Understanding Female Genital Mutilation in Birmingham

Findings from a PEER Study

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THE RESEARCH PARTNERS

Birmingham & Solihull Women’s Aid provides services for women and children who have been affected by the experience of domestic violence, rape and sexual assault. They are a registered charity, managing four refuges, a counselling and family support centre, floating support and outreach services, a women’s safety unit and helpline.¹

Options UK is the UK programme of Options Consultancy Services Ltd., a leading provider of technical and research expertise for service providers, policy makers and commissioners for the development of health and social sectors in the UK. Options specialises in Participatory Ethnographic Evaluation and Research (PEER), the methodology of this project, which was developed in partnership with Swansea University.

¹ For more information on BSWA please visit their website at: http://www.bswaid.org.
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HOW THIS REPORT IS ORGANISED

The primary objective of this study was to explore female genital mutilation (FGM) in Birmingham as currently there is limited knowledge around the perceptions of FGM within local communities. This report illuminates issues of the continuing impact of FGM on the lives of affected women and communities, access to services, beliefs and perceptions around FGM and related issues, evidence for continued practise and differences particularly between older and younger generations in Birmingham. The report is structured as follows:

Section 1 introduces the local context and demographic data
Section 2 presents an overview of PEER research methodology
Section 3 presents qualitative findings of the PEER research
Section 4 consolidates these findings to present next steps from the research for relevant agencies and individuals in Birmingham
EXECUTIVE SUMMARY

Female genital mutilation (FGM) continues to affect an estimated 100 – 140 million women worldwide, cutting across cultures, religions and geographic locations. In the UK context, research suggests FGM continues to affect a sizeable population of about 66,000 women with another 24,000 girl children at risk of FGM\(^2\). Though research is increasing on this highly sensitive issue, local in-depth knowledge is limited. In effort to address the dearth of local data, Birmingham & Solihull Women’s Aid (BSWA), Birmingham City Council and Safer Birmingham Partnership jointly partnered with Options UK (OUK) to explore FGM within the context of Birmingham.

By compiling sources of local demographic data such as 2001 census figures, National Insurance registrations and birth data by mother's country of origin, a clear growth in migrant communities in which FGM is traditionally practised is apparent, e.g. Somali, Eritrean and Sudanese populations are all increasing. Additionally, data provided by the African Well Women’s Clinic, currently the sole service in Birmingham providing support and de-intibulation for women affected by FGM, reveal rapidly increasing demand for support services. Although Somali women continue to be the largest service user group, other populations are increasingly accessing the Clinic, including Gambian, Sudanese and Eritrean women, the majority of whom present with type III FGM.

Summary of findings from PEER research

Between September 2010 and January 2011, 15 women recruited from Birmingham’s practising communities were trained in PEER methodology and conducted a total of 90 in depth interviews with women from their social networks exploring the challenges and opportunities of living in Birmingham, current perceptions and practises around FGM, and the wider implications for them, their families and support services. Researchers actively contributed to the construction of research tools and data analysis. Respondents ranged from 17 to 48 years of age and originated from a variety of African communities, with the vast majority personally affected by FGM. The following outlines headline findings of the research. More detailed discussion, accompanied with quotations from the peer researchers and respondents, can be found in Section 3.

Family life

A variety of contextual factors including social integration, marriage and access to employment and education were explored to understand the complexity of women’s lives, as FGM occurs within this lived context, as well as women’s areas of prioritisation as it may benefit the planning and delivery of FGM- and related interventions. Women reported largely positive views of living in Birmingham, however their immigration status, often tied to the husband’s status, could present barriers to accessing services such as education and employment and contributed to insecure home environments for some. Smaller/increasingly nuclear family structures in conjunction with changing gender roles and roles within the home were sometimes cause for anxiety and conflict within the home. Marriage, in particular, elicited particularly polarised views with the majority of respondents stating that men, on the whole, maintain control especially over resources within the home and that attempts to assert “women and children’s rights” were often challenged by male

partners, leading to increasing incidents of separation, divorce, and domestic violence. Younger women (<25) felt more optimistic to increasingly choose marriage partners and establish partnerships of equals.

English language skills were seen as pivotal in supporting women’s independence and access to employment, and education was highly valued for both women and their children. Barriers included women’s traditional views on gender roles prohibiting them from working outside the home often reinforced by familial/spousal discouragement, immigration status, and difficulty finding childcare cover. Traditional Muslim dress was a particular barrier for some women feeling employment options were limited and success upon application less likely if hijab was worn.

Women largely socialised with same-language or country groups, however the majority felt they were able to access resources such as health services regardless of social networks. Notably newer migrant groups, e.g. Eritrean women, felt social integration was more challenging and resources sometimes more difficult to access due to lack of tailored information to support their transition into Birmingham.

**FGM perceptions and practises**

Overall, women feel FGM is decreasing in popularity and practise within their communities in Birmingham and those of origin in Africa, however differences in opinion were noted particularly by age group. It is important to note that terms used by respondents to describe FGM are *only* applicable to these women, and not to the wider community. The term ‘sunna’, which has a number of meanings, was used by respondents in this research specifically to describe type I or IV circumcision, and was generally viewed as more mild/holding less risk. Crucially, some (mainly older, i.e. >35) women did not appear to incorporate ‘sunna’ into their definition of FGM therefore believing it to be an appropriate practise, whereas ‘pharaonic’ circumcision, describing type III, was viewed unanimously as “wrong” and “bad” and optimistically seen to be falling out of favour. Younger women were more likely to use rights-based language, considering all types of circumcision, including ‘sunna’, to be wrong.

A culture of silence surrounding not only FGM, but related issues of sexual/reproductive health and rights prevailed to the extent that a number of women were unaware they had been circumcised or what type they had until coming into contact with UK health services.

Beliefs about religious guidance on FGM directly influenced some women’s decisions to abandon or continue the practise, highlighting the need for greater clarity in communities on what their respective faiths state regarding female circumcision. Younger women were more likely to disassociate religion from FGM, viewing it is a purely traditional practise without foundation in religious texts/proclamations.

Although not engaged in this research, men’s roles, as viewed by women, set expectations for marriage and perpetuation of FGM. Women described men as pro-, anti- or indifferent/unaware of FGM. Women generally felt as practising communities become increasingly settled into Birmingham, men’s preference to marry circumcised partners will diminish.

By and large women felt older, less FGM-aware or newly arrived groups with little information would be more likely to perpetuate the practise, particularly if they are unaware of the legal context in the UK.
Arguments for continuing the practise included:
- Women and girls’ inability to control sexual urges (risking pre- or extra-marital relationships)
- Marriageability to “good men” increased
- Ensures virginity before marriage
- Maintains a girl’s purity and ‘cleanliness’ increasing attractiveness and acceptability within the community

Arguments for abandoning the practise included:
- Increased awareness of implications for health/sexual wellbeing
- UK law prohibiting the practise
- Increasing belief that religions do not condone or encourage female circumcision
- FGM is no longer a strict requirement for marriage

Finally, women highlighted the intense and often-conflicting pressures and expectations they face regarding maintaining or abandoning FGM practises between social networks “back home” and their Birmingham-based communities.

*The wider implications of FGM*

Women described a considerable range of detrimental effects to their emotional, physical and sexual wellbeing as a result of FGM, including but not limited to:
- Feelings of incompleteness or being ‘less of a woman’ as they compared themselves to women from non-practising communities
- Chronic pain, infection, difficulty menstruating/urinating, numbness, lack of sexual desire, pain during intercourse, and difficulty/higher risk pregnancy and delivery
- Women did not always realise physical difficulties/symptoms were related to their FGM
- The physical/emotional/sexual strain on marriages

Interaction with health services was discussed at length and women, particularly those who were older, with poorer command of English and those from newly arrived groups, had very low awareness of where and how to find support for their FGM. Overall a negative perception of the NHS emerged, especially for primary care services with particular criticisms of providers (i.e. GPs and GP staff) not taking ailments seriously or investigating symptoms thoroughly. This may be a consequence of both providers and women not recognising symptoms as possibly resulting from FGM and expectations of care or women’s lack of familiarity with the health service and primary care’s role within it. Informed questioning on FGM emerged as a clear area for future training for primary care staff.

Birmingham’s Well Women’s Clinic, currently the only service providing specialised FGM services, was largely unheard of among respondents, however those who knew of the service reported excellent treatment and care.

Women described the complexities surrounding de-infibulation and emphasised:
- The need for choice in pregnancy when to undergo de-infibulation (i.e. during pregnancy or intrapartum)
- "Being opened" may lead to emotional or marital difficulties, or stigma from communities for seeking services
• ‘Reversal’ is a potentially misleading term offering false hope to women who may not accurately understand what de-infibulation/support services are able to provide for their FGM

Finally, many women felt there to be a lack of information available on FGM and relevant support services, particularly for newly arrived groups and those with limited English and technology skills (i.e. access to internet). A preference for local ‘champions’ or advocates from within practising communities emerged as did the need for information and campaigns to be comprehensive in nature, integrating health, psychosocial, religious, cultural and legal messages as they are interconnected and interdependent in real life. This holistic approach is preferential as different people will respond or ‘buy-in’ to different types of messages. It was felt that one size does not fit all in education and advocacy efforts on FGM.
1. INTRODUCTION

1.1 FGM as a global practise

Female genital mutilation (FGM) is acknowledged to be a widespread and harmful practise, affecting an estimated 100 – 140 million women worldwide. In Africa alone, up to three million girls are at risk of FGM annually.

FGM is practised across Africa (in the North-East, West and East), but also in some countries in Asia and the Middle East, as well as immigrant communities in America and Northern Europe. The practise crosses cultures, faiths, and ethnicities, being practised by Christians, Ethiopian Jews and Muslims.

Female genital mutilation is classified into four major types.

- **Type I: 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 II: Excision:** partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).
- **Type III: (‘Pharaonic’): Infibulation:** narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.
- **Type IV: Other:** all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterising the genital area.

The serious health consequences resulting from FGM have been widely documented, and include pain, shock, haemorrhage, tetanus or sepsis (infection). In addition, women with FGM face long-term risk of complications during delivery; newborn deaths, recurrent bladder and urinary tract infections, and the need for further opening and closing of the wound (for instance, for childbirth or sexual intercourse, either done ‘traditionally’ or through surgery).

FGM has been extensively documented as being largely performed by women on girl children, though age at circumcision varies by practising community from childhood to early adulthood. Most commonly it is done on pre-pubescent girl children, at around the age of six to nine years old. It is commonly performed without consent, and with very little prior information. Circumcisers are most often women and community-based with little formal health training, but WHO has noted a worrying and increasing trend of health workers performing procedures.

It is also clear cross-culturally, FGM is viewed simultaneously as a means of practising cultural traditions and maintaining culture. The act of circumcision ‘purifies’ women through overt physiological control of her sexuality (or sexual organs), and is a means of enforcing pre-marital virginity, preserving a woman’s and her family’s social status and ‘honour’.

Controversy abounds, however, over the role that religion plays in perpetuating the practise. Following religious observances, such as those prescribed in the ‘hadiths’

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(which are Islamic religious texts, based on the pronouncements of the Prophet) on circumcision, are used by many to argue for the ‘rightness’ of the practise, but these do not specify whether they apply to men only. There have been international religious interpretations of the ‘hadiths’ which have specified that they do not apply to women4. Some (UK-based) religious leaders have also encouraged the view that FGM is cultural, and not a religious practise.

FGM has widely been seen as a violation of women and girls’ rights, and consequently as a form of discrimination against them. Many countries in Africa have now started to legislate against the practise, and grass roots advocacy efforts have started to make some impact in countries where the practise is widespread, such as Somalia.

1.2 FGM in the UK

FGM is illegal in the UK under the Female Genital Mutilation Act (2003), which includes an important amendment to incorporate all acts that were performed on UK residents, even outside of the UK. This means that parents who take their child abroad for genital mutilation are liable under UK law, and that FGM is a child protection (i.e. safeguarding) issue.

There is a great deal of secrecy surrounding the practise of FGM within the UK, one of the factors that makes an estimate of prevalence difficult. A recent report estimated that there were up to 66,000 women who had experienced FGM in 2001, and a further 24,000 under the age of 15 who were at risk5. Another study6 among young (male and female) Somalis living in London found declining levels of the practise, with a much lowered risk of having had FGM, depending on age of arrival in the UK. There was a clear attitudinal shift among both men and women in younger age groups, and who had lived since early childhood in the UK, towards condemning the practise as harmful. There was also some evidence, however, of a shift towards ‘milder’ forms of FGM, such as ‘Sunna’ (widely interpreted as Type I or Type IV).

1.3 Background to FGM in Birmingham

Birmingham’s Migrant Communities

Demographic data has demonstrated that Birmingham’s emerging immigrant communities come from areas where FGM is practised, including Somalia, Ethiopia, and Sudan, among others. For instance, data on national insurance (NINO) registrations can be used as a measure of in-migration, as it records nationality of those applying. Over the last five years, NINO registrations for people from 17 different countries where FGM is practised have been recorded for Birmingham7. NINO data does not record children however, and may mask the presence of ethnic

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4 See [http://www.emro.who.int/publications/HealthEdReligion/CircumcisionEn/index.htm](http://www.emro.who.int/publications/HealthEdReligion/CircumcisionEn/index.htm), accessed 02/02/11


7 A recent list of countries where there is reliable data on FGM being practised can be seen at WHO (2007) “Inter-Agency Statement on Eliminating FGM”
groups who have acquired further nationalities. Many Somalis resident in Birmingham have Dutch nationality, for instance.

Table 1 shows data from the 2001 census; NINO registrations and country of birth of women giving birth show migration from some countries where FGM is known to be practised. However, this does not show out-migration and therefore should be used with caution.

Table 1. Demographic indicators of change in Birmingham

<table>
<thead>
<tr>
<th>Country</th>
<th>Residents in 2001 Country of Birth</th>
<th>NINO Numbers 2002-7 Nationality</th>
<th>Births 2001-6 Mother’s Country of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>All non-UK</td>
<td>161,029</td>
<td>52,750</td>
<td>31,346</td>
</tr>
<tr>
<td>Africa C &amp; W</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nigeria</td>
<td>753</td>
<td>820</td>
<td>217</td>
</tr>
<tr>
<td>Ghana</td>
<td>372</td>
<td>460</td>
<td>119</td>
</tr>
<tr>
<td>Gambia</td>
<td>130</td>
<td>360</td>
<td>209</td>
</tr>
<tr>
<td>Cameroon</td>
<td>25</td>
<td>150</td>
<td>82</td>
</tr>
<tr>
<td>Total</td>
<td>1,280</td>
<td>1,790</td>
<td>627</td>
</tr>
<tr>
<td>Africa N</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sudan</td>
<td>230</td>
<td>290</td>
<td>91</td>
</tr>
<tr>
<td>Somalia**</td>
<td>819</td>
<td>1,630</td>
<td>1,700</td>
</tr>
<tr>
<td>Eritrea</td>
<td>28</td>
<td>440</td>
<td>48</td>
</tr>
<tr>
<td>Kenya*</td>
<td>3,769</td>
<td>250</td>
<td>216</td>
</tr>
<tr>
<td>Uganda*</td>
<td>1,408</td>
<td>120</td>
<td>109</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>62</td>
<td>100</td>
<td>73</td>
</tr>
<tr>
<td>Total</td>
<td>6,316</td>
<td>2,830</td>
<td>2,237</td>
</tr>
<tr>
<td>Middle East</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yemen</td>
<td>1,978</td>
<td>430</td>
<td>762</td>
</tr>
</tbody>
</table>

* Many residents from 2001 were from an Asian ethnic group
* Many Dutch and Swedish nationals arriving in Birmingham are believed to be Somali

People of Somali descent are recognised as being a large community affected by FGM. Schools data (which records native language) from 2008 shows that 2,611 Somali speaking children were recorded in Birmingham primary and secondary schools, of which we can assume half are female. Table 2 shows wards which recorded highest (above 100) number of Somali children in primary schools across Birmingham.
Table 2. Somali-speaking children in primary schools by ward in Birmingham (2008)

<table>
<thead>
<tr>
<th>Ward</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>All wards</td>
<td>2,611</td>
</tr>
<tr>
<td>Bordesley Green</td>
<td>343</td>
</tr>
<tr>
<td>Nechells</td>
<td>335</td>
</tr>
<tr>
<td>Washwood Heath</td>
<td>225</td>
</tr>
<tr>
<td>Aston</td>
<td>175</td>
</tr>
<tr>
<td>Sparkbrook</td>
<td>152</td>
</tr>
<tr>
<td>Lozells and East Handsworth</td>
<td>113</td>
</tr>
<tr>
<td>Other Birmingham wards</td>
<td>634</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,977</strong></td>
</tr>
</tbody>
</table>

Women of Somali origin are not the only ones affected by or at risk of FGM, but they are the most frequent users of specialised FGM health services in Birmingham, and arguably thus highlight where prevention efforts can and should be effectively focused.

**FGM-Related Services in Birmingham**

Specialised maternity and de-infibulation services for women who have experienced FGM are currently provided through the Heart of England Foundation NHS Trust (HEFT) in Birmingham. Current guidelines from the Royal College of Obstetricians and Gynaecologists recommends specialist midwifery services in addressing the health needs of women affected by FGM, particularly during pregnancy and birth.

Data from the HEFT on pregnant women who had undergone FGM and accessing services at the African Well Woman Clinic shows that women came from up to 11 countries, with the largest groups coming from Somalia, followed by the Gambia and Sudan. Recent data from the HEFT has shown rapidly increasing referrals of women to access these services, with 536 women being referred during 2008-2009. As they only include women with health complications and seeking services they underestimate total prevalence of FGM in Birmingham, but show rising levels of demand for the services. The graph below shows current levels of referrals over the past nine years to the African Well Woman clinic, with projected levels to the end of 2011 (the data for 2011 was not fully available at the time of writing this report).
Furthermore, data on women who accessed services for FGM through the clinic from 2009 give a snapshot of the types of FGM being practised, populations where women are carrying the highest burden of health needs, and the spread of sub-populations accessing FGM services. Somali women most frequently access care, with the majority having had Type III FGM.

Table 3. Country of Origin of Women accessing the ‘African Well Woman’ Clinic at HEFT for 2009

<table>
<thead>
<tr>
<th>Country of Origin</th>
<th>Type 1</th>
<th>Type 2</th>
<th>Type 3</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eritrea</td>
<td>3</td>
<td></td>
<td>15</td>
<td>18</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>&lt; 5</td>
<td>&lt; 5</td>
<td></td>
<td>&lt; 5</td>
</tr>
<tr>
<td>Gambia</td>
<td>13</td>
<td></td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>Kenya</td>
<td>&lt; 5</td>
<td></td>
<td>&lt; 5</td>
<td>&lt; 5</td>
</tr>
<tr>
<td>Iraq</td>
<td>&lt; 5</td>
<td>&lt; 5</td>
<td></td>
<td>&lt; 5</td>
</tr>
<tr>
<td>Somalia</td>
<td>20</td>
<td>6</td>
<td>50</td>
<td>76</td>
</tr>
<tr>
<td>Sudan</td>
<td></td>
<td>9</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>Yemen</td>
<td>&lt; 5</td>
<td>6</td>
<td>&gt; 6</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
<td></td>
<td></td>
<td>133</td>
</tr>
<tr>
<td>Total</td>
<td>177</td>
<td>12</td>
<td>74</td>
<td>263</td>
</tr>
</tbody>
</table>

Data from Heart of Birmingham PCT suggests that up to 7.1% of all live births in 2008 were to women who had experienced FGM, with an estimated 400 births per year to Somali women alone (in 2004). Concerns have consequently been raised about girl children being born into communities where FGM is practised. The Birmingham Child Safeguarding team estimated in 2010 that there was a cohort of up to 916 girl children who could be at risk of future FGM.
These data highlight the ongoing and increasing need for specialist maternity care, community advocacy and education around FGM. Women who have experienced FGM have a higher risk of birth complications, and without proper assistance (including de-infibulation), face serious negative health consequences.

Current Prevention Efforts in Birmingham

FGM has been recognised as an issue within Birmingham within the last decade. A group of relevant statutory agencies and third sector partners – ‘Birmingham Against FGM’ (BAFGM) – was recently established in 2005. BAFGM continues to push for greater awareness of FGM among relevant stakeholders (health staff and teachers, for instance), and works to develop local policies and guidelines on addressing FGM, to raise awareness of the consequences of FGM and recourse to action in affected communities, and to further understanding through research of how FGM affects women in communities in Birmingham.

The BAFGM group have increased child safeguarding activities in response to the prominence of FGM as an issue for Birmingham's women and girl children and as a result of their work, FGM has been recognised as a safeguarding issue for children and was included in the ‘Children and Young People’s Plan in 2006 – 2009’. At a grassroots levels, BAFGM aims to raise awareness of FGM and to expose the problems that FGM causes to young girls and women, and to emphasise the illegality of FGM in this country.

Awareness-raising activities focusing on the law and effects of FGM have been conducted in the community, and have targeted professional groups such as teachers. School authorities have, for instance, been engaged in monitoring female children from ‘at risk’ communities, especially during the long summer school breaks that offer the opportunity for travel and recovery from FGM. BSWA have also received funding for a part-time Somali worker to do grass-roots prevention work on FGM and its impact on women and girl children.

In September 2009 a report to the Birmingham Safeguarding Children Board established a strategic group to develop a Pan Birmingham Strategy relating to FGM. That group has drafted a Pan Birmingham Protocol for safeguarding. This protocol is being reviewed to include lessons from this research. An FGM Action Plan has been developed to further develop prevention activities.

This research was co-funded by the Migration Impact Fund and the Safer Birmingham Partnership, and was implemented by Birmingham & Solihull Women’s Aid in collaboration with the PEER unit at Options UK.
2. METHODOLOGY

2.1 PEER

Participatory Ethnographic Evaluation and Research (PEER) is a qualitative, participatory method of research particularly suited for work with marginalised or hard-to-reach groups. The process aids understanding of health and social perceptions and behaviours from an insider’s point of view as ordinary members of the target group are trained to conduct in-depth semi-structured interviews with peers they select from their own social networks. This structure encourages an egalitarian dynamic between researcher and researched as opposed to traditional extractive methods of qualitative research.

PEER has been implemented in more than 20 different countries, including the UK and has been specifically used to explore FGM on a number of occasions in various contexts and geographical locations.

PEER studies are held to a rigorous code of practice which is adapted for the context of the study.

Full details of PEER methodology is available in Annex I.

2.2 Training

In total, 16 women from Somali, Eritrean, Sudanese, and Sierra Leonean backgrounds were recruited using ‘snowball sampling’ in which social contacts of BSWA’s research supervisors were invited to take part in a three-day initial training workshop. BSWA was responsible for recruiting and organising training and Options UK co-led training and data collection activities alongside the two PEER supervisors.

Recruitment criteria included that women were 18 years or above, residents of Birmingham, from FGM practising communities, and were willing and able to commit to the research process.

Researchers spoke both English and their native languages and therefore interviews were conducted in a mixture of women’s first languages and English.

Over the course of three days, OUK facilitators, PEER supervisors and researchers worked collaboratively to develop research aims and conversational prompts or questions around three key themes, which acted as guides for in-depth interviews. Please refer to Annex II for a full list of prompts, e.g. how do people in the community feel about FGM and are there differences between men and women, younger and older groups, etc.

2.3 Data collection

Fifteen peer researchers conducted a total of 90 interviews over the course of four months, from September to January 2011. In addition each of the researchers contributed her own insights through group workshops and individual debriefing sessions held with the two research supervisors. The views obtained cover Somali, Eritrean, Sudanese, Sierra Leonean, and Gambian communities. Respondents ranged in age from 17 to 48 years with an average age of 29. Some had emigrated to the UK as recently as seven months earlier while others were long term residents of 30 years or more. A very small proportion of respondents were born in the UK. About half of the women interviewed were married and just over half did not have
children. Importantly, the majority of women interviewed in the community were personally affected by FGM, and those who were not circumcised tended to be younger (i.e. <25) and born and/or raised in Western European countries.

Peer researchers met with two friends on three separate occasions exploring three broad areas of: life in Birmingham, FGM, and the wider impacts of circumcision. Almost all interviews were carried out in person, although some were conducted through telephone conversations.

Researchers took brief notes of key issues discussed or particularly descriptive and relevant stories and then met with a research supervisor to debrief their findings. Research supervisors made more detailed notes and used these in-depth debriefing sessions as opportunities to probe further to gather additional information which aid in understanding the data.

A final feedback workshop was held in January 2011 which allowed OUK researchers, research supervisors and peer researchers to discuss preliminary interpretations of the data as well as feedback their experience of the PEER process. Detailed notes of this day formed part of the final analysis.

It is worth noting that this study had limitations. As FGM is illegal in the UK, some respondents were sensitive to this. Additionally as the subject itself is sensitive and not widely/openly discussed, particularly for older age groups, some data were not described in specifics as it was a challenge to get explicit data around particular issues, such as girl children being taken outside the UK for circumcision.

2.4 Data analysis

Data were analysed by two social scientists to increase validity of the data. Transcripts were coded and text (quotes and stories) selected and placed within a coding framework that emerged in the analysis phase. Preliminary findings were presented to the peer researchers and research supervisors in a final feedback workshop in which women clarified, elaborated, debated and verified early findings. Finally, for quality assurance and clarity in reporting a third social scientist reviewed the report.
3. QUALITATIVE THEMES AND DESCRIPTIVE DATA

The PEER research process produced an abundance of women’s descriptive stories, experiences, and beliefs surrounding FGM and related issues from a range of African communities in Birmingham. The following summarises and synthesises the main findings using, where possible, illustrative quotes from respondents which exemplify the rich qualitative data gathered. Quotations may have been edited for the purpose of conciseness or clarity and names have been changed to ensure anonymity of all participants and researchers.

Three broad themes were explored in the course of the research. Options UK’s previous research experience in FGM helped to determine some initial thematic areas to explore, while other questions were developed directly by peer researchers during the three day training workshop at the outset of the research.

We present the findings from the women’s interviews under three broad headings:

1. Family life in Birmingham
   - Social life
   - Marital life
   - Education
   - Employment
   - Social integration

2. Understanding female circumcision
   - What communities say about FGM
   - How people in the community feel about FGM
   - Continuation of the practise
   - Circumcision practises
   - Reasoning behind FGM
   - Pressure to circumcise

3. The wider implications of FGM
   - Effects of circumcision on women’s lives
   - Experiences with Birmingham health services
   - Birmingham’s Well Women’s Clinic
   - Access to help and information
   - The role of advocacy in FGM
   - FGM and UK law

3.1 Family life

It is important to recognise that the act and experience of living with FGM occurs within the context of a girl or young woman’s life and is not experienced as an isolated event separate from culture and community, but rather is a lived experience of culture. As such, data were collected on a variety of contextual factors and issues of social integration and migration to the UK were explored to better understand their role in shaping attitudes and perceptions of FGM. The participants and peer researchers themselves originated from a variety of countries and some had spent periods of time living in other countries prior to settling in the UK, including the Netherlands and Scandinavia. Women came from a variety of socio-cultural backgrounds and were not a homogenous group. This was taken into consideration in drawing conclusions about communities. Here we have focused on areas of life in Birmingham that are not only relevant to FGM but highlight the complexity of challenges and opportunities women from these communities face and the need for a holistic understanding of women’s lives and their priorities. This is particularly
relevant for developing interventions around FGM which need to be viewed by women from these communities as relevant and important to them to encourage uptake, but that may also have wider impact on related issues, e.g. domestic violence.

3.1.1 Life in Birmingham

Respondents reported mostly positive views of Birmingham as a “welcoming city” with faces from all corners of the globe, a variety of ethnicities and religions, languages, and cultures, which further contributed to feeling a sense of acceptance and being able to identify others like themselves within the wider community. A number of women who had lived in other countries (e.g. Western Europe) prior to arriving in the UK or indeed other parts of England compared life in Birmingham positively and emphasised the absence of harassment and a sense of acceptance of (Muslim) communities and cultural practise such as traditional dress; for some this felt like a relief from previous experiences.

They like it because it’s really multicultural – there’s no barrier to dressing; they like it more here than Denmark or Holland. Like if you see a woman walking around fully covered here, they won’t harass you, but in most countries they might. (Somali woman, 24)

Some women relayed a sense of opportunity once settling in Birmingham in employment, education, services and social life compared with other settings.

Here it’s easier to find jobs as well, even if you dress like that. They do have a lot of community centres here, and if you don’t speak the language, there are centres where you can go to learn English, and there are other Somalis (sic) here so you can socialise. And for her, she can study and do her own thing. From what she said, women prefer it here compared to other places. (Somali woman, 24)

Another positive aspect of life in Birmingham for a number of respondents was the presence of “women and children’s rights” which they felt were not recognised in many of their communities of origin in Africa. The concept of rights re-emerged in the context of marriage and later in the context of reasons for the abandonment of FGM.

However, not all women described Birmingham life so positively, but instead communicated several areas of difficulty. Immigration status played a key role in forming women’s perceptions of life in Birmingham. A number of women described frequent relocations around the UK and even locally, contributing to feelings of insecurity and stress and sometimes depression. Additionally, asylum seeker status prevented some women from accessing education or employment as they would have wished. Immigration status also contributed to difficulties within the marriage as their UK-status was often dependent on husband’s support. Many of the women experiencing these matters were recent arrivals to the UK and tended to be younger, though not exclusively. Immigration and marriage is elaborated in section 3.1.3. General feelings of being “overwhelmed” or “confused” by the various UK systems, some immigration related, presented further challenges, often due to language barriers. Navigating the school system, housing, interactions with the police, job centres, and bills were all cited as areas of difficulties by women.

It is very hard because of language problems, culture problems and family problems – if somebody doesn’t know the language they are always afraid 'cause [they] can’t speak to [the] doctor, police, employment centre and
schools...utility company [to] sort out bills and housing...all this is a problem for the women and the worst is the government system; the ones who work for government are not fair for minorities. (Somali woman, 35)

As the woman above touched on, smaller family structures and lack of extended family members and social networks who could support women presented the final area of difficulty described, and for many women “holding the family unit together” in Birmingham was a daily effort, as they navigated challenges mentioned above, but also managed the household with limited support, and often struggled with children and partners as traditional roles changed.

*It is generally hard to raise a family in Europe compared to Somalia. In Somalia, we have close-knit communities that help each other out. We don’t have nuclear families, e.g. mother, father, and children. Back home there are aunts and grandmothers, uncles; everyone is there to help out with babysitting and dividing chores. So it is more difficult here. In Somalia, you don’t worry about babysitting, you just go out. It is that simple.* (Somali woman, 39)

For some women experiencing these challenges, they felt they had less support to cope than they would have had in their home communities. The change in family unit is explored more specifically in the context of the changing nature of marriage and ever-evolving gender roles (see section 3.1.3).

*My friend just this year, she had two kids before she got married from a previous partner. This husband wanted kids of his own and she didn’t because she already had two who were very young and because of that they [fought] a lot. Also he is a student and she couldn’t work because she didn’t have a UK resident [visa]. After being married for three weeks they got separated; she threw her husband out of the house, she [didn’t] respect him. She was depressed because she didn’t have UK [residency] for a long time since 2005. Then recently she received her UK resident [status] about two weeks ago and now she found a job and she is working and happy.* (Gambian woman, 22)

As the above quote illustrates, some women found themselves in precarious situations, as they were pressured into roles they did not wish to have, e.g. a reproductive one, having more kids that they did not want, and extended family/support networks which may have exerted pressure on the husband or advocated for the wife in their home contexts were less available for women in Birmingham. Evading these pressures often depended on obtaining their own right to reside in the UK. Conversely, not getting it may make them more vulnerable to control by male partners, which is again explored more in 3.1.3.

3.1.2 Social life

Although a number of respondents reported socialising in Birmingham as presenting no problems, a greater number reported feeling restricted in their socialising due to a combination of barriers most notably language, but also culture and religion which may not allow for socialising in certain more typically “British” venues, such as pubs and, for young people, clubs. Additionally, permission had to be gained from family, parents, and especially husbands, which contributed to restricted mobility for some women.

Social lives largely took place in same-country or language groups, i.e. Somalis predominately socialising only within the Somali community. Although this was
sometimes out of choice, language also restricted interaction with other groups. This is illustrated by the young woman’s observations of her own community below.

They only socialise with each other really, like with other Somali people. Only a few Somali women would make an effort to socialise with women not from Somalia. They socialise with each other and go to each other’s houses and mind each other’s kids, but not with other people. They’re not social with other people because most Somali women don’t know the other language. For young people, it’s easier to socialise because they speak the language and know the system. It’s not just the language that stops them from socialising – it’s the culture. Most [of the] older generation are not very open. The younger people it’s not really a problem. And religion – if they are Muslim, then they share the same values. I guess for them, they can’t really socialise with them, they can’t really go to the pub with them, or go clubbing together. If you share the same values and norms, you’re more likely to mix with them. You mix with the people you see, so if you go to Somali (sic) community centres or mosques, those are the people you socialise with. (Somali woman, 24)

Socialisation is explored further in the section on social integration to follow.

3.1.3 Marital life

Discussions of marriage among respondents and peer researchers led to debate and some strong opinions. A couple of women refused to talk to about marriage altogether, though did not say why. It became clear that perceptions of marriage were very polarised, either viewed as a source of support and happiness or stress and restriction. Largely, the women’s opinions fell on the negative end of the spectrum. During the final feedback workshop, marriage was explored in depth and women volunteered their thoughts on the changing role of men, women and marriage and how these changes have affected their relationships and views of marriage. Some of the initial comments included that men are “bossy”, “selfish”, and “threatening if challenged”. During the final workshop, researchers felt that men on the whole “still have control over women in Birmingham” particularly over resources. They felt men feel threatened if women have access to income, and that this control was, to some extent, maintained due to barriers in terms of language, resources, family, and immigration.

There was a general consensus that marriage is changing as a result of living in Birmingham/the UK and that there are both positive and negative consequences of these shifts towards unions in which women are more able to assert themselves. Many younger women aspired towards a partnership of equals, where they would be able to assert their “rights”, and for instance where household responsibilities are shared.

For the young people, like my friend I interviewed, they have more of a westernised marriage. She’ll work and he’ll work and they both just chip in, but the older generation, it’s the wife who stays at home and does the housework and care for the kids. The husband will go out to work. It’s not normal for the woman to work if the husband is there. Of course it’s different if she’s divorced, then she’ll have to [go out and work]. (Somali woman, 24)

In addition to changing rights and roles in the household, decreased pressure from extended family (due in part to smaller family units) to maintain traditional roles, and patterns of selecting partners on the basis of emotion rather than family suitability is also observed.
It is different from Somalia – here, the wife might feel like she can – in Somalia, the husband can do whatever he wants. She wouldn’t want to get a divorce because she would put the whole family to shame. Here, you don’t have that pressure. It’s more likely for her to argue and stand up for herself. Here it’s more about the two people who are married if they get along, and communicate together and agree what to do. There it’s just more of a contract kind of thing. It’s not based on a relationship – not all of them, but for most of them it’s because they got married because it was arranged and because it was good for the family. Here, if you grew up here, it’s more likely that you get married out of love. Her’s was a love marriage – they met first and then they agreed to get married and approached the family. Then they approved. (Somali woman, 24)

Women of all ages cited increased feelings of independence and asserting a sense of “right” or authority in the relationship and household, but noted that this was often challenged by their partners or men in the community generally. Changing roles contributed to contestability over what a woman’s role in the home should be. In the data, this was more often associated with ‘older’ men (i.e. >35).

Women are more independent here and men don’t like that – men say women changed when they came here. (Eritrean woman, 30)

There seems to be a lot of confusion with marital life. Some women tend to over exercise their rights or understand their rights wrongly and end up dominating the man. Equally important, men find it hard to understand the independence of women and they end up in contradicting it. Overall these kinds of things lead to misunderstanding. (Eritrean woman, 32)

They say things like marriage is wonderful because there [are] two of you helping each other and supporting each other during tough times but others say men still expect women to behave like traditional and cultural, [for] example they want the woman to do domestic work like cleaning, cooking, etc. basically to serve the husband, whatever pleases him she has to do, [for] example how she dresses or how she behaves. For those reasons they say negative things about marriage. (Eritrean woman, 30)

There were serious consequences of women contesting their role and asserting greater independence. In some of the narratives, women said that conflict had led to domestic violence, separation and indeed divorce.

A lot more couples are separating these days because they know that they don’t have to put up with anything that a husband may do to them. They know that they can get help and be independent. (Somali woman, 33)

Just as women believe their roles and behaviours have changed in Birmingham, women felt men too were fulfilling different, and often lesser, roles as husband and father.

I am not married but I heard other people are having problems, a lot of separations. That is why my friend and I will not get married in this country anyways because the Somali men in this country are not good. They are not good because some of them khat and because of social benefit in this country they don’t take financial responsibilities like our fathers did back home. (Somali woman, 25)
Financial stress and employment issues were not always seen as the husband’s fault, but nevertheless were felt to contribute to breakdown of relationships.

*It is hard to stay married in the UK because Somali men can’t find work here so they try to run their own business but sometimes they are not successful. [The] husband and wife usually have financial difficulties and marriages break. Divorce is high in Somali community because of that.* (Somali woman, 35)

The peer researchers added that an additional change and indeed challenge for marriage in Birmingham is the absence of extended family networks. Women relayed that in Somalia, a husband seen to not be fulfilling his financial responsibilities to provide for his family could and most likely would be confronted by the wife’s family to improve and contribute otherwise she and the children would have an extended network upon which to rely and perhaps live with. This is not the case in Birmingham as some families are separated and women may be isolated and lacking this support in difficult times.

*She found marital life at the beginning not easy because she has to stay all day at home alone. This is especially so [difficult] when someone comes from [a] large family with big houses and suddenly found herself in a small house or flat in Birmingham. Being always alone at home is not easy because her husband go[es] to work or study every day.* (Sudanese woman, 25)

A considerable portion of women’s immigration status in Birmingham will be under their husband’s names, and our researchers shared examples of when this has been used as a means of “controlling” wives. Women who do not have leave to remain under their own accord may be at risk of being “sent back home” or, as one woman shared, losing access to her children and having to return home after the husband relocated to Scandinavia with them following a disagreement.

Despite the many negative comments about changing gender roles and marriage in Birmingham, it should be emphasised that younger women (i.e. <25) and those raised in Europe and the UK had more optimistic views of their future marriages. Increasingly, mixed-race/religion marriages, love marriages, and more equal partnerships were possible.

*Interracial marriages here are more okay – she knows a couple of Somalis who have married people of other races. It’s becoming more accepted – not just the Somali way of life. There is one rule here though that it’s okay for the girl to marry outside of Somali as long as they are Muslim, because the husband influences the wife.* (Somali woman, 19)

*For younger Somali girls here though that [restriction to the household] is changing. [It’s] drastically changed – my sister’s husband works part time, and is holding the children and waking up at night. It’s a different generation. There’s more of a partnership there.* (Somali woman, 19)

### 3.1.4 Education

Education was a valued opportunity for the majority of respondents either for themselves or for their families. Education in English language through ESOL courses was seen as pivotal in promoting some women’s sense of independence upon settling in Birmingham. English language skills were seen as both a potential tool towards “security”, and in accessing education and employment. A generational difference in the role of English was noted with young people describing English as a
must for jobs and to “make something of [one]self”, whereas older women felt it was important in more day to day living such as going to the grocery store or communicating with health professionals. English speaking skills were also viewed as important to help parents ‘understand their kids’ better as they grew up in a mixed community. For women, accessing language courses (and possibly others once these skills were established) held the added benefit of promoting the valued ‘multiculturalism’ and social integration mentioned earlier as it encouraged them to meet women from other communities as well as their own.

There are a lot of possibilities for adults [in education]. There are language courses for those who do not know the language adequately. Actually, it is also a way of socialising, getting to know people from other communities and getting to know facilities and services available to you. They get help from those who were in the same dilemma as themselves. Since they have gone through the process, your friends can help you and point out any ‘sticky bits’ to avoid. By sticky bits I mean an obstacle they had to overcome. (Somali woman, 24)

Multiculturalism in education was also important for children, as women felt their children ‘fit in’ well in Birmingham and received the same attention and treatment as other students from various backgrounds.

On the whole, education for children was viewed positively. Only one woman commented that parents “don’t trust the education they’re getting (Somali woman, 35)”. A recurrent theme of “pushing” children to succeed and to “make something of themselves” emerged throughout the interviews, however it should be noted that as with criticisms of men for not fulfilling certain husband/father duties above, women felt responsibility of their children’s education largely fell to them, which could be a source of stress particularly for those with limited knowledge of English and the UK education system.

Parents want their kids to go to school – they don’t want their kids to go through what they went through, struggling. They want them to do well and to make a life for themselves; they try really hard for them so they can have an easier life. They will pay extra money for tuition for their kids to make sure they don’t fall back and to make sure they succeed. It’s always mainly the mothers who work hard for their kids. Dads are involved, but it’s really the mothers who push their kids to go to centres. Dads will not get as involved as the mothers – they just go to pick them up. (Somali woman, 24)

Though education was largely seen as positive and indeed essential to the success of individuals and their wider communities, women did articulate barriers to accessing education including immigration status (i.e. without leave to remain courses cost and many women do not have access to income/resources to fund their studies), childcare restrictions, and again roles within the household not encouraging the woman to step outside and attend lessons.

She said about the education, it is not easy to go to school…[waiting]…two years it is [a] long time, then after she was waiting [another] six months until [she got the] chance to learn a language in [the] community; not college because she came by Visa and [she’s] not allowed to study directly in the college. (Sudanese woman, 25)

Several stories maintained optimism that opportunities for success were available with the right support.
The older women in the community may find it tricky – mainly because language is a barrier. The women do know there is support. For example, her aunty goes to uni and has worked her way up from ESOL classes to sitting in lecture halls with lots of other young students. It's going to be hard work – and there are definitely issues managing children because they often have to be home to care for them. But her friend's aunty shows it can be done. It's rare, but it's possible to get to that level. [Rare] Because their English isn’t implemented in daily life – even the bits they do learn they don’t use. It's easier to say speaking Somali with just other Somali women. The women don't see themselves in work or education and by the time they can get away from the kids to learn they say 'we’re old now'. (Somali woman, 19)

3.1.5 Employment

As with education, women noted similar barriers to entering employment in Birmingham including language, restrictions of childcare duties, lack of experience and/or appropriate qualifications, and immigration status.

Finding a job is very difficult if you don’t have UK [residency] because you are not allowed to work in [the] UK. My friend wanted to work since 2005 but couldn’t because she was not UK resident. Now she has her resident she found a job. There are a lot of jobs in Birmingham; if you work hard to find a job then you will get it. My friend is doing care work. (Gambian woman, 20)

Also similar to education, some women felt that an individual's attitude, low confidence, and feeling one must stick to a 'traditional' role restricted choice and pursuit of work. In some situations, husbands or other family members may be reinforcing these messages.

Somalis…aren’t moving out of their comfort zone enough in employment and education to get ahead. Women don’t have as many options. A lot of this she thinks is down to confidence issues, English barriers. For example, A’s mother went to ESOL classes and now she can go to the GP or shop alone. ‘But she takes me with her whenever I’m available to translate even though she doesn’t need my help. She has this mentality that she can't; they have this mentality that they can't even though they can [function in English without their children helping them]. They’re less confident because they are mostly new to Birmingham. Now my mum goes shopping and meets 5 people. She doesn’t even come back with groceries. So it depends on the individual’ [because some Somali women are mixing and more confident]. (Somali woman, 19)

One key barrier to employment, which was interestingly not felt to be a complication in other aspects of daily life in Birmingham or in accessing education, was dress and perceptions of employer’s attitudes towards traditional (Muslim) dress. Perceptions that some employers would be deterred by hijab, for example, contributed to lowered confidence in seeking employment and were viewed as a legitimate barrier to choice of job or success upon application. This is particularly interesting in light of previous discussions that many women felt their cultural practices such as dressing in full hijab in Birmingham were accepted by the wider community; challenges associated with dress appeared to be limited to the context of seeking employment.

I think it’s a mentality as well – for most people, even the girl said it – they have this mentality that ‘Oh, I’m dressed like this, I’m not going to get it [the job]’. So they won’t even really try. They’ve heard stories that women with headdresses didn't get a job. It does happen, but they hear stories too and that deters them
from trying hard. If there are two people with the same qualifications, they [employers] might take the other one because they think she will be more social and approachable because they’re not dressed in black. (Somali woman, 24)

They can never find work and if they do it is cleaning jobs. They hate taking income support but because of their clothing and hijab they can’t move forward and find what they want. (Somali woman, 35)

I guess there are [jobs], but for us it’s a bit limited because a lot of jobs you can’t do simply because of the way you dress and this limits your options. (Somali woman, 24)

Perhaps the only barrier would be dressing a certain way, wearing the niqab is sometimes an issue for a shop assistant because there is a uniform. Or the dress code says it would be a hazard [e.g. in nursing]. My little sister she went into Mothercare but was told the job would depend on the dress code. The black t-shirt was mandatory. She went back and took her CV and walked out and went to an Islamic bookstore and got a job. And she was able to say I didn’t need to change anything to get that job. If you’re going to be standing behind the till what does it matter? It’s not compulsory for full-face coverage – I understand that. I wouldn’t want that anyways, but the dress is different. Although, it is more accepting in Britain than other places I have lived. (Somali woman, 19)

3.1.6 Social integration

Next to discussions around marriage and gender roles, issues of social integration, i.e. feeling accepted and valued within a group, and the challenges of settling within the wider community featured prominently in interviews, with mixed definitions of what ‘integrated’ may mean and varying degrees of confidence that women are increasingly able to access services and resources. Although Birmingham’s multicultural population makes women more comfortable in the city generally and as they may be engaging with people from a range of different backgrounds in day-to-day activities, patterns of close social support networks appear to revolve predominately around the community of origin. Potential reasons for remaining within one’s own community besides personal preference may be language, religion, culture, and access to comforts from home.

In general they are integrating very well because Birmingham is multicultural and they can find other people similar to their culture and it is easy to find food from back home. Integrating with British people is hard because of language and culture differences. Some feel they [are] becoming British but some feel they are not fitting in because of culture and language. I don’t know the percentages of those people but I can say few people are adapting to British culture. (Somali woman, 24)

In our community, integration has a long way to go. Some women have integrated fine whereas others haven’t. Somalis prefer to live somewhere where there are other Somalis, preferably close to family, and their local shops. For example there are a lot living around the top end of Stratford road and Coventry Road because of the shops that are situated there. Not only for the Islamic butchers, halal food, but also the Somali clothing that you can buy. It has also become an area where you can go to socialise. That’s why I think integration has a long way to go. (Somali woman, 35)
Several women felt ‘other’ communities were not encouraging social integration more widely as they too tended to keep to themselves or at times could even be unfriendly.

*There is no social life in Birmingham. Everybody keeps to themselves unlike my own people from Eritrea. We find it easy to socialise with my own community better because we speak the same language and we have the same culture and we have something in common, e.g. we talk about back home and what is happening back home. For example, I have a neighbour who is from Jamaica; we say hello to each other when we are entering our building where we live but that is all. But when I meet any Eritrean woman who lives in my neighbourhood we will visit each other’s home and have tea.* (Eritrean woman, 30)

*People in UK, they ignore you, but people from Africa will never ignore you, they help you. For example when I met my friend in 2007, she didn’t ignore me like the British people in my college and now we are friends. British people ignore me and laugh at me maybe because of my English. Some British people are really nice, they got to know me and I got to know them.* (Sierra Leonean woman, 20)

Although respondents and researchers of all countries collectively appeared to feel most comfortable remaining predominately within their own ethnic communities and able to sufficiently access resources and services in Birmingham in doing so, two groups stood out as exceptions. Eritrean women asserted that as a ‘newer’ community to Birmingham, there was considerably less information and advice available to address their groups’ needs than, for example, more established Somali communities and that this further impacted attempts to settle into the wider context and systems. It is difficult to make generalisations about the subset of West African respondents given its small size, however all four women from this region explicitly stated actively reaching outside of their particular ethnic groups and although still largely had only ‘close’ African friends, they were from a range of nationalities.

Degree of social integration into the wider community was not only described from a cultural or ethnic perspective, but also importantly highlighted a generational difference (also associated with length of time in UK).

Young women from all groups were more likely to express that social integration with other groups was ‘easy’, with few if any barriers and that socialising with other communities was a regular part of daily activities, e.g. at school and college. Conversely, women in more traditional gender roles such as at-home mothers may be less able or find it less preferable to socialise outside the home. There is data to suggest some women in full-time housewife roles may be socially isolated to some extent, though this appears to be more likely with older women.

*It’s very easy for young girls – there is more of a support system. The language is easy and their social lives are good. For the older women they don’t integrate because their role is to be at home – or at least that’s what they think.* (Somali woman, 21)

*This friend spoke mainly about her group meaning young Somali women living in Birmingham because that is what she knows best. Integration in Birmingham is very easy because of college as it helps young people meet other young people and you can meet people from the same background. It is easy as a young Somali to adapt, make friends because so many other students will dress similarly and have a similar culture to you. Britain is a very multicultural*
place anyways so you’re not isolated and she never feels out of place of uncomfortable in Birmingham. She feels like it’s her home and does not feel she really has any barriers. Her mothers’ age group finds it difficult to integrate because of having kids and having to stay at home to care for them until they are a certain age (about 15 years old). (Somali woman, 19)

What she was saying is that it’s not too bad for most of us – the second generation, we go through education, we socialise and we do what most young people do. We socialise with other people who are not Somali (sic) and are getting the hand of English life. (Somali woman, 24)

Social isolation may also result from a combination of limited extended family networks described previously as well as the more individualised culture encountered, sometimes for the first time, upon settling in Britain.

It is a real culture shock for women coming to the UK and to Birmingham to live from Somalia. It is more individualised here – in Somalia life is all about cooking and spending time doing things together as a family and as a community. There is not so much community help and support here because everyone is so busy. This is true even in the Somali community, the links to other Somalis is not as strong as it would be back at home. Everyone just wants to bring up their own children and not be linked to others too much. (Somali woman, 19)

3.2 Understanding female circumcision

Women were asked to explore their communities’ perceptions and behaviours around FGM.

3.2.1 What communities say about FGM

What constitutes FGM?

The language of respondents and researchers alike became extremely important in understanding current perceptions of what the event of FGM actually includes. This language and subsequently what it means for continued practise of FGM in these groups is important for advocacy, information needs and recommendations to those working to address this issue in Birmingham; these are discussed further in section 3.3. It is important to note here that terms used emerged directly from participants to describe FGM and types of circumcision, are specific to this group, and should not be taken out of context and applied to the wider community. In particular, the term ‘sunna’ holds numerous religious and cultural interpretations and is used very specifically by women in this group to describe a type of FGM.

Throughout the research, although local languages and tribal practises may make further distinctions, the women collectively categorised FGM into two types: ‘sunna’ or ‘pharaoni’. ‘Sunna’ was described by almost all women as what WHO would classify as Type I or Type IV circumcision. However, there were conflicting views as to whether ‘sunna’ was considered FGM at all. ‘Sunna’ was regularly referred to as the “little nick” often viewed as “no big deal” as it “doesn’t hurt her” as more severe types of circumcision may. Variation and hesitation to talk in specifics even with the research group appeared to indicate that there is no single method for ‘sunna’, but that pricking the clitoris to release blood, partial and full removal of the clitoris are all possible variations. A number of women highlighted that ‘sunna’ was “allowed” under
Islam, but stressed it was optional and by no means something everyone must do for their daughters. There was evident lack of clarity on what Islam states regarding female circumcision; this is explored more later in the report.

The second category of ‘pharaoni’ circumcision was unanimously viewed by women as severe, “bad” and “not allowed by our religion”. Women across communities collectively described ‘pharaoni’ as WHO would describe Type III – removal of the clitoris, labia majora and minora, and use of some thread-like material to suture the vaginal opening to allow only a small passage for menstruation and urination.

Crucially, terms ‘FGM’ and ‘circumcision’ were used to describe ‘pharaoni’, unlike some women’s accounts of ‘sunna’ which sat outside of the definition of circumcision for many.

[They will not] circumcise because it is against Islam and it is [an] ignorant thing to do…sunna is allowed by Islam but it isn’t a must. (Somali woman, 35)

It is also important to note that use of language to categorise ‘sunna’ as circumcision or not also seemed to have a generational component with younger women categorising all types of circumcision, including ‘sunna’, as wrong. Younger women used rights-based language, describing circumcision as “torture”, “bullying” and “an act done to the girl without her consent”. The use of such language was not readily observed in older women (approximately >35), and it may be that older groups gauge severity of circumcision on other criteria such as health or religious implications. One older woman stated there were “no serious health risks” with ‘sunna’ and therefore it was still an optional procedure.

Mainly older women strongly disapproved of terms like FGM and believed these terms lend themselves to increased stigma, and insult affected women.

She knows a lady who is circumcised but does not like the term FGM. She does not view herself as mutilated but as circumcised. [That] creates stigma and self esteem issues and a label. Lady does not have issues of being circumcised; she understands reasons behind it and feels it does not hinder her at all in any aspect of her life as she has not suffered the health issues surrounding circumcision. (Somali woman, 33)

Culture of Silence

On the whole, women from all communities and ages agreed that FGM is not something openly discussed or even alluded to in any of their communities by anyone, even in more private settings: “It’s all a bit hush hush”. Some women did not even know they had been circumcised or the degree of their FGM until they came into contact with health professionals during pregnancy and were informed by healthcare staff.

A culture of silence emerged around not only FGM but related issues. Sex, relationships and reproduction are largely unspoken subjects for women in these communities, and are viewed as “taboo” particularly at a young age or before marriage. Women reported not being informed of pregnancy and family planning, losing virginity, puberty, or menstruation until they encountered these events first hand. Conversations around virginity often amount to the unspoken rule against pre-marital sex and as for relationships, women felt the message again was simply ‘don’t have one until you’re married’. In Birmingham, partially as a consequence of not being provided with this information in the home, a number of women reported
incidents of young girls approaching teachers in schools to access advice or information. In some cases this interaction reportedly angered parents who felt it was inappropriate for teachers to be discussing issues of FGM, sex and relationships with their children without their consent. However, the respondents queried how consent to discuss risk of FGM with a female student would be obtained if parents were reluctant or even definitive in their avoidance of these topics.

Peer researchers reported that although the mother-daughter relationship in particular could be a potentially beneficial space for open discussion around a variety of issues including sex and relationships, mothers, as others, did not believe young women should be talking about sex prior to marriage. Only one young woman in our group reported being able to discuss such issues with her mother, and noted her family was an exception.

A lot of parents don’t talk to their kids. I’m open in my house – I’ve met somebody. I have told my mother. She would just advise me. But for my friends, it’s not acceptable to date anyone. There is a real problem in the Somali community where the mother and daughter should be talking openly about relationships, but they think their daughters will become ‘too Westernised’. (Somali woman, 19)

Whether FGM was currently happening to young girls living in Birmingham was a particularly challenging issue to draw out from participants, further highlighting the culture of silence surrounding circumcision. Most of the peer researchers, however, asserted that if FGM did happen, it would be carried out abroad.

Most parents will take their children to Somalia for a year or so and then circumcise them while they are there. (Somali woman, 24)

The view that FGM is continuing in the community was contradicted by others who felt most young girls unaware of FGM altogether as it “doesn’t really affect them” these days. This is explored more in depth in section 3.2.3.

All researchers and respondents felt that circumcision as they define it was “bad” and that communities in Birmingham are increasingly turning away from this practise.

The religious debate

The role of religion and whether it allows FGM or certain types of circumcision was debated revealing an area of true confusion for women and communities. For many respondents, their understanding of their religion directly influenced decisions to continue or abandon FGM, so it is important to recognise its crucial role and need for clarity.

Younger women appeared to have a more definitive view that circumcision has never had anything to do with religion, but rather was a cultural practise mistakenly linked with religion in previous generations.

[Christian] people misunderstood the religion hearing ‘daughters’ when God said ‘sons’ [should be circumcised]. (Sierra Leonean woman, 20)

Some women explicitly state Islam does not allow circumcision. However they did believe there to be texts (‘hadiths’, or religious proclamations) and allowances for ‘sunna’, which is not considered circumcision by some.
They say female circumcision is ‘haram’, it is against our Islam, but ‘sunna’ is allowed but not [a] must and sometimes people argue that prophet Mohamed (peace be upon him) never said it in the ‘hadith’. (Somali woman, 35)

Religion and culture may be indistinguishable for some women, and respondents, particularly older women, often did not seek to understand the root source of messages encouraging continued practise of FGM. In the final workshop, OUK asked researchers if they had ever seen ‘the hadith’ in question which so many of them had referred to and none of them could identify a source. Also, the women had not been informed of the ‘religious link’ by a faith leader, but rather these messages were coming ‘from the community’, i.e. from religious communities within the UK and from gossip/conversation within social groups. The ongoing confusion associated with FGM as well as religious communities in the UK’s roles in spreading FGM-related messages warrants attention and clarification, particularly as women report the effects of discovering the misguidance as destructive.

The effects are, we thought that this was religious practise – that was a big damage to us because it is like somebody who was convicted to be hanged [death penalty by court of law] but later found out that it was a mistake to us. Circumcision is like that, our mothers were told you must do it in the name of religion and later on when they studied the Quran they found out it forbids us and that is devastating. Some people feel guilt and feel distressed to see their daughter suffer because of what they have done to them. Also they do know how they are suffering because the same thing happened to them. (Somali woman, 35)

3.2.2 How people in the community feel about FGM

Beliefs around FGM may be influenced by a number of different factors, and vary according to gender, age, education, and country of birth/long term residency. An overview of perceptions by group is presented.

Men

As the culture of silence surrounding FGM makes it difficult to be certain of male opinion and as this study did not interview men directly, the following are inferences of men’s beliefs and understanding of FGM. Men’s roles in setting expectations for marriage and perpetuating FGM were clearly important and there was some evidence that male attitudes towards FGM may be shifting, especially among younger generations. Respondents described men as anti-FGM, pro-FGM, or unaware/indifferent to FGM, but agreed that opinion among men continues to change as groups become more settled in Birmingham and aware of its risks.

In women’s narratives, some men were believed to be against FGM and would not want this practise continued for their daughters as they are aware of the consequences they have witnessed with their wives.

Desiring to have a partner who enjoyed or at least had some sexual feeling was also perceived to be important to some men, and as a result women said they were aware of instances where men avoided marrying a circumcised woman.

The women go through pain and the men know too – I hear men talk, and – like my brother he married a woman who is not circumcised and he says it is not painful for her or for him and it’s better for both of us. Nadia hears this too – she has a lot of friends from Somalia – they hear a lot of men making a joke of it –
saying that if you are with a circumcised woman, she’s like a doll – she doesn’t feel anything – she just lays down. Even the Somalian boys know it’s not good to be with a Somalian girl because they don’t have any feeling. This is the young people. Nadia has not heard that much from Eritrean boys. (Sudanese woman, 30)

Other men appear to continue to value FGM and women stated that although they do not openly discuss it, they "want their wives done" for reasons discussed more in depth later. However, the shift in attitude can be seen in the story below.

*I heard a story about one woman, when she married and when the family sent the girl for the husband. When he found the wife was not cut, he was surprised and he sent her back to the family...The girl’s family were in America and he was in Birmingham. He was living here in Birmingham and he is Somalian. She was born there and he came here when he was 16 years and thought it was something done for the ladies. It was an arranged marriage for her to come here.*

*This was in 2006, she was here then she disappeared. Then after some time, we heard from the man that he is a stupid man. Asha overheard the conversation between two men – he sent his wife back. The men thought he was stupid for sending her back. The men said that he was worried that he could not control his wife. One man said, ‘maybe he’s right – maybe he can’t control her – she’s beautiful and she’s educated’. (Somali woman, 33)*

Although the story above is likely uncommon, peer researchers corroborated that incidents of impending or new marriages in which the husband disapproved of the wife’s FGM or lack thereof did sometimes result in an annulment of the union.

A further group of women felt that men were largely unaware of what is involved with FGM or that they were indifferent and did not express a preference for circumcised or uncircumcised partners in Birmingham today.

Although only four women originated from West Africa, all four respondents expressed that men from their communities were decidedly still pro-FGM whereas Horn of Africa communities described more variability, and several emphasised a shifting attitude towards anti-FGM.

**Women**

Again women do not often speak about this issue, but a variety of views were described in the communities.

*[Women just] get on with their lives [and don’t discuss it].* (Somali woman, 24)

It was felt that many women still believe it is necessary to control their daughters, however they are not necessarily practising FGM as a means of achieving this control. A clear generational difference is explored below.

**Older versus younger generations**

On the whole it was perceived that older women and men (>35) and those who had not been long in the UK were still very much committed to continuing the practise of FGM and believed it to be beneficial, if not essential, to a young woman’s life particularly in the UK environment as, “UK [born/raised] girls are out of control”.
The older generation tends to still have the mentality that it is the right thing to do. They still believe it is in the best interest of the girl and most of the times have this mentality of ‘it’s been done to me and I turned out just fine’. They also believe that if a girl is not circumcised then she will be extremely horny and won’t be able to resist temptation. Of course not all older people have this mentality, some of them are turning back to their ‘dean’ (religion) and realise now that what was done to them was wrong and they are strongly against doing it to their daughters. (Somali woman, 24)

Older people will do to their children as it is in their culture otherwise it will bring shame on their family. They feel it is the correct thing to do [circumcision]. They feel that a girl will not find a suitable husband if she is not circumcised. It is slowly dying out in our community. There is more awareness now in terms of health, it isn’t a taboo anymore to talk about circumcision publicly. It is realised that it is a cultural thing and not a religious thing. Culture and religion was mixed, they used to think anything that was culture had something to do with religion. (Somali woman, 39)

There was general consensus that attitudes among the elder groups was changing with time and increased awareness of the risks and lack of benefits.

Younger men and women, who are generally seen to be increasingly bicultural adopting mixed traditions and beliefs, are also more decidedly against continuation of FGM if they are aware of it at all. Respondents regularly commented that young people were “unaware” or “unaffected” by FGM today.

The young generation, they don’t think about these things anymore. Even if a young woman is circumcised they will not do it to their children. (Somali woman, 39)

Education level

Women seemed to agree that education level and particularly level of awareness of FGM influenced whether one expected to continue practising FGM. Better educated women and men were viewed as more aware of implications citing only risks and no benefits of circumcision. They were also thought to be more proactive and confident in speaking out against FGM and more likely to be involved in campaigning, though there was little evidence for current campaigning among respondents.

Educated people tend to be more aware of the health implications and psychological problems this can cause to a woman and therefore most young educated men would not want their future wife to be circumcised. Some uneducated men still see this as ‘dhaqan’ (tradition) and prefer a woman that is in fact circumcised. They don’t fully grasp the implications it causes not only on the girl but also for their marriage. (Somali woman, 25)

Educated [people] are more open-minded, they meet other people from different backgrounds. They talk about things; they form their OWN opinions. They won’t say, my parents said this so this is the way it is. (Somali woman, 39)

However, as educated women are still subject to strong cultural pressure for circumcision, better educated women may still experience or perpetuate the practise.
She said to me that because of the illiteracy many say that it is good and that a girl cannot get married without undergoing a circumcision (i.e. women who have not been schooled are less aware of the side effects or negative effects of circumcision, so think it's a good thing. But she said that even older women – like her mum – who have been educated can be circumcised. They think the girl won’t find someone to marry her, and the family will be ‘dishonoured’ because they will think that the girl can go out and do what she wants. They will not want to take the risk that she may have been with someone else before – with a circumcision, you can tell if a woman has been with someone before, or if she does ‘not feeling something’. It she does not feel something, she has been with someone else). (Sudanese woman, 30)

Men and women were viewed to be accessing more information and heightened awareness which discouraged FGM both in Africa and Birmingham.

It’s dying out even in Africa, there is awareness. In Somalia there is a car with a microphone that travels around to protest against circumcision. They inform people who live in the villages about the detrimental health effects…to open the taboo and to talk about it. (Somali woman, 39)

Country of origin / long term residence

Those born in the UK were viewed to have largely been privy to better education and were adopting more ‘Western’ or bicultural practises. UK born women (and men) were expected to largely be “strongly against it”.

UK is quite different, people who are born here are exposed to another way of life, another culture and because of that circumcision is not an issue. (Eritrean woman, 30)

People in UK that have grown up here have a totally different mind. Having said that, initially years ago women were not fully integrated yet into the European society, they want to circumcise their daughters but there was no means to get [to] perform the circumcision. They used to go out [of] country (i.e. Somalia) to perform it. Young women in the UK who are up to 25 years approximately would not be circumcised. If they came here as a young child. Because they came to a new country, circumcisers are not available, no means to go back to Somalia, also there was increased awareness; [the] practise [is] slowly dying out. (Somali woman, 39)

As with education level however, not all women believed being born in the UK or having lived here for a considerable period meant attitudes had shifted fully to being against FGM and felt that some individuals were holding onto this practise in Birmingham regardless of level of education.

She said that her friend has a young sister. When she got married the mother of the groom asked the bride’s mother before the wedding day if her daughter is cut or not. The mother was shocked because the son was born here in England so she had not expected her to ask about that because he was educated. They did get married though. (Somali woman, 33)
3.2.3 Continuation of the practise

On the whole, FGM is believed to be on the decrease in Birmingham communities.

Nyla said that it doesn’t happen here and before, people took their daughters home to get this done, but it doesn’t happen now like it did before. I think it doesn’t happen so much because we know more about it now – we talk more about it and people are more aware of the risks and dangers to the girl. (Sudanese woman, 30)

Throughout interviews some disagreement arose as to whether people from Birmingham hoped to sustain the tradition of circumcision, with some asserting “not in the UK”, “No!” whereas others were less certain. Even throughout the research process, peer researchers changed position, initially asserting it was not something done to UK-based girls, but in the final workshop acknowledged that it may be happening to young women living in the UK but probably performed abroad.

I have heard people say ‘sunna’ can continue but it is not must to practise it. People say if somebody does not know what the Quran says about circumcision they will continue because they don’t know it is wrong and ‘sunna’ will continue even though it is not in the Quran [because] people say it is in the ‘hadith’. I don’t know, people are different, there [are] some who are religious and there are some who are not; there are some who are traditional. So I don’t know who wants to continue. Maybe the religious ones will want to continue ‘sunna’ because they are always saying ‘sunna’ is in our ‘hadith’ and even though it is not a must but it is good to do something extra when you are religious. For example pray extra. (Somali woman, 35)

Some narratives stated that it does not happen in the UK or with communities based here – only “back home” and within older groups. However, other respondents shared first hand experience of encountering normally UK resident women abroad requesting circumcision for their daughters.

When I was in Eritrea, I have seen Eritrean people come from overseas like UK and performing ‘tahara’. (Eritrean woman, 30)

The general consensus was that older, less FGM-aware or newly arrived groups with little information would be more likely to perpetuate the practise, particularly if they are unaware of the legal context in the UK. Conversely, UK-born and those more familiar with British society may see legality as a tool to abandon the practise.

Hoda said if they were born here, they see it as a crime to do circumcision – they don’t see a reason to do that. If there is pressure to be circumcised the pressure usually comes from those who have not been here for a long time. The men still want her to be a virgin, but they will accept for a daughter to be un-circumcised. (Somali woman, 30)

Unfortunately there are many out there that are keeping this improper practise alive, so yes I think no matter what is happening they will still carry on. Even now in my country people who do circumcision end in prison for three years, but they do it undercover. Here in Birmingham she thought that people don’t want to do it. Ayda said she was sitting with a group of women, and that a mum was saying how she wanted to take her granddaughter to Sudan to have it done on her. At that time, there were a few people there and my friend told her that [if] I know that you travel with that girl, I will tell the authorities. I will report it
that you’ve done that on her. That woman was so upset and doesn’t talk to that
girl anymore. She said ‘how could you talk to me like that? I’m older than you?’.
She tried to explain that it’s a crime and people die from that, but the woman
said it was her tradition. None of the other women said anything and that
woman did not take her granddaughter up to this day; but she never forgot her
friends. (Sudanese woman, 30)

One of the peer researchers used the law as a strategy and directly confronted her
mother when asked about taking her children back for the procedure responding that
“I will go to prison”. We then had a discussion about how the law and punishment act
as a potential tool for women like her to say no to having their daughter’s
circumcised. It is one means in which they do not have to be seen to challenge their
culture or their elders. “It is easier to say no with the law as an excuse”.

3.2.4 Circumcision practises

Despite respondents originating from a variety of countries, tribes and religious
backgrounds, the experiences of circumcision were often very similar. It should be
noted these accounts are not from within the UK but rather took place in countries of
origin. As was previously described, there were two types of circumcision for women
in this study: ‘sunna’ and ‘pharaoni’.

In line with other research findings, most commonly the grandmother or possibly an
older and ‘known circumciser’ in the communities will perform the procedure. Very
seldom did women believe anyone with medical training or access to sterile tools was
involved. With few exceptions, women reported the family home of the girl
undergoing the procedure to be the chosen location, although some communities
have designated ‘huts’ for this. Age of circumcision ranged quite widely across
groups from two years to 20, however almost all reported circumcision takes place
“before puberty” with age six to nine most common. This younger age was related to
the need to be able to “hold the girl down” which becomes more difficult as girls get
older and also so that one might “forget” the experience.

Notably, the older cases of FGM were among West African women only. Conversely
to the Horn of Africa communities, this may be linked with one girl’s assertion that
they hope for you “to remember everything so you won’t do anything bad”, alluding to
circumcision as a tool to prevent girls from being sexual beings.

3.2.5 Reasoning behind FGM

The following is an overview of the main reasons given by respondents supporting or
deterring them from the practise of female circumcision.

Arguments for FGM

A belief that girls are subject to great temptation and lack the ability to ‘control
themselves' emerged time and time again. Lack of ability to control oneself was in
the context of pre-marital sex and infidelity in marriage.

[FGM is done] so that the girl doesn’t get tempted to have sex with anyone
except her husband. (Somali woman, 24)

Men want a woman to be circumcised. If a woman is not circumcised she can
cheat. (Sierre Leonean woman, 20)
One of the peer researchers shared that her brother had told her, “that if you light a match once, it burns and burns; the match being told as a metaphor for having sex once, then not being able to stop”

Marriageability remains dependent in many communities on girls ensuring their ‘purity’ and ‘cleanliness’. Marriage is, as noted in previous discussions, still desired if not required for women to start their own families even within these communities in Birmingham.

Some people say it doesn’t make a difference if you are circumcised and some people say it is our culture so we must do it – if you don’t do it you don’t get married so it does make a difference because of marriage. (Sierra Leonean woman, 20)

Additionally, concepts of ‘dirt’ and ‘uncleanliness’ may be used to ridicule uncircumcised women, convincing them FGM is necessary to ensure attractiveness or acceptability to others.

FGM as a tool to maintain a girl’s virginity is essential for some groups to marry a daughter off to “a good man”. Circumcision becomes a must, “So the husband is for sure that the girl he married is still a virgin” and in addition to ensuring ‘virtue’, sexual benefits were insinuated: “for his benefit; he will be pleased”.

As girls are often viewed to be unable to ‘control’ their desires, control must therefore be assumed by mothers and fathers and later husbands. Stories are often used to warn young girls and women from sex outside of marriage.

There is no hadith, but because people want to control the ladies this is why they do circumcision. It is very forbidden for daughters to have a relationship with anyone out of marriage. A story is told to daughters about a man who took his family to the jumble, far far away from anywhere and anyone so that he could protect his daughter. He grew old and sick, and his daughter fell in love. Over time, she found a baobab tree and each day she cleared the trunk a little bit more to make a bed for herself and her loved one. When it was ready she took her loved one there and she lay with him and became pregnant. The father found out, and even though he was sick and old, he killed her. This is the story that is told to warn daughters against pre-marital relationships. (Sudanese woman, 47)

When a girl is having her period, her genitals are receptive to sperm and can become pregnant even by sitting on her brother’s bed. This is a story that is told and encourages girls to wear many layers to stop this happening. (Sudanese woman, 30)

The reason they perform ‘tahara’ is to control women/girls’ sexuality so women will not have sex with other men when their husbands go on long trips. (Eritrean woman, 30)

Despite many women being more aware of the related risks of FGM, and against ‘pharaoni’ circumcision some believe the argument to “still do type I” is “for their own safety – to control their daughter’s sexuality”.

One researcher summed up the many arguments for FGM from a recent experience visiting a circle of older women from her community.
They [the older women] tell [my friend] that if she doesn’t [have circumcision] people will avoid her and see less of her. They will think she is dirty and not clean and they will laugh at her because she can’t control her feelings and that she might go with anyone. The older people tell you this. Even if you keep moving in the chair (squirming), they will joke with you if you can’t sit still – they will joke, ‘what’s wrong with you? Haven’t you been cut?’ A circumcised woman will just sit still. Or they might joke that ‘I think they didn’t cut you properly. We will have to get the lady to come and see you again’. You just laugh it off. (Sudanese woman, 30)

Arguments against FGM

As communities in Birmingham and countries of origin continue to increase their awareness of the consequences of FGM (which will be described in more detail in Section 3.3), men and women are better able to argue against the practise.

Understanding the various health implications, realising the equipment used to perform procedures is often unclean and dangerous, and pain during the circumcision, in marital sex lives and in birth are all arguments against FGM.

As described before, the law in the UK has also become a tool and argument against circumcision which some women are invoking in their own lives to end the practise in their own families.

Religious arguments and clarification from religious leaders against FGM, although still in need of further exploration, have contributed to women and men, particularly younger generations, condemning the practise.

Women in Birmingham also highlighted that although marriage is still central to their communities and families, circumcision is no longer a “strict requirement for marriage now” as it may be at home or in previous times. This was attributed to men’s desire to have wives who may enjoy sex and also better understanding on both men and women’s parts of the health risks involved in circumcision, particularly for sex and pregnancy/delivery.

3.2.6 Pressure to circumcise

The role of tradition

It is what our mothers did before us and what everybody is doing in their community. It is our tradition. (Somali woman, 35)

Women and their families are, as we have previously discussed, in a period of transition, adjustment and settling into new communities with opportunities and challenges that come with living in a new cultural context. As many of them highlighted in their perceptions of social integration, maintaining cultural links through food, language, clothing, and places of worship helps to ease this transition and maintain traditions. Tradition can also, however, become outdated or unsuitable to new contexts or, as with FGM, recognised as detrimental to the individual and community at large. Nevertheless, the concept of FGM as a tradition in many of these communities sustains a pressure to continue the practise which, for some, is difficult to resist.

A number of women agreed that viewing circumcision as a necessary tradition was more pervasive in older age groups, those with less education, and those less
familiar with the UK context. Women from these communities are often mobile, spending considerable periods of time in their countries of origin and then returning to Birmingham, presenting a unique challenge to adjusting themselves to suit the role of 'insider' depending on where they are based and with whom they are surrounded.

Pressure to sustain tradition from "back home" featured prominently in narratives. Although women in Birmingham may feel they have the tools in the UK to argue against FGM and may feel 'lesser' in comparison to uncircumcised women in the UK (as will be elaborated later), they sometimes face the opposite pressures when returning home as FGM is normalised in those communities. What is deemed the 'insider' in Birmingham may paint them as "rebellious", "forgetting their culture" or an outsider in their home context. The pressure to 'fit in' with regards to FGM should not be underestimated. Several women communicated that pressure to conform with communities back home continued to play on them or their daughters now in their visits home.

The people in the community and children that have already been done will tease you and pressure your family to circumcise you. If someone has not been circumcised they can't go anywhere, for example the market or madarasa or school without being teased or being called names by everybody. The mother is pressured to circumcise her daughter because her daughter will not be married if she is not circumcised. (Somali woman, 35)

Holiday times in particular appear to be windows during which traditional pressures from back home and teasing by community members is likely to occur as many women and girls return home.

Women say there is a girl, she [did] not have FGM. She went on holiday and she told her cousin that she [did] not have it done. For her next day all her age were shock about what they hear [sic]! And they were kept laughs at her, told [her] you are Giph [sic]. She was so upset the way they treated [her] and she is not clean so who will marry her so [she is] better to go back [maybe she] can find someone can marry [her]. (Sudanese woman, 25)

For instance, holiday back at home [Somalia] it is still done for girls – less severe one [Type I]. They find it strange that you don't want your child to be circumcised. They ask, 'why don't you fix your child before you go back? You have the chance now to do it'. (Somali woman, 39)

Ultimately, mothers are generally left to make final decisions regarding their daughter’s circumcision. Although a father can prevent this if he decidedly forbids it, mothers arrange procedures and are consequently responsible for their daughter’s behaviour should they choose not to circumcise. This pressure can be great for some women who report mothers being pushed from the family home in instances where daughter’s have ‘misbehaved’ and engaged in pre or extramarital relationships. Though this is rare, respondents were aware of the significant decision which faces many, generally older, mothers in Birmingham as they continue to grapple with living in mixed cultural contexts with sometimes competing and incompatible pressures.

3.3 The wider implications of FGM

Women described a considerable range of detrimental effects to their emotional, physical and sexual wellbeing as a result of circumcision, more severely for women who had ‘pharaonic’ or type III circumcision.
3.3.1 Effects of circumcision on women’s lives

Emotional and psychosocial wellbeing

Participants described a range of emotional and psychological reactions to FGM; some women said that they had not heard anyone expressing detrimental effects of FGM on emotional wellbeing and others described themselves as victims. The culture of silence surrounding circumcision may contribute to some individuals’ limited acknowledgment or awareness of emotional consequences.

Severity of circumcision contributed to degrees of perceived emotional distress.

[It] depends on the degree of circumcision, I can’t really say because I’m not sure. I don’t feel it has these implications; maybe because my degree of circumcision was not severe. I haven’t heard anyone complaining about these complications. I’ve heard that there are books out there that talk about this. I think overall maybe that our community doesn’t see this as emotionally distressing. (Somali woman, 33)

Some women described feeling ‘uncomfortable’ with women from non-practising communities who were uncircumcised. Close relationships outside of a woman’s own community were limited, although women engaged in comparisons to others which sometimes contributed to significant feelings of inadequacy or “incompleteness as women”, which only developed upon relocating to the UK. Low self-confidence and feeling like “less of a woman” played heavily on some women’s minds.

She feels something is missing in her body that makes her fewer woman [sic], not enjoying life. Because she has gone through circumcision it makes her worry too much, when she is in her home country she feels ok because other people are in similar situation but in western countries she feels she could have benefitted from having all her genitals; these things make her angry and emotionally it is hurting her. (Eritrean woman, 24)

She said to me sure the circumcision of females affects the emotional female because she feels she is different from other women; maybe if she did not have FGM…she live [a] normal…life. (Somali woman, 35)

Some women spoke in terms of feeling victimised, and some described their mothers who allowed their circumcision as victims of ignorance. A couple of individuals described going through a process to finally “forgive” mothers and other perpetrators in their communities, while several other respondents felt mother/daughter relations were permanently damaged by the experience and believed that the act was “unforgivable”.

[The] majority of Somali people have forgiven their mothers. They feel their mothers did not know any better; they are victims themselves. (Somali woman, 35)

Finally, in the context of Birmingham, several, generally older, respondents reported feeling judged by the wider community and in daily interactions with various service providers in the community specifically about FGM, which led to further emotional distress. This judgment, along with traditional dress, were the two areas seemingly contradicting the earlier positive overall experiences of living in Birmingham.
It is something that was done to us and now that we are in western countries where circumcision is not practice the community feels they are asked about circumcision and they feel embarrassed. Questions like ‘were you done?’ and ‘why do you practise circumcision?’ and you could see on their face, ‘how does it look like?’ and you feel that they are about to look at you down there. Those people are like your colleagues or your school mates, community workers, police, etc. (not a medical person)….that affects your mind. (Somali woman, 35)

Physical wellbeing

The physical consequences of FGM were common across most women citing:

- chronic pain
- pain during menstruation
- difficulty passing blood or excessive bleeding during menstruation
- infections from the procedure
- repeat infections / urinary tract infections
- difficulty or pain urinating
- pain related to sexual intercourse (elaborated further below)
- numbness
- difficulty in pregnancy and more specifically
- higher risk, painful labour/delivery and possible inability to have natural birth

She did type three; she feels very bad pain she have [sic] her period. I know one of my friends when the period comes to her she have [sic] to be on the bed three to four days, she can’t go to her work every month. (Somali woman, 35)

A handful of narratives stated physical consequences of FGM only related to childbirth and not to other areas of physical health and did not recognise additional symptoms among their friends as potentially resulting from circumcision.

Sexual wellbeing

Sexual difficulties were not only extensive and pervasive among respondents, but their impact went beyond the marital bed.

Lack of sensation and diminished or lack of sexual desire was reported by a number of women and sex was described as something done “for the husband” only.

Pain and difficulty during intercourse, particularly at first intercourse, was a common experience but one that relates to traditional cultural expectations for the husband to “open” his new bride himself; the pain and blood loss that results from first intercourse is culturally viewed as proof of the woman’s virginity.

She said it is affecting her sexual life when she [has sex] with her husband, she feels very bad pain. She said, ‘I heard one girl when she married, [the] first day after her wedding in the night her husband tried to open her virgin many time [sic] but he couldn’t because his wife had type three and it was difficult to reach her. Then he took his wife to the doctor to open her virgin [sic] which they have to ask the doctor for [a] certificate to prove she was a virgin. (Somali woman, 35)

One individual spoke directly about an attitudinal shift that in the context of Birmingham it now seems more accepted for men to take their wives for de-
infibulation prior to first intercourse. As it was unaddressed by other respondents and peer researchers it may be that stigma persists around this issue among some communities in Birmingham and therefore it may benefit from further exploration particularly in the context of available clinic data from HEFT.

When a woman marries, it used to be embarrassing for the husband to take his wife to the hospital to be cut or opened so that she can have sex; he had to do it himself using only his penis so people will see him as a man and because of this all the women who have been opened by their husbands bleed severely...in UK all husbands in our community will [avoid] that tradition because they will never feel embarrassed about asking their wife to consult a doctor because they know people in our community these days will not see them as not being man enough, but will judge them as an evil man if they do it themselves. Plus no woman in our community will let her husband to do that [sic], so that tradition has changed to mean the opposite these days. (Somali woman, 35)

Both men and women complained that circumcised women did not enjoy sexual activities with their partners because of the pain associated with FGM, and that this was described as upsetting for both sexes. This reflects a positive change in attitude away from FGM as a prerequisite for marriage, men may more commonly want a partner who can engage in sexual activity out of choice and desire.

During sex she feels nothing and she just lies there like an object, no response. They [the community] say there is no sexual feeling. (Sudanese woman, 33)

You hear complaints from men; you hear that their wives don’t participate in ‘lovemaking’. I hate using this word but this is why they tend to ask the extent of circumcision before marriage. Men say that women just lie there during sex. Men feel their circumcised partners don’t feel anything and they don’t like that anymore. They are men aged between 20 to 40. (Somali woman, 33)

Generally people say like if I compare Eritrea, men prefer Ethiopian women than Eritrean women because Ethiopian women are not circumcised. (Eritrean woman, 30)

A key finding of women’s experiences of health complications, was that women described working collectively to influence one another and ultimately have an impact on the marriage and, therefore possibly the family unit.

An Eritrean woman [in Birmingham] wanted a divorce when the elderly from the community went to her and asked why she wants a divorce she said she has been trying hard to keep her marriage going. Even she was not enjoying married life, she said she had no feeling at all, it is the husband who is initiating [sex] and he always complains [about] her sex drive. For a long time the marriage was like this but now she doesn’t want to continue because it has no meaning for her. In the end she had to share this information with elderly who were trying to bring them together, but she did not want to share because she felt ashamed as well as embarrassed. In the end they got divorced. (Eritrean woman, 30)

It affects her sexual life because there is no sexual feeling and isn’t motivated sexually and there is pain during sex. She is not happy with her sexual life and her husband is not [happy]. Eventually the marriage will deteriorate because she is not feeling sexually active. She feels one day her husband might leave
her for another woman. It makes her feel less of a woman and she feels depressed. (Eritrean woman, 24)

3.3.2 Experiences with Birmingham health and other services

Lack of awareness of where and how to find appropriate health support for FGM related complications is present among some women in the community. This was largely associated with older women with limited English skills or those newly arrived to the UK who may need additional assistance in identifying and accessing services.

A number of women expressed feelings of shame, embarrassment or even fear to approach health services in Birmingham communicating concerns of being judged individually or of their culture being judged. Fear and potential stigma from community reactions to seeking services was also described.

Although some participants described some positive experiences of the health service, an overall negative picture of NHS services emerged. Women’s perceptions of health staff’s beliefs about their communities extended to assertions that they are sometimes unfairly treated based on being a minority group, and perhaps from a particular community. In particular, feeling dismissed or not being listened to were prominent concerns, and some women felt that GPs and GP staff were disinterested in exploring complaints of ailments, including non-FGM related ailments, thoroughly.

It should be stressed however that these are firstly perceptions and secondly that these perceptions may be somewhat born out of lack of familiarity with the UK health, and in particular primary care, system and standard procedures.

When I look back I ask myself why the emergency department and GP did not take my sister’s suffering seriously. Is it because we are less humans? What if we were rich or different race, would they have investigated my sister’s pain quicker? [The] majority of Somalis don’t trust the UK medical personnel; they go to a private German doctor in Mosley, Birmingham. (Somali woman, 39)

When we visit GP, the doctor automatically thinks you are just there for fun and you like to come to the doctors and you just want medicine. The day I get sick God forbid, I dread going to the doctors. The medical personnel in Birmingham think that all Somalis are [the] same; they don’t see us as individuals…or maybe they don’t like us. (Somali woman, 35)

The community always complain about NHS; they say the health service is poor; the doctor doesn’t want to know what is really wrong with you when you go visit him, he will only prescribe painkiller. So some people prefer not to go to the doctor when they are sick because it is always the same so they will say it is better to stay home and see what happens. Eritrean people feel that the health people [are] always undermining them. Some of the GP receptionists will not book you an appointment when you call unless you tell them what is wrong and then they will say we will call back. Then the nurse calls back [and] she will again ask you what is wrong with you again; then if she feels you don’t have to see the doctor then she just prescribes you painkillers. There was one woman who was suffering internal problems…she died because of poor health service. She dies of appendicitis inflammation; she could have been helped but doctors kept giving her painkillers never stopping to investigate…in the end they were too late. (Eritrean woman, 30)

Such perceptions shared within the community can, however, contribute to avoidance of health services for FGM complications.
Some women felt they could benefit from information or services around their FGM from GPs, but because of lack of awareness or linguistic barriers among health providers and women, they feel inhibited to initiate those conversations. Additionally, health providers may fail to meet them halfway by raising the issue.

_Most of the people say the health personnel and GP don’t know about circumcision and they don’t ask or offer information. People don’t know about the affects of circumcision during childbirth until they get pregnant and see their midwife who tells them about circumcision. It is difficult to find information and help because language and the health service don’t talk about it._ (Eritrean woman, 24)

_They don’t know where to go and the GP don’t ask [sic] about if [you are] circumcised; for example when they first register with GP – they don’t ask if you had circumcision._ (Eritrean woman, 24)

Conversely, some women felt health staff asked too many questions and were inappropriately intrusive into other areas of women’s lives they felt were unrelated to their presentation with FGM complications.

_Approaching health service is [a] headache for them. Health services will visit the women and they ask the woman how is [your] husband? The healthcare service ask too [many] private questions and women think they will bring problems. Back in our home country nobody will ask you about your private life when you see health professionals for physical health, but here in UK healthcare personnel will ask you too much questions [sic] about your private life and people in my community think this kind of questions [sic] will bring either depressions or cause the husband and wife to have marital problems. In our culture we don’t talk to strangers about our private life; we only talk to friends you trust and family members._ (Sudanese woman, 30)

As other evidence from this research shows, often women are experiencing a complex array of difficulties which involve psychosocial and sexual wellbeing and marital challenges which many women may value the opportunity to share and receive support for. This presents the need for healthcare staff to recognise when symptoms may be associated with FGM and to then practise informed questioning, taking an individual’s wider needs into consideration, endeavouring to strike a balance between appropriate care and being sensitive to the individual and her circumstances.

However, GPs were also viewed by some women as the first point of reference for health issues and the venue which they most prefer to receive information and advice from. Women also largely believe that going through a GP is often necessary before referrals to more specialist FGM services might become an option.

Ultimately, referrals were welcomed and women who obtained them felt the care in specialist services, whether FGM related or otherwise, was much improved from primary care. However, referrals were viewed to “take a long time” and some women may not be capable of pursuing GPs to move onto specialists due to language barriers, coming from cultures in which “pushing” doctors is not viewed favourably, or as many woman, particularly newly arrived and older, may be unaware of the option for further help.
3.3.3 Birmingham’s African Well Women’s Clinic

A substantial proportion of respondents and peer researchers had never heard of Birmingham’s Well Women’s Clinic, while the rest were under the impression that women were only made aware of this service during pregnancy when midwives informed them.

They have no idea where the clinic is. When women get pregnant they get information from [a] midwife and later from [the] Health Visitor but nobody talks about circumcision. My friend who is pregnant was asked by the midwife if she had circumcision and when she said yes the midwife told her she will have problems when giving birth, midwife explained to her about cutting so she is able to have the baby. (Eritrean woman, 30)

Nowadays help is given to pregnant ladies but not other women. Pregnant women will be offered help like reversal. (Somali woman, 39)

She said that women who already had a baby at the hospital know about it because when they get to the hospital for scan and blood test or give birth the midwife asks if you are FGM practise and do you need any help to be open? (Somali woman, 35)

Respondents provided evidence that GPs and maternity staff had not made referrals to the Well Women’s clinic when it would have been appropriate:

She said that her friend was FGM and she had heard that she can get it open before delivery, but unfortunately her midwife didn’t know about the clinic in Heartland Hospital. Her friend stopped searching for that and when she was going to have the labour it was so difficult. The baby came fast and they didn’t have time to open her first so she [tore] under the delivery and could not walk normal for more than three or four months. (Somali woman, 35)

Women with experience with the Well Women’s clinic were very complimentary describing staff as “helpful” and respectful.

Complexities of “being opened”

In discussing the various types of support available through the Well Women’s clinic, many women raised the issue of de-infibulation. Some women felt that they were not asked early enough in pregnancy about whether they wanted to undergo de-infibulation before or during labour; this preference varies between individuals.

My friend who was pregnant was opened; when my friend was in labour the midwife told her that she needed to be opened. That made my friend frustrated and upset because she would have preferred to be opened in the beginning of her pregnancy instead of now when she was in labour. (Sierra Leonean woman, 20)

De-infibulation was regularly mistakenly referred to as “reversal” and remains somewhat unclear from interviews whether women fully understood the difference and that de-infibulation cannot return a woman’s genitalia to its original state, or whether that was simply colloquial language for the procedure.

Additionally, and importantly for healthcare staff working in FGM services, the experience of “being opened” was, for some, cause for emotional or physical
discomfort and potential difficulties in relationships or the cause of possible stigma from their communities. Not all women wish to undergo de-infibulation and may wish to be “closed up again”. As UK law prevents this, women may undergo procedures considered more ‘cosmetic’ or may return to their countries of origin for re-infibulation.

A friend who had a baby in Sudan was stitched back when she had the baby. When she came to Birmingham she had another baby, but she was not stitched back. She feels uncomfortable (after de-infibulation) because she’s used to being closed. She feels like the air is breezy down there and she feels it’s all open, and she wished that they did close her back. Other people in the community accuse her of wanting this for her husband, because he gives her gifts because he will be happy with that, so he will shower he with gifts. But she says that’s not it (the reason). She says, ‘all my life I was closed and that’s what I’m used to. Anything else I am not used to it – if it’s good, or if it’s right or if it’s painful’. (Sudanese woman, 30)

[A] woman who was circumcised [suffered]; she had trouble with period, trouble urinating, general pains, poor blood flow. Doctor advised her to reverse (de-infibulation). She was in a dilemma because of culture. She had it reversed secretly. She only had it reversed for health reasons. [Her] husband didn’t care. (Somali woman, 39)

For example, a Somali lady did vaginal rejuvenation since she already had children; she wasn’t planning on having other children. She had an unexpected pregnancy long after this operation. She chose elective C-section so as not to ‘ruin’ herself downstairs. She was previously circumcised. She also did a laser treatment, to make it ‘tighter’. (Somali woman, 40)

She said the GP, if we enquire [with] him or her in general about this issue no one asked [sic] [answered]. But my friend told me even when the woman gives birth, they just open her, take baby out and leave her like that (open). And six months later she went back to her country (Sudan)...she did it again. Her husband requested. (Sudanese woman, 30)

During the final feedback workshop with researchers, women previously unaware of the option for de-infibulation articulated sincere optimism that this was finally an opportunity to “do something for ourselves”.
3.3.4 Access to help and information

In general, women expressed difficulty in finding information and signposting on to support services for FGM related issues. Younger women appeared to have a better command of electronic media and the internet was cited as a potentially very useful source of information and advice. However, older women stated this was “only good for young people who use those tools” and additionally that it is “only good if language skills are good”.

One woman declared that information should be readily available to the community; it should be “right under our noses”.

Taking into account previous conclusions on social integration behaviours, access to education services and places of employment as well as language skills, some women are restricted in their means of accessing quality information and may not be in a position to seek it out themselves.

In discussing ideal venues or trusted sources for information on FGM, the peer researchers recognised potential in women from their own communities, GPs, religious leaders and other healthcare services. They collectively stressed the need to encourage “talking openly” across communities and listed the following priority areas for improved information and advice:

- Newcomers’ need for additional/tailored information, particularly health related
- Raising awareness in all communities, not just practising groups
- Access to services / support groups
- Increased partnership working with churches and mosques
- GPs should be playing a bigger role

3.3.5 The role of advocacy in FGM

A number of women described how the culture of silence around FGM contributed to difficulty in identifying allies in the community as it is sometimes uncertain who is still for or against practising circumcision. Older women, with some agreement from younger girls, felt that openly advocating on FGM was “young people’s territory”. However, young women expressed feeling unaware of the issue and/or unskilled to engage in targeted or effective advocacy efforts, such as awareness raising campaigns.

Individuals from within practising communities were viewed as more trusted, non-judgemental sources of information and advice than those who come from outside the community. Conversely, advocates seen to be ‘officials’ are sources of anxiety or even offense if not linked or familiar to communities.

Some people are for circumcision like ‘sunna’; some are against and some are embarrassed about it. When government creates workers to raise awareness people in the community think different, they think the workers are there to report badly on them so that they can be punished, so they don’t trust them when they ask about circumcision. If the teacher asks about circumcision they feel they want to accuse them. If the doctor or medical personnel asks them they feel they want to accuse them. The people in the community think the workers would always be suspicious of them; it does not matter if they tell them that they don’t practise circumcision anymore and would not practise ‘sunna’
either; they will still not believe them but instead cause problems for them or they will torment their daughters which is a no-no in our community. (Somali woman, 35)

People from Eritrea will be comfortable with their own people advocating against FGM because there is a language barrier and they will open up to their own people more. (Eritrean woman, 24)

Women communicated a clear preference for information and campaigns to be comprehensive in nature, integrating health, psychosocial, religious, cultural and legal messages as they are interconnected and interdependent in real life. This holistic approach is preferential as different people will respond or ‘buy-in’ to different types of messages. One size does not fit all in advocacy around FGM.

People say practising is [a] primitive way of living and it should stop as people advance [with] education and time; meaning the old ways should change. Educating people about the risk of circumcision will make them stop practising female circumcision. Also by telling people that it isn’t a religious requirement that will stop the practise for most people who think that it is a religious thing to do. Generally tell them not to change the natural body that God gave you and tell them about the advantages of not being circumcised. (Eritrean woman, 24)

3.3.6 FGM and UK law

Interviews positively revealed there is high awareness across communities of a law prohibiting FGM in the UK, but not all respondents were aware of the consequences of breaking this law, or that taking a child outside of the UK to practise circumcision was also illegal.

Messages were said to come from within the community in the UK, radio and TV campaigns back home. Public service announcements and campaigns were not readily recalled from living in Birmingham.

Several respondents and several more researchers stated that the community in Birmingham would still practise FGM if the law were not in place. However, this number was in the minority. A larger number of women reported knowing women who wanted to maintain the practise but who were effectively deterred out of fear of the law.

Finally, respondents gave examples in which women had been able to use the law as a tool for abandoning the practise with more traditional family and community members both in Birmingham and in their countries of origin. For example, on of the peer researchers confronted her mother and refused her requests to circumcise the grandchildren as she would “go to prison” and explicitly stated, “it is easier to say no with the law as an excuse”.
4. NEXT STEPS

The following section explores ways in which the research findings and particularly experiences of women from practising communities may inform next steps for agencies such as a BSWA and partners in order to improve the health and wellbeing of women and girl children at risk of or who have already experienced FGM in Birmingham.

4.1 Cross-cutting issues

Understanding risk and safety

This research indicates that FGM in Birmingham continues to be a safeguarding issue warranting continued efforts and attention. Overall peer data suggests FGM is on the decrease in Birmingham in terms of current intentions to circumcise girl children whether in the UK or by taking them back home for circumcision, however, narratives clearly described instances of normally UK-resident families returning to countries of origin for circumcision, as well as continued pressure from ‘back home’ and from older or more traditional members of Birmingham communities to sustain the practise. As such, it is important to not become complacent believing that young girls, even those born in the UK, may not be at risk anymore because of this trend. Risk for young women in Birmingham should not be underestimated as the generational shift articulated by respondents is young itself, i.e. age 30 appears to be a turning point for attitudes. Some of these women will not yet be married or have children presenting an opportunity to positively influence attitudes towards FGM for future generations. Additionally, recent data on migrant communities indicate that ongoing in-migration of women and families from practising countries will continue as a result of marriage and other means, and these newly arriving women may be at heightened risk. Finally, although risk is often discussed in terms of probability of experiencing FGM in the future, risk for women in the community already circumcised should not be dismissed in terms of health, pregnancy, psychological wellbeing and other areas of impact.

Immigration status and women’s lack to recourse emerged as a particular safeguarding issue in that women’s status was often attached to that of the husband’s and this was, in some instances used as a clear means of control and an active barrier for some women to access services both FGM/health related and otherwise, e.g. education and information services. In these circumstances this may constitute a wider issue of domestic abuse, emphasising the wider lived context in which FGM occurs.

Agencies such as BSWA, with extensive history and expertise in domestic violence and related issues, are particularly well placed to continue work on prevention and providing support for women in these circumstances. However, efforts can only be sustained and indeed improved if FGM remains firmly on the safeguarding agenda and involved agencies are subsequently sufficiently resourced to provide services to women/girl children.

The role of advocacy and community engagement

There is substantial evidence that awareness on FGM is limited. A number of women were unaware of their own circumcision until coming into contact with midwifery services in the UK. Women are keen to access more information on FGM, prevention, and options for care, support, and de-infibulation. Community education
and engagement is likely to be most effective as increased knowledge, particularly of health implications, was directly linked to abandonment of the practise. However the issue of FGM should be considered as part of a wider community development approach as it remains a highly sensitive and difficult topic to raise and, as discussions on life in Birmingham revealed, women and their families live complex lives facing a range of challenges and new opportunities. It is crucial for agencies working on FGM prevention/support in Birmingham to acknowledge that women may have different priorities and competing needs, such as housing, benefits, immigration, health and employment. By taking a wider community development approach, information on FGM may be better received by practising communities, minimising the sensitivity of raising the issue, whilst simultaneously increasing their awareness and use of other key issues / services they may wish to access.

Women emphasised the importance and preference for advocates for prevention to come from within practising communities, as they are more likely to be viewed as trusted sources of information and advice. That is not to say advocates from non-practising communities are unwelcomed or ineffective, but that opportunities to encourage local FGM ‘champions’ may add to programme or community-level recognition of FGM and related issues. Additionally, peer researchers created a list of suggested opportunities they felt were appropriate for advocates within communities and services to work together to raise awareness and engage communities in active discussions around FGM:

- Encourage cross-generational women’s discussion groups, organised by local FGM champions in practising communities
- Involve families, friends and, if possible, both genders, in forums and community discussions and, where appropriate, involve Well Women’s Clinic staff
- Campaign against FGM with non-practising and practising community members, i.e. women’s organisations, trusted religious leaders who maintain a clear anti-FGM stance, media, and ordinary members of the community
- Establish and sustain women’s groups in which leadership skills are regularly developed. This again promotes a wider community development approach.
- Support local groups working on community projects on FGM or related issues, e.g. domestic violence

Ultimately, for events and community engagement efforts to be successful, activities must be properly resourced with consideration for things such as appropriateness of venue, transportation for community members, food, availability of a crèche for those with children, etc.

**The importance of communication and language**

For many woman, particularly older or newly arrived women with limited access or knowledge of electronic sources such as the internet and English skills, access to information, advice, and support for FGM and related issues, is very challenging. Clear, thorough, readily available and culturally appropriate information is necessary to support and ultimately influence communities’ perceptions of FGM as a detrimental practise.

In line with a wider community development approach, women’s information preference was for integrated messaging, providing comprehensive information about health, relational, religious, cultural and legal aspects of the FGM debate to show united opinion from a wide range of perspectives of the negative effects of
circumcision. Additionally, as FGM is part of a spectrum of sexual/reproductive health and rights issues not openly discussed within these communities, opportunities to raise FGM alongside these additional issues using a rights-based approach should be considered.

Given challenges such as language or lack of computer literacy, considering means of delivering information directly into communities may be necessary. Examples from peer researchers included tailoring advocacy and informational materials by language groups and not forgetting less established groups such as the Eritrean community who often feel there is less information available to them generally. Also, developing skills of local champions from within communities may again aid in delivering messages directly to communities if they could be initiated from within.

Terms used in communication materials and discussions between professionals and women should be chosen with consideration. ‘FGM’ is not a familiar term to most women from practising communities and ‘circumcision’ may be more appropriate. Avoidance of the term ‘sunna’ is recommended despite its use in this group as a term to describe a specific type of FGM. Sunna has numerous religious and cultural interpretations and may, outside of this research, be cause for confusion or misinterpretation and therefore should be avoided as a colloquialism. ‘Reversal’ is additionally commonly used by health professionals and communities alike, however risks misleading women and possibly offering false hope that their circumcision can be reversed. De-infibulation or ‘being opened’ are therefore more suitable.

Finally, there have been instances where women report feeling judged by professionals, reflecting a need for those working in safeguarding and health to be formally trained to implement informed questioning around FGM, which will not only be better received by women but also build confidence in professionals working on this issue.

4.2 Health services

4.2.1 Birmingham’s Well Women’s Clinic

Awareness of Birmingham’s Well Women’s Clinic was incredibly low among respondents. When peer researchers were informed of this service and realised it was not solely for use during pregnancy, women were interested and eager to know more. As such, the Clinic should consider means to better publicise their services, keeping in mind the need to clarify firstly, that it is for all women affected by FGM and not just pregnant women, and secondly, that the message of de-infibulation does not inaccurately convey ‘reversal’ as there was some uncertainty from women’s narratives whether this was fully understood. To raise awareness of the service within communities, activities such as leafleting or printing ads in local free newspapers, which are often dropped door-to-door and in local languages may be beneficial.

Recent data provided by the Clinic indicate a rapidly increasing demand for services. As women become more aware of the service, the Clinic must be supported in terms of human resources, hours, space and other resources to absorb this ever-increasing demand. Ensuring the Well Women’s Clinic has the capacity to meet increasing demand directly supports current guidelines from the Royal College of Obstetricians and Gynaecologists recommending specialist services are in place locally for women with FGM, particularly during pregnancy and birth.
4.2.2 Maternity services

Data highlight the ongoing and increasing need for specialist maternity care. There were some reported incidents in which women felt they were not appropriately referred on to support services during their pregnancies. To take best advantage of windows of opportunity, inclusion of FGM in local midwifery curriculum and continuing professional development courses may be worth considering in order to ensure all frontline maternity staff engaging with women from practising communities are aware of what to look for and how to implement informed questioning about circumcision and refer onto specialist services if they cannot be provided in-house.

Women stated a preference for early support for FGM in pregnancy. This was particularly relevant to the issue of de-infibulation as women were keen to know their options of when and how this could be done during pregnancy. If Birmingham maternity units do not currently routinely ask questions during antenatal screening about female circumcision, this may be an appropriate place to introduce such an opportunity for early advice and information and signposting to specialist services if desired/required. Workshops in which health professionals and women from practising communities collaborate on how best to identify and take advantage of these opportunities so they are culturally appropriate may be suitable. User engagement in the design of maternity services is beneficial for issues beyond FGM and was recommended by peer researchers.

Lastly, the effects of de-infibulation may go beyond physical changes. Well Women’s clinic staff and midwives should be cognisant that ‘being open’ may contribute to psychological and other support needs and possibly raise the need for onward referral to counselling/support services.

4.2.3 General Practice

GPs in particular stirred emotions and raised criticism from a number of women. There are likely two sides to this in that women, particularly those with limited experience of the NHS, may have somewhat unrealistic expectations of what GPs are able to provide during consultation and lack of familiarity with the health service may therefore be creating frustration or disappointment for women. On the other hand, there is evidence that GPs and GP staff are unaware and untrained in how to recognise signs and symptoms of FGM and are therefore missing opportunities to link symptoms to FGM and ultimately signpost women on to support services. Women themselves may also not make connections between particular symptoms and their circumcision.

The role of GPs is particularly crucial to identify and refer women who would otherwise not be picked up by maternity services, e.g. women who have already experienced FGM and have had their children, or girl children at risk. Training opportunities for GPs and practice nurses are recommended, focusing not only on recognising signs and symptoms, but informed questioning with women and mothers of girl children from practising communities who may be at risk.

Ultimately, women showed a preference for specialist FGM services, however women emphasised GPs are a potentially crucial source of information and referral, thereby necessitating their improved and increased involvement in this issue in Birmingham.
4.2.4 Partnership working across health professionals

Efforts to increase awareness of the Well Women’s Clinic not only among women but other health services should all be considered. Activities could include holding workshops with GPs and GP practise nurses; site visits to maternity units and vice versa. Encouraging inter-professional workplace visits may further address what were viewed as ‘missed opportunities’ for women to be referred to the Clinic by midwives and other health specialists.

The confounding effects of immigration status may mean women are initially hesitant to approach services or require additional support in the form of psychosocial services. Awareness among health professionals to recognise these signs and to appropriately signpost women onwards to agencies such as BSWA is needed.

4.3 The role of schools and children’s centres

Schools may be an additional appropriate venue to engage in community education and awareness raising on FGM. All girl children in Birmingham will attend school and therefore are in regular contact with professionals who, with appropriate training / guidelines, may be able to act in a safeguarding capacity if necessary. Ward data identifies areas of particularly high concentrations of children from practising communities and, as children are likely to attend school locally, could be used as a tool to identify schools and areas in Birmingham to target prevention/awareness-raising efforts and particularly to focus efforts on staff awareness. Peer researchers suggested school nurses needed to be informed of specialist FGM services with a clear contact for additional information and that establishment of clear referral pathways between schools, local safeguarding agencies and specialist services should be in place in the event concern over a girl child’s wellbeing arises.

Additionally, peer researchers noted that mothers are generally much more directly involved with their children’s education than fathers. Educational venues are viewed as places to meet other women when studying and support social integration, which may be particularly important for women at risk of isolation. This, coupled with women’s high valuation of access to education generally suggest schools may be potentially ‘safe places’ to initially introduce topics around FGM in the form of workshops or women’s groups, without fear of men being aware or involved at first if this is a concern.

Like schools, children’s centres may be opportune venues in which to reach out to women and provide courses or group opportunities, particularly to those who have young children and may otherwise find identifying substitute childcare to attend such activities more difficult.

Final considerations

There were several additional recommendations that emerged from the research and peer researchers themselves, which do not fit only one service. Firstly, though data show Somali women to still be the main group accessing services and the largest migrant practising community in Birmingham, all services should acknowledge the increase in other practising communities and that women and girl children from, for example, Eritrean and Gambian communities should not be overlooked. Secondly, as religious messages and interpretations of religious proclamations continue to influence decisions to carry on or abandon the practise, clarification should be sought and if possible, clear anti-FGM messages from faith-based leaders shared. Thirdly,
men’s roles in setting expectations for marriage and to some extent circumcision as a prerequisite for marriage continues to influence women’s beliefs and behaviours around FGM. However, as this research did not directly engage with men and captured only women’s inferences, opportunities to explore men’s perspectives directly, through formal research or community engagement, may elicit valuable insights and should be considered.

Finally, all services including health, social and education should always remain cognisant of their audiences and that communities may require materials to be translated or tailored for particular needs. One researcher emphasised the need to not forget about women with learning difficulties or other disabilities as they too are often at risk or affected by FGM and the related issues presented throughout this report.
ANNEX I – PEER METHODOLOGY

PEER is a qualitative, participatory, research method that is effective for working with hard-to-research groups. The process helps to understand health and risk perceptions and behaviours from an insider’s point of view. The approach is based on training members of the target community to carry out in-depth conversational interviews with trusted individuals they select from their own social networks.

PEER has been implemented in over 15 different countries in the past decade and has a strong track record in health and social research. The method is particularly strong in producing insight into sensitive topics (e.g. behaviour perceived to be deviant or illegal, and sexual behaviour), gender relations, power dynamics within households and communities, and barriers and motivators to behaviour change.

The approach is particularly suitable for marginalised communities who are difficult to reach effectively with other research methods. The resulting data describe the lived realities and perceptions of the peer researchers’ social worlds. By tapping into established relationships of trust between peer researchers and their friends, PEER generates rich narrative data that provide insight into how people view their world, conceptualise their behaviour and experiences and make decisions on key issues.

During training peer researchers were given instruction in interview skills and supported to develop their own interview guides exploring three broad areas reflecting the focal areas of the study. A copy of the interview guide developed are available in Annex II, but the three main areas of interest are shown here:

1. Life in Birmingham
2. Understanding FGM
3. Wider implications of FGM

Peer researchers were trained to ask about what other people do in relation to particular issues, rather than asking for personal information. They were also encouraged to seek out stories and examples of particular circumstances or experiences in order to get detailed, rich data and aid their recall of interview content. After each set of three interviews, supervisors from the research team met individually with each peer researcher to collect their findings in a series of debriefing sessions, making detailed notes of the narrative data collected by the women. During such debriefing sessions the supervisors would further question the peer researchers about what they thought other women do or think in relation to the issues explored.

Following the completion of data collection a final ‘De-briefing and Analysis’ workshop was held with the peer researchers who explored some of their fellow researchers findings, discussing these and helping to initiate data analysis.

De-briefing and workshop notes form the final data set which were then analysed by a social scientist. Data were thematically analysed according to the main themes presented in Section 4.

The PEER method was chosen for the following reasons:

- It generates in-depth, contextual data on a range of issues related to the research topic
- Existing relationships of trust between peer researchers and their informants mean that findings are more detailed and insightful than if they had been gathered by an outside researcher
- PEER involves the participation of the target population from the early stages of programme planning, ensuring their voices are truly heard and encouraging their participation as activities develop and move forward.
- The method is particularly suitable for carrying out research with hard-to-reach populations.
- PEER builds capacity within the community to carry out research in future; further it builds the confidence of researchers and provides them with additional skills and work experience to improve their CVs.
- By participating in PEER, peer researchers become 'lay experts' in important issues in their community, and form a pool of expertise who can be involved in future studies and the development of support services.
ANNEX II – PEER PROMPTS

Theme One: Family life

Note: The theme of family life will give the researchers an idea of how women in the community are living in Birmingham.

Q1 How do women in our community find life in Birmingham?
Q2 How do women in our community find social life in Birmingham?
Q3 How do women in our community find marital life in Birmingham?
Q4 How are women in our community finding education in Birmingham?
   - for adults?
   - for children?
Q5 How are women in our community finding jobs? Are there opportunities available?
Q6 How are women in our community integrating in Birmingham? How do they see themselves?

Theme Two: Female Circumcision

Note: Explain to your friend that we are interested in all types of Female Circumcision. Explain that people in our community means other people like us living in Birmingham (from Sudan, Eritrea and Somalia).

Q1 What do people in our community say about Female Circumcision?
Q2 How do people in the community feel about Female Circumcision? Is it different for:
   - Men and women?
   - Older and younger people?
   - Educated and non-educated?
   - People born in the UK vs, people born at home?
Q3 Do people want to continue this practice?
Q4 What do other people say actually happens during Circumcision?
   - Who does it? How does it occur?
   - Where does it occur?
   - When does it occur?
   - What stories do people hear about the experience?
Q5 What do people in our community say about the reasons to circumcise? What about the reasons not to circumcise?
Q6 What do people say about the pressure to circumcise? Who decides?

Theme Three: The wider implications of female circumcision

Q1 What do people say about the effects of circumcision on female's lives?
   - Emotional well being & psychological?
   - Physical well being/health?
   - Sexual well being/health?
Q2 When approaching health services, what do people in our community say about their experiences?
   - Understanding of health care personnel?
   - About being referred to another service?
Q3 Do people in our community know about the Well Women Clinic at the Heartlands Hospital? What are their views on this?
Q4 What do people say about finding good help and information on Female Circumcision?
- Is it easy to find? Is it difficult to find? Where do they get it from?
- What are people's ideas on how this could be done better?
Q5 What do people say about advocating against FGM?
- What are people's ideas on how this could be done better?
Q6 What do people in our community know about the UK government views on Female Circumcision?