Evaluation of FGM Prevention among Communities Affected by FGM: A Participatory Ethnographic Evaluation Research (PEER) Study

Endline Phase 2

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Acronyms

AAF	African Advocacy Foundation
Bawso	Black Association of Women Step Out
BME	Black and Minority Ethnic
BSC	British Somali Community
BSCA	Bolton Solidarity Community Association
BSWAID	Birmingham and Solihull Women’s Aid
BWHAFS	Black Women’s Health and Family Support
CBO	Community Based Organisation
FC	Female Cutting
FGM	Female Genital Mutilation
FORWARD	Foundation for Women's Health, Research and Development
GSWG	Granby Somali Women’s Group
NHS	National Health Service
NGO	Non-governmental organisation
OSCA	Ocean Somali Community Association
PEER	Participatory Ethnographic Evaluation Research
PR	PEER Researchers
SCA	Southall Community Alliance
SDS	Somali Development Services
TFGMI	Tackling Female Genital Mutilation Initiative

About the Tackling FGM Initiative

Trust for London, Esmée Fairbairn Foundation, and Rosa Fund, three independent charitable organisations, collaborated to establish a UK-wide Special Initiative to fund community-based preventive work to safeguard children from the practice of Female Genital Mutilation (FGM). The Tackling FGM Initiative (TFGMI) ran between 2010 and 2016. By supporting organisations based within practising communities, the Initiative aimed to strengthen the voice of women and children already affected by, or at risk of, genital mutilation in all its forms[1]. Approximately £2.8 million was invested in 12 organisations across the UK over the course of the Initiative, with ten organisations continuing their work through to 2016. A Small Grants Programme additionally funded 39 organisations across the UK from 2013-2016. Options UK was appointed to monitor and evaluate the TFGMI.

About the funders

Esmée Fairbairn Foundation funds the charitable activities of organisations that have the ideas and ability to achieve change for the better. Its primary interests are in the UK's cultural life, education and learning, the natural environment and enabling disadvantaged people to participate more fully in society: www.esmeefairbairn.org.uk

Trust for London is one of the largest independent charitable foundations in London, providing grants to the voluntary and community sector of over £6 million per annum. It aims to enable and empower Londoners to tackle poverty and inequality, and their root causes. Established in 1891, it was formerly known as City Parochial Foundation: www.trustforlondon.org.uk

Rosa, the UK Fund for Women and Girls, is the first UK-wide fund for projects working with women and girls. Rosa's vision is of equality and social justice for women and girls and a society in which they:

- Are safe and free from fear and violence.
- Achieve economic justice.
- Enjoy good health and wellbeing.
- Have an equal voice.

Rosa will achieve this by championing women and girls, raising and distributing new funds and influencing change: www.rosauk.org

About the evaluators

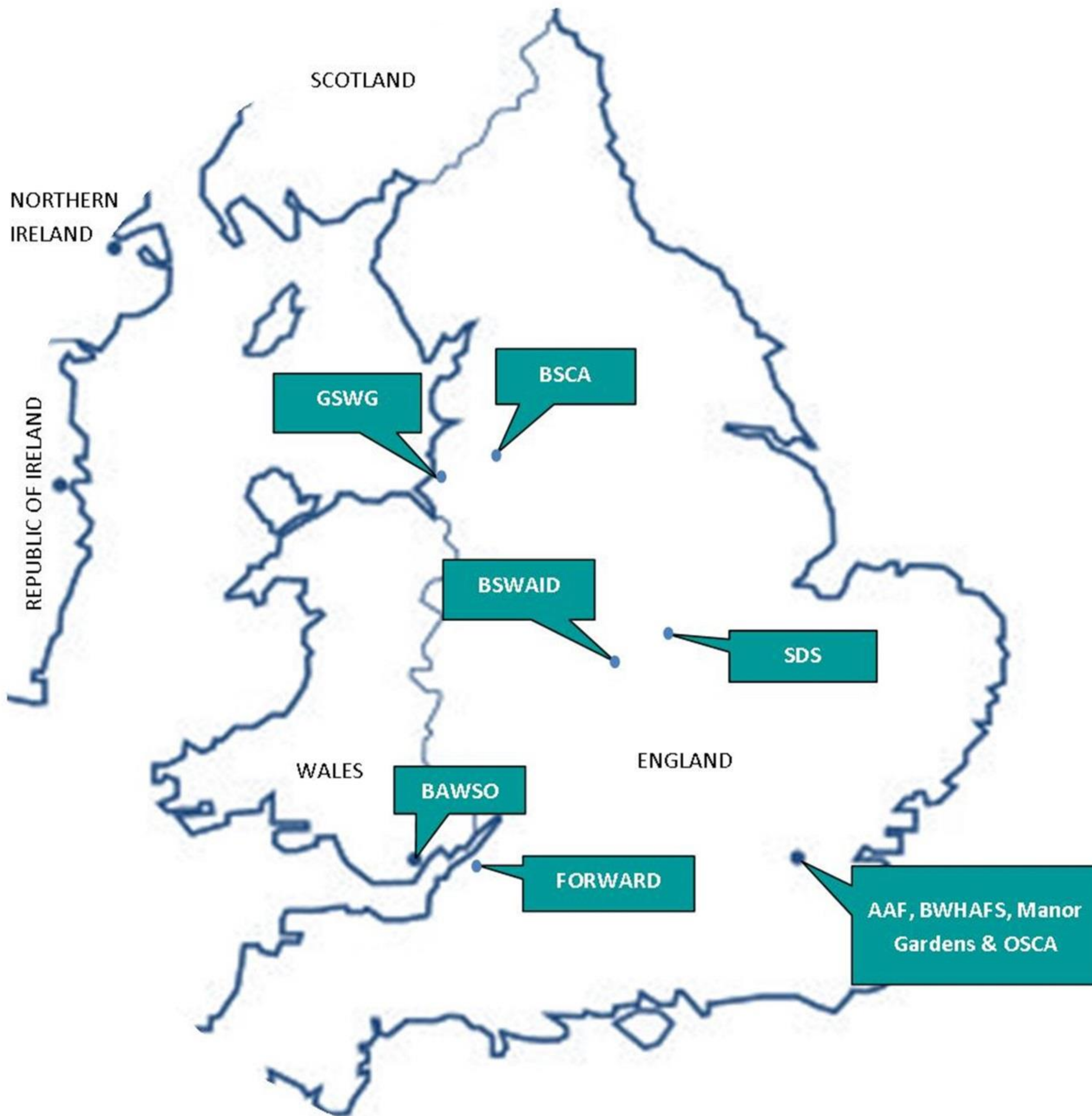
Options UK is the UK programme of Options Consultancy Services Ltd, a leading international provider of technical assistance, consultancy, and management services in the health and social sectors.

To learn more about Options UK, visit www.options.co.uk/uk. The PEER approach is a specialism of Options, developed in collaboration with academics at the University of Swansea. For more information about PEER, contact peer@options.co.uk or see www.options.co.uk/peer.

Disclaimer: The views expressed in this report represent those of the authors, and not necessarily those of the various organisations that supported the work.

[1] The World Health Organization defines four types of FGM. For definitions see: http://www.who.int/mediacentre/factsheets/fs241/en/

Map of PEER study partner organisations



1. Introduction and methodology

1.1 Introduction to PEER

Between 2010 and 2016, a number of community organisations worked to reduce women's and girls' vulnerability to Female Genital Mutilation (FGM) in England and Wales, as part of the Tackling FGM Initiative. The Initiative aimed to encourage projects to report the outcomes of their work; in other words, changes in attitudes and behaviours over the course of the Initiative. This has been evaluated using a Participatory Ethnographic Evaluation Research (PEER) approach.

In PEER, ordinary community members are trained to conduct in-depth, conversational interviews with others in their social network. An emphasis is placed on collecting stories and examples, and interviews take place in the third person (e.g. "What do people in your community say about…?"). These factors encourage respondents to move beyond normative responses (what they feel they *should* say), as discussions take place between trusted friends rather than with an external researcher, and the interviewee does not feel that their personal opinions and behaviour are being scrutinised or judged.

PEER provides rich narrative data about the ways in which people conceptualise and talk about FGM in their daily lives. It does not provide prevalence (quantitative) data on how many cases of FGM there are, how many women/girls are at risk, or how many girls may have avoided FGM due to the projects. However, PEER does provide insights into people's attitudes towards FGM, how they feel about the prevention of FGM, and whether they perceive this as being effective.

1.2 Evaluating the Tackling FGM Initiative using PEER

The Tackling FGM Initiative used PEER to measure shifts in attitudes to FGM, including support for the practice, and to assess how that change is happening.

Each participating project undertook a baseline PEER study at the start of the Initiative in 2010, at the end of Phase 1 in early 2013, and repeated again at the end of Phase 2 in 2016. PEER evaluated how and why change in attitudes towards FGM was happening, as well as how the work conducted by projects may have contributed to this. The results provide lessons and recommendations for the future of anti-FGM work in the UK.

1.3 Methodology

In all studies, project staff leads were trained during a one-day workshop on research questions, ethics and basic interview skills. They then selected several community members to be trained as PEER Researchers (PRs) and repeated the PEER training. Over 340 people participated in all three studies, with approximately 100 PEER Researchers interviewing one to three friends each.

In the 2016 PEER study, 29 PEER Researchers interviewed 51 respondents between them, who were friends known to and trusted by them (giving an overall total sample size of 80). The ages of PEER

Table 1: Demographics of PEER Researchers and their interviewees

	Age (mean years)	Marital status	Educational status
PEER researchers (29)	36.8	Married: 8 Divorced: 4 Single: 6 Missing: 11	Higher Education: 14 Secondary School: 4 Missing: 11
Interviewed friends (52)	35.5	Married: 15 Divorced: 7 Single: 6 Missing: 24	Higher Education: 17 Secondary School: 7 Primary school: 2 None: 1 Missing: 25

Researchers and their friends ranged from 21-65 years of age. PEER Researchers were mostly women who had had some contact with the ten projects (for instance, who had attended a workshop), who interviewed friends in order to elicit detailed narratives about FGM in the UK. A large range of age groups and ethnic backgrounds are represented among the PEER Researchers and their respondents, including Somalia, Sudan, Eritrea and Zimbabwe.

Research questions were framed around the 'last two years' to specifically evaluate changes occurring during Phase 2 of the programme (2013-2016)[2]. PEER questions are 'conversational prompts' and were developed with PEER Researchers during the training workshop. PEER elicits narratives of change, as well as rich descriptions of attitudes to FGM among affected communities. Interviews between PRs and their friends were fed back to project leads during 'de-briefs' where further meanings within the data were explored. Project staff took detailed notes which were typed up and sent back to Options UK for analysis. Full PEER questions are presented in Appendix 1.

Table 2: PEER Researcher questions

Q.1 What do people in our community say about FGM?
Q.2 How has this changed over the past two years?
Q.3 What do people in our community say about efforts to end FGM?
Q.4 What do people in our community think about the needs of women affected by FGM?
Q.5 How has our project impacted on our community and FGM?
Q.6 What more should be done to tackle FGM?
Q.7 Please tell me a story.

2. PEER research findings

The PEER questions were broadly divided into, firstly, exploring views on the prevention of FGM and, secondly, women's access to care. This section explores prevention, in terms of:

- Attitudes towards support for FGM and how this has shifted over the life of the TFGMI.
- Ongoing support for FGM.
- Perceptions of efforts to end FGM (including 'mandatory reporting').

Women's needs and access to services are explored in Section 2.8 below.

2.1 Attitudes towards FGM: How have they shifted between 2010 and 2016?

The PEER data from the baseline and endline studies show significant shifts in understanding of and attitudes towards FGM. Overall, strong progress has been made in raising awareness and building opposition to FGM across communities and people affected by FGM. Groups where there was a visible shift towards speaking out against FGM included parents, grandparents and young women who either had undergone or were at risk of FGM. The voice of women, stating their opposition to FGM and their role in ending the practice, comes through very strongly. As one respondent put it:

> *"There are many women in my community who live everyday with what FGM has done to them. It may have been a one-off incident but it will stay with us and hopefully end with us."* **AAF, female respondent, London**

[2] Some projects started later than others, and the period of two years was chosen as it covered all of those included in the PEER study.

The PEER narratives support the conclusion that a critical mass of people speaking out against FGM has been achieved in many areas. There have been public discussions about FGM, with many reporting that the status of FGM has changed, and that it is no longer being viewed as a 'taboo' subject. The wide range of those involved in these discussions, including not only people from affected communities but also frontline professionals, the media, community leaders and others, has contributed to a perception that talking about FGM is now 'normalised'. There are important exceptions to this (see Section 2.6) but the majority view is that there has been much progress over the last two years in reaching audiences and shifting support for FGM.

> *"This has changed over the last two years because FGM is universally being targeted. It is no longer taboo and more people have the confidence to talk openly about it, which means that more people can ask for help or recognise that they need help rather than suffering alone. Everyone is now more aware of FGM and there are campaigners all over. Within our community FGM is discussed more openly than ever before. People's attitude has changed towards FGM."*
>
> **BSCA, male respondent, Bolton**

Previous PEER reports, particularly at baseline (in 2010), suggested that when it came to FGM, few people had a clear idea of what other people in their communities thought or did, because the issue was not widely or openly discussed. However, in the data from 2016, many respondents felt that they knew what their communities felt about the issue, corroborating the respondents' reports of increased discussions around the issue in recent years. Many said that the majority of the community was against the practice now.

In some areas, there was also a strong feeling that some of the larger communities had reached 'saturation', meaning that they were more confident to take a public stand against FGM than others, and that the campaign to end FGM now needed to target smaller ethnic groups. This has been consistently reported since the end of Phase One (in 2013) of the FGM Initiative. Targeting only specific ethnicities can result in ill-feeling and backlash towards the campaign to end FGM (see Section 2.11).

Overall, respondents felt that changes in attitudes, awareness, levels of information and opposition were closely linked to the work of the national-level, anti-FGM campaign and in particular the community-level work of the ten projects.

2.2 Why have attitudes shifted?

There has been a variety of influences on attitudes towards FGM, many of which are complex. These have included: high-level political engagement with FGM; a renewed focus on FGM by the media; changes in laws and policies on FGM (particularly 'mandatory reporting' and parental liability); increased duties by frontline professionals to both provide information and identify potential cases of FGM; and increased community-based prevention.

> *"Many people have learnt the UK law and they know now that it is a crime to commit FGM, and when they got the correct information about the religion and health problems, they understood that this is true and FGM is not good for women. Even the number of the people supporting the type 1, is dramatically decreased."*
>
> **SDS, female respondent, Leicester**

Isolating which particular factors have been the most influential is often difficult. The PEER narratives, however, indicate that firstly, it is the comprehensive approach taken in local areas which has really worked. In many narratives, the combination of greater legal awareness working alongside community-based prevention has worked to shift attitudes. This is corroborated by other TFGMI results, including survey and project data.

Secondly, the approach used by the TFGMI is widely endorsed. There is a strong feeling among respondents that a response by frontline professionals alone would have been too punitive. The vital role that the TFGMI projects have played in developing culturally-appropriate ways of talking about FGM as a part of child protection is often referred to. Talking about FGM in private spaces, where people from affected communities are allowed to talk about the sensitive ways FGM has impacted on their lives, has been an important way to gain local level support for the campaigns to end FGM.

Lastly, access to services has played a crucial role in challenging support for the practice. The link between prevention of FGM, access to services and attitudinal shift has also been reported in previous rounds of PEER research. However, there is now a much wider and deeper awareness of the complex needs of women affected by FGM. This is often cited as a reason to stop support for FGM.

The voices of parents, and in particular of mothers, in rejecting FGM for their daughters has also become very prominent in the PEER data. FGM prevention efforts have managed to galvanise support around a community-identity of protecting children from harm. There is thus strong support for the law among those who support efforts to end FGM, but with important concerns about how child protection is being implemented. These are explored in Section 2.6.

"At first, people in my community took offence to the campaigns to end FGM as they felt that they were being demonised, but the positive approaches from your projects enabled them to understand the meanings behind the campaigns. Some people's traditional mind-sets towards FGM shifted." **AAF, female respondent, London**

"Some people have reacted negatively when the issue was raised in hospitals or in schools. The project has done great things for the community. It helped people get educated about the practice in a manner that they understand and appreciate without feeling offended. As the law on FGM keeps on changing, projects like this are vital for our communities."
AAF, female respondent, London

"A lot of parents I know are happy to have their children taught about FGM and to have schools create awareness of it. Many people in the Somali community have worked with the council to end FGM through BSCA. Many women have struggled with child birth due to FGM so the majority of the people in our community are happy with any efforts made to conquer FGM in the maternity services." **BSCA, female respondent, Bolton**

"People are not shying away from the topic. If it is brought up people won't ask 'why are you speaking about it?' and tell you to stop talking about it. This is particularly common amongst the mothers. I've noticed this a lot over the years." **FORWARD, female respondent, Bristol**

"I think naming it FGM has helped because people in my community do not think it's a form of mutilation so they often argue about it, but this has increased discussions about the topic and has enabled the advocates to challenge people's views." **BSCA, female respondent, Bolton**

2.3 Women affected by FGM

"It's also not a taboo anymore to discuss this, for example when I used to come to the first session of FGM, some years back I never used to like for people to see my face, take pictures of me, related to FGM. So I used to put clothes on my face to hide my face when people were taking pictures of the group but now I don't care. It becomes so normal to discuss and to talk to people about this." **OSCA, female respondent, London**

Many people credited the personal testimonies of women affected by FGM in shifting attitudes towards the practice. This may have been in very private forums such as small discussion groups or at more public events. However, the greater confidence of women affected by FGM to talk about FGM without fear of recriminations shone through in the PEER narratives and project reports.

"Affected women have been talking about their experiences a lot more… Affected women are relied on more to speak out…They do a phenomenal job." **BWHAFS, female respondent, London**

"A young lady shared her personal experience with FGM and it was incredibly emotional and powerful… Her honesty and strength helped everyone understand how young women today are still affected by this. She spoke about how it affected her life and how traumatic it was. It was very educational and informative and it helped everyone understand the ramifications of FGM." **SDS, female respondent, Leicester**

However, some respondents felt that women from larger diaspora communities – for example Somalis – were more empowered to speak out because their communities were being more supported by community-based organisations, while women from smaller diaspora communities such as Gambians and Libyans were still struggling to be heard.

While the majority of respondents felt that the issue was vastly more discussed in private and public life over the last two years, a minority of respondents believed there was still not enough discussion about the issue at community level.

"My friend believes that people in our community do not really talk about FGM as much as the community should. He thinks that the community is lacking drive and enthusiasm to do and talk about the issue of FGM on a bigger platform." **OSCA, male respondent, London**

It is important to note that this is not universal. In some areas, people reacted strongly to affected women talking about FGM, especially if they felt that this affected community 'reputation'. This underlines the critical importance of having good support mechanisms in place for survivors to talk about their experience.

"Many resent affected women for speaking out. Sometimes it's other affected women who feel this. Some elder members in our community still think it's shameful for affected women to speak out. Do they want a medal?" **BWHAFS, female respondent, London**

For instance, respondents from Liverpool mentioned communities actively closing down discussions on the topic for fear of the community's reputation being affected. This was particularly keenly felt among the Somali community in different places.

"I think the community talks less about FGM because the spotlight is shining directly on them and they do not want to create another issue to add to their long list of issues which are now being addressed in the media like terrorism, honour killings et cetera, so

the community have actively stopped talking about FGM." **GSWG, female respondent, Liverpool**

Even with increased awareness and public conversations about FGM, conversations on the topic within families, particularly between men and women, may still be difficult. This echoes the experience of the TFGMI groups, who found that this needs to be actively encouraged and supported.

> *"Most families, when discussing this topic, it would generally be between a mother and daughter, mother and aunt, aunt and niece et cetera. Discussion with a male member of the family doesn't tend to happen. This hasn't changed. [There is] still reluctance to talk about certain things – cultural barriers are still present."* **FORWARD, female respondent, Bristol**

2.4 Awareness and discussion of different types of FGM

The World Health Organization defines FGM as having four Types, and many respondents mentioned learning about these types as one of the benefits of the anti-FGM campaign and the work of the ten projects. The respondents most commonly talked about Type 3[3] in the 2016 data, associating this with the most severe health and psycho-social problems.

> *"…a woman told me that her sister was circumcised in Somalia (Type 3: infibulation) and the whole area was sealed. The people didn't realise that, because she has small open[ing] where she could urinate. But when she grew up and got her period, the small open[ing] closed which caused her to be very sick."* **SDS, female respondent, Leicester**

This type of FGM was also mentioned frequently as being the type for which women struggled to access appropriate services.

> *"For those who've had Type 3, [there are] difficulties in child-birth especially in this country. Some doctors who have not seen Type 3 FGM before don't know what to do."* **Manor Gardens Welfare Trust, female respondent, London**

> *"For the last five years people in our community started Sunna because they have found out that type 3 FGM has a lot of health complications."* **Manor Gardens Welfare Trust, female respondent, London**

In several narratives, this severe type of FGM was contrasted with other types, broadly referred to as 'Sunna'. It is often unclear which type of FGM this corresponds to, but is likely to be Type 1 (FGM involving pricking/drawing blood and/or removing part of the clitoris in order to draw blood), or Type 4 (other harmful types, such as pricking or piercing). 'Sunna' was said to be the acceptable alternative to more severe forms of FGM such as Type 3, and fulfils a supposed religious requirement for FGM. Support for 'Sunna' has been consistently reported during the lifetime of the TFGMI, and is harder to end support for as it is perceived as less harmful. The PEER data shows that a minority still support 'Sunna' although support is declining.

> *"I would say more of the older generation are against it now, because they realise the dangers of it. Like my mom, she would say in the past the Sunna type is not harmful, but now she says it is harmful and there is no point of doing this as it is against our religion."* **BSWAID, female respondent, Birmingham**

[3] Often referred to as infibulation, the WHO defines this as 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).

A small number of respondents from Zimbabwe involved in the work by AAF in London reported increased awareness that the practice of labial elongation (FGM Type 4), practised in their community, is FGM and harmful to women and girls.

> *"In my community, outreach and mobilisation done by Sacred Bodies has made some Zimbabweans realize that there is also Type 4 FGM practised in the Southern part of Africa including Zimbabwe. This was a shock to them at first as it did not involve any cutting, thus this has caused lengthy debates at times. However, they have now realised that pulling the [labia] is regarded as Type 4 FGM and damages the genitals."* **AAF, female respondent, London**

2.5 FGM and the law

"If it wasn't for the law I don't think that Somalis would have stopped this. The law gives women the power to say no. If the woman is educated she can use the law to threaten the father or the mother-in-law that she will go to the police if they try to have her daughter cut. This has happened. I know a case where the mother threatened to tell the police that the aunt wanted to do FGM on her daughter. She also told the husband that she would tell the police if he supported the aunt and had the daughter cut." **Manor Gardens Welfare Trust, female respondent, London**

"My friend didn't want to talk more about it and just finished with 'FGM is cruel it should be illegal and those who do it to the poor women should be punished'.'" **OSCA, female respondent, London**

There is wide support for the UK law on FGM among people from affected communities who do not support FGM. There is a strong perception that the UK law does have a deterrent effect. Previous rounds of PEER data also found that legal awareness had an effect on some, but that there was a significant minority who did not believe that the law would be implemented, or that they would be detected. This appears to have shifted within Phase Two, with more people reporting that FGM was more likely to be detected, and that there was visibly more political will to prosecute.

"Even last week saw a friend of mine who was going home and she has two daughters. I said to her, 'but you are not going to circumcise your girls' and she said to me 'no way! Have you not seen David Cameron on TV!? He said he is going to put everyone in jail, anyone that circumcises a girl. Why would I put myself and my children through that?'"

OSCA, female respondent, London

There were specific examples of women using the threat of the law to protect themselves and their children as parents. The majority of respondents acknowledged that the law was a positive step for ending FGM because it meant law enforcement could support the anti-FGM work of activists and communities. Respondents argued that it allowed individuals to use their knowledge of the law to threaten family members to stop the practice.

Despite the predominantly positive view of the law, there were many more concerns about 'mandatory reporting'. This is explored fully in Section 2.6. However, people also felt that there was now a greater need for education since measures such as 'mandatory reporting' have been brought in. Legal approaches in themselves are not enough to shift attitudes.

> *"Law is not the only answer. More work needs to be done with education."* **FORWARD, female respondent, Bristol**

There was consequently strong support within the PEER data for the educational and supportive role that many of the projects had played, furthering understanding of child protection, for instance.

There was also strong support for FGM prevention and education about the law to be targeted at those with less legal awareness, such as newly arrived members of affected communities.

2.6 FGM, 'mandatory reporting' and parental liability

Overall, the law was seen as a powerful and effective part of ending FGM, with tangible impacts on reducing the cases of FGM. However, community education about the law could be improved to overcome widespread fear and anxiety, and professional education about handling 'mandatory reporting' when women with daughters are accessing support services could be improved.

A major concern for most communities was how 'mandatory reporting' was going to be handled in their contact with health, education, and social care agencies. There were several stories of women feeling interrogated, judged, and falsely accused, particularly in educational settings. More support may be needed.

> *''Basically my cousin wanted to take her two daughters who are both under the age of 10 on holiday and the Head Teacher at her children's school got extremely worried and called my cousin into school to have a chat about the holiday she was planning. The Head Teacher began saying that she is concerned about FGM taking place on that holiday and does not feel comfortable to allow the girls to go abroad. The Head Teacher then made a social services referral and had the children's passports revoked. This made my cousin very angry and upset and she did not even have FGM herself. She did not support FGM and did not understand where this accusation was coming from. My cousin has now lost trust in the school and is not happy with the way this was handled.''* **BSWAID, female respondent, Birmingham**

While many respondents felt that overall the quality and competency of health and support services to deal with FGM had increased, there were repeated calls for continuing training for teachers, health professionals, and other relevant actors to ensure they handled their roles sensitively, with a focus on offering women support for any concerns related to their FGM as well as questions to identify risk.

> *"Change can only happen with cooperation from other groups. Training of healthcare professionals about mandatory reporting, what to do, dos and don'ts – this needs pushing, more so than the legislation itself. This will require the help partly of the government, NGOs and communities – all combined."* **FORWARD, female respondent, Bristol**

2.7 FGM as a human rights issue

In the baseline data it was reported that little evidence was found of FGM being framed or discussed as a human rights issue by community members. This continued to be the case in the 2013 and 2016 data sets, with a few exceptions. For example, a few respondents from Bolton explicitly talked about FGM as a human rights issue.

> *"Over the last two years there has been a shift in thinking. There is a lot more focus on FGM. In Bolton people are now discussing it more and the learning is getting out there. The 'community champions' have also been out in the communities and have made the community a lot more aware about the human rights issues regarding FGM."* **BSCA, female respondent, Bolton**

"Many people from the people of new and emerging communities in Bolton think that FGM practice is a barbaric tradition and it violates the basic principles of human rights." **BSCA, female respondent, Bolton**

More frequently however, respondents demonstrated their understanding that FGM is a rights violation through more indirect language, likening it to violence against women, and others seeing it as a gender-based issue through which men exert control over women, or as a form of child abuse.

"He believes that the younger generation definitely do not support it because they feel and understand it's wrong and it's the women's body so she should get the choice in the matter and she should not be forced to do anything, especially FGM." **OSCA, male respondent, London**

2.8 FGM and health complications

Most respondents who mentioned increased awareness and discussion of FGM over the last two years talked about becoming more aware of the risk of health complications associated with the practice. Much of this learning has come from listening to women affected by FGM speaking out against the practice. There is also clearly a much wider understanding of women's health and other needs, and the multiple ways in which FGM affects them.

In discussing FGM, many respondents in the 2016 data mentioned the lifelong health complications for women, including bleeding, pain and infection from the initial process, menstruation problems, urinary tract problems, problems with sexual function, psychological, emotional and relationship problems, and complications during childbirth. There were several stories about women and girls suffering health complications at various stages in their lives because of FGM.

"I was circumcised twice when I was eight years old. The first time, my father took me to the circumciser and I had the Sunna type. My mother was not satisfied, so 3 days later she took me to a different circumciser's home where I had all of my genitals cut off and sewn together. As a consequence, I lost a lot of blood and was in and out of consciousness… My mother and fellow women were screaming at the circumciser, and at some point they gave up hope on the idea that I would live… My problems with FGM did not stop there and it continuously affected me as I grew up such as experiencing difficulties with menstruation." **AAF, female respondent, London**

"… my sister, who is 28 years old, nearly died in London Hospital whilst in labour with her first child – she had been circumcised at 11." **BWHAFS, female respondent, London**

Where, previously, secrecy shrouded the details of the practice and long-term health complications were not immediately linked to the practice in many people's minds, this appeared to have been replaced by a good understanding of the severe health risks and lack of medical or hygiene benefits of the practice among respondents.

There are risks in focusing on health-based arguments alone as part of FGM prevention, as this has been associated with medicalisation of the practice. However, in these PEER narratives, many people believed their communities were increasingly turning away from the practice because of deeper understanding of the harmful health impacts of FGM.

"An increased conversation about health implications has slowly changed people's minds about the practice. In our culture when a woman gives birth, other women in the community collect money or buy gifts to give to the new mother. During this visit women usually talk about child birth and labour experience, and most times FGM complications are brought up in the discussions. This is when you hear regrets of going through the practice and often women say 'I will break away from the practice.'" **AAF, female respondent, London**

There were, however, also a few cases where women reported having no health complications after having undergone FGM, and in a few cases these women appeared to be more likely to vocally support continuing FGM. This underlines the difficulties of using health-based arguments alone. FGM project leads said that women who underwent FGM and support the practice present real challenges to their efforts to shift attitudes.

2.8.1 Deeper understanding of mental health impacts on women

There is now a deeper understanding of the psycho-social effects of FGM on women and girls, and a rejection of the practice because of this. Many of the respondents in the 2016 data discussed the trauma of the practice, sexual issues and consequent problems within their marital relationships, post-traumatic stress disorders and negative feelings towards their families. With more women affected by FGM telling their stories, respondents appeared to recognise that these women required more psycho-social services or community support.

> *"Mental illness is a huge unaddressed factor – affected women need access to specialist counselling."* **BWHAFS, female respondent, London**

> *"Women who have experienced FGM need a lot of support, both emotional and practical support, such as signposting them to the right services. I think people in our community often ignore the emotional support that's needed for FGM survivors as it is a trauma that they have experienced in their lives. However, people in our community do not see it that way and often brush it under the carpet. I definitely believe people would benefit greatly from more psychological support."* **BSWAID, female respondent, Birmingham**

As the quote above suggests, there are many barriers to women's access to mental health services, not least of which is the stigma surrounding this issue in communities affected by FGM. Rising awareness of women's mental health needs is thus a welcome development. As Section 2.13 will explore, there is also rising awareness of the lack of availability of these needed services.

2.9 FGM and sexual function

"There is a woman who had Type 3. She didn't know about her genital organs. When she got married, during sex she had a massive tear and bleeding. She only realised that when she was in her twenties her life was over. She will never forget this – she cannot know what it is like to be normal. She asked for divorce after this, as she cannot be with a man." **Manor Gardens Welfare Trust, female respondent, London**

"People in our community say that FGM is good and protects girls and keeps their virginity. It keeps them safe so they don't go out and have boyfriends and stops them from getting sexually transmitted diseases. It also protects women who are married if their husband goes on a work trip or to war as they wouldn't be needed by their husbands for sex. The people that usually support FGM are grandparents and paternal aunties because of family honour as they all share the same surname. So it protects the family name." **Manor Gardens Welfare Trust, female respondent, London**

As the above quotes from Manor Gardens Welfare Trust illustrate, the perceptions of links between FGM and the necessity to control women's sexuality often underpin support for FGM. However, talking about the effects of FGM on women's sexuality has been one of the key ways in which support for the practice is being undermined. This needs careful handling, and support for women to talk about these issues in private spaces.

The importance of sexual function and pleasure was also more prevalent in the 2016 data than it was in the baseline or 2013 data, with many respondents highlighting the lack of sexual pleasure within marriage as one of the major reasons for negative psycho-social outcomes.

> *"The women affected by FGM need psychological support in terms of their sexual relationship because they become passive in sexual relations, which may lead to a sort of depression and they avoid such relations, which in the long term results in separation or divorce, or the husband having a girlfriend."* **Bawso, female respondent, Cardiff**

There were many stories in the data of women who had undergone FGM, struggling to enjoy sex or divorcing their husbands because they could not stand the pain of sexual intercourse, and conversely stories about women choosing de-infibulation in order to be able to enjoy sex with their husbands. Wedding nights were discussed frequently, from stories of excessive bleeding and trauma to women enjoying their wedding nights because of having had de-infibulation. The increased discussion of sexual function and pleasure suggests a rejection of the idea that men's sexual pleasure should take precedence over women's, as exemplified in one respondent's story.

> ***"****My mother said I should be opened during birth. I listened to her. This took place in Sudan and the doctor re-stitched me after the birth. My community had said that you should be re-stitched otherwise it won't satisfy your husband. For the second pregnancy I had, this time I asked not to be re-stitched. I didn't care about how my husband was feeling, I only cared about myself. I feel more empowered now. I have five daughters and none of them have been cut."* **Manor Gardens Welfare Trust, female respondent, London**

One respondent argued that sex education, including discussion of how FGM affects sexual function, needed to be strengthened for both married and unmarried young people and adults.

> *"She didn't feel anything when she used to have sex and there was no enjoyment. Someone in her position would need education around how FGM can affect things in the bedroom, and so would men – the husbands of FGM survivors. The husband would need to know what to do to ensure his wife stills get enjoyment out of sex. Although sex is a taboo in my community, it still needs to be talked about – as the effects on sex is a serious side effect of FGM. Sex is very important in a relationship. If it's not going well there will be a lot of resentment, problems and tension."* **FORWARD, female respondent, Bristol**

As the quote above illustrates, respondents also supported strategies for involving men and deepening their understanding of the effects of FGM on women. The project reports indicate that this has been a successful strategy, and that engagement with men has worked.

2.10 FGM, religion and culture

"I think our community is realising that FGM has no place in our Deen (religion) and that it is a very old traditional practice.'' **BSWAID, female respondent, Birmingham**

"My friend thinks that some people think this is our culture and they don't understand the damage that this could cost and some believe this is un-Islamic and it should be promoted as un-Islamic and as a barbaric practice." **OSCA, female respondent, London**

The practice of FGM is often (incorrectly) given a religious justification. There was a clearer rejection in 2016 data that FGM is religiously condoned and, in fact, an active voice that views it as an irreligious practice.

> *''I have not come across personally anyone who supports it in the UK. Most people speak about it in a negative way, saying that it's bad and non-Islamic.''* **BSWAID, female respondent, Birmingham**

Respondents in this data described receiving information about religion and FGM from the work of the ten projects, from the increased discussion and publicity around the issue, and through word of mouth in the community. Unlike in the 2013 data, respondents in this data did not mention as many instances of receiving anti-FGM information from religious leaders, and several respondents in fact called for more work with religious leaders.

The lack of religious justification was considered one of the strongest factors encouraging many people in the UK to abandon the practice, and one that people shared by word of mouth within the UK and with families and communities in their countries of origin.

> *"More importantly she thinks the [fact that the] projects have used [the] religious element to campaign against the practice… has had [an] impact. She says although short term the laws were important, but for the long term one needs conversation not only that this is not religious obligation but this is also against principles of their religion."* **OSCA, female respondent, London**

> *"I think the best thing that the project at GSWG has provided the community with is the opportunity to discuss the issue of FGM. By discussing, misconceptions on religion and culture can be challenged. But without the debate, I think that the practice would very much carry on within the community."* **GSWG, female respondent, Liverpool**

However, some respondents reported that their peers (particularly from countries of origin or newly arrived) still believed FGM to be 'Sunna', or a religious requirement, having had less access to education on FGM.

The recognition that the practice was not religious did not mean that FGM did not continue to have strong traditional and cultural significance within the segments of communities still supportive of the practice.

> *"People used to do FGM for religious reasons but now it's more for tradition and cultural reasons."* **Manor Gardens Welfare Trust, female respondent, London**

> *"Culturally, it is a rite of passage and one is not considered a grown woman if one is not initiated into the FGM/BONDO Society. People's views are quite strong as it is seen as part of 'our national/cultural heritage.'"* **AAF, female respondent, London**

2.11 Opposition to FGM

Overall, respondents reported the majority of their communities being opposed to the continuation of FGM in 2016. Strong progress was seen in the data between 2010 and 2016 in increasing opposition to FGM across a range of key stakeholders, ranging from affected women, parents and grandparents, and religious leaders.

"More women are openly rejecting it because our collective voices and stories are strong. The truth in stories is very powerful. It makes people think, even those who are initially pro-FGM. It is hard to deny the testimonies and pain of so many women" **BWHAFS, female respondent, London**

2.11.1 Groups opposing FGM

Opposition to FGM is now said to be widespread and concerted. As explored above, the voices of women with FGM talking about its harms have been a central part of the stories of change. However, the visible opposition of particular groups also appears to be more prevalent in the 2016 data.

Parents

"I never thought about FGM as something that was wrong in the past. I just used to think that it was something that happens normally in our communities and eventually my daughter would have to go through the same. I was not aware of the effects of FGM as a whole until I attended the workshop. This made me question the validity of FGM and as a result I did not view this any longer as a normal practice. I made the decision shortly after that I would not subject my daughter to this practice." **BSCA, female respondent, Bolton**

"We have daughters—I would never touch my daughter...she will never go through it." **BWHAFS, female respondent, London**

Not surprisingly, those who viewed FGM as child abuse were also very supportive of the UK law. In many of the narratives, they expressed that the law actually provided parents with the means of resisting pressure to conduct FGM.

"We think the law is great", **BWHAFS, female respondent, London**

"The grandmother was insisting that she'd look after the children on her own to give my friend a break. But my friend felt there was something funny going on and she cross-questioned her mother. The grandmother revealed that she was planning to have my friend's daughters cut. My friend went mad, told her that she not only would her mother go to prison but my friend would also. She told her about all the health complications. It was a terrible holiday for my friend and now she can no longer trust her mother." **Manor Gardens Welfare Trust, female respondent, London**

Men

Men (particularly fathers) who had witnessed the health complications of FGM with their wives or families and wanted to protect their daughters, were also likely to oppose FGM, and this is a new development under Phase Two, where men have become more involved in the campaign against FGM.

Some respondents said that opposition to FGM has increased among men more generally. For example in Bristol, a FORWARD female respondent felt that the number of men (particularly fathers) attending anti-FGM

"I heard a story from a friend who works in a GP surgery. Two weeks ago a girl aged eight years old was brought to the surgery by her father. The girl's mother had taken her back to Somalia on holiday and the father was worried that the grandmother had performed FGM on his daughter... The doctor handled it very well and did not alarm the girl. In fact the girl hadn't been cut. But this shows that the father was protecting his daughter and also that the doctor was sensitive and knowledgeable about this." **Manor Gardens Welfare Trust, female respondent, London**

conferences and workshops with their wives had increased incrementally each year of the programme. As with the previous PEER reports, there was discussion around younger men knowing little about FGM, but once they learned the details of it being strongly opposed to it. Unlike in previous reports, there were examples of men actively intervening to stop their daughters being cut in the 2016 data. Male respondents interviewed in 2016 were all against FGM.

> *"…he thinks that people behind FGM should be brought to justice and he is absolutely against the procedure, he said it's wrong and it's against my religion!"* **OSCA, male respondent, London**

There were also comments from female respondents about how positively the men's workshops from the ten projects had affected their husbands, allowing them the language and confidence to discuss FGM with their wives and peers. Of note, the survey data shows that men from affected communities had less support for all forms of FGM than women, but a significant minority was more likely to support 'lesser' forms of FGM known as 'Sunna'. This and women's own testimonies underline the importance of continued engagement with men.

Young people

Young people and adolescents were also described as being mostly anti-FGM due to their level of education, their exposure to multi-cultural influences, and their exposure to school- or media-based anti-FGM campaigns. Young people were seen as less wedded to a single cultural identity (acculturated) and generally more educated, empowered, exposed to multiculturalism, and more able to make their own decisions about their sexual/marital partners, meaning FGM was no longer a definite requirement for marriageability.

2.12 Continuing support for FGM

> *"People forget that some young people still have views that support FGM, for the sake that they are protecting their culture. This is most prominent amongst those who have come from Somalia recently, and have been living in the UK for mainly around five years, and have come directly from a community where nobody would talk about FGM. Now when they are in the UK where everyone is talking about it, with the campaign against FGM, they would ask why are we talking about it and they end up putting women down around the city and in the UK that have decided to speak about it. People forget this fact but it has been a major problem."* **FORWARD, female respondent, Bristol**

While the majority of individuals within affected communities were seen as opposing FGM in the 2016 data, there were still a few minority groups within communities who continued to support the practice. Those who supported the continuation of FGM were described by respondents as groups who were 'ignorant', 'uneducated', 'older', 'illiterate' or 'newly arrived'.

The experience of the TFGMI has shown how important context is to understanding support for FGM across the UK. Support for FGM was highest in urban areas with high turnovers of new arrivals, for instance, South-East London where AAF works. Survey data confirms that support in this area is higher than others. However, support for FGM was also evident in areas with more long-term settled populations where there was a stronger attachment to maintaining culture such as Liverpool. Support for the practice is

> *"Many were raised to believe that FGM is compulsory for every woman, due to religious and cultural beliefs. Therefore, they do not see anything wrong in practising it. Most families support FGM. They feel a woman cannot be regarded as a proper woman without any sort of FGM practice done. However, a very small minority in our community do not support FGM. They feel it is unfair for women to suffer in that way in order to please men."* **AAF, female respondent, London**

often difficult to shift when it is viewed as a necessary part of women's cultural identity.

There was a reported divide between the stances of the generations, with respondents discussing the 'older' or 'elder' generations (grandparents and sometimes parents) being generally in favour of continuing FGM.

> *"[My friend thinks] FGM is still supported by many of the older generation and probably a lot of people that live back home. But she thinks in England, that most youth do not support it at all, and are confused as to why it is even done. It is the middle age group who might still be 50/50, as they are more attached to the old wicked ways. People find it hard to let go of customs as they might see it as their identity being stripped off."* **OSCA, female respondent, London**

Many respondents discussed elder generations as struggling to access information about FGM in the media and through the work of the projects, mostly due to problems with illiteracy and language barriers – this was seen as one of the main reasons for their continued support for FGM. In a few cases where these barriers have been overcome, mostly in London, older people had been persuaded to oppose FGM.

> *"A small number of the older generation have come to realise that FGM is not a religious requirement and the understanding that any cultural practice that is as harmful as FGM ought to be stopped. There is however a number of the older generation who still support the practice and are only scared by the threat of prosecution in the UK, but still have it done to granddaughters and nieces abroad."* **AAF, female respondent, London**

Despite the strength of support for FGM among older generations, in general their influence on household-level decisions is declining over time, evidenced by how often in the data the support of the older generation was contrasted with the rejection of FGM by the younger generations.

Despite the vast majority of young people being anti-FGM, there were a few instances where young people were supportive of the practice. This was said to be because they did not fully understand the risks and felt that it was a cultural or religious tradition being demonised.

> *"A friend of mine is the only child. She has been brought up by her father and not with her mother. After, people say it's the mother who encourages this but her mother passed away long ago so she has only her father and brother. She doesn't even have a sister. She told me she is in support of FGM and if she has a daughter it's 50% that she might do it."* **OSCA, female respondent, London**

Respondents also identified men as a group where support for FGM may be higher (as the survey data also suggests) or where greater involvement of men was needed so they could provide better support to women affected by FGM. The overall picture from the 2016 data was of men engaging more with the facts around FGM through the media and workshops, and fathers in particular taking up a stance against FGM for their daughters. This is a real shift from previous years. FGM has previously been viewed as a 'woman's issue' and there have been

> *"I still think men need to get more involved. They are still reluctant. My dad is still reluctant to talk about FGM. Some men are more willing to talk about it. A lot of men in my family don't want to talk about FGM. This is a shame. Men definitely need to be involved in the campaign to end FGM."* **FORWARD, female respondent, Bristol**

> *"The men in the community, older men, know what FGM is but don't get involved in this issue but the younger men are not really aware of FGM and the implications of this practice."* **GSWG, female respondent, Liverpool**

difficulties in getting men to understand that they have a role in ending the practice, protecting their children from harm, and providing support to spouses.

Some younger men were also reported to support FGM because they were insufficiently informed of the practice, believing it to be a minor procedure which was religiously or culturally necessary.

> *"I've noticed Somali boys a lot – young teenagers and of school age. They haven't really been told about it or if they have they have been told that FGM is a good thing if they want to marry a girl."* **FORWARD, female respondent, Bristol**

There is still an ongoing need to engage men in FGM-prevention debates at local level and to develop strategies to reach male audiences.

Lastly, women who had, themselves, undergone FGM were sometimes seen as the strongest and most persuasive supporters of the practice. Reasons for their support included the social status that they had acquired through the process, resulting in feelings of deeper connection to their culture and respect for them as a cut woman in countries of origin.

This group has the potential to be particularly influential in their stance as affected women who want to continue the practice, because they feel it has not affected their health. However, in both project reports and the PEER data, women who have had FGM are also the most effective at countering this support, as they can argue that there is a high risk of harm to women even if some are 'unaffected'.

> *"I think the younger generation do not support FGM but I do know two of my friends who are only 29 and 30 but advocate for FGM. They say as they only received the less harmful type of FGM and it did not cause them any lasting damage why would they not do it to their daughters."* **GSWG, female respondent, Liverpool**

> *"There was a woman who went to a workshop and said she'd had Sunna and it didn't affect her. She said that she still had her sexual feeling and she enjoyed sex. She also went to a second workshop on FGM and at this workshop there was a woman there who had also had Sunna but it had gone wrong. When she heard about what this woman had been through and how awful it had been for her, she felt completely different. …. By the end of this workshop, the woman who had said there was nothing wrong with Sunna, realised that that all types of FGM were wrong including Sunna. She realised that she'd been lucky that it hadn't gone wrong for her."* **Manor Gardens Welfare Trust, female respondent, London**

Support for FGM may be easier to maintain where cultural group identity is strongest. This underlines that the make-up of each 'community affected by FGM' needs to be understood in order to inform local-area prevention strategies.

Lastly, there was a strong consensus in the data that those who were 'newly arrived' members of affected communities were most likely to support FGM. They were viewed as being more attached to cultural identity, susceptible to social pressure from their countries of origin, and as yet unreached by FGM prevention programmes.

> *"My community is now well educated but those who are newly arrived to Newham always have strong views and are generally supportive of FGM practice."* **BWHAFS, female respondent, London**

> *"The older generation support FGM and also young, new arrivals from Eritrea and surrounding countries who haven't changed their attitudes and understanding. These*

are the ones that frequently travel back to Eritrea and Sudan under strong pressure from grandparents back home." **Manor Gardens Welfare Trust, female respondent, London**

This group was discussed as being highly vulnerable to uncritically continuing the tradition of FGM and falling foul of the law in the UK. To this end, many respondents called for education and awareness training in appropriate languages to target newly-arrived peers.

2.13 Accessing care and support for FGM

"I feel more informed at the GP, at my children['s] school and when going to hospital. I know about FGM and know how to talk about it with professionals." **BWHAFS, female respondent, London**

Respondents discussed how previously, because of the taboo status of FGM in communities, the health and psycho-social effects were often minimised, or people were simply unaware of them. In the words of one respondent there was "a general consensus that it happened to everyone and everyone should be able to deal with it." Under Phase 2, there has been wider awareness of women's health problems, including mental health and effects on their sexuality (see Sections 2.9 and 2.10 above).

In some cases, women reported not being aware that their health issues were linked to FGM, or that they had had a more severe form of FGM than they expected. In other cases, men who did not understand the complications women might experience were not always supportive of their wives accessing care.

"More people are aware of complications caused by FGM and the law. Women/young girls are using FGM services to get opened up and enjoying their wedding nights, more discussions in community centre which was never heard of before."
AAF, female respondent, London

Respondents felt that there had been a shift towards recognising the needs of women with FGM, especially in terms of health and psycho-social support, as well as increased awareness of sources of care and support. Sources of support ranged from Community Based Organisations to midwives, doctors and clinical practitioners who undertake FGM de-infibulation.

Overall, the ten projects were seen as vital sources of information, workshops, safe spaces, discussion, support, signposting, advice, and sometimes counselling services to support women's access to care. Community support groups like these were frequently described as the first point of contact for women wishing to seek care and support with FGM. Respondents had high levels of trust in their knowledge of FGM, access to information, and confidentiality. Some Community Based Organisations were also seen as providing an important service by directly increasing women's access to specialist health professionals, by providing referrals and contacts, but also through equipping them with the language and confidence to open up to health professionals. 'Awareness' of services is often not enough to link women into care. Women face additional barriers, in particular a low recognition of their own needs, and shame and stigma around accessing services.

Previous research has indicated that women may first encounter FGM-related services through ante-natal care, but recently it seems that access to de-infibulation services in particular has increased over the life course of the TFGMI. There is good evidence of women's use of these services, increasing in areas where projects have actively encouraged access to care, for instance, through women's discussion groups (called 'sister circles') in London, led by AAF.

There was also some evidence that women are feeling more confident in approaching care providers with their health concerns, and conversely, that GPs and other health professionals were raising the issue more in conversations with their patients. Where this was framed within supporting the woman to access care, it was well received. However, there are still some strong concerns about mandatory recording and reporting and how this may be affecting women's access to care. There was quite a lot of variability in the data on this issue, because in some areas respondents felt that they had poor access to support and information.

"My neighbour had the correct maternity plan because she told her GP about her FGM at her 12 week appointment. She was nervous but she did it. Having access to information is the key." **BWHAFS, female respondent, London**

Generally, respondents' experiences were better in areas where there was good joint working and better training for frontline professionals. However, there is still room for improvement, as women in many areas were unaware of local support services that they could access. In a few areas, budget cuts had resulted in scaled down or losses in valuable language support. In some areas, women complained of having to travel further to reach services. The general perception is that the rise in political will to end FGM has not been matched by a rise in access to services.

*"They need services from health sectors and also more knowledge to reach people who never participated or heard about FGM's negative effects." **Bawso, female respondent, Wales***

*"Specialist services where workers actually understand your needs are sparse. Black Women's is good but there needs to be others." **BWHAFS, female respondent, London***

Access to mental health services was said by some to be an emerging and deep need. This is difficult, because the recognition of the need for mental health support is often low among women and others from affected communities, and projects have worked to find ways to link women into care by getting them to recognise how their experiences with FGM may be affecting their wellbeing, mental health, or their current day-to-day relationships. As with clinical services, some people felt that there was not enough access to culturally-appropriate mental health services.

> *"The people that I have talked to about FGM really don't know what support needs are available within the community. If there are girls affected by FGM within the community, I don't think they get any assistance with counselling or therapy support, as it's hard enough to get assistance for mental health issues. I think it would be the same with information and services, especially in the statutory sector, as the NHS is stretched already, I can't see any services on FGM available within Liverpool."* **GSWG, female respondent, Liverpool**

Women also felt that there was a need to involve men, so that they could understand women's complex needs related to FGM, as well as provide psycho-social support to their wives. There was a perception that husbands may not support women's access to services such as de-infibulation, and that they need further awareness-raising on this issue.

Lastly, there were calls from some respondents for better and more widespread access to high-quality information on FGM. This was said to be good through maternity services, but women wanted to be given more information at other points, such as on registration at the GPs or in other places in the community.

> *"Health visitors should include inserts on the law and also the health effects of FGM within all the Red Books for children so that all women get spoken to about it and there*

is information about where they can get help… FGM should be included in schools, in sex education programmes so that young girls are aware of this. Similarly, community centres need to provide training on FGM and encourage one to one advice and drop in services." **Manor Gardens, female respondent, London**

This suggests that more could be done by frontline staff, especially in health, to re-frame conversations about FGM so that they are not just about detecting the risk of FGM, but about supporting women to resist pressures to commit FGM and to be linked into care.

2.14 Perceptions of national efforts to end FGM

"However the majority of the community feel the authorities are getting too involved in families and cultural business and it's just another way to control how they should live. I know some people who are so against the practice but when they see it in the media, they get so angry, because they say the media makes their community look bad." **AAF, female respondent, Leicester**

"By increasing news coverage and women coming forward it has helped, especially since documentaries about FGM have become more and more in the public eye." **OSCA, male respondent, London**

"Some people think it is good for the community to talk about FGM, but when people talk about affected women as if they are idiots/mutilated et cetera, the people become angry and they don't like that approach." **SDS, female respondent, Leicester**

There were mixed perceptions of UK-wide efforts to end FGM. Caution should be used when interpreting these results because , while there is greater intervention by frontline professionals and others and more reporting of FGM in the media, there is no national campaign on FGM in the UK. 'Community perceptions' often refer to a mix of agencies who are not necessarily working together.

Respondents acknowledged that the greater media attention had spurred action, raised awareness and increased discussion about FGM. This group believed that it was necessary to have national-level attention on the issue to improve safeguarding and enforce the law.

"There is no doubt that media can play a critical role in helping to end FGM. I am sure that media can easily spread the consequences and health effects of FGM. Using media to play a key role in eradicating FGM is an important issue." **BSCA, female respondent, Bolton**

However, many respondents were unhappy at the way in which people, most often women, were represented in the media. In some cases, objections were based on how people felt that community reputation was being affected, particularly if they were presented as being 'backwards' or 'barbaric'. In some cases there were also objections to public discussion of FGM among those who were more supportive of the practice. Backlash against efforts to end FGM can undermine efforts to reach wider audiences.

"People say positive things in front of others. When you ask them in private you get a different answer. This is same for FGM, majority of the community feels they are being targeted by the media and that their image is being destroyed." **AAF, female respondent, London**

As the movement to end FGM has widened in the UK, some respondents felt that other community-based projects were also starting to work on FGM without a clear understanding of affected communities.

> *"Everyone is on-board with the anti-FGM campaign. It is incredible but sometimes weird as it feels like some campaigners don't understands the intricacies of our cultures. Bandwagon campaigners are quick to label communities. It is terrible to be called 'wild' or 'barbaric'. It is truly uncomfortable."* **BWHAFS, female respondent, London**

One of the main reasons this group disliked the national-level campaign was that the media tended to neglect reporting on community-based initiatives, where many people from practising communities were actively working to end FGM. This was particularly keenly felt by people within the Somali community, who have historically been very active in community-level campaigns in the UK, and are often more outspoken against FGM than other FGM-affected communities.

> *"The media gives a one-dimensional portrayal of why people have practised FGM. They also never highlighted the point that it is now heavily rejected and mostly by Somalis"* **BWHAFS, female respondent, London**

This underlines the importance of working within 'do no harm' frameworks[4]. Mass media approaches to ending FGM carry the risk of offending and alienating people from affected communities. The use of prominent national champions is important for galvanising a national movement, but investing in local women's leadership is also crucial, so that there is a broader pool of FGM activists involved in speaking against the practice.

2.15 Attitudes towards the TFGMI-funded projects

"My friend thinks that this project has been good on community level; it has raised awareness to so many groups. She personally took part in several focus groups, and sisters' circles. It has been great she said to discuss FGM in a close confidential setting." **OSCA, female respondent, London**

Compared to the very mixed attitudes towards the national-level campaign, respondents were overwhelmingly positive about the work of the ten projects in their communities.

Respondents discussed the work of these projects as being culturally appropriate, safe, and informative, and as genuinely transformative of people's understanding of the issue. People were particularly appreciative of the information they gained from the projects on the legal, religious, and health aspects of the issue.

The projects' approach of creating dialogue in private spaces, which allowed people to discuss the often intimate ways in which FGM had affected their lives and families, was widely appreciated.

"Women are more likely to seek help. They now are more open to accessing services. It shows the power of information. Community organisations have a special way of cascading messages." **BWHAFS, female respondent, London**

> *"The project has immensely impacted the communities' mind-sets about FGM and encourages communities to move away from the practice. It enabled women and girls affected by the practice to access FGM support services and build better relationships with their partners and families."* **AAF, female respondent, London**

[4] 'Do no harm' frameworks consider how social change programmes can avoid or minimise risks of harm arising from an intervention.

The projects provided signposting and access to care, and in some cases actively worked to improve the relationships between communities and health and education professionals. Community-level work was viewed as the most effective method of affecting change, and especially when it was conducted in collaboration with safeguarding agencies, schools, local government, the police, and other relevant bodies.

> *"The work of FORWARD has therefore helped to alleviate the cultural interference, stereotypes and making communities feel like they are being targeted. Their work makes communities feel like they are part of a collective effort. They really work with the community as opposed to just giving resources. FORWARD uses the resources with the communities."* **FORWARD, female respondent, Bristol**

There were strong concerns that, with the cessation of the Tackling FGM Initiative, projects would not be continuing.

> *"The community believes that this is the negative aspect of a project, when something is started and people get involved and comfortable with it and then the project is ended. What happens to the people or communities affected who are left behind...?"* **GSWG, female respondent, Liverpool**

2.16 PEER respondents' views on future efforts to end FGM

"FGM projects should get more funding. Community organisations have the unique skills to support communities, especially with sensitive issues." **BWHAFS, female respondent, London**

"More projects like this need to happen so the conversation can continue. To ensure victims of FGM do not feel alone, and they are protected from this awful, despicable tradition. There could be more media coverage about FGM." **SDS, female respondent, Leicester**

"The organisations such as Bawso should reach the origin of the FGM problem. I think they should link between the local, national and international levels of this problem and then tackle FGM through law and human rights perspectives. I mean Bawso could extend their work to Africa, such as Sudan, Somalia and Ethiopia." **Bawso, female respondent, Wales**

Respondents were specifically asked, "what is needed to end FGM?". Most of the responses talked of the need for further funding, so that Community Based Organisations could carry on reaching people from affected communities. CBOs have clearly been highly valued as part of ending FGM, and were said to be the first point of contact for queries on FGM.

Respondents also talked about the need to reach two groups in particular, where support for FGM may be highest: new arrivals and men. It was consistently reported that new arrivals often had little contact with FGM prevention programmes and may still have strong support for the practice. Female PRs and respondents who had been a part of FGM prevention programmes also recognised

"I think also target hard to reach women – women with language barriers and women from communities that face isolation. " **BSWAID, female respondent, Birmingham**

"The government should help community centres stay open." **BWHAFS, female respondent, London**

"In particular, new arrivals from Eritrea and surrounding countries should be targeted. There are many women coming to the UK to join their husbands. There should be some sort of information given to them when they collect their visa at the British embassy/consulate about FGM and the laws of the UK." **Manor Gardens Welfare Trust, female respondent, London**

the need for more engagement with men, not just to tackle support for FGM, but also to enable them to provide better support to their spouses. This is probably the result of projects' success in broaching 'sensitive issues' such as sex within marriage for women who had undergone FGM. These approaches may be more successful with younger women who are more open to discussing sexuality.

> *"The big problem we still have when it comes to ending FGM in these communities is getting the men involved. A lot of them think that it's nothing to do with them as it doesn't directly affect them. This is wrong as it does affect them if their wives, daughters et cetera have undergone it. Therefore they need to be understanding about it. For example, if a man is married to a woman who has undergone FGM, he needs to be understanding when it comes to things in the bedroom and how it affects everything. Men need to get involved."*
> **FORWARD, female respondent, Bristol**

Despite concerns about 'mandatory reporting', there is still strong support for a more interventionist stance by the government. Some respondents particularly wanted frontline staff, such as nurses, doctors and teachers, to be able to provide support and information to women affected by FGM. There was also a concern that conversations about FGM should be framed around 'support' and not 'punishment' for women affected by FGM.

> *"Doctors and teachers should know more about FGM — they have a really big role to play in protecting women."* **BWHAFS, female respondent, London**

> *''Also when a woman discloses she has had FGM, I've heard about cases where people straight away ask her OK well are you going to cut your daughters or take them abroad, without first offering the support to the woman that just made a disclosure, this makes women feel unsupported and will make it harder for women to come forward to seek support if needed.''* **FORWARD, female respondent, Bristol**

Similarly, some respondents wanted to have women routinely asked about FGM and their needs for support, for instance, when registering with GPs. Support for more screening may be higher among respondents where projects have played a specific role in linking women into care, but the support for earlier intervention is definitely a new finding compared to previous PEER research conducted during the TFGMI.

> *"Similarly, doctors should know that women have had FGM before they get pregnant. Before any new patient is registered, all women should be asked if they have FGM. Otherwise it's too late as the doctor only discovers when they're in labour or having a scan. It would also help doctors diagnose e.g. for urinary infections."* **Manor Gardens Welfare Trust, female respondent, London**

For those who had been exposed to mental health interventions and understood them, there were also calls for more to be done to enable women to seek mental health services.

> *"Mental illness is a huge unaddressed factor. Affected women need access to specialist counselling"*, **BWHAFS, female respondent, London**

While there was strong support for efforts to end FGM to continue, there was also a concern that the successes of the campaign to date, and the strength of rejecting the practice among some communities, should gain more visibility and public acknowledgement.

"More communities should speak out against FGM. Somalis are not the only community practising." **BWHAFS, female respondent, London**

Lastly, an emerging finding was that more people talked about the need to tackle FGM in countries of origin, as this was where respondents felt that there was a high risk and family pressure to carry on FGM. But equally, people from the diaspora living in the UK may be unaware that social norms around FGM are shifting in countries of origin, even as they support it as a means of maintaining 'culture'.

"95% of the people are against FGM and the 5% are old people who are living in the nomadic area. The Somali government is even campaigning against FGM and the people understand now that FGM is bad thing." **SDS, female respondent, Leicester**

3. Discussion and ways forward

3.1 Changes reported over the last two years

The PEER research has generated rich insights into how people from affected communities view support for FGM and efforts to end the practice. Overall, respondents felt that in project areas, there has been a significant shift in support for FGM. The PEER narratives make clear that it is the comprehensiveness of the response which has led to this shift, including creating 'safe spaces' for discussing FGM, women's greater access to care, and a greater intervention from frontline workers.

Overall, the main changes respondents noted as having occurred between 2013 and 2016 included:

1. Awareness of FGM in terms of its negative health impacts, lack of religious justification and illegal status under UK law has improved since the beginning of the programme.
2. Women and girls (especially those affected by the practice) feel more able to talk openly about FGM, and able to publicly voice their opposition to FGM. Important conversations in affected communities about the risks of FGM have started. There is strong evidence that FGM no longer occupies a 'taboo' status within some communities.
3. Most respondents believed the majority of their communities, especially younger community members, were now against the practice of FGM.
4. There is still support among some portions of communities, particularly older women, newly arrived groups and some women who have had FGM but suffered few complications, to carry on performing FGM. However, there were examples of successful engagement with these groups.
5. Respondents identified that some women in some larger diaspora communities are more confident to take a public stand against FGM than others – there is a need to reach out to other, smaller ethnic groups.
6. FGM is no longer viewed as a religiously-sanctioned practice, as it was at baseline. However, it is still closely linked to cultural identity among those who support FGM.
7. High levels of media coverage of FGM issues are widely credited with increasing the discussion around FGM, but have alienated some sections of the community.
8. In some cases, there is resistance to highly publicised efforts to prevent FGM, which are understood as stereotyping affected communities as 'backward' or 'evil', compared to the local, culturally-appropriate, community-level services which are perceived very positively.
9. In some areas, women affected by FGM are becoming more aware of clinical support services. Community-based projects play a vital role in linking women into services and support. However, in other communities, local services are not seen as accessible or available.

10. Communities believe there should be more dedicated services and support for women, especially more or better signposted de-infibulation services and psychological and relationship support for affected women.
11. There is support for a multi-agency, interventionist approach by the UK government against FGM as a form of violence against women and girls from affected communities. There is especially strong support for continuing community-based support services, workshops, extending outreach to hard-to-reach groups, and social media campaigns for young people.
12. There is a strong concomitant concern that preventive approaches should not generalise, stereotype or stigmatise the affected communities.
13. There is a consensus on the importance of engaging men, religious leaders, and newly arrived individuals from affected communities in the prevention of FGM.
14. There is a strong feeling that health, education and social care professionals need more training on FGM and particularly the 'mandatory reporting' procedure in order to avoid the enforcement of these aspects being mishandled.

The efforts to end FGM both at community- and national-level have contributed to a huge attitudinal shift over the course of the Initiative. However, the work to support affected women to access care and to prevent girls undergoing this procedure in the first place still requires substantial support if it is going to build on its successes and address its shortfalls.

The community-level campaigns were reportedly received positively by affected communities and were often compared favourably to the national-level campaign, either as providing the grassroots level work to support the national-level campaign, or as providing culturally sensitive, helpful sources of support and information in contrast to the perceived negatives of the national-level campaign.

3.2 Recommendations for further action

Drawing on the findings of the report, several recommendations can be made for future efforts to end FGM:

1. **An interventionist approach by the UK government against FGM as a form of violence against women and girls from affected communities** is supported where communities feel part of the collective dialogue and effort and understand the priority is protecting children. This involves creating a better network and dialogue between communities and statutory agencies and possibly community sensitisation of the purpose and process of child protection.
2. **The creation of 'safe spaces' and one to one support to talk about the intimate ways in which FGM affects people have been vital in shifting attitudes.** People affected by FGM are willing to speak publicly about their experiences but must be given the right support.
3. There is especially strong support for **continued and expanded community-based work** to educate and raise awareness about FGM, especially targeting illiterate, older, non English-speaking, and newly arrived groups who, respondents felt, still support FGM.
4. Women affected by FGM from **smaller ethnic or geographical groups** should continue to be targeted.
5. There is an ongoing need to target men, as actors who can support their wives to seek care and act to prevent their daughters from undergoing FGM.
6. **FGM is seen by supporters as a strong cultural tradition.** Community-level organisations working with different groups are best placed to use culturally-affirmative approaches and to assert that FGM is not essential for cultural identity.

7. There is a strong concern **that preventive approaches should not generalise and stigmatise the affected communities**, but that media coverage should celebrate and support the efforts of communities to end FGM. There is a need for national standards on communication about FGM and affected communities which the TFGMI could develop and encourage media organisations to use.
8. There should be **more school-based awareness-raising activities** conducted with young people, both boys and girls, and from practising and non-practising communities. Not singling out one group of young people (i.e. girls from practising communities only) allows for greater understanding and discussion between peers. Social media campaigns and youth activism are also important for engaging young people.
9. There should be more **school-based outreach to parents to raise awareness** of the negative effects and the legal status of FGM as well as to establish the school's role as primarily a source of information and support but also a safeguarding body when necessary.
10. **There is strong support for international campaigns to end FGM** with respondents in our sample increasingly demanding that FGM programmes also tackle FGM in their countries of origin.
11. Communities felt that there should be more **training for health professionals, teachers, etc. to handle 'mandatory reporting'** sensitively without alienating or insufficiently supporting patients. As part of this, community-based work to correct misunderstandings about the role of health professionals can help to strengthen these relationships.
12. Respondents felt that there should be **more or better signposted de-infibulation services** accompanied by awareness-raising of the benefits of the procedure, among men and women
13. They also felt there should be **more dedicated psycho-social support and counselling services** for affected women and their families to cope with the lifelong effects of FGM.
14. Respondents felt that people of all ages in affected communities could benefit from **sex education including discussion of how FGM affects sexual function and relationships,** perhaps as part of school curriculums for young people and as part of community-based work or psycho-social support for adults.

Appendix 1

PEER Researcher question guide

These questions and probes were used as a guide by the PEER Researchers during their conversational interviews with their respondents:

Question 1. What do people in our community say about FGM?
- Prompt: Who supports it?
- Prompt: Who doesn't support it?

Question 2. How has this changed over the past two years?
- Prompt: Why?

Question 3. What do people in our community say about efforts to end FGM?
- Prompt: In our local area (schools, councils, maternity services etc.)?
- Prompt: In the media?
- Prompt: In our project?

Question 4. What do people in our community think about the needs of women affected by FGM?
- Prompt: How has this changed over the past two years?

Question 5. How has our project impacted on our community and FGM?

Question 6. What more should be done to tackle FGM?

Question 7. Please can you tell me a story about anything that we have talked about today?