

Women's Experiences, Perceptions and Attitudes of Female Genital Mutilation

The Bristol PEER Study

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(FORWARD)

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The Foundation for Women's Health Research and Development (FORWARD) is a not for profit campaign and support organisation led by African Diaspora women. FORWARD was set up in 1985. Our work responds to the need to safeguard dignity and advance the sexual and reproductive health and human rights of African women and girls. We work with individuals, communities and organisations to transform harmful practices and improve the quality of life of vulnerable girls and women.

Our vision is that women and girls live in dignity, are healthy and have choices and equal opportunities to fulfil their potential.

- **We educate** policy makers, communities and the public to facilitate social change and realize the full potential of women and girls.
- **We advocate** for sexual and reproductive health to be central to wellbeing.
- **We support** programmes to tackle gender-based violence, in particular female genital mutilation and child marriage.
- **We empower** and mobilise vulnerable girls and women to articulate their issues and exercise their right to services and choices

Our Values

FORWARD believes that...

Protection of women and girls' rights and dignity are non-negotiable.

People's voices, needs and experiences should inform all our work.

Participation of girls, boys, women, men and community leaders promotes equity and ownership.

Provision of safe spaces and specialist services for girls and women should be central to programmes.

Partnerships and alliance building with civil society and community organisations, donor agencies and governments creates synergy and accelerates change.

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Introduction

This research aims to gain an in-depth understanding of some of the experiences and perceptions of women coming from countries with high prevalence rates of FGM living in Bristol. This was through a Participatory Ethnographic Evaluation and Research (PEER) conducted by FORWARD in December 2008.

Background to the research

The past two decades has seen an increase in interest on the issue of FGM, largely due to the influx of migrant communities coming from countries where FGM is practiced to host countries in the United Kingdom. There is currently a large migrant population of almost 600,000 Africans, which means that FGM needs to be addressed as an issue in several areas, including health, education, social care and asylum in addition to others. Research undertaken by FORWARD in 2007 estimates that there are nearly 66,000 women living with FGM in England and Wales and 21,000 girls under the age of eight who were estimated to be at risk of FGM.¹ The media has played a pivotal role in popularizing the issue of FGM, although sadly sometimes in a negative manner, thus affecting communities who currently form an integral part of the UK population. Below are some examples of extracts from the daily UK papers:

"Female circumcision is believed to be on the rise in the UK despite a new law to stop girls being sent abroad for operations, the BBC has learned. The new act aims to stop some African communities evading the law by sending girls overseas for the treatment. But a BBC investigation has found this has not stopped some parents forcing girls to go through the procedure. And experts fear FGM is also being carried out in the UK." BBC news report, 2004.

"During a highly disturbing, four month investigation by reporters from the Daily Mail, evidence was uncovered that thousands of British-African girls, in towns and cities throughout the country, have been forcibly "cut". This practice is an abomination which has no place anywhere, let alone in a civilised society." Extracts from the Daily Mail, January 2008.

"Thousands of girls mutilated in Britain. The NHS is offering to reverse female circumcision amid concerns that there are 500 victims a year with no prosecutions." Headlines from the Times, March 2009.

There have been various myths and beliefs about the practice of FGM in the UK, with most evidence being anecdotal. Apart from two research studies (Morison et al, Ahmed M), there has been limited information on communities from FGM practicing countries. Little is known about their experiences, attitudes and perceptions towards FGM and what their main issues and concerns are. FORWARD initiated this pioneering research in Bristol to remedy this lack

¹ These figures were based on the 2001 census and are likely to have increased since then due to migration to the UK from practising countries.

of information. The nature of the PEER methodology allowed the women we worked with to open up and discuss some of their obstacles towards living a 'better life in the UK'.

FORWARD conducted the PEER research study in Bristol with 8 adult women from the Somali and Sudanese communities (4 women from each community). The research was conducted in December 2008.

The research aims to answer the following questions:

- What is the continuing impact of FGM on the lives of affected women (sexual, reproductive and mental well-being)?
- How do women affected by FGM perceive and interact with statutory services (especially health services)?
- How do women feel about the practice of FGM, for themselves and younger generations and are there any intergenerational differences in attitudes?
- Is there any evidence for the continued practice of FGM in the UK?
- Are there any ethnic variations with regards to the practice of FGM in the UK?

By highlighting some of the ordeals and the reality of living in Bristol for women from FGM practicing communities, FORWARD aims to understand what these women are facing, and how this can be addressed both locally and nationally. FORWARD believes that there can be no effective policies developed towards accelerating social change without a thorough understanding of the social context and the environment in which the women in Bristol live.

Background on FGM

"Female genital mutilation comprises all procedures that involve partial or total removal of the female external genitalia and/or injury to the female genital organs for cultural or any other non-therapeutic reasons" (WHO, 2008). FGM is a deeply rooted practice that is practiced predominantly in more than 28 countries in Africa, and in a few countries in Asia and the Middle East. As a result of migration of people from FGM practicing countries for political or economic reasons, FGM has also become a reality in Europe, North America, Australia and Canada.

There are four types of FGM (see Box. 1), but the most severe form is seen more commonly in countries that comprise the Horn of Africa, Somalia, Sudan, Eritrea and Djibouti, where the FGM prevalence rate exceeds 80%. According to the WHO, 100 to 140 million girls and women have been subjected to FGM, and there are an estimated 3 million girls in world wide at risk of undergoing FGM every year.

Box 1: WHO Classification of FGM

Type I: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy)

Type II: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision)

Type III: Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).

Type IV: All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.

FGM has been associated with both short and long-term health effects and complications. The severity of health effects depends on the type of FGM performed, the skill of the circumcisor, the cleanliness of the tools and setting used, and the physical condition of the girl or woman, in addition to other factors (WHO, 2006). Most of the short term complications occur due to unsanitary conditions, failed procedures by inexperienced circumcisors or inadequate medical services once a complication occurs. Short-term complications can include severe bleeding, infection, urinary retention, shock and may even result in death. The long-term health effects can include urinary tract infections, cysts, abscesses and keloid formation, reproductive tract problems such as irregular menstrual cycles, dysmenorrhoea, painful sexual intercourse and chronic pelvic inflammatory infections. A recent multi-national study by the WHO has also associated FGM with increased difficulties during childbirth, including postpartum haemorrhage, the increased need for undergoing caesarean section as well as an increased risk to the new born baby, such as infant resuscitation, stillbirth or neonatal death (WHO, 2006). The physical consequences are only one part of what the girl/woman endures during her life, as she might also suffer psychological effects such as post traumatic stress disorder, sleep disorders, recurrent flashbacks, nightmares and panic attacks.

FGM has long been understood as a "*bargaining social tool with patriarchy*" (Kandiyoti, 1988) and a means to curb female sexuality (Lax, 2000) and has also been associated with marriageability (Toubia and Sharief, 2004). In communities that practice FGM, it has become a means for women to earn respectability, a degree of mobility and an acceptable social status. A three year study in the Gambia and Senegal conducted by Ylva Bernlund and Bettina Shell-Duncan (2007), concluded that: "*the decision of whether, when and how to perform FGM resulted from a constant process of negotiation about how to position oneself in light of shifting social relationships, contexts and experiences, representing proximate social experiences and actors that affected decision making.*" Thus the decision making

process is a much more complex process and is more fluid and non linear than expected and conceals a continuous dilemma that women face, highly dependent on several factors.

In each community where it is practiced, FGM is seen as an important part of the culturally defined gender identity. FGM cuts across religions: Muslims, Christians, Ethiopian Jews and traditional African religions practice it. It is mostly carried out on girls between the ages of 0 and 15 years. However, occasionally, adult and married women are also subjected to the procedure. The age at which female genital mutilation is performed varies with local traditions and circumstances, but is decreasing in some countries (UNICEF, 2005).

Understanding the age at which FGM is performed is important in particular for immigrant communities, as FGM practicing communities living in UK or other Western countries might need to change the age range at which they cut their daughters based on whether they will be able to travel or not to take their daughters back home (WHO, 2006). Additionally, as girls get older, they may resist undergoing FGM.

Regardless of the varying reasons and the form and severity of FGM, or the occurrence of any complications, FGM is considered a violation of the rights of the girl and woman. A series of historical events at the international and regional level managed to bring to focus the issue of FGM bringing attention to it and generating debate, including the Vienna conference in 1993, International Conference for Population and Development in 1995 and the 5th World Conference on Women in Beijing in 1995 in addition to others (World Bank, 2008).

At the international level, FGM is recognized by the United Nations (UN) as a human rights violation and is mentioned in the following international treaties:

- The Convention on the Elimination of all forms of Discrimination against Women (CEDAW)
- The Convention on the Rights of the Child (CRC), where FGM is specifically mentioned.
- FGM is also mentioned indirectly or specifically in other UN treaty bodies including Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and the Covenant on Civil and Political Rights.

At the regional level, FGM is also addressed in the following regional treaties:

- The African Charter on Human and Peoples' Rights (the Banjul Charter) and its Protocol on the Rights of Women (The Maputo Protocol).
- The African Charter on the Rights and Welfare of the Child
- The European Convention for the Protection of Human Rights and Fundamental Freedoms

Research Design and Methodology

Participatory Ethnographic Evaluation and Research (PEER) is an innovative qualitative research method used by social scientists and anthropologists to learn about communities and understand their behaviour, beliefs and perceptions particularly with issues that can be hard to talk about such as sexual behaviour, health seeking behaviour, family planning and other similar topics that are perceived as sensitive. The word peer refers to belonging to the membership of any significant social network, such as friends, neighbours or work colleagues. Through PEER a relationship of trust and rapport is built with the community through equipping members from the community to become 'PEER researchers'. These PEER researchers conduct informal in-depth interviews with their friends on questions which they develop themselves after identifying the issues which were important to them. The aim of the interviews is not to collect demographic or social 'facts' through accounts of individual experience, but to elicit the meanings that actors attribute to the social behaviour of their peers (Price and Hawkins, 2002).

The PEER methodology was chosen for this research as a result of a successful pilot PEER study that was conducted in London, in July 2008. PEER has been used in several countries by the PEER unit at Options Consultancy. Through the pilot study, FORWARD adapted the methodology to implement this research. The PEER method has received ethical approval from the University of Swansea Ethics Committee in 2007.

Some of the positive attributes of PEER are that it is quick and easily adaptable; it enables an in-depth understanding of the social and behavioural context of the community; the women that participate in the process adopt the role of researchers thus becoming experts within their community and rapport with the community is already built as the interviewers/researchers belong to the community.

PEER is an empowering methodology which gives the researchers a sense of ownership of the project, building their confidence and skills. The researchers are trained to ask questions in third person (e.g. what do people in the community think about ...?) thus making it easier to talk about difficult and private issues such as sexual behaviour and FGM. The interviews, themselves, are loosely structured and as the researchers interview their friends, it is easier to initiate dialogue as friends talk with minimal barriers.

PEER differs from other qualitative research methods such as focus group discussions or in-depth interviews. In focus groups, participants might not say all they feel in front of a bigger group, whilst in-depth interviews are more structured.

The PEER Process

The study was conducted over a period of 3 months. The process involved the following four steps: recruitment of the supervisors and researchers; training of supervisors and researchers; collection of data and data analysis.

Research Findings and Discussion

The data collected from the research was extensive as well as rich in the reality of the women's lives. Below are some of the most crucial issues which the women voiced during the research process.

All of the quotes in the document are the voices of the women involved in the research, from the interviews which the researchers conducted with their friends as well as the interviews that they had had with the research team. Some of the quotes have been edited for linguistic purposes. The research does not aim to compare the different communities, but portray the social construct based on the information provided.

Women's lives in Bristol

Life in Bristol was seen as not easy, particularly for newcomers to the city, as time was needed to adapt and learn the language. Most of the women felt a strong sense of isolation, in particular during their early days, with some women even mentioning that they felt 'scared and intimidated in going out even for short periods to the local shops'.

Life in the UK is very lonely and depressing in the beginning. They (the community) find the culture is totally different from the culture, prevailing in Sudan; relationships with neighbors seem very different and this is why a lot of families prefer to live in neighborhoods with a similar culture.

When we first came to the UK most of us felt depressed and lonely because of the cultural differences, we find western people have different life values which are very strange to us, as we came from Muslim culture most of what we see is very embarrassing and shocking.

The length of stay in Bristol was a very important factor in how much the two communities felt settled and able to adapt in the city. The longer the duration meant a more likely possibility for adapting to the environment. Civil war in Somalia brought an influx in migration to the UK in the 1980's and 1990's while the number of Sudanese asylum seekers has gone down since 1994 and most Sudanese migrants since then are professionals and academics. As such, adaptation was seen most amongst the Somali women who felt that they were able to get used to the system and knew where to access facilities. While the women from Sudan took time to adapt as they were newcomers in the city.

100% people who came to this country early about 10 years ago have adapted very well and are enjoying living in the UK but those people who have come recently they didn't adapt and they still need more time.

Marital life was an important aspect of the women's lives and there were clear variations due to the different social contexts to which the Somali and Sudanese communities lived and experienced. It was mentioned that amongst the Somali community there was a high incidence of divorce rates, as the women were sometimes the main breadwinners in the

family, with their husbands either absent or not working. The use of khat by the men was mentioned as one issue which the women complained of as affecting their lives. There was also a sense of shifting gender roles, with most women feeling that they were doing everything in the household, including providing for the family, cooking, cleaning and raising the children, as well as other responsibilities.

Some of our men don't like to work and they just depend on benefits, that's why they separate because they are not working, and they have kids, and all the night and day he can sleep (the husband) and not help you. So you do everything.

Most of the men from the Somali community have left everything to their wives, and this has become so much for the women to deal with at one time. She has to take care of the house, the husband, the children, the cooking and the cleaning. It has become so much for her. Whilst the husband is not even around and has no role, I know one woman who told me that her husband can disappear for 3 months, staying with his friend and they chew khat all the day, so his children only see him once every 3 months.

Divorce rates in the UK have increased rapidly because things are done differently to the UK than back home. It was very important for the man to go out and earn at least a small amount as he could not leave his family starving. In contrast, the Somali men here tend to be lazy as they know that both he and his family can rely on benefits.

As for the Sudanese community, the women mentioned that their marital relations were strong, and that for most of them, as they were newlywed or had only been married for a few years, they did not feel that there were any tensions or stress in the relationship. Most of the women identified with the fact that living in Bristol and migrating to the UK was a difficult process, as life in their home country was very different, both socially and economically. For the majority, they had come to Bristol to join their spouses, as such they came and joined their husbands settling into his life.

I think that married life here is very strong and intimate, because the couple lives far from their family, so they support each other, participate in decision-making, and solve their problems together. There might be some difficulty but that's natural. I believe that the good relationship between the couples is one of the best advantages of living here.

Our marital life in Bristol is warmer than marital life in Sudan. We spend more time with our husbands, sharing everything in our life and we make decisions together. Even when we argue it does not last for long. If my husband invites his friend for a meal I can sit with them chat and have the meal together (usually women do not share the meals if there is a male visitor) this applies to most of the Sudanese women. We miss this type of life in our country.

We find lots of help from most of our husbands, maybe because of the fact that we came as brides from the start to Bristol, and in Sudan we had our own status, most of us were working and had different professions, so I think our husbands probably might feel sorry for us and want to make sure that we don't feel bad or sad. So they try to make sure you get into the system and do courses. To be honest you can really feel quite depressed, as your life changes so much.

One of the researchers told me that we don't have anyone other than our husbands they are our brothers, friends and everything, so when we put the children to sleep, we have nothing else to do than sit down and talk with each other, maybe because we both need each other. Any friendship which you've actually made is through his friends.

For the Somali women, this differed as most of the women had already migrated away from their homeland since the civil unrest began. Some families had already migrated and come to other European countries before finally settling in the UK. The war, living in the diaspora and the varying migratory pattern amongst countries are crucial factors that can cause tensions within families and marital relations.

The main concern, which affected the Somali women in particular, was the lack of control of their teenagers. Some had teenagers and older sons and daughters who were born in the UK, or had lived most of their life in the country. All the families strongly voiced their fears that they were losing their children, that the children were losing their identity and that they have become so difficult to control and raise. Most attributed this to the fact that they were living in a country different from theirs and that the children had lost their cultural identity.

I think it is because this country is a free country, my friend has a teenage child and if he came back home late at night, he will say to her 'f..... off'. What makes them like this? It is because they see the white people do and say whatever they like to say.

Fathers can do nothing, because if you say something, the children can tell the police, so you can't do anything to them. Here we are afraid because our children will lose their culture; parents can't do what we do back home.

Family life in the UK is more strained than it would be back home in Africa. Family has no value within the family household as the children have adapted to western ways. Therefore, it is difficult for the parents and children to lead happy stress-free life. Also, the traditional views that parents carry do not go down well with the young girls of today. They seem to want to do the opposite to what the parents would like them to do. Mother-daughter relationships nowadays are not how they used to be.

The children are felt to be disobedient and not listening to the mothers while the fathers are either absent or not actively involved in the issues or have lost hope in their teenage sons, leading to a rise in tension and family breakdown.

When they become teenagers, they become not afraid of their mum and dad so they can do anything that they want, and not listen to them.

Bringing up children is very difficult here because I believe the law gives children freedom which they do not deserve. Parents feel that they are always observers in dealing with their children, which sometimes makes children in a stronger position than their parents!

A similar PEER research study that FORWARD conducted simultaneously with Somali youth in Bristol also showed that young people (in particular teenage boys) felt that they were not heard by parents and that they had no role model to look up to. They felt their actions were partly due to the sense they had of being torn between two worlds. They expressed their anger, through associating with gangs, and being 'bad' was seen as something to aspire to. What was also noted was that the girls were the ones who excelled in their education and work, and they were higher achievers than Somali boys.

Social networks and support

Most of the women in Bristol emphasised that both the Somali and Sudanese communities in the city had strong social networks. These strong networks made it easier for new families or people arriving into Bristol for their first time. Through visiting and provision of moral support, they made everyone feel welcome in the city.

As Somali we open our homes to new ones, we help them as we can. It could be by offering them a place to stay until they found one or give them food, or take them to the different services.

Actually we get the first help from our community. They help us to find where we need to go, like different advice offices. They also help us for translation and interpretation and allow us to live with them before we find our own place to live in.

In our Sudanese community we try to support the new ones as much as we can. It can be through offering the person a place to stay or donation of money. We also help them to find their way around and how to access the services, such as health, housing and education. We have a nice tradition for new married couples to welcome them to the community. By having a party or simply visiting them or showing them around the city. This is especially if the woman is a new bride from back home. This is how we build up new relationships and things move on from there.

It was strongly highlighted that on initial arrival to Bristol most of the women felt a strong sense of loneliness, in particular those women who had come as new brides to the United Kingdom. Part of the reasoning behind that sense of loneliness was felt to be due to the lack of knowledge of the English language, thus making it very difficult to adapt in the new environment.

One woman described how her initial conversations with her family back home, she would be crying because of her feelings of loneliness and isolation. All the women described that this was a phase which they had experienced prior to settling in. It is with this similar experience that most members in the community try to make newcomers feel more welcome and comfortable.

I think everyone knows how hard it has been for them in the beginning, so we do our very best to get the person on the right track. From my own personal experience life was hell for me because I could not speak or read any English.

As for adapting in Bristol, most of the women felt that it was not easy to adapt in particular to the differences in cultures. It was also felt that adapting needed to take time, and that those who had come to Bristol earlier and children were the ones more likely to adapt than those who had arrived recently in Bristol.

At first it's always difficult to adapt easily in a different country there are big steps you need to take. Learning the language and getting to know the culture, as well as other things. It takes time to settle but it does work.

I don't think we have adapted yet. Not even for our husbands who have been here for many years. Maybe we are too isolated in our community and everything is provided for us so that we isolate ourselves. But I think the UK is designed so people stay with their community. Or maybe in bigger cities things are different. For myself, adaptation is to know the rules and how things work around us. People here do feel left out, that's why they have their own community to rely on. We are happy here but one day we want to go back.

Governmental support to communities was mentioned quite a lot, and most of it was positive. Most of the women felt that on arriving to Bristol they had two sources of support, the support provided by the community which has been mentioned above, and the support that the government provides (housing, social benefits and income support). Most of the women involved in the research acknowledged that their community had been provided with support through the different services, but someone had to inform them what was available and what they were entitled to before they could apply. This was also one of the major forms of help provided by members of the community who had already had experience with the system, who oriented newcomers, giving them the necessary information of where to go and who to talk to and how to apply.

I got financial support from the government and the house rent. But it's not easy to get information about how to get support because they think you should know this information! I was lucky because I had helpful neighbours who advised me, my husband also knows more than me because he has been living here for longer.

From the government side, when we registered as refugees lots of efforts were made to help is in getting accommodation. If we have relatives we stayed with them

and if not we were put in hostels and given food, until we were moved to a suitable accommodation. They also put us in ESOL classes and helped us in getting jobs.

Once you come to the UK there is a lot of support available from both the government and the community. For example first you are set up with temporary accommodation then moved to a secure permanent place. You are also provided with help for food, clothing and financial aid.

Despite the praise of the support provided by the government a lot of the women said that the process has become much more difficult with the new immigrants arriving in Bristol and the waiting times have become more difficult. The communities also had limited trust in some of the social services provided by the government.

People think involving support agencies is like involving a third party in your affairs and you never know what their intentions are. I know of a person who took her daughter to the GP because she wasn't sure what was wrong with her skin. It looked burnt but the mother did not remember what had caused it. The GP immediately put the child under the social services investigation register. The mother received a warning letter of child neglect from social services and she was panicking. Luckily social services did not take the child away from her mother. But such scenarios make you think twice before you seek support from other services.

Health services, use, experiences and perceptions

From the discussions with the women, it was clear that confidence and trust in the health services was minimal. Most of the women felt that engaging with health professionals was not an easy task due to several factors, most importantly language barriers, a sense of lack of understanding due to cultural differences and feelings of not being respected. Due to this poor communication most of them felt discomfort in confiding in their doctors especially on such a sensitive issue such as FGM.

All the women usually try to avoid being examined in that area because they don't feel comfortable, especially those who are newcomers who, because of the language, have to have a third person or the husband as an interpreter. They are not used to this situation and it is only after they have gone through it a few times that they don't mind.

No we are ashamed to talk about this thing and we cannot give them the reasons why we do FGM because they always let us feel that we do wrong things and that we are uneducated.

The majority also said that they would feel more comfortable if the doctor or health professional was a female.

Some people don't know if the health professional is going to understand or if they have any knowledge on FGM. Others feel shy to talk about it but they don't mind if the health professional is a female, it makes it easier.

The new ones don't feel confident because this might be the first time for them to talk about FGM to anyone that is not from their own background. So they don't know if the health professional is going to understand the issue. Sometimes it helps if it was a female health professional.

Having experienced FGM made the women feel different from other women. This made them avoid speaking about their FGM to health professionals and even from undertaking crucial routine tests such as the cervical smear tests. Even those who managed to talk about their FGM to their doctor or nurse did not all receive a positive response from them. Some had faced negative comments which made them feel humiliated and belittled. Whilst others received a good response which usually meant that the health professional had an understanding of FGM and dealt with the woman with sensitivity.

When I go to health centre I feel I am different from other women. It bothers me when people ask me questions especially when I have not met the person before. I can't be happy to talk about this type of FGM as it makes you different than the other women.

They do not have any confidence to talk and speak about FGM. Even they can't involve any doctor on FGM. The first reason behind this is that traditionally it is very difficult in our country to talk about the affairs of FGM and it is very shameful to speak on it. It is also shameful to talk about the area of urination or even a woman's reproductive organ.

Because our women have their private parts looking different from the majority of patients, they are reluctant and put back appointments such as the smear-test. They worry about what the doctor will think, especially if they are cut so they prefer not to be tested at all.

From my own experience I did not face any problems; I was cut "Sunna." I know a friend that had to be opened before her delivery. She was lucky because she had found a midwife who knew about FGM so she booked her to have the operation before the delivery.

Silence and pain: the voices of women

Some of the justifications for FGM that were given by the women were that a woman that had not undergone FGM was not a "full woman". FGM was seen by their communities as something that needed to be done to bring dignity to both women and girls and to preserve their chastity

It is a tradition we found. Our mothers did it because their mothers did it for them.

It's something people believe in very strongly, no one even asks what's behind it! It's something that must be done.

Usually, most of the women never questioned it. There was no need to do so as it was part of their norm. They accepted FGM as it was, not necessarily because they agreed with it, but because in most cases it was seen as a tradition that went from generation to generation. Additionally, most of the women who underwent FGM as girls had no choice as they were children and there was nothing they could have done.

They say it is attractive and nice to our husbands, and this lets them not to think of re-marrying. It is because men always like to be strong so when he "opens" his wife he feels satisfied, so all our mothers and grandmothers do it to please men, as well as protecting girls from thinking of having sex.

"The memorable thing about FGM is when you have to pass urine. It is so painful as if a bee has stung you".

Throughout the research, what came across most in the information was how much the women endured pain and how they dealt with it in silence, accepting it as part of their reality.

"FGM is with us everyday" was one woman's quote on FGM.

From the day the girl was cut, to when she got her period, to when she married and when she delivered her babies, FGM was very much part of everything, a wound that will stay with the women throughout the rest of their lives.

The pain which the women felt impacted 3 major areas; the physical aspect; the psychological; as well as the sexual aspect.

The Physical Impact

FGM physically affects the girl right from the day that she is cut. In Somalia the women mentioned that girls were cut between the ages of 6-10 years, which was a similar range given to the girls in Sudan, between the ages of 5 – 10 years.

It affects our life and makes us suffer a lot during the period, because the space they left is so small. In the wedding night we suffer for more than one week from the scars because our husbands prefer to open us by themselves.

Yes sometimes the scars we have are so severe that we need to see the doctor to give us medication, during this time we can neither eat nor drink because of the pain.

Of course, it impacts a woman's life since the first day and forever. The problem begins during the circumcision when the girls suffer pain and panic. After that urine

retention can happen to her for several days and the urine comes out with difficulty and it's painful.

FGM has many problems with women and girls suffering most of the times. They might have problems such as vaginal infection, itchiness, back pain, period pain, and difficulty during delivery and even becoming pregnant. Lack of sexual feelings and lack of enjoyment because they cut a part of her body which Allah created for her soul.

I had a friend of mine in Somalia who was circumcised and was bleeding for a whole day without her mother noticing what happened to her. She was only 8 years old and she thought that this was something normal that happens after the circumcision. She was found unconscious by her sister and her mother rushed her to the hospital to get help. In the hospital all the hospital staff were men, they cut her and stopped the bleeding and stitched her back again. She had suffered from shock, and it took her a much longer time to recover. When she returned her friends started to call her names such as 'twice circumcised' and 'double stitched'. My friend had a difficult time and it took her a long time to cope with the whole experience.

“The pain that I have every time I have my period, it is like ‘oh my word’!!”

My friends talk about how FGM affected them during child birth. I think the psychological effect that FGM causes is paramount. The pain you endure during the cutting and then when you have sex for the first time, every time someone touches your private parts, you think 'here comes the pain again'.

The Psychological Impact

It has been indicated by a few researchers that there is minimal acknowledgement on the psychological impact of FGM, in particular in countries in the developing world, where mental health might not be accepted. In the research findings most of the women emphasised vividly the psychological effect of FGM that they felt, with recalls of negative psychological experiences such as flashbacks and fear of the whole process and feelings of looking ugly 'down there'.

One woman said she felt ugly before marriage. When she got married she also did not feel happy. Even people might ask why she doesn't have a bikra (the hymen).

Having your private area examined brings a lot of memories back. Women feel very shy and it's uncomfortable.

Some of the researchers experienced difficult situations during their conversations where their friends broke down in tears as this was the first time that they had thought about or discussed what they were feeling.

I think the psychological impact starts from the moment of circumcision. The girl feels shy to expose her private parts to strangers. The pain is not only from the operation, because the girl might not understand why they are doing it! And she does not find answers, with the questions left in her memory forever. The cruelty starts with suspicion from the girl who is in love with her family, she cannot be able to believe that her heart that her mother could be involved in that [FGM] so the girl will feel lonely.

Young girls may suffer from depression, knowing that they will have even bigger problems about FGM in the future after they marry.

The feelings that the women feel on being circumcised, (even though not shared with anyone) express a strong sense of deprivation, which is in most cases bottled up.

When the girl is as little as 5 or 7 years, they attack her in her private area. After some time, she may feel that they have taken or stolen from her something private that belonged to her. She might not understand its value, but she has a general feeling that she is suffering, and being uncomfortable when she goes to the toilet to urinate.

I have the friend who I did the interview with, when she started talking with me, especially on how much she had suffered and still is with her intimate relationship with her husband, she cried so much and it was tears of real anger. She was telling me how she had returned back from her honeymoon feeling so unhappy. She felt that no one considered her feelings and they were all waiting to hear her experience. She felt that her husband was really so considerate of her feelings and the pain she went through.

“The psychological effect appears when the girl sees the bleeding coming from her private area with so many women trying to stop her from moving. She has lost everything, even her dignity”.

The Impact on Sexual life and Sexuality

All the women who had experienced FGM felt that it had affected their sexual life, some of the most common comments, were that they felt that ‘something was taken away from them’.

During our discussions with the researchers, one woman commented ‘I really want to know what people feel. I even wanted to sit and ask white women, what she exactly felt’. The majority of the women felt that it was a difficult issue to discuss, even with their husbands.

I cannot speak to my husband about my feelings because I don’t even know what I am supposed to be feeling, but I saw a lot of films and saw how they felt. I discovered that FGM deprived me of most of my sensation. Even if I do feel it is not

that much. I sometimes feel that my husband is trying his very best to help me have a sexual sensation and it takes me a long time to have any feeling.

Sex was not an issue that was easily talked about in both Somali and Sudanese cultures, as it was a private matter, although it was felt that this might be changing particularly for girls who grow up here.

The way we look at sex it's a different issue in my community. We never talk about sex, so we don't have much expectations. But for girls who grow up here or even back home these days, maybe they will have more expectations.

Knowledge on sexuality and sexual health was limited. Most women entered into their marital relationship with only the basic knowledge which they had in biology classes. Others mentioned that the limited knowledge they had acquired on sex was from films and novels that they had read during their school years.

Many women, even those married for several years lack proper sex education. They usually rely on their husbands for this kind of knowledge.

The wedding night was seen as one of the worst times in their life. They vividly expressed their feelings of that first night, on how painful it was and how much they suffered.

The big night or the wedding night is supposed to be the happiest night in the woman's life. But for a woman who has had FGM it becomes the worst night of her life.

The night of marriage is a nightmare for those circumcised pharonically. Some suffer for such a long time. You can find that men do not respond to the request of the wife to stop. As some men think that women naturally exaggerate. They keep pushing without mercy. They can end up seeking medical attention instead of enjoying the tourist areas and hotels.

“When we returned home after our honeymoon, I did not think of it as a honeymoon, it is a KILLING MOON. I saw how my mother was worried, she couldn't ask me anything but had a lot of tears in her eyes and I cried a lot and hugged her”.

Some looked at it with remorse as they felt that at the same time that they suffered, their family celebrated their virginity, oblivious of the pain experienced.

In the wedding night, the woman who is cut has lots of pain and bleeding when she has sex it will be very painful. While she is suffering, their family and friends will be celebrating her being a virgin. When the time came I felt a lot of pains but I could not speak to stop him or do anything. Maybe I felt ashamed or I wanted to reach the end to feel

relaxed because I knew I had no choice and I felt like an injured bird. The only thing I did was cry and I hated everything in my life. I hated our tradition and I hated most my grandmother. But I didn't hate my mother, because I knew she did not want to harm me but she could not do anything.

“One wonders how many cuttings a woman has to go through in her lifetime”.

The wedding night was seen as a terrifying experience to the extent that one woman relayed one discussion which seemed to summarise how most women visualised it :

I recall that one of the women was trying to convince a girl to marry a man who was not cute by telling her that all

men are monsters at night.

Even those that do speak with you it is always something like 'sajamik on what is coming to you'. So it's more to scare and warn you off on what you are going to face with your husband. Maybe when living abroad, those men might be a bit more open minded and might have some discussion with you.

There were variations between different tribes and regions in both Somalia and Sudan in their traditions and rituals in the wedding night. One difference in traditions was seen between South and Northern Somalians. Women in the North are “opened” on the wedding night by a midwife. This act is witnessed by the bride’s mother, her mother in law and her husband. The main purpose of which is to make sure that the bride is a virgin. In South Somalia the bride had to be opened by her husband.

Some people open the cut woman at the first night of marriage. In South Somalia the man cuts it with his thing [penis], because if he can't then he is not a man.

My wedding night turned out to be a night of worries. One touch from my husband made him realise that I was so closed up he couldn't penetrate me. Fortunately he was understanding and told me not to worry we will do something. The following day I had my period and had to fake it for a month [the period]. Since he was returning back to Russia for his work, he could not take it anymore and talked with his mother who suggested that they bring a nurse to open me up. They never consulted me or even informed me that a mid-wife was coming to open me. In the evening my mother in law, the mid-wife and another woman from the village came and told me what they were going to do. The two women had to be present to see if I really was closed. It was embarrassing for me and I did not want to be seen in front of them. The midwife spoke to them and they eventually agreed after a lot of resistance. She opened me up and the women were outside the house making a lot of noise. This implied that I was a virgin and they were happy. When my husband came, he really was like 'we have to play sex before I go back to work'. I was in pain, nevertheless I had to give in but it was painful.

Marital sexual relationships were a constant reminder of pain for most of the women who had undergone Type II or III FGM.

Despite her husband being understanding, one woman told me that "the pain is pain". For her even trying gradually [penetration] was painful, to the extent that she felt that maybe trying harder might have eased the constant pains. She reached a point that she actually hates having sex with her husband.

Sometimes the husbands also had to face the consequences of the extreme tightness and how they reacted towards their wives very much depended on their own individual personality.

There was a story of a woman who really had a big problem after she married. Apparently she suffered for 2-3 months without telling anyone of the problem. She was so tight her husband could not have sex with her. She didn't go to the doctor she might have been ashamed about her being cut pharonically. They solved their problem by themselves by the man managing to penetrate after a long time.

In the wedding night, the groom might feel happy and proud that his wife is a virgin. The pressure then starts when they see their women are suffering and don't know what to do about it. Their friends will constantly ask them how they are doing in order to make sure that they are maintaining their manhood. But in reality how they feel in their bedrooms is a different story. They want to have sexual pleasure in their wedding night. They also want to make sure that where there is a cut it does not get back together. But to see someone you love feel a different way is demoralising.

It was hard to talk about sexual feelings and desire. It was embarrassing to talk about pleasure and what the woman wanted in order to be sexually satisfied. This was very much explained by the cultures and how girls were brought up from childhood to not talk about sex. A girl who touched her private parts was always told off. It was a forbidden area. A woman who talked about what she wanted with her husband during sex was seen as "open" or "one who had prior experience." As such most women decide to take whatever is given to them, as their main aim is to provide pleasure to the husband.

100% no one can talk about sexual satisfaction with their husbands. You might find only 10% who might be direct and talk about this issue. But there are 90% of us, maybe because of the way we were brought up, that have a certain limit in what they can talk about, especially in these areas. So you find that there is limited discussion on the topic of sex. Maybe the only time you might hear information is the day of your wedding. It is really embarrassing, even mothers do not like to talk about it. If she does give you advice she would never go into the nitty gritty details.

Women generally do not like to talk about this subject [sex]. It is believed that privacy must be respected. It is well known that FGM reduces women's sexual desire and women believe in this information and so do not push themselves to find ways to enjoy sex. They believe that pleasure is for men only.

As for their own sensual pleasure it was more common to enjoy acts of foreplay. This could be due to the fact that the breasts, thighs and lips were also erogenous zones in the body which can be stimulated during foreplay.

They cut all the clitoris, we cannot feel sex a lot. We feel mostly during cuddling, and when our breasts are played with, more than having sex.

She preferred the other things much more, like the kissing and the cuddling. She tries to fake her pleasure. She was not always excited, but did not want to offend her husband.

Women's rights, the FGM Bill and UK legislation from the women's perspective

Women's rights were perceived by most of the women to be what their role was as Muslim women. As such, from their perspective women's rights was mostly described in two differing ways:

1. The woman's right as a wife and how she has different duties
2. The right of the woman to seek and obtain benefits from the government

There was limited conceptualization of women's rights and what rights were perceived to be, although during the discussions it was clear that some of them had an understanding of rights, but could not relate it with their daily lives.

The rights of children and women are not known by many people in my community because they do not want to know. I think if we should know these rights we will find that they are useful to us. For example, if we keep in mind why we do not have the right to hit or beat children, because of the psychological impact this has on the child and how it affects the relationship between mother and child, we would have learnt something useful.

I do not think that people know a lot about the rights of women or children in the UK. In my view, Sudanese women are in full awareness of their rights and obligations to their families from the religious aspect. The men are treating their wives well and they give them all their rights. I do not think us as societies are in need of rights. We do not have many problems.

Yes they are aware of the rights however they do not experience abuse or anything else that breaches the right of women and children. African families are usually quite calm and do not suffer as a result of domestic violence or drug abuse as they know of their Religion and what the Quran states. Religion is a main aspect of their life.

Others had limited information on rights and confused it with the rights to seek benefits from social welfare.

I do not know anything about the rights of women and children here and unfortunately I don't know how to get this information. I remember that through chatting with one of my neighbours, I knew that I deserved a sum of money to prepare for the new born when I give birth.

As for knowledge on the FGM Act it was stated by the majority that they had limited information on the current FGM law. Most of those who had knowledge of it had lived for a longer period in the city, with newcomers having the least awareness of it.

There are a very few people who are aware about the rules and regulations related to FGM in the UK and most of our community do not understand completely and do not have the full information about the rules of the law and its consequences if FGM is done to their child.

Yes they know something about the law of FGM but it is just a general concept. They do not have enough information and there is no direction and particular people to ask and contact. However the parents do not circumcise their girls in this country because they know and are aware of the law of FGM in the UK.

They all know of the law, but even so they don't think that this will stop them. Stopping it requires a lot of time.

Most of my community do not know. Because I didn't know but it has been written clearly in big font in Charlotte Keel Health Centre that if we do FGM to our daughters they will charge us a lot of money and send us to the prison!

With regards to what the community felt about the law there were varied opinions including the following:

- The law was not enough as no one had been persecuted
- That the law would not prevent people from practicing FGM
- That no one will know if someone takes their daughter to undergo FGM
- The law was good and will help to protect their daughters

Some of the women felt that it is very easy to find ways to circumcise their daughters and that the UK government will not be able to prevent this. Some of the women explained that those families who were not planning to stay permanently in the UK will definitely not stop the practice, as they would feel it to be important to have their daughters circumcised.

My Somali friend said that no one cares about there being a law. But they all said that there has to be some prosecution for people to really feel scared or take caution.

We know that in 1985 the UK passed a law against FGM but no one has ever been prosecuted. It goes underground.

We heard some people talking about this law but we are not sure. We all hope that what we heard is true because this law will help us to protect our daughters especially when we go back home, because it will stop our mothers and grandmothers from doing it behind our backs.

People find loopholes to escape from the law. Also she thinks that she will not be living here she will just take her daughters back home and they will live there.

The woman told me: how will they know I did that [FGM]. Even if they examine her, I can say that we went to our family in our country and they did it to her without my knowing. Who will they prosecute then? Will they prosecute my mother or my husband's mother back home?

The Way Forward

The media and the popular attention to the issue of FGM in the UK has focused on the "quick fix" of passing legislation as a means to protect innocent children. While passing laws may be useful, they do not necessarily address the needs of African women in the diaspora. Many communities find that the idea that the government can protect children from their own families is unacceptable to them and is probably not even feasible. The best way to prevent the practice of FGM in girls in this country and elsewhere is to encourage women's self empowerment so that they can protect themselves and their own children. It is also imperative to ensure a community's support to any efforts being done on this front. This could only be through listening to their needs and concerns and finding a means to engage with them in a constructive way.

In order to advance and shift attitudes of how the communities perceive FGM, it is imperative to first provide a platform that will allow the community to feel secure and not alienated.

All the participants in the research, including supervisors, researchers and the interviewees voiced concerns and highlighted the main issues that need to be addressed for trust and integration to occur; as well as a thorough understanding of the different cultures amongst communities and their environmental context.

Some of the recommendations include the following:

1. Engagement with the community and Integration

- It was clearly voiced that education and learning the English language were important, in particular to those who have recently migrated to the UK, as language was pointed out to be a major barrier in communication. One possibility could be that community based organizations are provided with funding to support community learning, especially identifying where members of the community could find adequate information
- The women already network today, through encouraging a more structured networking, it could be possible that crucial information such as where and how to access facilities could be provided.
- Youth service centres could also provide information for the community in particular engaging with the community.
- Address scholars and religious leaders and use them as a route to the community
- Collaboration should be encouraged between the communities, working with men and children to protect girls.
- The trust of the community cannot be gained without engaging with them and providing them with the space to voice their concerns
- Media releases can sometimes feel hurtful to the community, even if not meant to cause any harm. As such it is important that the media filters releases that which are not culturally sensitive, so as not to alienate the community.

2. Providing a safe space for dialogue and discussion

- Most of the women identified that their experience in the research was extraordinary as they felt that they were able to discuss issues openly in a safe environment. The women need a space to talk about things, where they can come together to counsel each other and develop a sense of power from their solidarity. They may also want to talk to women from other communities and learn from their experience on how they were able to heal themselves.

3. Raising awareness on FGM and other issues

- Within the community there is a need for people to raise awareness through 'community champions' who are of the community.
- There is a need to engage with men and raise awareness of negative impacts of FGM.
- The more empowered the women the more they will be able to protect their daughters

4. Health services

- A need for specialist services, the current Well Woman Clinic in Bristol is hardly known by any of the women, and it is not accessible every day.
- In the current health clinics, most of the women felt that they would prefer female doctors and interpreters, as it would make communication much easier.
- Good mental health support is important for a healthy living, in particular for women who have undergone FGM, and especially those with differing experiences, even if counselling is not acceptable, support groups could be facilitated, where the women will be able to talk about their issues
- It is also crucial that health professionals, teaching professionals and social workers are trained on FGM and that they become more culturally sensitive.

5. The FGM Bill and child protection

- Awareness of the law has been identified and has been used by the women as a way to protect their daughters when they visit back home.
- It is important to understand that policies would be a top down approach unless they are really thought through and unless the community is involved in the process, so it is important that work is done with the communities working 'with them and for them'