the beginning of her marriage but says her husband is more understanding now .
(Case Study 1 - Appendix 1)
- One survivor acknowledges the difficulty it causes in her marriage because she does not want to have sex.
(Case Study 3 - Appendix 1)
- One survivor says sex continues to be painful and she does not enjoy it and makes excuses not to have sex which has caused difficulties in her marriage
(Case Study 4 - Appendix 1)
- One survivor says sex is so painful that she has to sit in cold water afterwards and also makes excuses to avoid sex which has led to domestic violence, which is just accepted as a way of life by women.
(Case Study 7 - Appendix 1)
- When one survivor refused to have sex with her husband (due to the pain), she was told she was not a good woman and felt pressured to have sex even though she does not want to.
(Case Study 12 - Appendix 1)
- One survivor explains that the impact of the FGM has resulted in her having no feelings towards her husband.
(Case Study 14 - Appendix 1)
- One survivor indicated that she was not too active sexually because she did not feel anything and it was causing problems.
(Case Study 16 - Appendix 1)

Sexual difficulties are therefore causing significant amounts of stress in women's lives because they are having sex even though they do not want to because of the pain. This is likely to make them feel inferior because they are merely the means of the husband's gratification. It is therefore also important to raise awareness of such consequences of FGM to men. This could help shift their attitudes so they are against the practice as they would realise the impact on men.



4.4 Social Effects

Women who have not had FGM or who are not willing to subject their daughters to it could also be psychologically affected because they are stigmatised by other family and community members and deemed unclean or unmarriageable. This can lead to isolation and being excluded from the community. This can result in pressure to conform that needs to be resisted. For example one participant of Gambian background (**Case Study 2 - Appendix 2**) who had not had FGM said she was ostracised and bullied as a child: *“I remember the bullying intensified when one of the girl’s stood outside the toilet and had probably heard that I wasn’t trickling but was gushing. When I came out she told me I was unclean and impure and she went and told the other girls and they stopped hanging around with me.”* She went on to explain how she wished she had FGM because she felt so isolated. She also felt the same when her marriage broke down because her husband accused her of sleeping around because she was uncut.

Women and girls in the UK can also face similar type of bullying or pressure. In another example, a 23-year-old woman of Somali background (**Case Study 6 - Appendix 2**) who had not had FGM said she felt left out when she was growing up. She said she would feel left out when her older sisters (who had FGM) used to talk about it and felt even more left out when she became aware that her friends at school had been cut too: *“I thought I was missing out and really wanted to have it done and kept asking my mum to let me get it done.”* However, she said she was put off the idea when she found out about the health problems her sisters faced, which was reinforced by a TV documentary on FGM. Another Somali young lady aged 17 (**Case Study 7 - Appendix 2**) explained how her cousins pressured her during a trip to Somali. She was around 14 years old at the time when they were trying to persuade her to agree to having FGM. She said she that although she managed to resist the pressure, it was difficult.

One survivor explained how she made others feel inferior to her because they had not been cut (**Case Study 9 - Appendix 1**): *“I used to walk in proud making them feel less than me. It was me suppressing my feelings and showing that I’ve been brave and cut properly whilst they have been pinched and still remain unclean. I thought they were lower class than me; I was proud that I was able to go through the worst type of cutting.”* Another survivor, who has not had her daughter cut, is being stigmatized by her own community (**Case Study 12 - Appendix 1**): *“Both my neighbours are Somali and they won’t let their children play with my daughter because she is not circumcised even though one of the girls is her best friend at school.”*

Little attention has been given to the psychological needs of women and girls who have not been cut. It is therefore important to ensure that culturally sensitive psychological interventions are also made available to them. Counselling can have a dramatic impact on the mental well being of women and girls, which in turn can lead to increased confidence to resist and challenge a deeply ingrained cultural tradition. This kind of support is essential given that they are from a culture where it is important to be dutiful to parents and hold elders in high regard; telling them that FGM amounts to child abuse and resisting their demands will not be easy.

At the time of writing this report, there are currently no FGM mental health specialist services in Birmingham, which is a significant gap in services considering the size of the local FGM affected communities. For counselling to be most beneficial, the counsellors should not only be trained on the issue of FGM but women from FGM affected communities (who do not necessarily have to have undergone FGM themselves) should also be trained as they will be able to better facilitate conversations during consultations and able to respond and ask questions in a non judgmental manner / more appropriately.

5. Research Findings

- Reasons for FGM

Faith was cited as one of the reasons for the practice of FGM. However, this is discussed in Chapter 6. Other key reasons provided for FGM were linked to transition into adulthood, cleanliness, maintaining chastity and for pleasure of husbands (and therefore ensuring she is marriageable). The participants highlighted these as follows:

- The survivor was told she would be clean and would no longer be a girl and would be like everybody else and not be left behind. She was also made to believe that it is shameful to live with the genital area open.
(Case Study 1 - Appendix 1)
- The cutting also involved being initiated to be part of a society to take care of husbands.
(Case Study 4 - Appendix 1)
- Afterwards the survivor was told that she was clean and perfect and a good girl now.
(Case Study 5 - Appendix 1)
- The survivor believed it was a rite of passage from childhood to womanhood.
(Case Study 6 - Appendix 1)
- The survivor said it has to be done for a girl to be moral and was told that it is done for cleanliness, religion and because that is what husbands want for marriage.
(Case Study 8 - Appendix 1)
- The survivor was told that she was going to become a woman and was told it was going to remove dirt, make her clean and so she can become a real Muslim.
(Case Study 10 - Appendix 1)

These are deeply rooted beliefs as highlighted by this statement: *“My mother believed it was a rule that must be adhered to regardless of the consequences”* **(Case Study 1 - Appendix 1)**. Some of the other survivors said FGM was done because it was a tradition.

Due to such deeply held beliefs to justify FGM there will be parents in the UK who will be subjecting their daughters to FGM even though it is against the law. However, there will also be parents whose children may be being subjected to FGM without their knowledge or permission as in **(Case Study 11 - Appendix 1)**. The mother disclosed that the father took the daughter to Gambia where extended family members arranged for her to be cut. The mother was very upset about what her daughter was made to go through but very frightened to tell anyone due to the fear of getting into trouble. It is important that there are mechanisms for mothers like the one in this Case Study to be able to come forward and ensure the child receives the help that is needed without being prosecuted. In fact, during community educational raising campaigns it is important to reach out to mothers and fathers who may be in similar situations who do not want their daughters cut and encourage them to report concerns so that they can be supported and their daughters protected from being cut.

6. Research Findings

- Role of Religion

6.1 Is FGM Considered Islamic?

During the research we also attempted to find out the role of religion in perpetuating but also challenging the practice of FGM. As all the one to one interviews were conducted with people who identified as Muslim, we have only focussed on the role of Islam. Although FGM is not sanctioned by any faith including Islam, it does play a role in preserving the practice. Some of the women interviewed erroneously believed or were told that it was a religious obligation and even used the word Sunnah (Prophet Muhammad's pbuh practices) to describe FGM:

- Survivor was told by her mother that it was an Islamic tradition and God would be pleased with her and speaking against it would result in evil against her.
(Case Study 1 - Appendix 1)
- Survivor was given a number of reasons for being cut which included religion.
(Case Study 8 - Appendix 1)
- Survivor had believed it could be justified on religious grounds and was willing to do it to her daughters until she found out it was a cultural tradition.
(Case Study 9 - Appendix 1)
- Survivor was told she was going to be cut so she could become a real Muslim.
(Case Study 10 - Appendix 1)
- One woman of Indonesian heritage who had not been cut, said that girls are being made to have FGM in conservative areas in Indonesia because it was considered a religious obligation.
(Case Study 4 - Appendix 2)

Cleanliness and hygiene was also mentioned often as a reason for FGM, which is likely to be connected to religion because Islam places great emphasis on both physical and spiritual, cleanliness and purification. The other women understood that FGM was not a religious obligation but was done as a cultural tradition particularly associated with the transition to womanhood, preventing promiscuity and being marriageable. Despite delivering presentations schools highlighting that the practice is against all faiths, some girls did not appear convinced judging from their reactions and comments made in the questionnaires.

Interestingly of the six men interviewed, five said the practice was against Islam:

- Somali male said it was being done in name of tradition not Islam.
(Interview 1 - Appendix 4)
- Sudanese male said he was against the cutting and it was against his religion.
(Interview 2 - Appendix 4)
- Gambian male said when his mother made his sisters have FGM, his father, who was a very religious man, was very upset and even threatened to divorce his mother over the cutting.
(Interview 3 - Appendix 4)
- Somali male who is also an imam said that cutting was against Islam and would not subject his daughter to the practice.
(Interview 4 - Appendix 4)
- Somali male who was an imam said that FGM was against Islam but was referring to type 3 and alluded to other types being acceptable.
(Interview 5 - Appendix 4)

It is evident from these responses that some people in FGM affected communities believe that the practice is religiously mandated despite the fact that many Muslim theologians have stated it is contradictory to the teachings of Islam. This confusion probably arises from the fact that not all Muslim faith leaders are consistent with their messages and the levels of condemnations vary. This was highlighted by one imam we spoke to who was very strong in his condemnation of the most severe form of FGM, type 3 **(interview 5 - Appendix 4)**. He said this was prohibited in Islam. However, he was reluctant to say that the other types (1, 2 and 4) were against Islam. Another imam whom we wanted to work with to help condemn the practice, was willing to do this publicly by saying that Islam does not allow harm, but he was reluctant to openly challenge the secondary religious texts i.e. hadiths that are sometimes used to provide a religious justification for FGM (as highlighted in section 6.2). He was concerned about the reaction and backlash from his community.

Such mixed messages are resulting in some Muslims believing the practice is an obligation or at least recommended by Prophet Muhammad (pbuh) while others believe it is prohibited or optional. It is therefore clear that if FGM is to be challenged theologically, it is simply not sufficient just to state Islam does not sanction it. More detailed explanations need to be provided about why this practice is not only against the faith but also strongly condemned by it. This message needs to be delivered particularly by faith leaders from FGM affected communities, as they are likely to have more credibility than faith leaders from non-FGM affected communities. However, faith leaders from non-practicing communities, who are often less aware about the practice of FGM should also be trained on this issue and be familiar with the theological arguments if they are serving a community that also includes people from FGM affected communities. The religious texts commonly used to justify FGM and how these can be challenged is discussed in the next two sections.

6.2 Religious Texts Used to Justify FGM

The source of the problem arises from the following secondary religious texts known as hadiths (narrations that have been attributed to Prophet Muhammad pbuh) that are used to support the practice of FGM.

1. Not to cut women too severely

Narrated Umm Atiyyah al-Ansariyyah: A woman used to perform circumcision in Medina. The Prophet (peace be upon him) said to her: Do not cut severely as that is better for a woman and more desirable for a husband (Abu Dawud 41:5251).

When the Prophet (pbuh) saw a woman cutting, he told her 'not to cut too severely' - Some scholars will argue that because the Prophet (pbuh) did not ban the practice, this justifies its permissibility and / or he was only prohibiting more severe types of FGM and accepting less severe types. They ignore the fact that if the words attributed to the Prophet (pbuh) were actually spoken by him, he is making a statement that does not translate into an injunction for cutting. However, this narration has been widely regarded as weak or poor in authenticity amongst Islamic scholars throughout history because it does not meet the strict criteria to be considered unquestionable. **(Rashid, 2014)**

2. It is an honour for women to be cut

Abu al- Malih ibn `Usama's father relates that the Prophet said: "Circumcision is a law for men and a preservation of honour for women" (Ahmad Ibn Hanbal 5:75; Abu Dawud, Adab 167).

This text is used by some to justify that FGM is a recommended practice even it is not obligatory. However, this narration is also regarded as weak and fails the test for being authentic. Also some scholars interpret this narration to mean that when a woman is married to a circumcised (i.e. ritually clean) man, it is an honour for her. It does not mean that it is an honour to subject the woman herself to circumcision. **(Asmani & Abdi, 2008: P9)**

3. When two circumcised parts meet

Muslim (349) narrated that 'Aa'ishah (may Allaah be pleased with her) said: The Messenger of Allaah (peace and blessings of Allaah be upon him) said: "When a man sits between the four parts (arms and legs of his wife) and the two circumcised parts (al- khitaanani) meet, then a ritual bath (ghusl) is obligatory."

When a husband and wife are intimate, 'two circumcised parts (khitaani) meet' - the likelihood is that this is used to provide evidence that women were cut historically to justify continuing the practice. Proponents consider this hadith to be one of the strongest justifications for FGM in Islam because this is regarded as authentic. Some scholars say that the two circumcised parts are referring to that of the husband and of the wife, indicating that women were circumcised. However, others scholars point out that the term khitaan in Arabic strictly refers to male circumcision and FGM is referred to as khifaadh as explained earlier. The term khitaanani, though in dual, is not evidence for FGM because the use of one word or quality to refer to two different persons or things is an acceptable Arabic language style. In this case khitaanani refers to the male and female organs but which are different with respect to circumcision i.e. male is circumcised, the female is not. The feature of the more common or prominent one i.e. male circumcision is used.

(Asmani and Abdi, 2008: Page 10)



6.3 Role of Islam to Challenge FGM

In section 6.2 we have discussed how the religious texts that are commonly used to justify FGM can be challenged. However, the practice can also be challenged by using the following theological arguments:

1. Challenging Using the Quran

There is no mention of FGM in the Quran and not a single verse can be used to justify it although proponents of the practice will argue that there is no evidence to forbid it either. However, there are several verses that can be used to condemn the practice.

Examples include:

“...and there is no changing Allah’s creation...” (Quran 30:30)

“You will not see any flaw in what the Lord of Mercy creates” (67:03)

“and make not your own hands contribute to your destruction” (Quran 2:195)

There is a principle of ‘do no harm’ in Islam. For example, the Quran banned the killing of female infants, a common practice in pre-Islamic Arabia: *“...when the girl child who was buried alive shall be asked ‘for what sin was she killed’”* (Quran: 89: 8-9).

It can be argued that all forms of barbaric acts of violence committed against girls and women in today’s society equates to the modern day version of ‘burying girls alive.’ The proponents of FGM will argue that this does not apply because male circumcision is practiced amongst Muslim communities. However, research shows that circumcision in men does not impair their sexual function or satisfaction and has many well documented medical benefits (Castleman, 2015) therefore does not cause harm. On the contrary, FGM has no medical benefits and harms physical and psychological health as well as affecting sexual functioning.



2. Challenging Using the Sunnah

There is no evidence in any hadiths to suggest that the Prophet (pbuh) subjected his daughters or his wives to FGM. The daughters and the wives of his companions were not circumcised either. For those who say that the practice is recommended by the Prophet (pbuh) are overlooking the fact that he would not recommend or make obligatory something he did not do himself. If the women in his family were circumcised, it would have been well known and would be widely practiced in all Muslim majority countries, which it is not.

Wanting to curb the sexual desire in girls and ensure they virgins (and therefore marriageable) is such a deeply rooted cultural tradition that it is prioritised over and above religious beliefs. Even though there is overwhelming evidence that FGM is not a religious practice and conflicts with the teachings of Islam, communities still continue to practice it. They will even provide erroneous religious justifications to reinforce its continuation. These links between religion and FGM therefore cannot be ignored especially because faith leaders themselves are providing conflicting views on the matter. To eradicate it, religious leaders need to speak with one voice unequivocally condemning this harmful practice in all its forms. To achieve this, they must engage with medical experts and gain an understanding about the functions of the female genital organs and the harmful effect of cutting (including physical, psychological and sexual). This will enable them to fully understand what FGM entails when they provide advice or rulings about it. They also need to take the lead and not exhibit double standards when it comes to chastity and morality. According to Islamic teachings, these are equally applicable to males as well as females. Subjecting FGM to girls is degrading and disrespectful because they are all regarded as not being able to control their sexual desires and assumption is being made about their sexual behaviours.

Until this happens, fatwas (religious edicts) condemning the practice will have a limited impact as we have already observed. For example, in 2007, Grand Mufti Ali Gomaa's issued a fatwa condemning FGM which was followed with a statement by the Azhar Supreme Council for Islamic Research (highest religious authority in Egypt) explaining that FGM has no basis in Islamic law. However, although FGM prevalence has declined from 91% in Egypt, the levels still remain high (UNFPA Egypt). Similarly in the UK, religious and community leaders have united to sign a joint declaration condemning the practice and stating it is not supported by any religious doctrine (Gov.uk). However, its very impact will be limited if religious leaders within FGM affected communities are not all equally condemning the practice (in all its form) or not willing to do it publicly as highlighted by this research.

7. Research Findings

- Social Attitudes

To eradicate the practice of FGM a major attitudinal change is required. During the research we explored whether there was any support for ending the practice, whether people were willing to translate this support into action and what the barriers were to changing mindsets.

7.1 Attitudes of Women

The survivor accounts revealed the highly stigmatised and negative attitudes held against girls and women who do not have FGM, which seemed to be driving the cutting. They were regarded as unclean and unmarriageable (see chapter 5). There was evidence of ostracisation and bullying of girls and their families, which could result in families succumbing to pressure and even girls themselves 'wanting it done.'

Case Study 12 (Appendix 1)

"Both my neighbours are Somali and they don't let their children play with my daughter because she is not 'circumcised' even though one of the girls is her best friend at school."

Case Study 2 (Appendix 2)

"I remember the bullying intensified when one of the girls stood outside the toilet and had probably heard that I wasn't trickling but was gushing. When I came out she told me I was unclean and impure and she went and told the other girls and they stopped hanging around with us."

Case Study 6 (Appendix 2)

"I thought I was missing out and really wanted to have it done and kept asking my mum to let me get it done."

The women interviewed who had not been cut unsurprisingly did not favour maintaining the practice. Half of the women who had been cut were also strongly against the practice and wanted it to end. The other half remained silent on the issue, which did not necessarily indicate they supported it. Some may have felt uncomfortable openly criticising a tradition that was a part of their culture to an interviewer who was from outside of their community. Others may be against the practice but not strong enough to go against social norms.

These attitudes may not necessarily reflect the wider community due to the small sample of women interviewed and the fact that those that agreed to be interviewed may have done so because they do not support the practice. However, the fact that these women do not want to continue the practice and those who have daughters have not carried FGM on them is a positive sign. This indicates there is at least some willingness to go against community norms

and resist pressure to end the practice. Some were even willing to report concerns to the police but most others preferred and felt more comfortable contacting a voluntary organisation such as a women's group.

Case Studies of Survivors from Appendix 1

- Survivor said she would not allow her daughters to go through it and would not be taking them back to Somalia **(Case Study 1)**
- If she was concerned about a girl in the community she would contact the school or a women's organisation **(Case Study 2)**
- She was willing to contact professionals and even go to the police if she felt a girl was at risk **(Case Study 3)**
- Would be willing to call the police if a girl was at risk **(Case Study 5)**
- She is bringing her sons and daughters up to challenge the tradition of FGM **(Case Study 12)**
- She would not do that to her daughter if she had one **(Case Study 13)**
- She said she would never put her daughters through FGM **(Case Study 14)**

A couple of the survivors even wanted physical examination of girls up to them becoming teenagers **(Case Studies 3 and 5 - Appendix 1)** pointing out that France do more checks. One of them said that when her daughter was born the health visitor did explain to her the reasons for not getting FGM done. However, she said that no one checked up on her daughter again and pointed out that she could have easily taken her abroad for FGM and no one would have known.

It is important to utilise women who are breaking the cycle of FGM (by not subjecting their daughters to it). Activities should be identified where their support can be utilised in public campaigns so they can share their stories and views. Some may not wish to be identified due to the backlash they may face from others in their communities and should be supported in sharing their stories anonymously.

Women who have not been cut could also be recruited for public campaigns to highlight that despite not being cut, they have got married. One survivor was willing to provide such support but anonymously. MWN UK therefore utilised this opportunity and filmed an interview with her without revealing her identity for a campaign video. Even with the support of these voices, eradicating FGM will be challenging because the main instigators of the practice are other women. Despite the traumatic experiences of FGM some women will be made to feel guilty and will be torn between the welfare of their child and societal pressures. They will also worry that by not having FGM, the matrimonial opportunities for their daughters will diminish. This area needs attention. The confidence of women needs to be built up so they are more resilient to pressure from family and other community members. For example, they could be helped to vocalise their views sensitively but with robust counter arguments. However, the first step needs to be to encourage women to have conversations about FGM amongst themselves. When being interviewed most survivors said it was not an issue that is discussed amongst friends because they feel very uncomfortable talking about such personal matters. A few even said the research interview was the first time they had spoken in such detail about their experiences, consequences and feelings.

7.2 Attitudes of Men

We were able to interview 6 men for the study who were between 33 and 58 years old, who were of Somali, Sudanese and Gambian backgrounds (see Appendix 4). Their interviews revealed that it was usually an issue not discussed amongst the men, it was regarded as a women's issue because according to them the main instigators were the women.

Somali Male (Interview 4 - Appendix 4)

"In my family my sisters have had it done and my wife has had the cutting, but I haven't had a conversation about it."

The research did show that women did not involve them in the decision-making. There was evidence that some couples did not even discuss the issue even amongst themselves leading to discord amongst couples. The survivors gave examples of their mothers hiding the cutting from their fathers because they opposed the practice (see Chapter 3 on the Primary Instigators). Any educational campaigns should therefore encourage open dialogue between husbands and wives.

Gambian Male (Interview 3 - Appendix 4)

"Men have the information hidden from them. My father was really upset when my sister had it done. He was a religious man and really against it and threatened to divorce my mother if she did it again to any of the other daughters."

Men who were married said that they were against it after witnessing the consequences with their wives. Those who were not married were also against FGM indicating that they would not marry someone that was cut. One male said when he was ready to get married he requested for a woman that was not cut. The link between FGM and sexual / relationship problems was also evident in our research and it is also important to raise awareness of these. Painful sexual intercourse and not wanting to have a physical relationship with their husbands was highlighted by many of the survivors. This issue was also highlighted by one of the imams interviewed. He said: *"I know that many of the couples that come to me for issues such as domestic violence that result from bedroom issues, and most probably we have to ask the question why is this?"*

Somali Male (Interview 1 - Appendix 4)

"If she does not have any feelings then what's the point? I don't ever want to marry anyone from our community."

Somali Male (Interview 5 - Appendix 4)

"I asked for someone who was not cut and equally will make sure my daughters are not cut."

Somali Male (Interview 6 - Appendix 4)

"There is no point in getting married to someone who has had it done, what pleasure do they feel if this is taken away from them."

There was also evidence that when men were involved in deciding on whether their daughters should undergo FGM, they were not cut. This is evidence that men can play an important role in decision-making that can eventually result in the practice being abandoned.

Somali Woman (Case Study 1 - Appendix 2)

She said she was not cut because of her father

Somali Woman (Case Study 3 - Appendix 2)

She has not had FGM and puts it down to her father but thinks that her mother did not share his views:

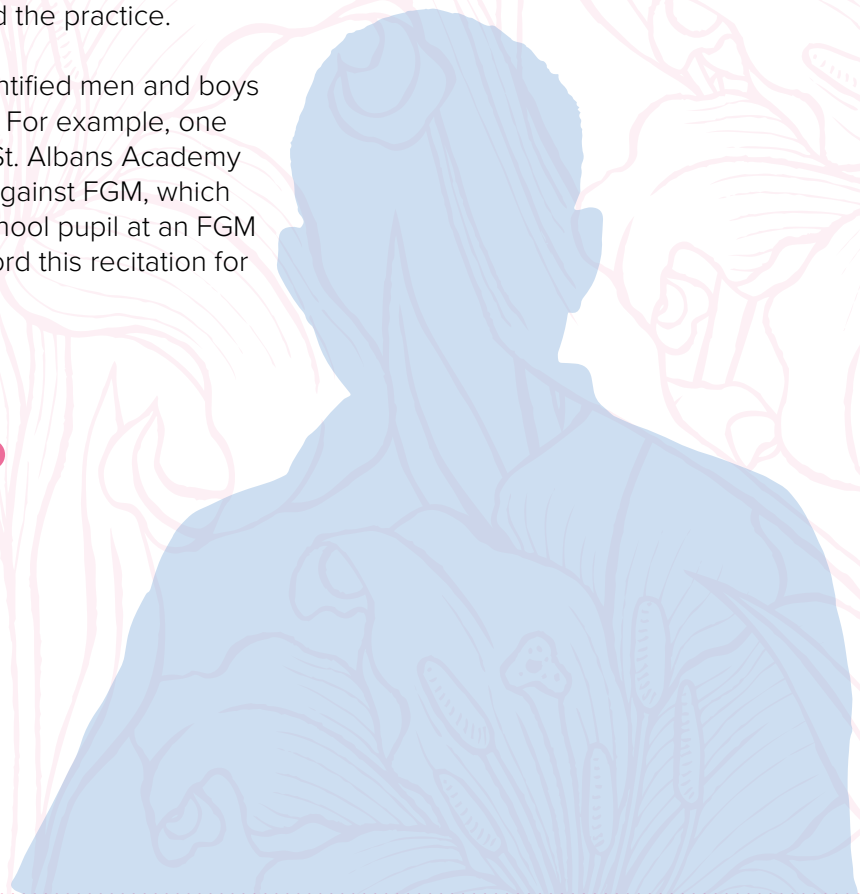
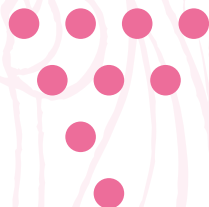
“My dad told me it is haram (unlawful in Islam) and it’s completely against our religion, however, my mother on the other hand has stayed quiet.”

Gambian Male (Interview 3 - Appendix 4)

Although his wife has had FGM, he has five daughters and they have not been cut because he and his wife do not believe in it.

This suggests that discussions on ending FGM should not just involve women but also men including influencers such as faith leaders. Men can be important agents of change but seem to be currently under utilised in the UK. It is important that information campaign aimed at girls and women should also highlight that some men and boys are against FGM, especially highlighting that some are refusing to marry cut women because it affects the sexual relationship. This is important to highlight given one reason used to justify FGM is because it increases the man's sexual pleasure. This may also result in more support to end the practice.

During the research MWN UK identified men and boys willing to speak out against FGM. For example, one Yemeni male member of staff at St. Albans Academy wrote an Arabic / English poem against FGM, which was recited by a Yemeni male school pupil at an FGM event. MWN UK were able to record this recitation for a campaign video.



7.3 Attitudes of Boys

When trying to find out to views of boys we held workshops in a mixed school. When the boys and girls were together in the class, both genders were not willing to express their views. We then decided to speak to them separately. Five sessions were held for the boys aged 13 to 16 years old, each including approximately 24 boys. However, they were from diverse backgrounds. Approximately one third in each session were from FGM affected communities. This means that of the 120 boys, approximately 40 were from FGM affected communities (the vast majority of who were from a Somali background).

Most of the boys from the FGM affected communities seemed to be unaware of what FGM was and seemed horrified when they found out and seemed surprised that girls living in the UK were being subjected to it. This is perhaps not surprising because it had already emerged through the interviews from adult men and women that men did not seem very involved in the issue. However, a small number of boys who were new migrants and perhaps only been in the UK for about 2 years held conservative views on the issue. They wanted to hold on to their culture and said that they should not be changing the tradition of their forefathers. They felt that ending the practice was a Western notion and that the West were putting a negative spin on FGM. They went as far as saying that it was good for girls to go through it. One was so vocal that he left the session by mutual agreement and was spoken to later by school staff. Such views indicate the importance of working with new migrant communities and not just with well established and settled communities.



7.4 Attitudes of Girls

When trying to find out to views of girls we held workshops in two girls schools (including one Islamic school) and one mixed school. After an awareness raising session questionnaires were handed out to be filled in anonymously to find out more about their views. Not all girls filled them in. We delivered workshops to 560 girls aged 11 to 16 years old. We separated out the questionnaires of the girls from FGM affected communities, which totalled 77.

Most girls (79%) were Somali and the remainder were of Yemeni, Egyptian, Congolese, Gambian, Nigerian, Sierra Leonean and Zimbabwean backgrounds. The vast majority were of the Muslim faith (91%) and 9% were Christian. Only 13% of the girls were born in the UK with most being born outside of the UK including countries of origin such as Somalia, Gambia, and Nigeria or in another European country such as Holland, Denmark, Finland and Norway. However, a large number were born either in Somalia or Holland. It was noted that a few were more recent migrants and had only been in the UK for about 2 years.

The responses to the questionnaires and also reaction of a few of the girls did indicate that some had undergone FGM. For example, 10% preferred not to say if they knew anyone who had FGM. In fact 3 girls did admit to knowing of girls who had FGM. However, they did not say where this had been carried out (i.e. in the UK or abroad) and whether it was done before settling in the UK. When asked whether they had FGM, most said they had not but 3 girls chose the option 'prefer not to answer.'

One girl said that a friend had admitted to having FGM and was boasting about it but as soon as she found out the other girls had not had it done, she stopped talking about it. This incident perhaps highlights that some girls may not see it as an abuse but something that is honourable. It is important that such attitudes are taken into account and sensitively challenged when delivering workshops to girls because there may be girls present who associate FGM with positive messages such as getting pampered with new clothes, presents, singing, dancing and that the cutting is about becoming clean, a celebration and a transition to adulthood.

If having FGM is associated with positive messages and not having FGM results in being stigmatised, then girls are likely to feel pressurised into wanting FGM. For example, one 23 year old interviewee who has not had FGM (**Case Study 6 - Appendix 2**) said that when she was at school (in the UK) and found out that her friends were cut, she also wanted it done: *"I thought I was missing out and really wanted to have it done and kept asking my mum to let me get done."* Now she says she feels lucky she did not have FGM. It is therefore important to find ways to make girls more resilient to peer pressure and not just give them the information but to also better equip them with the skills to counter the arguments that will be used to justify FGM.

It was noticed that three girls (aged 15-16 years old) during the sessions seemed completely disengaged from the workshop. They did not appear to be listening to the workshop or even looking at the speaker or the presentation. One even covered her ears with her hands and became very distressed. She eventually left the classroom. Outside of the classroom she repeatedly asked about the Islamic position on the issue and had to be constantly reassured it was not a part of any faith. She also wanted to know what the law said and the sentencing associated with FGM. This was explained to her. Although she did not admit to having FGM, the teacher and head teacher were informed for follow up conversations and support with her. These incidents highlight that girls will be reluctant to disclose FGM if they have had it due to the fear of the consequences of getting their family, especially parents, into trouble.

There was also reluctance amongst girls to disclose concerns about FGM because 20% said they were unsure if they would tell anyone if they or a friend were at risk. Some indicated that they felt uncomfortable about breaching a friend’s confidentiality. However, it was encouraging that most would be willing to tell someone if they or especially a friend was at risk because they understood the consequences of FGM as highlighted by some of their comments:

“I would tell someone as my friend would be risking her life.”

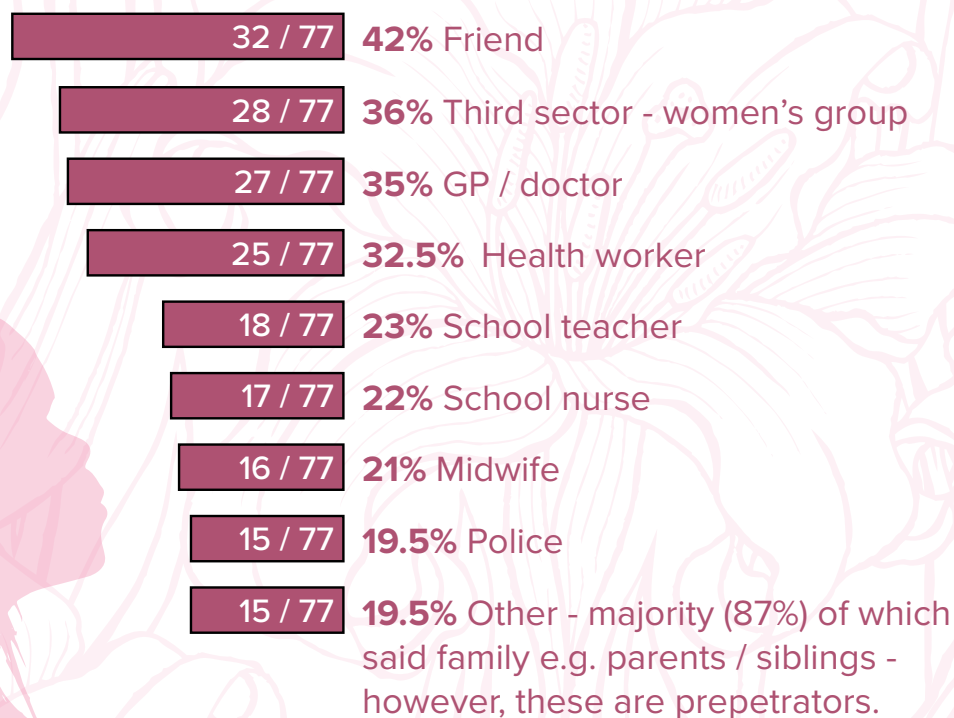
“I would not want to see my friend suffer.”

“I would not want my friend to go through the pain.”

“I would want to save my friend.”

It is therefore important to ensure girls understand the important role they can play in helping safeguard their friends especially because girls at risk of FGM are most likely to tell someone in their peer groups in preference to a professional such as a teacher, school nurse or police etc. or contacting a helpline or third sector organisation (see figure 2 below).

Figure 2 Who girls would disclose or report concerns of FGM to



During the workshops, one 13-year-old girl did disclose that she had undergone FGM (see Case Study below). However, it had been done before arriving in the UK when she was only 6 years old. The school safeguarding lead and the local Multi Agency Safeguarding Hub (MASH) were informed so she could be provided with support such as counselling.

Case Study - Disclosure of 13 year Girl at School

"I was about 6 years old when I was taken to a house where women surrounded me. They lay me down and pulled my trousers down and one started cutting me with a blade.

When I started screaming one of the women covered my mouth with a cloth. I found it difficult to breathe. Every time I screamed the cloth was put back over my mouth. My mother was unaware because her friend had taken me to this house to get me done. My dad did not know what happened and still does not know.

The images of what happened still come back to me about 2 or 3 times a week. Sometimes I start screaming. I get very angry and upset when I think about what was done to me. Sometimes I just stop talking to everyone around me and I calm myself down.

I have tried talking to my mum but I find it hard and don't feel comfortable talking about my feelings. I want to get help about my feelings in school but I don't want my parents to know."



This case highlights that there will be girls who are living with the consequences of FGM which they have had prior to arriving in the UK but are not receiving the medical and therapeutic help that they need. Girls like this may not be disclosing as they are worried about getting their families into trouble and therefore missing out on vital support. More needs to be done to encourage such girls and their families to disclose so they can start receiving the right help as early as possible.

8. Conclusion and Recommendations

8.1 Conclusion

This research has highlighted: experiences of women who have undergone FGM, why some women did not have FGM; male and youth attitudes; the procedure of FGM and its consequences; why the practice is carried out; who are the main instigators; and the role of religion. In doing so we have been able to share important insights that could help to eventually end the practice of FGM.

From the research we were unable to determine whether FGM was being specifically performed in Birmingham but there was some evidence that it is taking place in the UK. However, women and girls in Birmingham are living with FGM but not coming forward and asking for help (unless they are identified by health professionals). There are women and girls who had their FGM prior to arriving and settling in the UK, which means they have not broken the law. However, it appears they are reluctant to ask for help due to the perception that they may get into trouble, stigmatised or viewed with suspicion (especially women who have daughters).

It is important more is done to encourage such women and girls to come forward. For example, one 13-year-old girl only disclosed her FGM because of a school workshop. She is now receiving much needed help to deal with her flashbacks and trauma. However, it is unlikely the girl is receiving specific culturally sensitive counselling. This is a major gap in Birmingham that needs addressing given the significant size of FGM affected communities and the numbers of women identified as having FGM during maternity clinics.

Counselling is not only essential to improve mental health, but can also help play a crucial part in stopping the practice of FGM. Only when women are able to deal with and process the anger, resentment and feelings of loss and betrayal by their parents, will they fully understand what happened and why it happened. This in turn can give them the confidence to challenge the practice so others (especially their daughters) do not have to go through what they have endured.

Health professional need to be trained to be more vigilant at identifying medical problems that may be linked to FGM and not just focusing on identifying risk of FGM. This will help more girls and women to get the medical and psychological support they need. They are also more likely to disclose if doctors and nurses use sensitive language and ask the right questions. As medical professionals such as doctors are usually highly respected in these communities, they can play also an important role in helping communities to abandon FGM. They can raise awareness of its harmful effects and health risks by speaking at community events and by speaking to influencers in the community such as religious leaders.

Due to such deeply held religious or cultural beliefs that are used to justify FGM there will be parents who will be subjecting their daughters to FGM even though it is against the law. To prevent detection some may be opting for a medicalised procedure either in the UK or abroad (such as the Middle East) or choosing the less severe type 4 FGM (which also may not be viewed as FGM or against the law). There was evidence of this during the research and these trends need to be addressed.

However, there was also evidence that some women and men are willing to go against social norms and break the cycle by not subjecting their daughters to FGM. Some survivors do not want to put their daughters through the trauma and consequences of FGM they have experienced. The accounts of the survivors we spoke to were powerful. It is important that such survivors are encouraged to speak to other women in their communities and young girls. If information is received directly from survivors, it is more likely to have a greater impact than information received from outreach workers or from professionals such as from health or police. Different ways need to be identified to unlock the voice of survivors. However, most of the survivors we spoke to were originally from African countries, with half being from Somalia. We struggled to obtain one to one interviews with women from the Yemeni community. Outreach into Yemeni communities remains a gap including for awareness raising campaigns, which needs to be addressed.

Highly stigmatised and negative attitudes towards girls and women who do not have FGM (which is often driving the cutting) is likely to result in ostracisation and pressure to conform. It is therefore essential to build the confidence of people who are against FGM so they are more resilient to such pressures. This means not just giving them the information but to also better equip them with the skills to counter the arguments that are commonly used to justify FGM. Such training should be targeted particularly at women and girls because they are most likely to face the pressure, as the main instigators of the practice are other women. Despite traumatic experiences of FGM some women will be made to feel guilty and therefore be torn between the welfare of their child and societal pressures. They will also worry that by not having FGM, the matrimonial opportunities for their daughters will diminish. However, there is an indication that attitudes are slowly changing because some men, women and children in FGM affected communities are willing to report concerns of girls at risk to women's groups and the police. As girls were more likely to tell a friend, it is important to emphasise to children the important role they can play in safeguarding.

As some men are against FGM they can be very important agents of change. Some men and boys who are aware of the consequences of FGM (particularly on the sexual relationships) don't even want to marry women who have had the procedure. Such views need to be highlighted to women because one reason commonly stated by those who support the practice is that it increases chances of marriage because it is something that the men want. However, male voices are currently under utilised in Birmingham and the rest of the UK.

Male religious leaders can also play an important role in ending FGM. It is evident from these research that some people in FGM affected communities believe that the practice is religiously mandated despite the fact that many Muslim theologians have stated it is contradictory to the teachings of Islam. FGM has to therefore be also challenged theologically. It is simply not sufficient just to state Islam does not sanction it, which is what happens in most educational campaigns and workshops. More detailed explanations (using religious texts) need to be provided about why this practice is not only against the faith but also strongly condemned by it.



8.2 Recommendations

Although recommendations have been made throughout the report, a summary is listed below. These measures collectively can support abandonment of FGM in Birmingham and the UK and hopefully stop FGM from perpetuating down the generations.

Community Campaigns

Recommendation 1 (Yemeni Community)

Targetted awareness raising in the Yemeni community through an outreach worker from that community.

Recommendation 2 (Support Groups)

More space needs to be provided for men and women to discuss the practice of FGM and connect those who are opposed to the practice to each other, including setting up of survivor groups.

Recommendation 3 (Building Resilience Against Peer Pressure)

Give confidence to men, women and children to resist peer pressure. This means not just providing information on FGM but also developing skills to counter the arguments used to justify the practice. An important element should include breaking the link between the status of a woman and girl and having FGM.

Recommendation 4 (Better Awareness of Type 4 FGM)

More awareness (especially through case studies) that type 4 FGM is also a form of child abuse and against the law and that it should not be viewed as an alternative to type 1, 2 and 3.

Recommendation 5 (Highlighting Indirect Impact of FGM on Men)

Emphasising to men and boys that one of the consequences of FGM is problems with sex and relationships such as the reluctance of women in wanting to have sex because of the pain and an issue that will also impact them.

Recommendation 6 (Delinking FGM from Status and Marriageability)

Emphasising that having FGM does not negatively affect marriage chances highlighting that some men and boys are against FGM and do not want to marry cut women. This is important to highlight given one reason used to justify FGM is because it increases the man's sexual pleasure. This may also result in more support to end the practice.

Recommendation 7 (Utilising Voice of Survivors)

Utilise the voice of survivors and of women and men who are breaking the cycle of FGM (by not subjecting their daughters to it) - local voices can be more powerful.

Recommendation 8 (Tailored Campaigns for Different FGM Communities)

Campaigns should be tailored to each community with activities used to robustly tackle the underlying reasons used to justify FGM without skirting around some of the more sensitive reasons such as men's sexual pleasure and faith. The hierarchy of reasons may vary from one FGM practicing community to another. On the other hand information campaigns highlighting there is no health benefit but a key reason is because the women believe it is what men want, then again this will have a limited impact. Similarly if underlying reasons are religion then these should be challenged robustly (see recommendation 9).

Recommendation 9 (Using Religion to Challenge FGM)

If the underlying reason for FGM is religion and a broad-brush approach is used such as it is against faith and actual texts not challenged then there will be little impact as faith will always trump everything. More detailed theological explanations need to be provided about why this practice is not only against the faith but also strongly condemned by it.

Recommendation 10 (Work with New Migrant Communities)

Targetted work with new migrant communities including boys and men as they are more likely to want to maintain culture and tradition.

Recommendation 11 (Involvement of Youth)

Get more youth involved in schools including boys as peers may be able to have greater influence. This should include creating youth champions that are at the forefront of a campaign

Recommendation 12 (Extending Airport Campaigns)

Not restricting police warning campaigns at airports to outbound flights to 'countries of prevalence' in Africa and also finding ways to sensitively target those travelling to other Middle Eastern countries particularly Dubai and Saudi Arabia.

Recommendation 13 (Utilising Medical Professionals as Influencers)

Medical professionals such as doctors should play an important role in efforts to support communities to abandon FGM by raising awareness of its harmful effects and health risks by speaking at community events and to influencers in the community such as religious leaders.

Professional Training

Recommendation 14 (Awareness Raising in Primary / Junior Schools)

Provide FGM training for governors and head teachers at primary and junior schools so they are more receptive to allowing awareness raising of FGM to their pupils, which should include giving assurances that workshops can be delivered using age appropriate and sensitive language.

Recommendation 15 (Identifying FGM through Health Problems)

Doctors and nurses need to be trained to be vigilant in identifying medical problems that may be linked to FGM (and not just in identifying risk of FGM) so more girls and women are identified so they can receive medical and therapeutic help. Health professionals also need to be better at identifying FGM as an underlying cause of mental health issues that women and girls from FGM affected communities may present with.

Recommendation 16 (Specialist FGM Counselling Service)

Ensure culturally sensitive psychological interventions are made available ensuring counsellors are trained on the issue of FGM including training women from FGM affected communities in counselling.

Recommendation 17 (Mechanisms for Knowledge Transfer)

Staff turnover amongst professional is a risk for continuity in knowledge and experience of dealing with FGM cases. Mechanisms need to be put in place to ensure knowledge transfer continues regarding prevention, psychosocial and medical care.

Reporting Concerns

Recommendation 18 (Promoting how Reporting can be done Anonymously)

Encourage reporting of any medical practitioners suspected of cooperating in the practice of FGM including raising awareness of anonymous ways of making these reports.

Recommendation 19 (Promoting Third Sector FGM Organisations)

As people are more likely to report concerns to third sector and women's organisations, such groups that deal with FGM should be promoted within communities.

Recommendation 20 (Role of Friends and Reporting)

Ensure girls in schools understand the important role they can play in helping safeguarding their friends.

Appendix 1:

Women survivors of FGM (Case Studies)

- All survivors interviewed were of Muslim background.
- All interviews conducted June 2014 to April 2015.

Case Study 1

Ethnicity: SOMALI	Age: 34	Type 3 FGM
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She has been in the UK for 14 years and has had type 3 FGM. She recalled her story: *“I was given a new dress to wear and this old woman and my grandmother came to the house. My grandmother told me that I would be ‘cleaned’ and I would no longer be a girl, and that God would be pleased with me.” She also said: “I will be like everybody else and would not be left behind.”*

She broke down when she recalled how she struggled to close her legs while being held down. She said she was in pain for a week and purposefully given little food or water. She explained how her questioning about being cut led to an angry response and was even told it was a religious requirement: *“Never tell anyone, it is Islamic and a Somali tradition...and those who speak about it, evil will come to them and they will never get the things that they want.”* She says women in the community including her mother believe it is a rule that must be adhered to regardless of the consequences of FGM: *“She thinks it is shameful to live with the genital area open.”* She did not disclose the exact age when she had FGM but was less than 10 years old.

A major impact of her FGM was her periods because they would last a long time. *“I would start praying and my periods would start again and Ramadan was the worst. My family would think I was making excuses not to fast as I was not sure when my periods would stop.”* Another major impact has been that sex with her husband is very painful: *“At the beginning of my marriage I was beaten a couple of times but my husband is more understanding now.”* She said that because it was embarrassing to talk about intimate matters, women don’t talk about these things. However, she expressed an interest in wanting to talk to other women in her situation. She broke down again during the interview. When she resumed the interview she said that childbirth was very painful too and that she could never put her daughters through this: *“I would never allow my girls to go through this. I will never take them back to Somalia or get them done in an Arab country.”* She believes that some families may be taking girls to have FGM done in Middle Eastern countries because the procedure is carried out in a sterile environment i.e. in hospital clinics. At the end of the interview she said this had been the first time she had shared her story of FGM with anyone.

Case Study 2

Ethnicity: ERITERIAN	Age: 32	Type 1 FGM
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She said she still remembers having it done and under 10 years old at the time. *“It was horrible and painful and I do still remember although I try not to. The old traditional woman came around.”* She said that because she has had boys, she doesn’t have to worry about FGM but feels that if she had daughters then the elders would have pressured her into getting the girls to have FGM: *“I feel that I would not have been able to challenge our elders.”* She says that although she did not have any problems with delivering her children acknowledged that she did not get sexual pleasure and had problems with intimacy: *“Its just something you do to have children. I’m not whole. I’m not intact. Something was taken away from me.”* She said if she was concerned about any girl in the community she would speak to a friend and then contact the school or women’s organisation.

Case Study 3

Ethnicity: DJIBOUTIAN

Age: 34

Type 3 FGM

Although she was born in Djibouti, she has been living in the UK for 8 years. She believes many girls in her community has had the severest form of FGM, type 3 and she referred to it as 'Pharaonic' and said: *"All my cousins, my sisters and my friends have had the procedure."* She said all of them have suffered health problems and pain and still do including difficulties it causes in their marriages. She also recalled the 'awful pain' during her wedding night and alluded to the fact that sex was painful and sometimes she didn't 'want to do it,' but had no one to speak to about it: *"It has created difficulty in my marriage. Sometimes I don't want to, I am dry down there, sometimes it feels so rough. I always feel sick but not allowed to talk about it."*

She then recounted what happened on the day she had FGM: *"I was 6 or 7 years old at the time. I took a special bath and I was told to clean well down there. My mum prepared the best foods and I was given the best presents. My mother, my aunties and the cutter lady gathered around me. I remember there were also 8 to 10 ladies in the room who were waiting to hold me down on the floor. I was so scared, I was never told what would be happening to me."* Since that day, which she says she still remembers very well, she has had to endure many health issues such as problems with her periods and constant urine infections: *"Sometimes going to the toilet is very difficult and it takes a long time; I need to go more frequently or spend many minutes trying to empty my self out only to find that I've leaked already. Sometimes when I lie down it can leak out. This is really very embarrassing for me."*

She said that she wanted more done to protect girls from this type of abuse including checking girls from birth to teenagers, through physical examinations. She said she was willing to call professionals including police if she knew a girl was at risk.

Case Study 4

Ethnicity: SIERRA LEONEAN

Age: 34

Type 3 FGM

She said that it is a strong tradition in her community back in Sierra Leone and because it is practiced by the Bondo secret society, she felt unable to talk about it for years. She had it when she was about 10 years old and still has nightmares: *"Some nights I still wake up with these dreams seeing that mask telling me to swear that I'll never tell anyone. I remember it like it was just yesterday."* She recalled how her mother took her to the village where she was greeted with singing and dancing and could hear drums and then a white sheet was tied around her body She then described what happened: *"The women from the Bondo society took the girls to the Bondo Bush. When I was cut, I screamed so much. Afterwards we (all the girls) had to agree to be part of the society and to take care of our husbands. I was given new clothes to wear and was taken back to my village."*

She said her life changed after that moment and her toys were taken from her and given to her younger sister. She said she would 'see' the 'Bondo Devil' (she was referring to the masked women she would see in her dreams). She still gets frightened thinking about it and gets nervous when she sees a sharp tool or a blade. She says that sex was painful when she got married and continues to be: *"I didn't enjoy it at all and would make all sorts of excuses and this made my husband really upset. Our relationship would end up being difficult. I think this is when my depression started. Sometimes to avoid sex I now go to sleep early."* She says she feels she has no choice but to just cope.

Case Study 5

Ethnicity: SOMALI

Age: 28

Type Not Disclosed

She was born in Somalia and didn't want to say how long she had been in the UK. She had FGM when she was about 5 or 6 years old. She recalled how on the day she was given lots of attention and made to feel special: *"My mum bought me a lovely polka dot dress and I had Henna put on my hands. My mom told me that all my friends will be there and that there will be a party with all my favourite foods. I couldn't believe it, it wasn't even Eid Day but it felt like it."* She recalls trying to ask questions when her mother was bathing her and was told: *"Don't to talk to much, men do not like women who talk too much."* She said she was then taken to a room and put on a table. She was held down ladies when it happened and can still remember how painful it was: *"The pain was unbearable. I kept asking what is this, then I screamed with pain and then saw blood, lots of blood and some skin."* Afterwards she was told that she was *'clean and perfect now'* and *'a good girl now.'* She said that her mother now regrets having her cut and has apologised and acknowledges she was following tradition and not religion. She said that she will never forget what happened and keeps having nightmares about the 'cutting' and thought she could see the 'cutter' when she gave birth. Her doctor has told her she suffers from anxiety and has been given tablets for her depression. However, she said she wants to talk about it and there are no support services for women like her.

She said more action is needed to identify women who have had FGM such as identifying and recording it during a cervical smear. She also felt that young girls were not being adequately protected and gave example of how no one has checked up on her daughter: *"When my daughter was born in 2010, a health visiting team came to see me. They produced a green form regarding FGM. I was given reasons for never having it done to my daughters, here or back home. To this day nobody has ever come back to check on my daughter. I could have gone back home and had the cut done on my daughter and nobody would have known. These checks have to be done regularly."* She also mentioned we need to follow France because they do more checks. She said no checks happen on those returning from abroad. She also suggested that forms should be signed (by families) stating that FGM will not be carried out on their daughters. She is so against FGM that she said she would inform the police if she knew a girl was at risk.

Case Study 6

Ethnicity: SIERRA LEONEAN

Age: 34

Type Not Disclosed

She recalled how she went through the 'Bondo' ceremony when she was 10 years old and felt apprehensive speaking about it: *"I'm not sure if I should be telling, I hope nothing happens to me and my family. There were quite a few of us that were led to the ceremony (by women), you know it's a rite of passage for women from childhood to womanhood."* She said that the ceremony was not explained to her and remembered being really scared and then getting shocked: *"When I was cut, I was bleeding very heavily and they put ash in that area. I also remember having a fever."* She says every time she has a fever now, it reminds her of that time in the 'bush.' She said that when she came out of the 'bush' she was given money and gifts and there were celebrations. She still feels anxious about it as it is still in the back of her mind but when she goes to the doctor she never mentions her cutting: *"The doctor just recommends I try and go for a walk and perhaps exercise. He has never asks me about my childhood or why I feel like this."*

Case Study 7

Ethnicity: SOMALI

Age: 43

Type 3 FGM

She was born in Somalia and has been in the UK for about 13 years. She said her father was against it so her mother carried it while he was out for most of the day. Afterwards when he found out, she said he nearly divorced her mother. She said the female cutter, who worked in a local hospital as a cleaner, had stolen some needles and anaesthetic from there. She explained how she has had FGM carried out on her three times while less than 10 years old. She said the first time she was left bleeding and her mother had to take her to hospital: *"She put the needle in to paralyse the lips but she injected it in the wrong place and then cut the clitoris and tissue. She then sewed me and tied my legs. I bled so much that I think she cut my main artery so my mum took me to hospital where I had to stay overnight."* She said her second FGM was when the 'cutter' returned a week later to check and said she had to redo it as the areas was not sealed properly because the areas had open up. It was done a third time because she fell down while she was playing and started bleeding: *"A different woman came and used herbs and the thorns from the tree - I remember it as though it was happening now."* As she told her story and described the severe pain she kept breaking down. She says the 'cutters' carry on cutting even when their eyesight becomes poor.

She explained she has had problems with her periods since childhood and had to be 'cut open' the night before her wedding night: *"The first night was horrible, I bled a lot. In Somalia they cut you and the husband must sleep with the wife on the first night, otherwise he is not a considered a complete man and this is done to avoid shame."* She says sex is still painful and she has to sit in cold water afterwards every time but sometimes she makes excuses. She says one impact of FGM is domestic violence: *"Men don't understand the pain for women and end up beating their wives and they just accept this as a way of life."* She has also suffered each time when giving birth to her four children, all born through caesarean: *"I gave birth in Norway and no one has seen a mutilated vagina before. Five or six doctors came to look at the area. I felt so humiliated and embarrassed."* If she found out someone was at risk she would report it to the police but says that she has heard that 'pinching' is done to those who don't go abroad. She hopes the community will talk about it more but won't because it is seen as shameful and she herself would like to help raise awareness by possibly speaking about it.

Case Study 8

Ethnicity: EGYPTIAN

Age: 62

Type Not Disclosed

She said she had her FGM done when she was about 9 years old and that it was her mother who had decided with her father that this was going to happen. *"My family were from a rural area and in those areas in order for a girl to be moral you have to have this done."* She says she still remembers it and was done by a lady they referred to as 'daya' who was like a midwife. *"It did hurt when I had it done, but I had no choice. I remember being shocked and I kept asking what are you doing? I can't remember what she used but I've never felt pain like that."* She remembers the reasons her mother gave her for it such as religion, for cleanliness, and because that is what husbands want when you get married: *"She said we would get good marriage proposals from men who were educated and had money."* She did not seem to have health problems and said it did not affect the delivery of her children. She also felt because people were more educated now it did not happen (in the UK).

Case Study 9

Ethnicity: SOMALI

Age: 37

Type 3 FGM

She was born in Somaliland and has been in the UK for 25 years but had her FGM done before arriving in the UK when she was 4 years old. She says when she is alone she still thinks about it and sometimes certain things will trigger the memories such as the smell of Dettol. However, her opinion has changed over time: *“If you asked me 10 years ago, I would have said its ok and probably would have had my daughter done too but now, never!”* She changed her mind when she found out that it could not be justified on religious grounds and that it was a cultural tradition. At first she said she used to be proud of it despite the pain and explained that girls who have had the most severe type will feel more superior to those who had the lesser types: *“I used to walk in proud - making them (those who had pinching) feel less than me, I was suppressing my feelings and showing that I’ve been brave and cut properly whilst they have just been ‘pinched’ and still remain unclean. I thought they were lower class than me I was proud that I was able to go through the worst type of cutting.”* She said she is against it now and her and her husband would never do this to their daughters. Although she is against FGM she said: *“I still believe it stops girls from being promiscuous and messing about because you are flat.”*

She recounted what happened when she got married and that there is pressure on men to have sex even if she is in pain: *“On the night before the wedding I was ‘cut open’ for my husband so that he could engage with me. It is really important for a man to be able to penetrate a woman during the night of the wedding as this shows his masculinity.”* She believes that all women in her community have had it done and says she had heard that girls used to be taken to other UK cities such as Sheffield and Hull to get it done but now girls are being taken to Dubai or Egypt so it can be done under anesthetic. She remembers one childhood friend being taken to Oman to have it done. She wasn’t aware of any specific details or information that could be passed on and it was just what she has heard.

Case Study 10

Ethnicity: SUDANESE

Age: 37

Type Not Disclosed

She recalled her experience and remembered being forced to lie down on some old mattresses on an ‘angareb’ (a wooden bed). She said she could still remember what the woman, who sat on a low wooden stool, said to her: *“She told me I was now going to become a woman and said real women never cry. She then said she was going to remove dirt and make me clean so I become a real Muslim.”* She then went on to explain how other women grabbed her arms and legs and held her down and covered her eyes. They also reminded her that her sister and cousins had also had it done. She did not confirm her age when she had FGM but was under the age of 10.

Case Study 11

Ethnicity: GAMBIAN

Age: Under 16

Type Not Disclosed

One mother contacted the researcher anonymously and withheld her telephone number to share the story of her daughter. A couple of years previously, her mother in law kept putting pressure on her (and her husband) to take their daughter back to Gambia for a visit. The mother in law said she was not well and wanted to see her grand daughter. She explained how they gave in to the mother in law's demands and her husband took their daughter for a holiday to Gambia where she was subjected to FGM (when left alone with family members): *"I wasn't there for my daughter; her aunt and grandmother got this done. I don't know what my poor child has gone through."* She did not disclose the age of her daughter but indicated she was under the age of 16. She was too frightened to give details because she realised what had taken place was against the law and was worried about getting into trouble but wanted to share her story so others could learn from it.

Case Study 12

Ethnicity: SOMALI

Age: 31

Type Not Disclosed

She was taken back to Somalia to have it done when she was 6 or 7 years old. She says it was her stepmother and grandmother who wanted it done and arranged it despite her dad being against it. On the day she was told to take a bath because she was going to be 'circumcised' and that she would be getting new clothes and her friend would be getting it done too. She explains how she felt excited because she didn't know what was going to happen and even offered to go first. She then described what happened next: *"The lady who came was old and took a blade out of her box. I became scared and tried to hide. They caught me. It was very bad. They tried to hold me down and they cut me. I had so much pain afterwards and was shaking. Afterwards I couldn't walk and I could not go to the toilet, I forgot about my new dress."* She said her dad was upset when he found out and feels she can't forgive her stepmother. She said that she doesn't know what happened to her friend because she never saw her again and recalls her being taken to hospital and her family being very upset. She thinks her friend may have died because when she asked about her she was told never to mention her again.

She went on to explain that her ordeal did not end there and included health and marital problems: *"When I had my period I was always in so much pain. When I got married a couple of nights before my wedding I had a small cut again; it was so painful. I cried so much. On the night of my wedding it was so painful and the pain carried on for months. I didn't know what I could do to heal it, so I tried to be asleep most nights. As I wasn't having sex my husband he told I wasn't a good woman. I could feel pressure to have sex when I didn't want to."* She then said that when she became pregnant her baby was still born and then she was blamed for it. However, she decided then that if she ever had daughters she would not put them through it. However, her husband did not agree with her and worried about what the community would say. She said her marriage eventually ended because of the domestic violence that was associated with her FGM: *"My husband would hit me when I would not sleep with him and I couldn't take it anymore and we separated and finally divorced. I don't care for a man now - my mind is now free."*

Although she said she is bringing up her daughter and sons to challenge this tradition of FGM, there are others in the community who are stigmatising her: *"Both my neighbours are Somali and they won't let their children play with my daughter because she is not 'circumcised' even though one of the girls is her best friend at school."*

Case Study 13

Ethnicity: SOMALI

Age: 34

Type 3 FGM

She says she really resents what her mother put her through: *“I hate what she has done to me, may Allah (God) forgive her.”* She had done when she was 6 years old. She said her mum decided it was too much money to get it done in the clinic so this old lady came to the house instead. She recalled how her legs were bound for days and she couldn't go to the toilet.

She says she has really suffered because of her FGM and would like to talk to someone about it: *“I hate anyone touching me and I had to have both of my boys via caesarean.”* She says she feels blessed that she has sons so she does not have to think about FGM although she added she would never do that to a daughter if she had one.

Case Study 14

Ethnicity: SOMALI

Age: 42

Type 1 FGM

It was the first time she was speaking about her experience and therefore felt apprehensive: *“Allah (God) forgive me that I am talking about it now.”* She says she was happy up until the age of 7 but then she had FGM and felt as if her dreams stopped after that. She remembers that she stopped speaking immediately afterwards. She says she still remembers the cutter and feels really angry every time she recalls that day. She admitted that it has impacted her relationship with her husband: *“I have no feelings for my husband, I think it is because of the cutting.”* The experience continues to affect her mentally: *“If I see my husband's razor, it reminds me of that time.”* After talking about her feelings she said she would like to talk to others who have had similar experiences but said it wasn't the done thing. She has 6 children and says she would never put her daughters through FGM.

Case Study 15

Ethnicity: YEMENI

Age: 17

Type 4 FGM

She said she had a medical procedure in Saudi Arabia as her family used to live there prior to moving to the UK: *“I cant remember how old I was but I don't mind that I have had it done. It was nothing much, just a little cut and makes no difference to me. It is not like in other communities where it is cut off and then everything is knitted up back together.”* She said that her family did not make her younger sisters have it done after moving to the UK. However, she said that she has heard that the practice does take place in the UK: *“There is some private clinic in London, owned by an Arab, that was doing it. I even heard about a relative, who in her 20s who did not have it done as a child but wanted to get it done. She went to a GP that was also from the same background and asked him if he would do it for her.”* She did not know whether this relative was successful at getting the FGM done.

Case Study 16

Ethnicity: NIGERIAN

Age: 52

Type 2 FGM

She had accompanied her friend while she had talked about her experiences. But decided to make contact by phone to inform us that she had FGM too: *“Well I wasn’t going to say anything but I had it done but it hasn’t affected me. I am from the Yoruba tribe and we practice type 1 and 2.”* She said regardless of the type, it was causing problems with their husbands: *“We are not too active; it does cause problems in the bedroom. I don’t feel anything.”*



Appendix 2:

Women who have not had FGM (Case Studies)

- All survivors interviewed were of Muslim background.
- All interviews conducted June 2014 to April 2015.

Case Study 1

Ethnicity: SOMALI

Age: 34

She was born in Holland and has been in the UK since 2004. She said that she has not been cut because her father, who she says is very religious, was really against it. She said that he had warned her mother not to do it. The family have not returned to Somalia and one reason was due to the fear of 'cutting.' She said that there are other women in the family who have been through FGM and believes some in Birmingham still do practice it because it is such as old tradition but would be willing to speak to someone about it if she became aware if someone was at risk: *"I would probably speak to a health worker or a women's organisation."*

Case Study 2

Ethnicity: GAMBIAN

Age: Unknown

She has been in the UK for 5 years. She said that she did not have FGM because her mother knew it was not necessary because she was educated. She said at the time they were living in Gambia with one of her aunties who also did not believe in FGM. However, she said that people in the community were aware of it which led to her being ostracised and bullied: *"I remember the bullying intensified when one of the girls stood outside the toilet and had probably heard that I wasn't trickling but was gushing. When I came out she told me I was unclean and impure and she went and told the other girls and they stopped hanging around with me."* She explained how there were groups of girls at school who had FGM done and when she felt isolated wished she had it done too and felt the same when she got married: *"To fit in I wish I had had FGM done to me. Also felt it when my first marriage broke down because my husband thought I'd been sleeping around because I wasn't cut."*

Case Study 3

Ethnicity: SOMALI

Age: 24

She has not had FGM but puts it down to her father but thinks her mother did not share his views: *"My dad told me its haram (unlawful) and it's completely against our religion, however my mother on the other hand has stayed quiet."* She said that although she has not really aware of others in the community who have had FGM done she says the practice is still continued in Somaliland: *"Some of my cousins who have come over from Somaliland have had FGM done."* She was very strongly against FGM and said it was an 'outdated' tradition which had no place in todays society and wanted more awareness raising on the illegality of FGM. However, if she had concerns she said she was more likely to contact a women's organisation about it.

Case Study 4

Ethnicity: **INDONESIAN**

Age: **34**

She said she had not been subjected to FGM as she had lived in the West all of her life. However, she said that it is also happening in Indonesia particularly amongst conservative areas: *"It is apparently 'wajib' (obligatory) and done to prevent promiscuity."* She said the practice was carried out more amongst poorer families because they think it is more hygienic: *"They think it cleans the filth from genitals and also contributes to a girl's growth."*

Case Study 5

Ethnicity: **SOMALI**

Age: **22**

Although she was born in Somalia, she lived in the Netherlands before moving to the UK and has been living here for the last 12 years. Although she has not had it done, she says her relatives have had it done back in Somalia. She didn't just blame the older generation but also felt youth needed to make the change: *"This is an outdated practice and we can't blame the older generation and we are the ones that have to change the root causes."* She said she would definitely alert professionals if she had concerns about any girl.

Case Study 6

Ethnicity: **INDONESIAN**

Age: **23**

She has not had FGM but her older sisters had it before they came to the UK from Somalia. She said when she was a teenager she felt left out because when her sister's would talk about it, they wouldn't let her be part of the conversation. She said she felt even more left out when she became aware that her friends at school had been cut (before arriving in the UK): *"I thought I was missing out and really wanted to have it done and kept asking my mum to let me get it done."* However, she said she got put off when one of my sister's spoke about the health problems she faced during her childbirth. She said this was reinforced by a documentary she watched on TV and now feels lucky she did not undergo FGM.

Case Study 7

Ethnicity: **SOMALI**

Age: **17**

She went back to Somaliland when she was 14 years old and to learn about her culture. When she spoke to girls of her age, they said that they had no choice to have it done because if it was not done it was result in bullying. During her stay she was also pressured by girls of her age to have it done but did not succumb to the pressure.

Case Study 8

Ethnicity: SOMALI

Age: 20

When she was a teenager, her father suggested that her and her sisters should be cut to 'silence them' because they had started to 'answer back' and were 'talking too much'. Her mother then arranged for an appointment for all of them to be cut at a hospital in Dubai. *"My mum offered us all £250 to have it done. We agreed to this. We were told nothing about the type of FGM we were going to have but just told that it's the 'Sunna' it is the one which is ok and as it's done in a medical facility."* However, she said that after travelling to Dubai, there was a mix up with the appointments and they could not get it done and rescheduling could not take place during their stay. She said they all returned without having FGM.

Appendix 3: Women's focus group

A focus group was held with the aid of an Arabic translator with 6 women (four Yemeni and two of Egyptian backgrounds) who were in their 50s, 60s and 70s. Below are the significant comments from the most vocal women:

Case Study 1

Ethnicity: Egyptian

Age: 54

She was not sure which one type of FGM she had done in her country of origin but recalled being taken to a hospital. She said she can't remember much about it and that the FGM has not affected her. She says her friends have also had it done and don't complain about it but added that they don't talk about such things. She also did not feel that it was a serious issue: *"It is a very old traditions and I feel that the West is making a big deal about FGM."*

Case Study 2

Ethnicity: Yemeni

Age: 52

Although she did not feel cutting takes place in the UK but continues in rural parts of Yemen, she thought the procedure was acceptable providing it was medicalised but then said: *"The educated will know we shouldn't do this to our girls."*

Case Study 3

Ethnicity: Yemeni

Age: 61

She couldn't remember how old she was when she had FGM because of her age. She said her friends (who are from the same rural areas in Yemen) had it done too. She explained girls would have 'khitan' done in their homes using a razor and said it was for protection: *"My dear old mother used to say it was to protect me until my wedding night."* She expressed discomfort about having to talk about her body: *"I don't even know if I should be taking about this; it's a shameful when you have to talk about your body like this."* However, she said she was against cutting and would speak to others if she had concerns.

Appendix 4: Men from FGM Affected Communities (Interviews)

Interview 1

Ethnicity: SOMALI

Age: 34

He has been living in UK for the last 25 years and is aware of FGM: *“When I used to live in London I used to hear about girls being taken abroad in the summer.”* Although he felt sad for the girls and understood that FGM was life destroying and consequences life long, he said if he knew it was taking place, any action he would take would depend on the age of the girl: *“I would not involve police due to sensitivity but would be willing to speak to a third sector organisation.”* He said it was done in the name of tradition and not Islam and felt the main instigators were women while men are aware but claim ignorance. He also couldn't understand why men weren't saying anything because it affected them too: *“If she does not have any feelings, then what's the point? I don't ever want to marry anyone from our community.”* He suggested more conversations with families and community were needed and was even willing to arrange a male group to discuss the issue.

Interview 2

Ethnicity: SUDANESE

Age: 58

He was against FGM and acknowledged that his religion does not condone it and would be willing to get help he knew someone was at risk. His attitude was influenced by the experiences of his wife. He recalled when his wife gave birth for the first time in Norway: *“The baby wouldn't come out and my wife was screaming. I thought she was going to die. The doctors came and started looking at her private area and then decided to perform an emergency caesarean.”* They explained it was because of FGM why the baby would not come out. The experiences of his wife made him more aware of the impact of FGM. While he was working in the NGO sector he said when he came across women who had FGM, he would help them get medical treatment: *“One lady who had her whole area cut and sewn back hardly had anyway to urinate or menstruate.”* He said there was a need for a space where men could speak to each other whose wives had been cut: *“It is a taboo subject and will remain so if we don't openly have discussions about it.”*

Interview 3

Ethnicity: GAMBIAN

Age: 47

He provided examples of the ethnic tribes in Gambia in which FGM was prevalent such as the Mandika, Jola and Fulla tribes. He also explained why the females in his family had it done: *“My wife had FGM, as well as all the girls in her family otherwise they would have been ostracised.”* He blamed the women in his community: *“Men have information hidden from this them. My father was really upset when my sister had it done. He was a religious man and really against it and threatened to divorce my mother if she did it again to any of the other daughters.”* He broke down when he said that he was unable to help his sister at the time.

He has five daughters but they have not been cut because he and his wife do not believe in it. However, he says his mother in law back in Gambia keeps contacting them asking them to bring their daughters back to get them cleaned. Now he no longer allows his daughters to speak with their grandmother. He started to speak out about FGM within the community but is less vocal now due to fierce criticism and intimidation he has received from people from within his community here, and in Gambia.

Interview 4

Ethnicity: SOMALI

Age: 47

He is a local imam and says that it is against Islam and would not subject his daughters to it. He explained that he was unaware of the practice when he was a young boy growing up in Somalia. Although he is aware that the females in his family have had it done he feels uncomfortable talking to them about it: *"In my family my sisters have had it done and my wife has had the cutting, but I haven't had a conversation with her about it."* He said that too many people in his community think it is a women's issue so men don't talk about it and it is about time religious leaders were provided training on this issue: *"We don't get taught about issues that affect women. I know that many of the couples that come to me for issues such as domestic violence that result from bedroom issues, and most probably we have to ask the question why is this?"*

Interview 5

Ethnicity: SOMALI

Age: 33

He is an imam and has not been in the UK for long and has spent many years living in Europe. He said that he was against FGM and explained that when he was ready for marriage, he didn't want to marry anyone who had been cut: *"I asked for someone who was not cut, and equally I will make sure that my daughters are never cut."* However, as the conversation progressed he said although type 3 FGM was definitely against Islam, types 1, 2 and 4 were more accepted amongst some religious scholars: *"I have to do more work and understand types 1, 2 and 4 myself."*

Interview 6

Ethnicity: SOMALI

Age: 34

Prior to living in the UK, he had lived in Holland and Norway. He became aware of FGM when his family (jn Somalia) requested money for it: *"I was the sole breadwinner sending money back to my family regularly and they asked for money to buy my sister clothes, jewellery, food and for an old lady to organise the ceremony."* He said when he questioned what this ceremony was, he was told 'girls become women after this ceremony.' He said although he did not understand what FGM was at the time but he does now and would not marry anyone who has had it done: *"I am not married so there is no point in getting married to someone who has had this done, what pleasure do they feel, if this is taken away from them."*

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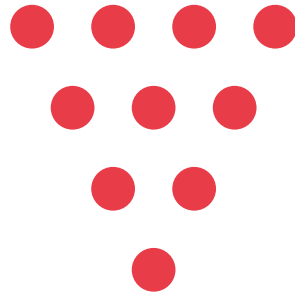
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