

My Voice 2

Women and Female Genital Mutilation (FGM) in Scotland: A Participatory Action Research Project

June 2017

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The My Voice research project was conducted by Queen Margaret University. The project was coordinated by Waverley Care, with support from DARF. Funding was provided by the Scottish Government Violence Against Women Fund.

This report should be referenced as:

O'Brien, O., Baldeh, B., Hassan, J. and Baillie, M. (2017) My Voice 2: Women and Female Genital Mutilation (FGM) in Scotland: A Participatory Action Research Project.

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Scottish Charity No. SC036500

Funded by:



Scottish Government
Riaghaltas na h-Alba
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Acknowledgements

This research could not have taken place without the PEER researchers who we would like to thank for their enthusiastic participation. They gave up their time to attend the research training, carry out the interviews and meet for the data collection. We would also like to thank their friends and contacts who participated in the research as PEER interviewees. They brought insights and knowledge way beyond our expectations. Jamila Hassan from Together for Better Life (TBL) was instrumental in making the link for us with the Sudanese women who are part of TBL. Staff from TBL also volunteered their help at key stages during the project, participated in different events, provided translation and interpretation when required, and have assisted in the interpretation and analysis of data. Many other organisations helped and supported the work and we would like to thank all of them. We also gratefully acknowledge the funding from the Scottish Government Equality Fund.

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1. Executive Summary

Introduction and scope of the study

This report describes findings from the second phase of My Voice, a participatory action research project on Female Genital Mutilation (FGM) in Scotland. My Voice aims to facilitate community engagement with FGM affected populations, to enable their voices to contribute to the development of awareness raising around FGM and to ensuring culturally appropriate FGM services for Scotland.

The objectives of the project are:

- To establish the perceptions, attitudes and experiences on FGM in Scotland
- To engage FGM affected communities in participatory research
- To gather evidence from communities affected by FGM to be used as a basis for dialogue and interaction in the development of appropriate FGM services in Scotland

The first phase of My Voice aimed to document perceptions, attitudes and experiences of FGM among specific groups within affected communities, including young women (under 25 years), young men and older men, as well as religious leaders. In this second phase the focus has been on women over 25, arguably the most affected group, who are mostly married or have been married, with children and in many cases dealing with the negative health impacts of FGM.

My Voice presents data that has been identified and collected by affected communities. It is the story that women with FGM wanted to tell. This information is essential in order progress the understanding of the challenges and complexity of the issues facing FGM affected communities in Scotland and helping to determine ways in which community participation can be built in to the Scottish response to FGM more effectively.

Methodology

Phase 1 piloted a methodology based on the Participatory Ethnographic Evaluation Research (PEER) methods, developed by Options UK, and used widely in England and Sub Saharan Africa for documenting attitudes and practices around FGM as well as other sensitive issues (Brown et al 2016, Brown and Porter 2016, Brown & Hemmings 2013, Forward 2016, Forward 2010, Hemmings 2011, Khalifa & Brown 2016, Oguntoye et al 2009, Price and Hawkins 2002). Questions were developed by the PEER researchers around three themes. In this second phase the PEER methodology was used with women to establish more specific information about knowledge and the impact of FGM. Forty-eight women participated in the research, either in the two-day research training as PEER researchers, or as interviewees. They came from four different African countries but the majority of women (32 out of 48, or 67%) who have contributed to the data reported here are from Sudan. This means that this report is focused heavily on the experience of Sudanese women and in particular those who have experienced infibulation.

For this research 19 women from both Glasgow and Edinburgh were recruited and selected to attend the PEER training workshops along with the lead researchers. One theme was developed during the training on the impact of FGM on adult women. The interview guide is listed in Appendix 1.

A final consultation workshop was carried out in March 2017 when the initial data had been collected and analysed. The PEER researchers from both Phase 1 and Phase 2 attended and were given the initial findings. They were invited to comment on and add to the findings through group work and participatory activities.

Findings

Knowledge norms and values

On the whole most of the women who participated in the research, in particular the women from Sudan, had a good understanding of FGM. They did not all comprehend the implications of it, in particular infibulation. The process of childbirth was perceived as a key moment for women to learn about FGM and be given information about health impacts and details of the law in Scotland.

Older women make the decision to carry out FGM and in Sudan these women are from the man's family. Although women are the main decision makers about whether or not FGM takes place, we heard that men often play a role in the decision making about FGM as well as the type of FGM that is carried out. In addition, men are perceived as more able to resist family pressure, partly because in Sudan that pressure comes from the man's family. Also men do not face social and gender conventions about acquiescence with older people to the same extent as women do.

There are stories here about men imposing very damaging forms of FGM on their daughters but also of husbands who are sad and troubled about their wives' unhappiness, have not enjoyed the difficulties they and their wives face in their sexual partnership and who want to protect their daughters from the same fate.

Women had strong memories of having FGM carried out and described the excitement and happiness of preparing for the celebration, of wearing henna and gold jewellery. However, the excitement quickly turned to horror and pain when FGM was carried out on them. For many it was a life-changing event resulting in years of urine infections, painful periods and infections.

In Sudan infibulation is central to most women's experience of FGM. It is seen as essential for marriage in order to ensure men's sexual pleasure. The smaller the vaginal opening the more the FGM is valued. Although women talked about sunna, a less invasive form of FGM becoming more common in Sudan, infibulation is still taking place and highly valued as ensuring a women's chastity and suitability as a wife.

Marriage, gender and sexuality

Many of the participants said that FGM is considered essential for marriage. It is considered a guarantee there is no sex before marriage, that the woman is a virgin and that the women's sexuality will be controlled within marriage.

Despite hearing about changing attitudes, social norms in Sudan are clearly still very strong around FGM particularly in rural areas and families exert great pressure on families in Scotland to carry out FGM on their children. Women without FGM are stigmatised through the calling of names and being ostracised as well as facing the possibility that they will not be able to find a husband willing to marry a woman without FGM.

When marriage takes place the tradition in most of Sudan is that a man is expected to open an infibulated woman up through penile penetration to prove that he is a real man. If a man was unable to open a woman himself, women went to midwives or doctors to open them up but we were told that traditionally this was kept completely secret from everyone as the man's masculinity and virility would be called into question and he would not be considered a 'real man'. After defibulation carried out in this manner sexual intercourse has to take place on a regular basis in order to stop the opening from closing over. Women talked to us of extreme pain during this period.

After a period of marriage or after childbirth, Sudanese women are under pressure to undergo further infibulation to tighten the opening. Women can be just as stigmatised if they do not undergo this reinfibulation as if they had not had FGM in the first place. Many of them told us how hard it is to resist pressure from families and in one case we heard that a woman has cut off relations with her family as a result of them physically holding her down and forcing her to be re-infibulated after childbirth. Traditional marriage in Sudan is a constant process of being defibulated and re-infibulated, with associated pain and trauma.

Health consequences of FGM

Due to the extreme nature of infibulation, there are many direct consequences for health as well as long-term consequences throughout the life of women who have experienced it, particularly in childbirth. The main health consequences of FGM for all the women, whether they had been infibulated or not, were urinary problems, infections and poor flow, menstrual pain, pain as a result of FGM being carried out poorly, and the problems associated with sex, pregnancy and childbirth. Smear tests were also mentioned as a problem for women and many of them avoided them all together. For women who are infibulated being pregnant and living in Scotland means making a decision about being defibulated before the birth. Older women in the community who had already had children were the main source of information about childbirth. Midwives were also mentioned as an important source of information to the women and relations of trust with midwives in Scotland were described. The decision to have defibulation carried out before childbirth was clearly a difficult one for many women. In Sudan women said that they are opened at the time of giving birth but in Scotland it is felt a better option to carry out the two processes separately to ensure defibulation is carried out in a calm, prepared and safe environment. Many women did not understand why the two processes had to be carried out separately and if they then required a caesarean or an episiotomy, felt that they might have made the wrong decision. However, women also described greater physical comfort, an improvement in urinary and menstrual flow and less discomfort when having sex after defibulation.

The law and prevention of FGM

Contrary to research carried out for Phase 1 of My Voice, many more of this cohort knew that FGM is illegal in the UK. Some women said that they only knew about it once they had children, because it was that point in time that they had contact with the health professionals such as midwives, doctors or health visitors who made them aware of it. A few women said a lot more needs to be done about raising awareness about the law and this particularly needed to be targeted at new arrivals as well as younger women who had not yet had children. Some women recounted stories of social work and police involvement when they were returning home for family visits or holidays, and this raised some uncomfortable issues of feeling harassed when travelling. However, despite this most women said that they didn't think the practice should continue anymore and therefore did want the authorities to take action.

We also heard some examples of good practice where multi agency approaches resulted in a woman being supported to resist pressure from her family to carry out FGM on her daughters.

There were many concerns raised about reporting anyone to the authorities with most people saying they would not contact the police directly if they thought someone was considering having FGM carried out on their daughters. Concerns about reporting were about betrayal and people becoming criminalised. However, some people were prepared to talk to service providers particularly in appropriate voluntary organisations. Some older women said they would go to social workers for help and advice. Younger women were more likely to say they would report to the police. Despite these concerns people felt the law should be applied and FGM should be eradicated.

What is to be done about FGM?

Much progress has been made against the recommendations from Phase 1 of My Voice. These are detailed in Section 4. The recommendations still stand with one addition.

Recommendations

1. Delivering the Scottish National Action Plan to Prevent and Eradicate FGM

We recommend that:

- Findings of My Voice feed into the National Action Plan to ensure the voice of FGM affected communities are integrated into the objectives and activities
- Ongoing training sessions are carried out using practical activities to bring together professionals charged with delivery of the Scottish National Action Plan with the FGM affected communities (e.g. PEER researchers from My Voice or other representative groups)

Additional recommendation (Phase 2):

- Ensure that findings from Phase 2 of My Voice about the particular needs of women with type 3 FGM are fed into appropriate services and in particular health services

2. Community engagement

We recommend that there is:

- Ongoing support and development to increase confidence and develop action plans for continuing meaningful community engagement with existing PEER researchers from My Voice
- Expansion of PEER to working with women, as well as in other parts of Scotland with significant populations from FGM practising countries

3. Service delivery

We recommend that:

- An FGM specific service is established which acts as a focal point.
- The service acts as a conduit and point of contact for FGM affected communities and service delivery.
- The service can play a role in working together with existing diaspora organisations
- The service establishes a safe space for discussion and interaction for affected communities.

4. Working with Young People

We recommend that young people are:

- Included in initiatives around FGM
- Supported to take the lead in developing age appropriate activities to develop knowledge and confidence

5. Working with women

We recommend that:

- Women affected by FGM are fully engaged with delivery of the national action plan and national awareness-raising
- There should be more support for diaspora organisations to facilitate their input into the Scottish response to FGM
- Expansion of specialist support services is required for women directly impacted by FGM

6. Working with men

We recommend that:

- Men are encouraged and supported to work with FGM, in terms of understanding the issues facing women and the support they might require as well as the importance of prevention, and the issues that affect men around FGM more directly
- The issues can be embedded within work on gender equality ensuring a wider and more interconnected approach

7. Engaging religious leaders

We recommend that:

- Further work is carried out with religious leaders to ascertain attitudes and knowledge and to work with faith based organisations in particular to assess whether these are good locations for awareness raising and education/training for FGM affected communities, and whether some key religious leaders could become agents for change in their communities

2. Introduction

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There is growing evidence that attitudes towards FGM are changing in countries where it is traditionally practiced, as well as amongst diaspora migrant communities around the world (UNICEF 2016). Despite figures which show that the practice is declining, population growth in Sub Saharan Africa means that the actual number of girls at risk of FGM is growing, resulting in an urgent need for effective interventions to reduce the practice even further (UNICEF 2016). Organisations established to raise awareness about FGM in the UK have existed since the early 1980s but, similar to international efforts, attention to the practice has grown in recent years largely due to the increase of people coming into the UK from countries where FGM is practiced. Research carried out by the Trust for London/Forward show that attitudes towards FGM by affected communities have changed (Brown and Porter 2016). Scotland is a recent recipient of African migrants. Census records show growth in ethnic diversity in the Scottish population between 2001 and 2011. The numbers of people in Scotland identifying as

African grew from the very small number of 5000 in 2001 to 30,000 in 2011 and has most likely grown significantly since then (Simpson 2014). Populations of people from other countries in the Middle East and Asia where FGM is practiced have also grown during this time in Scotland.

Estimating the numbers of people who have FGM in Scotland is a challenging task. The Scottish Refugee Council Report Tacking Female Genital Mutilation in Scotland, A Scottish Model of Intervention (Baillot et al. 2014) drew on a range of data sources to calculate that 23 979 people (men, women and children) are living in Scotland who self-reported being born in a country where FGM is practiced and 2750 girls were born to mothers from those countries. However, it is impossible to know how many of the former are women or the FGM prevalence rate amongst the women and girls. There is further debate on this in the Scottish Refugee Council report as well as the report from the first phase of My Voice (Baillot et al. 2014; O'Brien et al. 2016).

The two nationalities which are most represented among the participants of My Voice , Nigeria and Sudan, are ranked 1st and 8th respectively for populations in Scotland from countries which practice FGM. The 2011 census records 9458 people from Nigeria and 749 people from Sudan living in Scotland. When these figures are adjusted for national prevalence of FGM in country of origin, Sudan moves up to being the 5th highest. In Scotland, in 2012, 381 Nigerian women gave birth to 186 daughters and 32 Sudanese women gave birth to 15 daughters (Baillot et al. 2014). These numbers are likely to have increased in the subsequent years. As mentioned above this information gives us no indication about whether these mothers are from FGM practising cultures within their countries and if they are, whether they or their daughters have had FGM carried out. The research has simply demonstrated the existence of people from FGM practising countries in substantial numbers in Scotland, an important contribution to the debate because it was not widely recognised prior to the research.

Awareness of the practice of FGM and its consequences have increased in recent years in Scotland, particularly in the sectors of health, education, social care, law, criminal justice and the border agency among others. Consistent campaigning by affected communities has resulted in a political response at a local and national level. In February 2016 the Scottish Government launched the National Action Plan to prevent and eradicate Female Genital Mutilation (FGM) 2016-2020 (FGM Scotland's National Action Plan 2016). The activities of the plan are intended to deliver the objectives of 'Equally Safe', Scotland's strategy to prevent and eradicate Violence to Women and Girls. The plan highlights the importance of working with communities and third sector organisations stating:

FGM will continue to be an issue in Scotland until communities themselves choose to abandon the practice and we recognise that in order to find a solution to eradicate FGM, working with communities is vital to breaking the cycle of violence. The views of communities affected by FGM must shape and inform future policy and service provision (Scotland's National Action Plan 2016:21).

My Voice plays a role as a conduit for communities' input into the strategy by carrying out research and empowering affected communities to speak out on the issues they consider most important.

2.1. From health to human rights

In the early years of the campaign against FGM it was framed as a health issue, and efforts to eliminate it focused on the adverse health consequences of the practice, such as infection, including HIV, and the problems that can result from poor cutting, damaging the bladder or cutting arteries. This focus may have unintentionally promoted the 'medicalization' of the

practice, with the result that it is increasingly being performed by medical professionals rather than by traditional practitioners (Shell-Duncan 2008). Obermeyer (1999) and others carrying out early systematic reviews of clinical results have highlighted the difficulty of producing robust evidence to demonstrate long term harm to people that have had FGM. Existing evidence tends to be based on personal anecdotes and small samples. The secrecy of the practice, which has increased since FGM has become illegal in most countries in the world, has added to these challenges. However, from a human rights perspective, medicalization of the practice does not in any way make FGM more acceptable. It is a practice, which is physically invasive, painful, traumatic and potentially extremely dangerous and can cause death. It is carried out without consent and on vulnerable children. Shell-Duncan (2008) has argued that although there is evidence of resistance to FGM going back centuries through local campaigns in the countries where it is practised for example in Egypt, Kenya and Sudan among others, international attention to the issue, the so called global movement, developed

Terminology

Discussion in relation to terminology in this report is summarised below.

FGM The use of the initials FGM standing for **Female Genital Mutilation** is contested by some groups for a range of reasons. Some women with FGM resist the implication that they have been mutilated and prefer the use of other labels. Many communities find the term 'circumcision' more natural. However, campaigners would argue that circumcision is a much more neutral word that does not carry with it the associations of pain and long term impact that can occur through the procedures carried out to women. An alternative approach has been to talk about Female Genital Cutting (FGC) or the combined term FGM/C which is widely used in international development and academic literature. Cutting does describe more accurately what actually happens. In the first phase of My Voice we found that many participants did not know what FGM meant. Most languages have a specific term to describe FGM and these terms were used by the PEER interviewers. However, it has become the convention in policy documents in Scotland to use the term FGM and therefore we will use this term throughout the report, but with reservations, and the awareness that this is not the term used by most people affected by the practice.

FGM affected communities Throughout this report we will use the term 'FGM affected communities'. Options UK recommends avoiding the term 'practising communities' arguing that it assumes that people are still practising FGM which can perpetuate stigma and may be wholly inaccurate (Hemmings 2011). Affected communities is a broad term which can include anyone from a potentially practising community, whether they still practice it or not, or even people who traditionally do not carry out FGM but live closely with those who do, who may or may not have had FGM practised on them, but still experience the impact of the practice.

Traditional midwives When interviewing the women from Sudan they used the word 'midwife' to describe the people who carried out FGM on them, but also delivered their babies and stitched them up, i.e. carried out re-infibulation after childbirth. There is a big distinction between a trained midwife who works in health services and traditional cutters who carry out FGM and infibulation. In this research therefore, we have decided to change the word 'midwife' to 'traditional midwife' when women are referring to these women except in women's direct accounts.

out of a series of conferences focussing on human rights and gender inequality in the 1970s¹. Shell-Duncan argues that the initial phase of the campaign which framed FGM as a health issue was soon rejected and subsequently there was an active desire to distance the campaign from a health approach and move towards a human rights framework for justifying opposition to FGM (Shell-Duncan 2008). FGM is now firmly established globally as a rights based issue and in Scotland it is embedded within the violence against women strand of work in the Equalities Unit in the Scottish Government and is included in the *Equally Safe, Scotland's Strategy to prevent and Eradicate Violence against Women and Girls*.

Type 1: Often referred to as **clitoridectomy**, this is the partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals), and in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).

Type 2: Often referred to as **excision**, this is the partial or total removal of the clitoris and the labia minora (the inner folds of the vulva), with or without excision of the labia majora (the outer folds of skin of the vulva).

Type 3: Often referred to as **infibulation**, this is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoris (clitoridectomy).

Type 4: This includes all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area. Type four also includes **elongation** (pulling and stretching) of the labia minora/majora and other procedures which do not involve removal of tissue from the genitals.

2.2. FGM in Sudan

Because the majority of this report is about FGM among Sudanese women in Scotland, some background and context to FGM in Sudan is relevant here. Sudan has one of the highest prevalence rates for FGM in the world with rates estimated around 87% (UNICEF country report, updated in 2016). Johansen (2017) who has carried out very comparable research on migrants from Sudan and Somalia with FGM living in Norway, has written that infibulation (type 3) is nearly universally practiced in the Democratic Republic of Sudan. Infibulation is described by Johansen as the most pervasive form of female genital mutilation and involves the almost total closure of the vaginal orifice. She writes that infibulation in Sudan is associated with a complex set of key cultural values which hinge on ideals and practises related to women's virginity and virtue and men's virility and sexual pleasure (2017: 2). Sudan was the first African country to legislate against FGM, making infibulation illegal in 1946 in the Sudan Penal Code (UNICEF 2016). Campaigns fighting for eradication started around the 1960s and continue to raise awareness and campaign for FGM to end. However, despite many years of combatting FGM in Sudan and a decline in the support for the practice, evidence for an actual decrease is small and it is still widely practiced. There does appear to be a significant shift from type 3 to type 1 and 2, particularly among educated people in urban areas.

One of the most difficult barriers for the eradication of FGM is the misunderstanding of its relation to Islam, as well as its role in securing marriage. These two aspects create strong social norms which alongside sanctions such as name-calling and being ostracized effectively

¹ This includes the UN decade for Women from 1975 – 1985, as well as the human rights conferences of the 1980s and 1990s and finally the impetus given to a rights based approach in the International Conference on Population and Development held in Cairo in 1994 and the Conference for Women held in Beijing, China in 1995.

reinforce the continuation of the practice. In this report we describe the impact of these sanctions, whose strength is so great that even girls who do not have FGM carried out on them as children, sometime request it as adults prior to or after marriage either at the request of a male partner or because of fear of losing that male partner.

2.3. Methodology

My Voice is a participatory action research project, using a PEER research methodology. PEER research ensures that people involved in the subject of the research are at the core of the information gathering and can talk about sensitive subjects with people in their social network who trust them. My Voice has based its methodology on work carried out by Options UK², who have worked with a range of projects on FGM, maternal health, and other sensitive topics. They have worked closely with Forward and other FGM organisations across the UK and supported the implementation of My Voice.

Through PEER research a relationship of trust and rapport is built up with the researcher who can conduct in-depth interviews with friends in their social network enabling questions to be asked on highly sensitive issues. The questions are developed by the PEER researchers themselves as part of the PEER training and therefore cultural appropriateness is at the heart of how the questions are developed. The methodology used in My Voice uses third person questions (i.e. there are no direct personal questions. Participants are asked 'what do you think people like you think about...'). No names are required. The method has a track record in generating rich narrative data about opinions, attitudes and beliefs and the context within which decisions are made. This can lead to important insights into how people negotiate or resist in decision making and the power structure within which these decisions are made. Gender power relations are most visible in the smallest social units such as families and households and it is not easy to disentangle the complexity of how they impact on everyday life. PEER research can play an important role in documenting these details and the impact they have on men and women from communities that practice FGM.

Queen Margaret University Ethics Committee granted ethical consent for the research and data is stored on secure data storage systems at Queen Margaret University in accordance with the University's data storage policies.

As mentioned in the first phase of My Voice, engaging people in discussions about FGM can lead to some people talking about it for the first time and can raise some very disturbing and difficult reactions, memories and flashbacks. This may relate to personal experience of FGM, or to the realisation that other members of the family are having problems as a result of FGM. It is therefore important that there is no coercion to being part of My Voice and that participants are free to leave if it becomes too uncomfortable for anyone. We informed participants that they did not have to take part, that they could leave at any time and we had names of agencies where we could refer participants for counselling if need be. FGM is also an illegal activity in Scotland and most countries in the world. Carrying out research in this area can therefore lead to uncovering information about illegal activity, or the risk of significant harm. Because the PEER methodology asks no direct questions or names, and therefore data is not attributable to a particular person we did not expect such disclosure to take place. Other PEER projects in sexual and reproductive health have found that the method works well ethically, with low to no risk of breaking anonymity. However, My Voice does have a robust safeguarding procedure in place, and after advice from Police Scotland, we are confident that there would be a swift and appropriate response to any disclosure of significant risk of harm through the data collection. All participants are informed of this. Consent is

² See <http://www.options.co.uk/peer>

requested from all PEER researchers and they are trained to gain verbal consent from the people they interview who are informed that they can leave the research process at any time they want without having to give a reason why.

We used a convenience sampling strategy, contacting people from affected communities through contacts in community-based organisations. PEER researchers were selected according to the profile of the research, which was adult women from an FGM affected community resident in Glasgow or Edinburgh. Because we worked closely with Together for a Better Life (TBL), a diaspora organisation that works to raise awareness about FGM amongst a large number of people from Africa and Middle Eastern countries, about half of the PEER researchers were from Sudan. The other half were from Nigeria with one participant from Zimbabwe.

The research questions were developed in collaboration with the PEER researchers. The research aims were discussed in detail. PEER researchers then used participatory exercises to explore issues associated with FGM in their social network and develop questions to ask their contacts.

For this research 19 women from both Glasgow and Edinburgh were recruited and selected to attend the PEER training workshops along with the lead researchers. A single theme was developed on the impact of FGM on adult women by the PEER researchers during the PEER research training. The interview guide they developed is listed in Appendix 1.

Data was collected shortly after each PEER researcher had interviewed on each theme. PEER researchers were encouraged to take notes after the interview had taken place, so that the interviews themselves are kept conversational in tone. They then came to meet one of the research workers with the project in a neutral location where they related the content of the interview and were further interviewed themselves on meanings and behaviour within the data. This was entered straight into the laptop and constitutes the data itself. As such, both the PEER researcher and the interviewees are counted as part of the sample.

Participation in My Voice Phase 2	
PEER researchers trained	19 women
PEER interviewees	29 women
Total number of participants	39
Interviews conducted	48

As with Phase 1 of My Voice, the PEER training workshops went very well with enthusiastic participation from the 19 PEER researchers. Simultaneous interpretation into Arabic was carried out at the workshop with an interpreter for the women who needed it. Interpretation was not required for any other languages.

Due to delays and difficulties collecting data in Phase 1 of My Voice (described in O'Brien et al 2016), we decided to conduct one round of interviews with one single theme for Phase 2. The interviewing was very successful and timely. However, once again we experienced a significant drop-out at this stage. Of the 19 women trained, 12 carried out interviews but three of those did not successfully make it to a debriefing session so that data cannot be used. Numerous attempts were made to arrange the debriefing sessions with these women but were ultimately unsuccessful. Many of the women described lives that were extremely busy with work, children, partners, and other relatives. Some of them are studying as well and are often responsible financially and in other ways for people back in their home.

A final consultation workshop was carried out in March 2017 when the initial data had been collected and analysed. The PEER researchers from both Phase 1 and Phase 2 attended and were given the initial findings and through group work and participatory activities invited to comment on and add to the findings. Simultaneous interpretation into Arabic was available to participants who needed it. This workshop also served as an opportunity to ensure participants had accurate information about issues related to FGM specifically health information and information about reporting and the law. Representatives from Police Scotland and NHS Lothian attended to give this information and to engage in debate around the findings related to health and legal issues

3. Findings

3.1. Knowledge, norms and values

In this round of research, the women were keen to find out about understandings of FGM as well as who makes the decisions about whether it is going to be carried out on a child, the impact of FGM on health and who people talk to about it. No direct questions were asked about personal experiences but many women recounted them in detail to us and volunteered information about their own experience of having or not having FGM and the attitudes that keep people conforming to the practice. They spoke movingly about how hard their own experience has been and how hard it is to resist this tradition, how strong the forces promoting it are to ensure marriage and to ensure that you are a good woman. Older women in the family, particularly from the father's side are the ones who make the decisions about whether or not FGM is carried out on a child. Good women do not question the decisions of older female relatives and men are excluded from the decision making with the result that parents are not expected to make these decisions. Stigma and insulting behaviour towards non-circumcised women reinforce social and gender norms and make resistance and change difficult bringing the risk of being alienated and castigated throughout the wider family.

3.1.1. What do people know about FGM?

In Phase 1 of My Voice we found that knowledge about FGM was poor, and that many people did not know what the initials FGM stood for. During the training for phase two we asked what words were used to talk about FGM. Tahoor, was the most common term. Khetan, khifadh, sunna and pharonic were also mentioned as well as FGM, female circumcision and female cutting. In the interviews women were asked about FGM in whatever was the most appropriate term in their language. Knowledge about FGM was good, especially among the Sudanese women. When asked if they knew what FGM was, all of the Sudanese women said they knew what it was. However not all of the women from Nigeria and Zambia were able to give accurate accounts. Some of these women said that FGM was not a current issue in their culture and it was a thing of the past. A description by a Sudanese woman went as follows:

It is an old traditional practice in Sudan named tahoor. It has two types. Pharonic is the oldest one. It is the severe one. You need to remove the clitoris and stitch, only leaving a small opening at the end. Type three has two types, one is the removal of the upper part of the labia and stitch it. We say that is like the outside of bread as it is smooth as a crust. The other one is removing the small labia and clitoris and stitch from the inside. We call this the sandwich. This is the worst one when they seal from the inside because the opening is very narrow and everything is inside not like the other one. Another kind is called sunna, it started recently when the government started to campaign against FGM³. It has no stitching. The clitoris is removed, Maybe a tiny bit of stitching. People say that is not circumcision, as if they have done nothing for her.

Others talked about removal of the clitoris and stitching of the area leaving only a narrow opening. When asked about who carried this out they said local traditional midwives had carried it out. Women talked about the cutters inheriting the practice from their mothers and grandmothers and inheriting the patients and their families too.

³ The campaign against FGM has been largely led by NGOs and activists. However, there were multiple references by the women to the Government being anti-FGM

One woman said:

In our family we use one midwife, now she is 80 years old and still practising. [...] she is not educated but has practised for a long time and has good experience.

The women from Nigeria and Zambia who were interviewed had less knowledge. One of the Nigerians had studied about it as part of her university education and had information through that but the other Nigerians said they didn't know much about what it was. A participant from Zambia said she did not know what it was. When it was explained to her she recognised the tradition of stretching and pulling, which had happened to her. She said her mother never spoke to her about it but asked her friends to tell her to do it. She explained that it was checked on when the time came to marry. Her grandmother was the one who asked if she was doing it when she was growing up. There is a strong taboo against discussing it at all but especially between a mother and daughter. She told the researcher that all the girls at school did it and no one ever talked about or knew why it was done.

Many women have never talked about FGM in their life; it is a memory from childhood that they have not mentioned to anyone. Some of the women in this research talked about pregnancy being a key time for learning about the FGM that had been carried out on them as the midwife could inform them what kind of FGM they had and explain it to them. For some of them it was the beginning of an understanding about the process. One woman said that she thought everyone in the world had had it done so she was very surprised when she was pregnant in Scotland to learn that there are people that don't do it.

3.1.2. Who decides?

Most women said the decision to carry out FGM was made by the older women, usually the grandmother.

The mother in law makes the decision, then they get praised 'Oh your granddaughter is well behaved, she is well trained'

A Nigerian women said her mother's family were the ones to put pressure on her mother to do it to her but her mother fought for her not to have it done.

With the example of pulling and stretching (type 4) given above, no one in the family talked directly to the woman about it. Her mother clearly made the decision but conveyed that decision via friends. Later her grandmother did get involved, making sure it was being done correctly.

In Sudan it is the father's family who have more say in the decision. Interviewees emphasised the difficulty in resisting this decision, how it was taken out of the hands of parents and made by the grandmothers and older women in the community. One of the values associated with being a woman is to be submissive and not to resist. It is impossible for a woman to say no to an older woman and in particular her husband's mother who is one of the most powerful women in the family. It is through this hierarchical system of gender roles that the norms and values associated with FGM are perpetuated.

Grandmothers are the main person responsible from when the child is three or four years old. She should attend to this so that it is done in a way that satisfies her. The parents have no role; the grandmother just tells them to do it. The grandmother will be from the father side. The mother cannot say no to it especially to her mother in law.

Women told us that it is a patriarchal system. The daughter belongs to the father's family. Even if the parents resist they cannot challenge the system of family and hierarchy. The girl's status determines the honour of the wider family.

3.1.3. Men and FGM

Men are traditionally excluded from this decision-making.

They (men) have no role, they exclude them. Even if the man is against FGM they say it is nothing to do with them, it is a woman's issue and they carry on and do it.

However, we did hear stories whereby men played a role in discussions and arguments about whether FGM was to be carried out or what type of FGM would be practiced. Others pointed to the importance of men in changing practice implying that they are better able to resist the pressure from the grandparents than women can.

In the past grannies took the decision but now parents are making it and most of them are not accepting it, except for the very poorly educated parents. The men are strong, so they don't let their parents get involved. If they weren't so strong it would definitely be more difficult. It depends a lot on how the man has been educated and on his religion.

Educated men might be working away from the rest of the extended family and this can help them make independent decisions. This was the case with one woman who had not had FGM carried out on her. Her father was a doctor and worked in the city away from the family so he was better able to protect his daughter.

As can be seen from many of these accounts although women are the main decision makers in whether or not FGM takes place, there are many occasions when men play a key role in the decision about it happening or not happening, as well as the type of FGM that is carried out. Men are perceived as more able to resist family pressure, partly because in Sudan that pressure comes from the man's family. Also men do not face social and gender conventions about acquiescence with older people to the same extent as women do. To be perceived as a 'good woman' you simply cannot resist or deny an older person's request, you have to submit to it, especially your mother in law and husband's relatives. Men are also perceived as stronger and more able to stand up to people or conversely more able to insist that things happen. There are stories here about men imposing very damaging forms of FGM on their daughters but also of husbands who are sad and troubled about their wives' unhappiness, have not enjoyed the difficulties they and their wives face in their sexual partnership and who want to protect their daughters from the same fate.

3.1.4. Henna and gold: memories of FGM

Although no one was asked directly whether or not they had had FGM carried out on them, interviewees spoke openly to their Participatory Ethnographic Evaluation Research (PEER) researcher about it. Most had clear memories of it happening. These accounts are all from Sudanese women.

I can't forget this day – it was the most painful day in my life. There were four women, we were happy because we had a new dress and had henna on. The girl is like a queen. They do it early at 4 or 5 years⁴. The four women and a big women took my hands [...]. There was lots of blood. I put the blame on my mum 'how can you let them do this to me?', My mum replied, 'are you stupid? All the girls do that and they are all fine'.

⁴ On the whole FGM is carried out at an older age than this woman states, between 5- 10 years. However, there is evidence that due to FGM being made illegal, it is being carried out earlier in some countries at an age where girls are less likely to either resist or to talk about it

Another said the cutter who carried it out on her was old, not qualified, very ugly. She had a very bad experience. She was very young but still remembers it clearly.

Another one said 'it is like a sickness for me, it makes me sick. It something that makes me not happy, from the first time they did FGM on me'. She said from that time she stopped playing and stopped going to the toilet. She can remember being scared. When asked if she remembered, she said 'it was 1983, you remember everything. I cried the night before, I heard a lot about it from my older sister. My granny and my mum held me; they gave me money and presents'.

The theme of the henna and parties was big in people's memories and stories:

It was a big celebration. We do henna and all the people come and give you money and we wear gold jewellery. In the town it is just the neighbours but in the country where I lived before, the whole village would come to congratulate you.

3.1.5. Types of FGM

There was a lot of awareness about the different types of FGM among the Sudanese women. Some of them mentioned that sunna is a less invasive form of FGM, and some women believed it originated in a government campaign against FGM saying that sunna had been introduced at this time, or was encouraged by the government as being less harmful than pharonic or type 3 circumcision. In some families the type of FGM because a source of conflict.

I have a friend who had sunna (type 2) but when the mother told the father about the type his daughter had he insisted on redoing it and doing type 3. This affected the girl psychologically and delayed her education.

Another one talked about being a small child aged four years old and the cutter felt she was too young to carry out type three on her but her father insisted. The cutter was reluctant to close the opening too much but her father insisted that she made the opening smaller and smaller using a matchstick to measure the appropriate size of the opening. Matchsticks were mentioned by other women and the size of a matchstick was perceived as being traditionally the right size for the remaining opening. For this woman these memories were vivid and very distressing, despite how young she was when it happened.

One woman said that she had sunna carried out on her but her grandmother wanted her to have type three. Her father was against this but he worked as an electrical engineer and was away from home a lot. When he was away the grandmother took the girls (two sisters) to market and found a doctor and had them stitched. Her father was furious when he found out. Two younger sisters do not have type three. This woman has continued to have on-going health problems during her life as a result.

3.1.6. Social norms

Sudanese women clearly conveyed that FGM was expected to be practiced on them, that it is still a powerful social norm. Some women said that in urban areas of Sudan it is not happening as much as it used to. Others said that they were from areas where it is still almost universal. The practice was maintained through the important role it plays in reinforcing gender roles and concepts of what it is to be a 'good' woman, as well as values attributed to men married to women with FGM. It is also reinforced by name calling and women who have not had FGM being ostracised. The name used in Sudan for someone who has not had FGM done is Ghalfa. This name means someone who has not had FGM but has also come to be used as a general insult. One of the worst things you can call a woman is to label her as

someone who has not had FGM. Insults and name-calling accompanied by being ostracised are intensely persuasive and effective ways of ensuring behaviour which conforms to social norms as was evident through many of the women's accounts.

We heard about one family from Sudan with three daughters. Two of them had had FGM but the youngest one had not had it carried out. She is at school in Scotland and is 16 years old. She wanted to be like her sisters and wanted to have FGM carried out. She was worried about being called names if she didn't. Her sisters teased her and insulted her. The mother was a friend of the PEER researcher and was worried about this. She said 'that daughter is going to get me in detention (arrested)'. She asked the friend to come and talk to the daughter. They sat and had coffee together and they all talked about it. Afterwards the young girl said that she understood it all now and didn't want to have it. The mother was very pleased about this.

However, the stigma associated with not having FGM is very strong. One woman said:

Those who don't go through it experience stigma because the community consider it as a symbol of hygiene and chastity. The community views them as dirty and having a bad smell and easily falling into sexual traps.

Another explained that protecting a daughter from such insults was part of the decision making around FGM:

They are worried about the future of the daughter and her marriageability. They do it for the honour of her family and to make sure she won't get pregnant out of wedlock. It protects her from stigma and insults from our community.

One of the PEER researchers from Sudan said that her sister has not had FGM. Her grandmother always insults her. This was a family where there was tension between the mother's family and the father's family. The father's family, who usually make the decision about FGM, had stopped the practice. The grandmother who insults them is the mother's mother. Every time she sees the sister she calls her Ghalfa, the insulting name for a non-circumcised woman and holds her nose when she goes near her, implying that she smells badly and making threats to her about what might happen to her. When the PEER researcher was recounting this story there was much laughter when she described her grandmother's behaviour. It was clearly a big issue in the family. A cousin wanted to marry this sister but she didn't accept him and married someone else. The cousin was upset and the grandmother's response was 'What do you want with her, she's Ghalfa'.

One interviewee spoke openly about not having had FGM herself. Her father was a doctor and her family had connections with Europe and decided not to have her circumcised. She talked about people holding their noses when she returned to Sudan for visits. She says she suffered a lot. She started to tell people that didn't know her that she is circumcised to avoid this type of condemnation. However, referring to growing awareness-raising about FGM in the Sudanese community, she says it is harder to hide the fact she is not circumcised because people are talking about it much more openly now.

3.2. Marriage, gender and sexuality

Where FGM is practiced, it is closely linked to gendered values of womanhood and marriage. The Sudanese women spoke a lot about the value given to FGM within marriage not just for women but also for men. FGM is considered essential for marriage. It is considered a guarantee there is no sex before marriage, that the woman is a virgin and that the women's sexuality will be controlled within marriage. In this section we discuss the pressure on families to perform FGM in order to ensure marriage and appropriate

gender norms, how to be valued as a pure and good woman and how to be judged a 'real man'. Stigma, name-calling and the threat of not getting married ensured compliance to the practice. As the majority of women who participated in My Voice phase 2 are from Sudan, it is inevitable that much of this section is about infibulation and the consequences of it in marriage as well as the impact of it on sexuality for both women and men. We heard about the trauma of the wedding night, and the devastating realisation for some woman of how FGM would affect their sexual relations with their husband. Because it is not considered acceptable to discuss sex or sexuality particularly among unmarried younger women, they had had no understanding of this prior to marriage. Women talked about how unhappy they were, how painful the wedding night was and how hard the early days of marriage.

The pulling and stretching involved in type 4 FGM is checked at marriage, usually by an older relative. The participant who described this process said that when marriage is going to occur they have kitchen parties, and the older women ask about it and check it and might beat someone up if they haven't had it done. Married women never talk about it, the only time it seems to be discussed is at the so called kitchen parties where it plays an important role.

3.2.1. Stigma

The theme of insults and stigma towards those who have not had FGM came up a lot when marriage was discussed. FGM was seen by most as absolutely essential for marriage:

It has a big role in marriage. If it is not practiced on you, you will not be wanted by men. Even though he accepts the situation, his mother would prevent him marrying you, because you would be unclean and you would exploit your husband by having repeated sexual intercourse with him.

Those who have not had FGM feel ashamed because the community values FGM. So they pretend they have it or say they have it because this secures them their marriage and protects them from being called names.

However, if a woman is found not to have it prior to marriage she can be asked to have it done or the marriage will not take place. One woman said that she had recently heard a story from home about a woman who was forced to do FGM a week before her marriage. Her fiancé had found out that she didn't have it and was insisting on it. She has psychological problems and is not eating or drinking. We were told that this was not unusual. Even where FGM is not being carried out on girls, it can be carried out much later, just before marriage.

One of the PEER researchers told us about a cousin of hers who was engaged to marry a man living in London. He returned to Sudan for the traditional marriage ceremony. He asked her what kind of FGM she had and she said none, so he left her and returned to London. A similar story described a friend of the interviewee who travelled abroad to marry but the man found out she did not have FGM and sent her back to Sudan immediately. Another said that she knew about a man who discovered his betrothed did not have FGM and was disappointed. He spoke to the mother and she had it done in secret to avoid scandal and the marriage went ahead.

We also heard from women that it is considered shameful to ask about FGM before marriage. If it is discovered that a woman has not had FGM after the marriage she can be divorced. Divorce is shameful especially if it is in the first months of marriage. It implies that the bride is not an honest woman, that something has been found out about her, which invalidates the marriage.

The Nigerian women also talked about stigma. One said it depended on the tribe but adults might not value a woman because she didn't go through the circumcision programme. It would imply that the woman doesn't have honour; they disrespect them- they believe they will jump from one man to another and lose their dignity and respect.

3.2.2. Being a 'real' man

The type of FGM can also play a role in marriage. Participants recounted stories of families arguing about which kind of FGM their daughters should have, because in many parts of Sudan it is not just having FGM that matters but infibulation and the size of the opening. Women explained that men value a small opening and a tight feeling when having sex.

When marriage takes place the tradition in most of Sudan is that a man is expected to open an infibulated woman up through penile penetration to prove that he is a real man. If a man was unable to open a woman himself, women went to midwives or doctors to open them up but traditionally this was kept completely secret from everyone as the man's masculinity and virility could be called into question. Johansen writes that despite the pain this causes to women it is perceived as a 'positive way of proving virility and manhood'. Cases of clinical defibulation were performed in utter secrecy to avoid shame (2017:7). Although we were told that these attitudes no longer exist, there were similar stories which emerged in this research. Some girls and women become aware of the problems of the wedding night as they are growing up because they are told about it by older sisters or friends, but others do not know about it until the wedding itself. Women described the pain and trauma of this:

If a woman is very narrow she can go to the midwife [to be opened] but it causes so much stigma to men as it means they're not a real man. The man will be insulted by his in-laws and they will ask him for money. They fine him if he cannot open his wife. The men pay whatever money is asked from them. It is shameful, he doesn't want to get it done outside, it affects his masculinity. The in-laws can use this to get something from him. They pay the midwife and the man pays double. That is still going on in rural areas.

A PEER researcher explained that this happened to her sister. The man was surprised about the issue because he had no experience. Attempts to have sex when they married resulted in problems for his wife. He called his sister in law who was older and asked her to bring his wife to the traditional midwife who opened her. They kept it secret and the family don't know this happened. He was happy with how it happened and insists that after childbirth she will not be re-infibulated.

One woman said she came to Scotland to join her husband. She and her husband found it impossible to have relations so she went to the doctor to be opened. It took her two weeks to get up the courage to go to the doctor, her husband was trying to get her to go but she was scared and ashamed. But the doctor reacted well. He explained that it is illegal in Scotland and helped her. Once again the action had to be kept secret from the family. Men are not seen as real men if they cannot open their wives themselves.

3.2.3. Infibulation and re-infibulation throughout marriage.

For women from Sudan who have been infibulated, it is a process that is continuous throughout their adult life. This is because being 'tight' is valued and women are under pressure to be sewn up again either after childbirth or for other reasons.

One woman explained it:

A man is happy and proud that his wife is closed and tight. He opens her by force so that he is a man. Over time it gets more open so he can ask her to go back for more fibulation. The husband encourages her by giving her gifts. The family also encourage her to do it to ensure the marriage continues and she doesn't lose her husband. She repeats the process of suffering daily. The woman is a victim of this cultural practice. Re-infibulation can be repeated frequently with or without birth.

Situations where re-infibulation might occur were described by another woman:

Men insist on marrying a woman who has had FGM because they enjoy this small tight sexual relation and they insist on it even if it does harm. They will make a woman re-infibulate again after a while to make it tighter. If he travels away they also tighten up to make sure [i.e. that she won't be unfaithful to him]. And they do it again after childbirth. The man is happy and gives her gifts and gold. This is not just in rural areas.

This woman married in Sudan and said her husband had come to Scotland before her and she was urged to get infibulated again, 'tightened up' as she called it, by her relatives before travelling to join him. She refused this and her husband didn't want her to do it either. He had suffered a lot in the early days of their marriage from the difficulties the couple had had having sex and he hated to see the pain she was enduring. Younger women are expected to respect the decisions and advice of older women in their culture and do what they say. Her relationship with the older women in the family has deteriorated because she did not do what they wanted. Another woman has resisted her mother's request to return to Sudan for re-infibulation by telling her that her husband doesn't want her to do it again. Both she and her husband have found their sex life has improved since defibulation. She said her mother hasn't raised the issue again. But her grandmother follows her around wanting her to get it done again.

One woman talked about how she was physically forced by her relatives to get re-infibulated. She went back to Sudan on holiday and they insisted on doing re-infibulation. She refused and her husband also did not want her to have it done. But the women of the family surprised her. They came with the traditional midwife and forced her down and performed it on her. When she returned to Scotland she immediately made an appointment with the doctor to have it undone. The doctor asked her why she had done it and did she not know it was illegal? She struggled to explain what had happened through the barriers of language. Since that time she has completely broken off with her family and says she won't go back until she can be sure they won't do this again.

Johansen writing about infibulation among migrants in Norway says that women from Sudan (but not Somalia) experience pressure to undergo reinfibulation after childbirth, and that out of four Sudanese women interviewed who had given birth, only one woman had managed to resist this pressure and she had never had FGM (2017:8).

Not surprisingly a number of women talked about hating having sex and said that FGM lead to poor marriage relations. They talked about how difficult the first days of marriage were and crying on their wedding night. One woman said she was married at 19 and her husband wanted to sleep with her every day. She was screaming and didn't like it. Another talked about how unhappy her husband was because when they first married he expected to have sex a lot, he wanted her to get pregnant straight away but because of the pain it was not possible.

Another said she wanted to get divorced the first night of her marriage. The pain from sexual intercourse was so severe. She started to hate it. She has never enjoyed sexual relations even after her third child. She says that is because they removed everything, there is nothing there. There are other women like her who have not adjusted to the constant pain and lack of enjoyment in sex, which in the words of one 'changed my life'. It is important that once penetration has taken place, sexual intercourse must take place regularly in order to prevent the defibulation from healing. Johansen has written 'this maintenance period is also painful, as sexual intercourse occurs despite the presence of open wounds, and infections and bleedings are common' (2017:3). As one woman put it 'women are scared about their wedding night because they heard from others how they suffered the first night and the following days, and instead of being happy they are just unhappy'.

Some had divorced, other said they wanted to separate and others described doing anything they can to avoid having sex. Women worried about this avoidance of sex because they thought their husband might want to go with other women. One woman talked to her mother about it and her mother said that after your first child the opening will be bigger and you will enjoy it more. She was pregnant at the time of the interview and is looking forward to this change.

However, we also heard about changing attitudes and in particular about some husbands (like those described in the previous section) who disliked the pain and suffering the women had to endure and the difficulties the couple had with sex. They were anti the practice of FGM and supported their wives looking for solutions. Some women said that attitudes are changing with men and some men no longer want to marry women with FGM. They want women to enjoy sex.

It used to be an essential condition for marriage but now after an increase of awareness it is not a condition. And now you even find men looking for women who have not have had it because they want more enjoyment.

One woman said her brother wanted to marry an uncircumcised woman. He is well educated and works in an embassy in the city.

Now in this generation they are more educated and they don't like women with FGM. For the men and even the women the opinion is different. They don't like it. In the past it was proof of virginity but now the men prefer women who haven't had FGM. The one who has FGM doesn't have any sexual desire. They want a woman who enjoys sex. Now people are educated and they prefer women as normal.

3.3. Health consequences of FGM

Health problems that result from FGM are well documented. As stated in the introduction the majority of PEER interviewers and interviewees in this research are from Sudan and therefore have experienced infibulation. Due to the extreme nature of infibulation, there are many direct consequences for health as well as long-term consequences throughout the life of women who have experienced it, particularly in childbirth. No direct personal questions were asked about health. Nevertheless, women recounted a catalogue of serious issues and personal stories particularly around infibulation. We also heard about how people obtained information about the health issues and who they could talk to about them. Most women said they talked to their friends, particularly older women in their communities who have already had children and can tell them about FGM and things to look out for in pregnancy. Some people were newly arrived in Scotland and said that they did not have people to talk to. However, women who had had a child in Scotland recently, named their midwife as a source of information, not just about going through childbirth with FGM, but also helping to develop awareness of what had happened to their bodies and how FGM affected them.

For some women pregnancy was the first time they understood what type of FGM they had had and the impact it had on their body. For others it was the first time they realised this was not something that happened to everyone. This information constitutes a major change since the work carried out by Baldeh (2012) who interviewed seven women with FGM who had given birth to children in Lothian, Scotland in the previous three years. All of these women said that no health professionals had asked them if they had had FGM or raised the issue with them during the pregnancy and there was little evidence of awareness and knowledge about FGM which would have resulted from training of health professionals. Moore, carrying out research in the UK in 2012 describes how midwives felt they had received inadequate training on the issue and how Scotland was perceived to be far behind the larger cities in England in training

health professionals with relevant skills and knowledge (Moore 2012) In 2015, as a result of Baldeh's research, FGM was added to the responsibilities of a specialist midwife working with gender based violence in Lothian. Similar responsibilities had been allocated in Glasgow and other areas responding to greater awareness of the issue throughout Scotland. The much more positive accounts told in this research reflect a growing expertise around FGM in health services in Scotland.

Despite the improvements described here we still heard of problems. A number of women who had type 3 FGM said that they had to go through two procedures, one for defibulation prior to labour and then sometimes they had to be opened up a second time during childbirth. This is clearly when an episiotomy is required in labour. Some women found this upsetting and didn't understand why they couldn't be opened up one single time during labour, which is what they said usually happens in Sudan. This issue was also brought up at the final consultation workshop for the PEER research. The NHS Lothian specialist midwife was present at the workshop and responded by saying that women have a choice about whether to be opened prior to labour or during labour but it is felt better for defibulation to take place in a planned intervention with a specialist health professional and that is why they are encouraging women to have the procedure prior to labour. During labour it might be harder to ensure that this procedure is carried out appropriately, and specialist health workers might not be available.

3.3.1. Infections and smear tests

A number of women talked about the health issues they had as an immediate consequence of FGM being carried out on them. These problems were largely with urinating, and problems with the wound through infections or because the procedure needed to be repeated because it was not carried out properly or had re-opened. Some did not urinate for a long period of time after FGM had been carried out and others did not drink to make sure that they would not urinate. These memories are very traumatic for some of the women.

One woman explained:

The FGM is done by old women who don't have good eyesight to see what they are doing. Sometimes the stitching is not done well and they leave two openings and the urine comes out in two parts. Sometimes they do it incorrectly, and stitch the wrong way and the hairs grow up inside. Sometimes they use contaminated equipment leading to tetanus or other infections. They use traditional methods to heal these, which can make them worse.

This woman said she always has a very bad infection, which made her itchy- she feels shy when she goes to the GP because she gets asked a lot of questions and as a result she doesn't want to go again.

A number of women had on-going problems with urinating and with urine infections. Women also recounted problems with menstruation saying that like the urine, the blood did not flow properly. Contamination because of poor urine and blood flow can lead to irritation and scratching which leads to cysts. One woman said that her cysts were so bad she had to be operated on before she could get pregnant. She had successfully got pregnant after that but the cysts had returned.

Many women told us that they found going for smear tests difficult or that they never went for them. One woman said she was too narrow and others said that the whole experience was too embarrassing and difficult for them.

3.3.2. Pregnancy and defibulation

Pregnancy is the single biggest health issue that women raised when talking about FGM. Some women said that everything is fine for people with FGM when they are having children and didn't describe any problematic issues. However, many women talked about being scared of pregnancy particularly those with infibulation. Talking to other women in the community, particularly those who already had children, was a major source of information. Women talked of being scared by these stories, which made it clear how painful and difficult childbirth could be. Some people gave personal stories and had experiences of health workers not asking them anything about FGM and they found it very embarrassing to raise it themselves. These tended to be women who gave birth some years ago. Women who had children recently had different experiences.

It became evident when talking about pregnancy that women were not always clear about which type of FGM had been performed on them. One woman said she had had sunna but then went on to describe 'being opened', and the problems associated with it which clearly indicate that she had been infibulated. Johansen has written that clinical evidence suggest that many women who claim to have sunna are in fact infibulated (2017:3).

One woman said she had thought that when she got married FGM would be over. She never asked the midwife about it and the midwife didn't ask her. However, those who gave birth more recently felt they could trust the midwife and valued the information and advice they received. Many of them related personal accounts:

I talk to close friends who have experience and the midwife who is best for advising in this issue. She tells you what type you have and whether you need to be open.

My pregnant friend told me that she had spoken to the midwife and she said how worried she was but the midwife told her not to be worried because FGM is well known here and the staff is well trained and in case of problems you can have a caesarean.

Women raised a lot of issues about defibulation. For first-time mothers there were difficult decisions to be made about when this should occur and how it would impact on childbirth.

A PEER researcher recounted a woman's story:

When she had her first born four years ago she talked to the midwife who told her she had FGM. They did defibulation a month before. When she went to deliver they found the hole wasn't big enough and had to open it some more. She said that in Scotland the staff are not qualified enough or experienced enough. This put her off having a second child and she waited a long time. In the second pregnancy the midwife asked her about FGM and it turned out to be a much easier delivery. This woman felt that in Sudan staff are more experienced and just open the women at delivery time.

A woman who had her first baby seven months prior to the interview in Glasgow, said that the midwife talked to her about FGM when she was pregnant. She is young so she hadn't talked to friends about it, just the midwife. She said:

When I met the midwife she told me a lot about FGM. The midwife said to me 'If you want I can open it for you. If you don't want that I won't'. We talked about it a lot. After four months I tell her 'I want you to open it for me. Do me a small operation'.

This woman said the defibulation that was carried out prior to her first labour was sore and uncomfortable for about a month. However, when it came to her second pregnancy the whole process was much easier.

Another woman said that the midwife explained that sometimes it could be problematic delivering the baby when a woman had FGM. They tried a vaginal birth but the baby was breech, so she ended up having a caesarean. She felt terrible; she never left the bed, just cried for 20 days, the caesarean was very bad. Not being able to speak English made it even harder, but she said she had recovered from the birth and now things were going well.

The importance of having good communication with women is highlighted in this story, which could have had a disastrous outcome as recounted by the PEER researcher:

A woman had a child ten years ago and said that no one spoke to her about FGM when she was pregnant. She did not bring it up so there was no communication about it. She got a massive pain and phoned the ambulance but labour had already started - she ended up having the baby at home. They took her to hospital afterwards.

One woman felt lucky that she had her second baby in London before moving to Scotland four years ago and was attended by a Nigerian doctor who was very familiar with FGM. The doctor opened her up during labour. She had a normal delivery- she was opened at the same time the baby was coming just as she claimed would happen in Africa. However, she told the PEER researcher that when you give birth in the UK they don't redo the stitches and that she had returned to Sudan to get re stitched.

Another woman talked about the surprise of the health workers when they examined her. The midwife was shocked and asked her how the pregnancy happened with such a small opening and also asked if some of her colleagues could see her. The woman gave permission and two more people came to look at her and were very surprised. She was also surprised as she thought everyone was like that and even though she had given permission for other staff to see her, she felt very ashamed. This was the first time she saw the area herself. The midwife said she needed two surgeries and she said she cried a lot after the surgery because she realised what had happened to her. The urine started to come and she felt a bit of sexual pleasure after defibulation. She relaxed physically and mentally and it was better for her and better for her husband. She was also able to have a vaginal birth, here in Glasgow.

3.4. The law and prevention of FGM

Contrary to research carried out for Phase 1 of My Voice, many more of this cohort knew about the laws forbidding FGM. Some women said that they only knew about it once they had children, because it was the health professionals who made them aware of it, midwives, doctors or health visitors. A few women said a lot more needs to be done about raising awareness about the law and this particularly needed to be targeted at new arrivals as well as younger women who had not yet had children. Some women recounted stories of social work and police involvement when they were returning home for family visits or holidays, and this raised some uncomfortable issues of feeling harassed. However, most women said that they didn't think the practice should continue any more.

I know about the laws in the UK. I heard about it from people. I won't do it for my daughter but I know people that have done it in Sudan. They have gone on holiday to do it, not to the capital.

No one talked to me but I heard from a friend that the police came and gave her a warning that if she took the girls to Sudan and did FGM she will face jail of 14 years.

One of the Nigerian women said she mostly knows about FGM because of her studies and is very strongly against it. She has also seen a lot of cases with medical problems and read about a lot of cases as well. She believed it is against human rights. Another said they know from the midwife that it is a crime and also there are some charities that raise awareness about FGM and its consequences. The suffering and pain women themselves experienced had a big influence on not carrying it out on their daughters.

If you have a daughter, you can't do it because it is illegal in Scotland. I don't want it for my daughter because I have experienced it and suffered a lot so won't do it. Even my husband doesn't want it.

Only one person was so concerned about her daughters marrying that she openly said she thought the practice needed to continue. Her argument was that the real vulnerability is not to get married which would leave woman unsupported and not accepted in her community.

People in my community don't know about the law. It's very rare to find women who know the law and generally they don't believe it is for the protection of children. FGM is the real protection for the children as it is the way to make sure they get married.

At least one account showed that there are examples of good coordination between services to make sure women are protecting their daughters on visits home.

One woman had twin daughters who are at a nursery in Edinburgh. She told the nursery she was planning to go back to Sudan for an extended visit for a year. She said the social worker and the nursery talked to her a lot about this and gave her documents to sign. They asked her whether or not she planned to carry out FGM on her daughters and when she said no, she was against it, they asked her how she planned to protect her daughters and talked this through with her. Social workers gave her a number and said, if you have any problems in your country you can call the number in the UK and they will call the embassy in Sudan and pick up your family and take them back straight away.

They recommended that she did not go for such a long visit this time. She went to Sudan as planned but only stayed for 2 months. She was scared about going and scared about coming back, she was scared that her mother and granny would do something to her daughters saying 'you know in my country if I have a girl and I go outside with my husband, my mum will take my girl and she can do anything because she has looked after them. Because of your religion you have to respect your mum, you can't be rude to her. You just can't'.

When she arrived back in Sudan she told her granny and mother 'you are not allowed to do anything to my daughter because there are a lot of laws in Scotland, maybe they are going to put me in detention'. She told the PEER researcher 'I don't want to do this to my daughters, it was done to me and it was very bad for me. But I am sick of the health visitor talking to me about it'. However, she feels that the visit went well, she was able to protect her daughters and she has returned for a subsequent visit to Sudan.

Other women spoke about getting information and being checked on before travelling.

She knows about the law, the health visitor told them and says that if they are going to Sudan they will examine the child before and after the visit. She didn't ask, she just signed the paper.

Another family faced problems with the police when they went to Sudan, and said that they felt harassed by them. She thinks there should be awareness raising before the police are involved. This family feel strongly that FGM should not be carried out on their children and therefore they should not experience this type of unwanted attention.

Some women felt much more needed to be done to make the law better known.

I did not know about the law until this training. I think nobody knows about it.

Women who have not been pregnant don't know about it. They ask other women here who have experience. They need to create awareness here, especially with women who haven't been pregnant yet and are new arrivals. She had no idea about the law until she went to the seminars.

A woman who does not have children said 'my friends told me that the midwife told them it is a crime in Scotland and that the children would be examined if they spent a long time in Sudan'.

3.4.1. Stories of resistance: the next generation

We heard different accounts from people about how much they think FGM is still an issue in their community. Because of the law it is unlikely that anyone would tell us much about ongoing FGM being carried out in Scotland. Some women said that FGM is still carried out with nearly everyone in Sudan and that this pressure has carried over to the diaspora community in Scotland. Others said it is a practice that is dying out in Sudan and there is no longer pressure to carry it out on children here. Many women made a strong distinction between urban areas where they said it is disappearing and rural areas where it carried on. One woman said that over half the Sudanese in Scotland are from villages, i.e. rural Sudan implying that there is still pressure on them from families at home to carry out FGM on their daughters. In her village hardly anyone has not had FGM, no one has not done it. Even younger people are still practising it.

Others talked about the change in practice so they said FGM was still carried out but was less harmful because it was mostly sunna (type 1 or 2). One woman said 'anyone 35 and over has pharonic, and 35 and under is sunna and now it has stopped for most people'.

Women told us about their particular battles with family to stop FGM:

My family ask me to do it. I don't want to do it. They keep teasing my daughter, they call her Ghalfa. My mum, my granny and my father, they all tease her. They don't accept it and keep asking me to do it for her.

My family still want me to do FGM. They live in a small village. I have been back on holiday twice. They are still doing it to other children in the village, they do it at a younger age now to stop the girls from talking about it so do it before 5 years old. I don't want to do it to my daughter. I talked to my husband and said I didn't want

to do it and he was ok with that. They talked to him as well when we were going abroad. I don't like FGM- they did it twice on me because my wound re-opened. I was very frightened and don't like it at all.

As mentioned earlier in this report, men were thought to want it less than previously and we heard stories where the husband felt very strongly that he did not want his daughters to have FGM, he did not want them to suffer in the same way his wife had suffered. This was considered helpful because 'a man can stand up to his family. He is strong.'

Some women tried to stop wider family members from carrying it out. One PEER researcher recounted an interviewee saying:

Women in our community know about FGM from our seminars. She supports the law; she would never do it. She has a niece and they wanted to do FGM to the niece in Sudan. She tried to stop it, but in the end they did it four years ago. They asked her for money to pay for the FGM ceremony for her niece, and she refused to give that. She supports them in different things with money but refused for this. But they found the money elsewhere. She is very angry with them. She talked to the girls and the girls themselves wanted it, they get gold jewellery, presents, gifts, they have henna on. Everyone gives them money and they save the money. They want all that, they don't understand.

Another said.

My niece was born in 2007. Her mother insisted on her having FGM, and they told me while I am here. I told her mother about the problems it caused and asked what benefit she would gain from it. She insisted and went ahead and after a week, they told me they did it and that she suffered a urine problem and infection. She stayed a week in hospital.

3.4.2. Prevention and mitigation: diaspora organisations

From the group of women who participated in the PEER research whether as PEER researchers or as interviewees, it is clear that many of them have good information about FGM, understanding what it is and with knowledge of the law. There are many more activities around FGM in Scotland now than there were five years ago particularly in Glasgow and Edinburgh and the central belt of Scotland where this research was carried out. Diaspora organisations are working with their communities to raise awareness and make sure people have accurate information. For example, Kenyan Women in Scotland Association (KWISA) has held events and training for women from Kenya and many other countries about a range of issues related to FGM. In the Sudanese and Middle Eastern Arabic speaking countries, the diaspora organisation called Together for Better Life was formed in 2016 and has been running a comprehensive model of awareness-raising that focuses on four dimensions of the practice: health, legal, social and cultural. My Voice and other third sector organisations have been carrying out training and awareness raising sessions.

Many of the women had already had information about FGM from diaspora organizations based in Scotland. In particular, Together for Better Life (TBL) was mentioned by the Sudanese women as a source of information and so was Jamila Hassan and other volunteers volunteering for the organization. TBL was started as women's group, and became established as an organization in 2015 and registered as charity in 2016. The purpose of TBL is to harness community's (African and Middle Eastern communities) resources to improve life of their co-migrants. Their work includes information and awareness raising sessions for communities affected by FGM with a particular focus on Sudanese. They train community members to

engage in informed conversations with their social network giving out information and raising awareness about health issues, the law around FGM, religion and cultural issues, as well as access to services and psychosocial support.

A number of women mentioned the seminars and training run by TBL as the source of information for their knowledge. One woman said

The interviewer (PEER researcher) is my friend. She invited me to one of the seminars- I couldn't go and asked her about it and the content etc. She is in an organisation TFB and she got training from them and learnt a lot. She learnt about types of FGM and health. It was useful for me- it means I get to know the kind of FGM I have because I was shy to ask my mum this.

When asked how she recognised the type of FGM she had she replied that she was shown photos and recognised which type was hers. She also learnt that it is criminalised in Scotland. Her husband is against it because he has seen her suffering. When they had their first baby she and her husband discussed it and he said if it is a girl we will not do that because you have suffered a lot.

3.4.3. Support of health professionals and service providers

Health professionals and service providers were also an important source of information about FGM, and the law against it with associated implications in Scotland. Among health professions, midwives were mentioned most frequently, which perhaps is not surprising in a group of adult women. A great deal of training has taken place for midwifery and obstetric services in Scotland since 2015 and it is heartening to see the impact in these accounts described by women who clearly had relationships of trust and confidence with their midwives. There is much still to do, but these specialist services emerged as being of key importance for giving out accurate information about health and the law. We also heard that that information is cascading through the women's social networks.

Additionally, there is evidence of good practice with early year's education working closely with social services to raise awareness at the time of travel home. While this appears to have been effective and there was support and advice for the woman in Edinburgh to help her protect her twin daughters that was described in Section 3.4, we also heard of frustration about how much priority the issue was given ('I am sick of my health visitor going on about it to me') and a sense of being 'harassed' by social services and the police when families travel to Sudan, with papers to sign and a feeling they are being watched. At the same time the women felt that they did not want FGM to carry on, they had bad experiences themselves and did not want those repeated in the second generation. In particular families who are campaigning to end FGM and have made tough decisions to resist family pressure felt that the police and authorities did not differentiate between them and other families and found interference unfair and on occasions humiliating. It is hard for people who feel they are fighting on two fronts, fighting their families at home not to have FGM carried out and a sense of fighting the authorities in Scotland to persuade them it is safe to take their children home. However, given the extremely strong pervasive social norms that are described here as still existing in parts of Sudan a tough response is required from the Scottish authorities.

Communities affected by FGM also want a robust response. At the final consultation workshop for the PEER research, where there was a lively discussion on these issues, people expressed the concerns about feeling harassed and criminalised. But they also raised the issue that some women travelled to Africa with young daughters and there was no contact from the authorities. One woman from a country where FGM is widely practiced protested strongly at the workshop that she had taken two young daughters out of the country and no one had

asked her anything before she left and no one had contacted her since she returned. She is passionately anti FGM and felt that someone should have been documenting her travel. Some workshop participants commented that going on holiday should not be an indicator of risk without additional information. On the other hand, they thought that there should be more focus on very small children who are preschool. There was a feeling that there is an uneven and inconsistent approach to who is contacted and who isn't.

It has been made clear in interviews and in workshops that women feel uncomfortable going to the police directly about any concerns they have if they think friends or family are considering carrying out FGM on a young girl. At the workshop they said 'It is not in our nature to report to the police'. There were concerns about betrayal if people reported. However, some people were prepared to talk to service providers. Some older women said they would go to social workers for help and advice. Younger women said they would go straight to the police 'I don't care, I'll go tell police. For young people, we don't care. We're different.' Another young woman said 'If I had a friend who was scared and had parents who were pressuring them – I would tell them to seek help'.

At the same workshop a representative from Police Scotland raised the possibility of having special help lines for reporting or having intermediary people such as trained members of the community possibly located in FGM support and diaspora organisations as a first point of contact for those who did not want to contact the police directly. Some people said this would help them have confidence in reporting.

The issue of reporting and a sense of criminalisation is one fraught with contradiction and tension. However, there are some examples of good practice and willingness for the community to engage on this issue to ensure people are more confident about reporting. These are positive signs for moving forward on this difficult and sensitive issue.

4. What is to be done about FGM? Conclusion and recommendations

This report has described findings from the second phase of the My Voice PEER research project. The focus on women from FGM affected communities, largely married and with children has resulted in detailed information about the impact of FGM on adult life for affected communities. In particular, the hard and painful effect of infibulation has been described and challenges for service providers who need to respond to this difficult topic are identified.

At the end of My Voice phase 1 we proposed a series of recommendations and next steps on how to facilitate community engagement with FGM affected populations in order to challenge and prevent FGM in Scotland and to ensure that prevention and support services for FGM affected communities are culturally appropriate. This section summarises progress against those recommendations, which has been carried out in Scotland in the last twelve months.

Since 2016 My Voice has had an FGM support worker based in the African Health Project at Waverley Care. A network of the PEER researchers who were involved in phase 1 as well as other interested individuals from FGM affected communities has been established. This network, called the FGM Community Network has met three times during the year and representatives sit on the FGM Multi Agency Implementation Group, which is coordinated by the Scottish Government. They have presented findings from the research at a range of events alongside others from the statutory and voluntary sectors. The network members have reported becoming more empowered and confident about doing this since becoming involved in My Voice. In March 2017 a final consultation workshop was held which brought together 35 of the PEER researchers who had been trained in both phases of My Voice. Findings from the research were fed back to the PEER researchers in order to facilitate discussion and proposals for recommendations. Because two of the main issues that emerged in the research have been health (largely obstetric care) and reporting (including the fear of FGM communities being criminalised), we invited a representative of Lothian specialist obstetric services for FGM and a representative from Police Scotland to attend that meeting. A lively exchange of ideas resulted from that and a number of concrete proposals and recommendations emerged which have also been fed into the recommendations below.

4.1. Recommendations

Much progress has been made against the recommendations from phase 1 of My Voice. These are detailed below. The recommendations still stand with one addition.

1. Delivering the Scottish National Action Plan to Prevent and Eradicate FGM

In Phase 1 we recommended that:

- Findings of My Voice feed into the National Action Plan to ensure the voice of FGM affected communities are integrated into the objectives and activities.
- Ongoing training sessions are carried out using practical activities to bring together professionals charged with delivery of the Scottish National Action Plan with the FGM affected communities (e.g. PEER researchers from My Voice or other representative groups).
- Additional recommendation (phase 2): Ensure that findings from phase 2 of My Voice about the particular needs of women with type 3 FGM are fed into appropriate services and in particular health services.

Progress to date:

- A network of trained PEER researchers from My Voice has been established.
- Representatives of the FGM Community network sit on the national FGM Strategy Implementation Group established to progress, monitor and evaluate the implementation of the actions from Scotland's FGM National Action Plan. Findings from My Voice have fed into reporting on implementation of the National Strategy.
- Representatives of the network have presented findings at events highlighting issues around FGM to ensure that the voice of FGM affected communities is included in the Scottish response to FGM.
- A final consultation event was held for the PEER researchers trained through My Voice to which representatives from statutory services (health and the police) charged with delivering the Government's National Action Plan attended. Dialogue and group discussions resulted in key findings and next steps.

2. Community Engagement

In Phase 1 we recommended that:

- Ongoing support and development to increase confidence and develop action plans for continuing meaningful community engagement with existing PEER researchers from My Voice.
- Expansion of PEER to working with women, as well as in other parts of Scotland with significant populations from FGM practising countries.

Progress to date:

- Existing PEER researchers are being supported in techniques of public speaking and engaging with others on the issues related to FGM through the network and public events they have attended.
- The second phase of My Voice carried out PEER research with women. Nineteen women were trained as PEER researchers and they conducted interviews with twenty-nine contacts. Many of the women and their contacts were from Sudan as described in this research report. Although this is not the biggest community affected by FGM in Scotland it is one which requires a great deal of support in health, especially pregnancy, and due to the high prevalence still in Sudan robust measures for prevention are extremely urgent.
- My Voice has initiated contact with appropriate organisations working with people affected by FGM in other parts of Scotland. A mapping exercise of relevant organisations has been started. Contact has been made with service providers already working with FGM and work is being done to raise awareness about FGM through Waverley Care's African Health Project work across Scotland. This includes work to raise awareness of the needs of African Communities at strategic and planning levels and this provides a point of first base for raising the issue of FGM with health boards.
- Women in this report pointed out that younger women who had not yet had children as well as people recently arrived in the country did not have easy access to information about FGM and/or the law in Scotland. These groups should be targeted with awareness raising and training.

3. Service Delivery

In Phase 1 we recommended that:

- An FGM specific service is established which acts as a focal point.
- The service acts as a conduit and point of contact for FGM affected communities and service delivery.

- It can play a role in working together with existing diaspora organisations.
- The service establishes a safe space for discussion and interaction for affected communities.

Progress to date:

- My Voice has now established an FGM specific service located in the African Health Project at Waverley Care. An FGM support worker is employed who acts as a focal point for enquiries, training and support. The African Health Project was seen as an appropriate location for My Voice because it is the only African specific health project in Scotland. It has a team of eleven experienced staff trained to work on sensitive health issues with Africans. A number of staff from the African Health Project and Waverley Care have now had training on FGM.
- A final consultation event was held for the PEER researchers trained through My Voice to which representatives from statutory services (health and the police) charged with delivering the Government's National Action Plan attended. Dialogue and group discussions resulted in key findings and next steps.
- The service is developing its role as a conduit between communities affected by FGM and statutory and other services. This was particularly evident at the final consultation workshop when dialogue was established with representation from statutory services. There has been dialogue previously but often a few people from FGM affected communities get invited to an event, which is largely attended by professionals. This time the two service providers were invited to an event run by and for people from affected communities. This meant that both sides were better able to listen to each other.
- The FGM Community network aims to bring together diaspora organisations as well as PEER researchers to enable a stronger community voice to develop.
- Service providers in the statutory sector such as the Police, social services and the health sector have carried out extensive training in FGM and this is reflected in some of the stories around good practice that we have documented in this report. However, more needs to be done to ensure this reaches out beyond specialist workers, and the central belt of Scotland.

4. Working with young people

In Phase 1 we recommended that young people are:

- Included in initiatives around FGM.
- Supported to take the lead in developing age appropriate activities to develop knowledge and confidence.

Progress to date:

- Young people have continued to be included in the work of My Voice through the FGM community network and events. There is a small but very committed group of young people who attend regularly. Phase 2 of My Voice has focussed a lot on the demographic, which was missing from Phase 1, adult women. This has perhaps meant that work supporting young people to campaign and raise awareness about FGM has not progressed as quickly as hoped and that will be a priority going forward.
- Young people have been supported to speak at events and attend meetings with the My Voice worker. More needs to be done to support campaigning and awareness raising. At the final event of My Voice in June 2017, members of UK integrate (previously Bristol integrate) who had in part inspired My Voice, will attend. They will speak about their experiences raising awareness about FGM through activities and in particular through

the media. It is hoped that My Voice and other organisations in Scotland will learn a lot from their visit.

- Schools are an important location for working with young people and could take a greater role in partnership working to empower young people to obtain information and raise awareness about issues to do with FGM.

5. Working with women

In Phase 1 we recommended that:

- Women affected by FGM are fully engaged with delivery of the national action plan and national awareness-raising.
- There should be more support for diaspora organisations to facilitate their input into the Scottish response to FGM.
- Expansion of specialist support services is required for women directly impacted by FGM.

Progress to date:

- Women are represented on the national FGM Strategy Implementation Group through the FGM community network; however, more awareness of the particular issues around infibulation need to be raised to higher up the agenda.
- The Scottish National Strategy on FGM is firmly embedded in the Violence Against Women Framework.
- Diaspora organisations such as KWISA and Together for Better Life have received some funding and carried out a range of activities. However, evidence from this report demonstrates how essential it is that they play a much bigger role in preventing FGM and supporting women who have had FGM carried out on them.
- More specialist services are still required to offer counselling, medical support for problems linked to infibulation and psycho-sexual counselling.

6. Working with men

In Phase 1 we recommended that:

- Men are encouraged and supported to work with FGM, in terms of understanding the issues facing women and the support they might require as well as the importance of prevention, and the issues that affect men around FGM more directly.
- The issues can be embedded within work on gender equality ensuring a wider and more interconnected approach.

Progress to date:

- Men have engaged with the FGM community network at My Voice and attended events around FGM issues on behalf of the network.
- Evidence from this report demonstrates how essential it is to work with men in order to assist families resist traditional pressures to carry out FGM on their daughters.

7. Engaging religious leaders

In Phase 1 we recommended that:

- Further work is carried out with religious leaders to ascertain attitudes and knowledge and to work with faith based organisations in particular to assess whether these are good locations

for awareness raising and education/training for FGM affected communities, and whether some key religious leaders could become agents for change in their communities.

Progress to date:

- Religious leaders have participated in FGM awareness raising particularly through the FGM zero tolerance event organised by KWiSA.
- Waverley Care has worked with religious leaders for many years and employs two in the African Health Project who have been involved in My Voice and can take this recommendation forward.

4.2. Conclusion

This research has documented the impact of FGM on adult women living in Scotland. A result of having a large percentage of women from Sudan participating in the research, there is detailed information about the impact of type 3 FGM which includes infibulation. Although the numbers of women with type 3 FGM in Scotland is not that large, the complex health and psycho-social support required, means that service providers need to be particularly well trained, with a sensitive approach to information of a very intimate and personal nature. The previous twelve months has seen much progress in the work on FGM in Scotland. There is greater awareness of the issues amongst service providers as well as the third sector. Stories of good practice and multi sector working emerged from this round of PEER research. It is essential that this work is now embedded within services, extending knowledge beyond specialist workers and outside the central belt.

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Appendix 1: Interview guide for PEER researchers

Developed by PEER researchers as part of the training for My Voice.

Demographics

Age category	←25	26–35	36–45	46–54	55→
Education					
Current employment					
Country / Community linked with					
Language					
Language interview conducted in					
Number of children					
How long have you lived in Scotland?					
Have you lived in any other European country?					

Interview Questions developed and asked by PEER researcher

1. Do you know what FGM (or use relevant term) is?
2. Since you came to Scotland has anyone talked to you about FGM?
 - a. If yes, who did you talk with?
3. In what situation did this conversation take place (probe for more questions?)
4. What health problems do people in your community face due to FGM?
5. Who do women in your community speak to about FGM when they are pregnant?
6. Do you feel there is stigma about having or not having FGM in your community?
 - a. If yes, who from (probe)
7. Do people in your community know about child protection laws and FGM in Scotland?
 - a. If yes can you tell me a bit more?
(probe- how do they think people know about it, what do they know etc.)
8. In your community who makes the decision to carry out FGM
9. In your community what is the role of FGM in marriage?
10. Tell me a story...

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