Migration, Social Norms and Experiences of Female Genital Mutilation (FGM) among Somali Communities in the UK

Mina Nakai

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Department of Geography,
Royal Holloway, University of London

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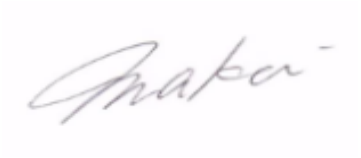
Declaration

I, Mina Nakai, confirm that the work presented in this thesis is my own. Where information has been from other sources, I confirm this has been indicated in the thesis.

Signed: 

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Abstract

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This thesis explores how and why attitudes and experiences of Female Genital Mutilation (FGM) vary between first and second generation migrants within Somali communities in the UK. It considers the role of migration in shifting or reinforcing social norms around FGM, and how these are challenged or reshaped by the post-migration generations. Key to understanding the attitudes and experiences of individuals is an engagement with how social norms around cultural practices, in this case FGM, are transmitted between generations through familial relationships, and within communities through social expectations.

The thesis includes discussions of the attitudes of men regarding FGM. This is relatively rare in studies of FGM, despite their role in maintaining or challenging social conventions around the practice. The thesis is unusual in its consideration of men's direct experiences of the impacts of FGM in the context of marriage. This focus on men, and also the impact of FGM on relationships both within families and friendship groups, reinforces the approach that this thesis takes to understanding FGM in its wider social context.

This research was carried out in two locations, London and Manchester, where there are a large number of people of Somali heritage. Several Somali

communities in both locations were selected to participate in this research project. Data was collected through 80 individual interviews with both men and women, and with first and second-generation migrant community members. This provided the basis for an examination of how migrant generation and gender are implicated in the attitudes towards FGM, as well as the experiences of the procedure. The research was conducted over an 18-month period, involving significant engagement in community activities, as well as everyday ethnographic observations in community centres.

Key findings include the significant differences between first- and second-generation groups in both experiences and attitudes, although there is diversity within generations and genders. The thesis highlights men's experiences and the potential implications of these for their own health. The research also stresses how FGM has an impact on family and friendship relationships, something which is rarely covered in the existing literature. The overall research findings could contribute to efforts to eradicate this practice in the future.

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Chapter 1: Introduction

1. Introduction

> *I just came back to the UK, finished summer holidays. It's weird going to school because I just had a crazy summer. But I can't tell people. I thought I can't tell people because people will think I'm crazy. I didn't think oh mum will be in trouble, or anything like that. I didn't know it's a crime. I didn't know it's illegal. It just felt weird. I didn't think people in the UK had it done. But after I done it, I realised actually lots of girls in the UK have it done. It's a big thing. You might know. After I met lots of friends who have had it done, I did talk with them about what happened to me that day. I can't talk with friends that haven't had it done, but I have lots of friends who have had it done. We talked about our anger towards our mums lots, but now we joke with each other about FGM.*
>
> *(Nafira, second-generation, female, Manchester)*

In this interview extract Nafira is reflecting on her experience of returning to school in the UK after her summer holidays in Somalia where she had experienced what is often termed female genital mutilation (FGM). The extract highlights how, before that trip, FGM was not something Nafira had known about, and she was unaware of its prevalence among her friends of Somali heritage in the UK. A key aspect of Nafira's experience was its impact on important

relationships, particularly with her mother, who was an immigrant to the UK from Somalia, and her friends. These themes of FGM experiences, migration, generational change and relationships are at the heart of this thesis.

The first time I heard about FGM was during a lecture as part of my Bachelor's degree in Japan, where I am originally from. At this time, awareness of FGM was not very widespread in the country. I was, however, able to meet a woman of Somali origin who moved to Japan as a refugee; she shared her personal experiences of FGM with me. The lecture, and opportunity I had to meet this woman, were the drivers for me to move to the UK to continue to study, and research into, this topic. My strong interest in FGM and belief that it is a harmful practice led me to work at the Orchid Project, which is a London-based NGO focusing on the eradication of FGM. Working at the Orchid Project was another important life event, which encouraged me to undertake this specific research topic.

During my time working with this organisation, a man came to the office asking for help to protect his daughter from FGM. I was aware that FGM was being undertaken within migrant communities in the UK, however it was the first time I was actually faced with a real case of the practice inside the UK. This experience had an effect on me personally and led to me to search for more information on FGM in migrant communities in the UK. While there was a growing body of literature on the health implications of FGM, and the need for medical professionals in the UK to support women who had experienced the

practice, there was limited research on experiences of FGM, inter-generational change in FGM attitudes within migrant communities and the wider implications of FGM on family relationships. It was noticeable that existing research almost always only considered the practice from the perspective of women. This is even though one of the key driving factors behind the continuation of FGM is men's expectations placed on women (Varol et al., 2015). As such, male involvement could also be important in the eradication of this practice in the future. The limited nature of existing research, and lack of research considering men's involvement and perspectives, led me to undertake this research.

This thesis explores experiences of, and attitudes towards, FGM among Somali communities in the UK. Key to this research is the importance of recognising heterogeneity within these communities, particularly along gender and generational lines, and acknowledging the complexities and intersections of household relations, community networks and transnational family links.

FGM is widely practised in Somalia, and continues to be practised inside Somali communities in the UK despite being an illegal practice (under section 70 (1) of the Serious Crime Act 2015, amended section 4 of the Female Genital Mutilation Act 2003). Young female UK nationals who have a Somali background are still taken to Somalia to be cut as described by Nafira at the start of this chapter (see also Dorkenoo et al., 2007 and FORWARD, 2018). As FGM is an illegal practice in the UK, and it is a very sensitive subject, particularly for those women who have direct experience of it, conducting research is challenging. As such, a large

amount of the existing research on FGM in the UK focusses mainly on estimating the number of people who are affected by FGM, national-level policies including legislation against FGM and protection for those that are considered at risk of the practice, and support available for women and girls who have been affected by the practice. While there is increasing research on the experiences of FGM and attitudes towards the practice among migrant communities within the UK, there is limited consideration of generational shifts and men's perspectives on FGM. This thesis seeks to contribute to this small, but growing, literature.

This chapter further explains the context of this research, my research aims and objectives, an overview of the methodology I adopted, and summarises the structure of this thesis.

2. Female Genital Mutilation (FGM)

2.1. Definition and terminology

FGM is 'the partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons' (WHO, 2020). According to the WHO (2018) there are four different types of FGM; clitoridectomy (Type 1) which is removing a part or all of the clitoris, excision (Type 2) which is cutting the clitoris and removing a part or all of the labia minora, infibulation (Type 3) which is removing part or all of the outside of the sexual organs and stitching up the entrance to the vagina and other practices are categorised as Type 4 FGM such as pricking the clitoris with a needle. The reasons behind and forms of the

practice vary between countries and communities.

There is significant debate about what terminology should be used to describe the procedure. The term ‘female circumcision’ was used in the international literature until the 1980s when ‘female genital mutilation’ was introduced. Since then, FGM has been the term adopted by a wide range of women's health and human rights organisations; this is because this terminology indicates the damage caused by this practice, which is far more extensive and long-lasting than practices of circumcision conducted on boys and men. For example, the World Health Organization (WHO), states,

> ‘Female genital mutilation is a deeply rooted, traditional practice. However, it is a form of violence against girls and women that has serious physical and psychological consequences which adversely affect health. Furthermore, is a reflection of discrimination against women and girls’ (WHO, 1997, p.5).

In the late 1990s, some researchers and international organisations began to use other terms such as ‘female genital cutting’ (FGC) and ‘female genital surgeries’ (Rahman and Toubia, 2005). Some medical professionals or international organisations use FGC rather than FGM because it is felt to be more neutral and less stigmatising of the practice and therefore the communities that continue with the practice. In Alhassan et al.’s study among African migrants in Europe, some participants disapproved of terms such as ‘mutilation’ and ‘cutting’, although others felt that the ‘shock value’ of the terms was important to change practices

(Alhassan et al., 2016, p.30-31).

Since 2003 there has been an International Day for Zero Tolerance for Female Genital Mutilation (on 6 February) led by the UN and the term is specifically used in the Sustainable Development Goals (SDGs) in Target 5.3: Eliminate all harmful practices, such as child, early and forced, marriage and female genital mutilation (Baudu and Kusuma, 2017); this was the first time the practice has been targeted specifically at the international agenda level. According to the 2005 Bamako Declaration on the Terminology FGM issued by the 6th General Assembly of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children, 'The term is non-judgmental as it is a medical term describing what is done to female genitalia. Mutilation is the removal of healthy tissue' (in Burrage, 2015, p.5). While it may appear to be non-judgmental, for a non-medical audience the term 'mutilation' can evoke a strong negative reaction and highlights the harm caused by the practice (Raafat, 2017).

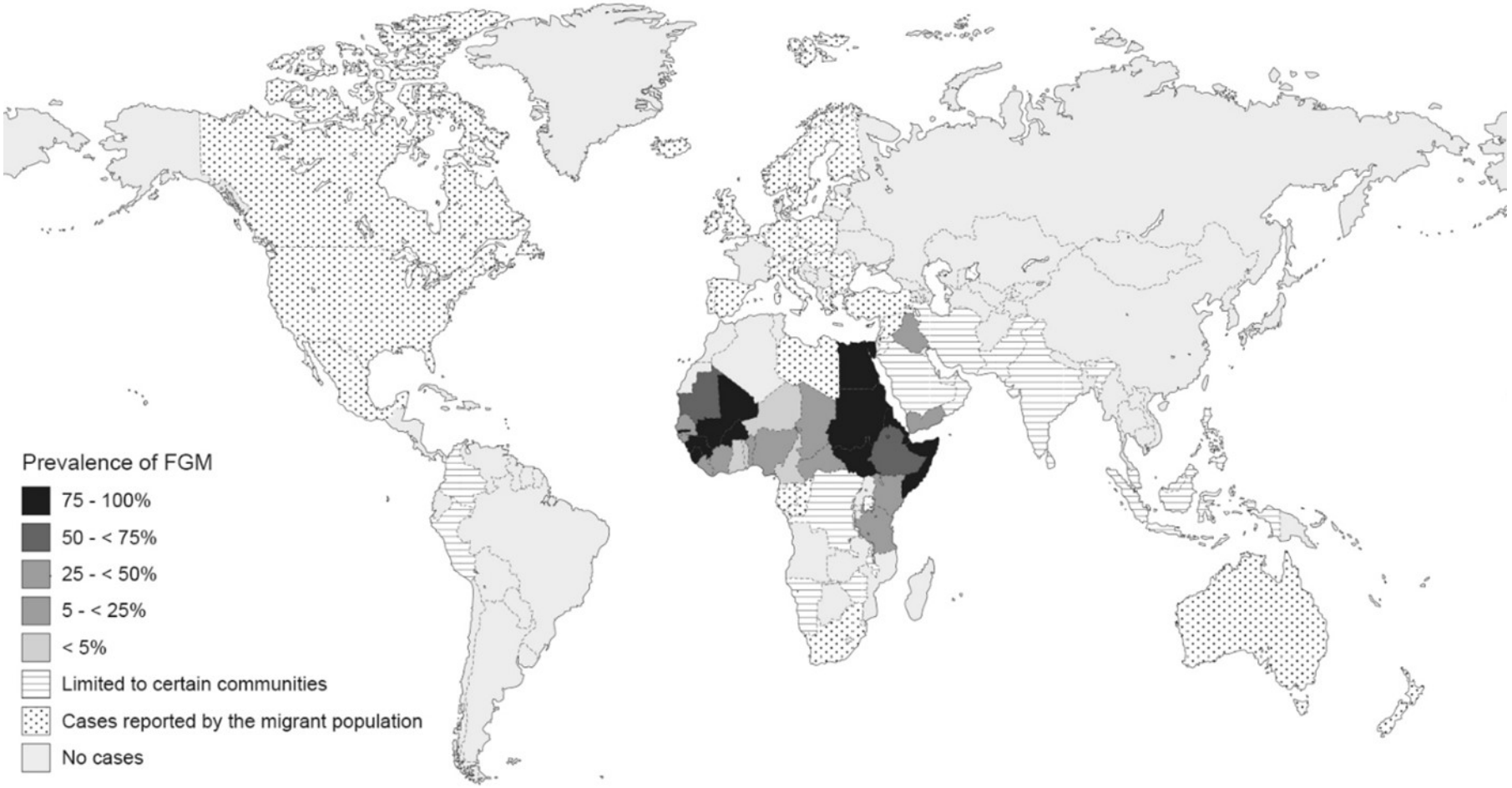
In this thesis I have chosen to use FGM. This is because I would like to make visible the damage caused by this practice. However, it is also important to note that it was often the term used by my participants, and it is how the practice is referred to in UK law and UN documents. At some points in the thesis I use the terms 'circumcision' or 'cutting'. This is either because it is the term used by participants, or it is purely done to avoid significant repetition.

2.2. Where FGM is practised

While there has been a decline in the practice of FGM in some communities (Batyra et al., 2020; Enselma et al. 2020), FGM remains widespread in 31 African countries, the Middle East and Asia (WHO, 2020) (see Figure 1).

There are an estimated 200 million girls and women worldwide today who have directly experienced FGM, with a further 68 million girls estimated to be at risk between 2015 and 2030 (WHO, 2012; Kawous et al., 2020). The prevalence of FGM varies greatly between countries, but there are several countries, including Somalia (97.9%), Egypt (95.8%) and Guinea (95.8%) which have a particularly high number of women and girls that have been cut (Kawous et al., 2020; UNICEF, 2020a) (see Figure 1). One of the challenges in researching FGM is the paucity of accurate data. Denison et al. (2009) pointed out that some countries, such as Senegal and Ethiopia, are making concerted efforts to reduce the numbers of girls who are at risk of FGM through campaigns involving international organisations, ultimately hoping to eradicate the practice.

Figure 1: Prevalence of FGM worldwide (Percentage of women who are living with FGM)



Modified from UNICEF (2020c)

While the origins of FGM practices are rooted in specific locations, FGM is spreading into countries where FGM does not exist as part of existing cultures and traditions (see Figure 1). Over recent decades, people living in the 31 countries where FGM has traditionally been practised have begun to migrate into Europe and countries such as the USA, Canada, Australia and New Zealand where FGM is not part of prevailing cultures (Vangen et al, 2004; Kawous et al. 2020; UNICEF, 2020a). This migration has been caused by many different factors such as civil war, famine, a desire to access better education or employment and political reasons (UNICEF, 2008). Moreover, EU member countries have actively accepted migrants from countries in Sub-Saharan Africa, including countries where FGM is still practised (Powell et al., 2004). These migration flows are causing the incidence of FGM to spread across Europe increasing both the number of girls who have undergone FGM and the number at risk of the practice.

European Union (2013) showed the number of women and girls who experienced FGM and number of girls at risk of FGM. The UK (65,790 women and girls) and France (61,000 women and girls) have a particularly high number of women and girls that have been cut; Italy (35,000 women and girls) has the third highest numbers. The UK leads the way in terms of the numbers of girls who are at risk of the practice with 30,000 girls in the UK; comparative data is not available for France. However, Leye, et al. (2007) estimated that between only 4,500 and 7,000 girls in the UK were at risk of undergoing FGM, and that only 13,000 to 30,000 girls had already had experienced it. Macfarlane and Dorkenoo (2015) estimated the number of girls and women who were circumcised, and living in the

UK had increased from 65,790 in 2001 to 137,000 in 2011. The big difference in the estimates raises some doubts over the validity of the data, and exemplifies the difficulties in estimating the exact number of girls affected by FGM in Europe.

Powell et al. (2004) pointed out that some European countries have specific legislation against the practice of FGM (Powell et al., 2004), while in others FGM is outlawed through existing laws (Barbera, 2017). Despite this legislation against FGM, in many of these countries the number of girls that have experienced FGM continues to increase annually (Johansen et al., 2018).

2.3. Justifications for FGM

The reasons underpinning the practising of FGM are varied, but have become embedded in the social norms of some communities, and passed between generations in the form of traditions. FGM may be seen as an important rite of passage to adulthood, where girls are then able to enter marriage. This is the case in some parts of Sudan, Kenya, Côte d'Ivoire and Mali (Dorkenoo, 1995; WHO, 2018). Alongside the practice of FGM, in some Kenyan communities, girls are taught dance and songs for the rituals that will allow them to enter into adulthood. Additionally, girls learn their society's rules about women's duties, responsibilities and roles, as well as skills relating to cooking and needlework (Utsumi, 2003; Adjetey, 2005).

Discourses around FGM often present it as an unchanging, traditional practice

that is so deeply embedded in social norms that it will not be eradicated. However, this fails to acknowledge changes in the type and forms of the practice, as well as locations and communities where it is now much less common (Hodžić, 2017; Eldin et al., 2018).

3. Theoretical context

This thesis seeks to contribute to the small, but growing literature on FGM and migrant communities in Europe in both empirical and theoretical terms. Firstly, the thesis seeks to provide data on the experiences of FGM among Somali migrant women and daughters of migrants in the UK. Research on FGM within Europe has tended to focus on providing an overview of trends, or has considered the health implications of FGM in order to shape support from medical practitioners. There has been much less community-level research on migrants' attitudes and experiences of FGM (although see Alhassan et al., 2016), and even less on the perspectives of second-generation migrants. Drawing on qualitative research adopting a feminist methodology, this thesis puts the voices of Somali women at the heart of the thesis.

Secondly, the thesis seeks to understand and explain trends in FGM practices and attitudes among Somali communities in the UK by drawing on social norm theory. This stresses that individual decisions are made within social contexts and are influenced by what are perceived as widespread beliefs or norms. As Mackie et al. (2015, p.4) state,

> ‘Beliefs about what others do, and what others think we should do, within some reference group, maintained by social approval and disapproval, often guide a person’s actions in her social setting. If a harmful practice is social in nature, programs that concentrate on education of the individual, or increase in the availability of alternatives, or provide external incentives, may not be enough to change the social practice.’

In relation to FGM, a social norms approach has been increasingly used in understanding continuities or changes in practice in countries where there is a high prevalence of FGM, as well as its adoption in programmes to eradicate the practice (see Chapter 3). However, as outlined earlier in this chapter, some migrant communities coming from high FGM prevalence regions are now settled in low FGM prevalence societies. FGM as a cultural practice is justified, reproduced or challenged through norms and conventions which are often tacit (Mackie, 1996, 2000). International migration uproots individuals and households from place-specific networks of interdependence and particular social and cultural contexts. This disruption could create new conditions in the host society where FGM is no longer seen as positive, and social pressure to practice FGM withers away (Barrett et al., 2021). However, as Alhassan et al. (2016) noted, little is known about belief systems that underpin FGM in the EU. This research with Somali communities in Manchester and London seeks to address this knowledge gap and bring together theoretical debates around FGM as a social norm and theories about migration and social change.

Considering migration involves not only the implications of moving between locations of different FGM prevalence, but also the potential generational tensions between parents who migrated and their children who were born in a country with low FGM prevalence. Additionally, migration usually does not involve a complete break with social connections and emotional ties to the place of origin, family members and friends. Instead, ongoing connections mean that decisions about FGM are made in the physical space of the UK, but within a broader social space of the Somali diaspora and homeland.

Finally, this research aims to add to understandings of the experiences of FGM beyond those of women who have been cut. While this remains important, as a practice which is embedded in social norms, which include assumptions about masculinity and men's preferences for a wife who has been cut, it is crucial to explore men's attitudes, but also to find out more about their experiences of FGM through their relationships with their wives, or their involvement (or not) with decisions about whether their daughters should be cut. There is currently very limited research on men's attitudes and experiences relating to FGM. As women are usually cut when they are young girls, adult females, usually mothers and grandmothers, take the lead on decision-making around FGM. There is little research on how FGM affects relationships between mothers/ grandmothers and daughters/ granddaughters. Additionally, the role of other inter-personal relationships, especially friendship, has often been ignored in studies of FGM. This research seeks to shed light on some of these relationships and the potential support or anxiety they can create, feeding into a more nuanced understanding

of social norms and the role of inter-personal relationships in FGM as a social norm.

4. Research aims

The overall aim of this thesis is to understand the role of migration in FGM experiences, practices and attitudes. It seeks to do this through a study of male and female Somali first- and second-generation migrants in the UK. I have broken this overall aim down into three research aims:

1. To explore how and why migration challenges or reinforces attitudes regarding FGM.
2. To investigate how and why attitudes and experiences of FGM vary between first- and second-generation migrants.
3. To investigate the role of inter-personal local and transnational relationships on FGM experiences and attitudes.

These research aims will be discussed throughout this thesis and will be brought together explicitly in the conclusion chapter, at the end of this thesis.

5. Overview of methodology

This research was based in Somali and Somaliland communities in both London and Manchester. The target group of participants was first-generation Somali migrants, the population of Somalis who migrated from Somalia or Somaliland to

the UK, and British Somalis who have first-generation Somali migrant parents, and were born and raised in the UK (second-generation migrants).

Talking about FGM is often taboo for both males and females in the Somali community; it is unusual to talk about FGM with people from other ethnic groups, particularly someone of a background or from a country where FGM does not exist as part of the culture and tradition (Dorkenoo et al., 2007; Connor et al., 2015). As such, before undertaking my field research, it was essential to build strong relationships within the communities to ensure that people were comfortable enough to discuss sensitive subjects, including sexual aspects, with me. It took about two years to build relationships with locals who access the Somali community centres, be welcomed into the Somali communities and for agreement to participate in the research.

The data collection for this project took about eighteen months in total, involving individual interviews with eighty participants in both Manchester and London. I had conducted research in the same communities in London for my Master's dissertation and I used the first year of my PhD to build further relationships with community members in Manchester. Given the sensitive nature of the topics being discussed, I decided to undertake interviews on an individual basis, rather than as groups, to ensure that participants were comfortable discussing their experiences allowing me to gather rich data. This also lay behind my decision to conduct semi-structured interviews in a conversational style. This helped put participants at ease, and meant I could adapt to the situation, while also ensuring

that I covered themes of relevance to my research questions.

I conducted interviews with an equal number of men and women as part of my aim to consider the role of men in FGM practices and the impact of FGM on men. Recruiting and discussing the issues of FGM with men was particularly challenging, but has resulted in original data and perspectives on the topic. The methodology adopted for this research is explained in further detail in Chapter 4.

As outlined earlier in this chapter, there is significant debate around the terminology used related to FGM. In addition to discussions about what term to use to refer to the practice, there is also contestation about using the word 'victim' to talk about women who have undergone FGM (Khosla et al., 2017 for example). While I have chosen to use the term FGM in acknowledgement of the harm that the practice involves, I opted to not use the term 'victim' in either interviews or the write-up of this thesis. This is because I wanted to acknowledge the agency of the women who had experienced FGM in dealing with the consequences.

6. Structure of this thesis

This thesis is structured into eight chapters. The following chapter, Chapter 2, provides a contextual background on Somalia and Somali communities. Chapter 3, provides the theoretical context for this research, focusing particularly on debates around social norms, changing attitudes and practices of FGM and the role of migration, as well as expanding on the patterns of FGM outlined earlier in

this chapter. Chapter 4 outlines, explains and justifies the methodology for this thesis. It was significantly challenging to undertake this research because of its sensitivities and my position as an outsider. This chapter describes the research design, methods used, ethical aspects of the research, positionality and analysis.

The next three chapters, Chapters 5-7, draw out arguments based on the data collected in interviews and observations. Chapter 5, provides an analysis of the experiences of FGM for first- and second-generation women, outlining similarities and differences both within and between generations. Chapter 6 focuses on explaining the patterns discussed in Chapter 5, considering the social norms which underpin decisions about FGM, and the forms of overt and implicit social pressure, both within the local community and transnationally. In Chapter 7 attention moves to a consideration on men's experiences of FGM, and the impact of FGM on intra-family and friendship relationships.

The final chapter of the thesis is the conclusion, which summarises my findings in relation to the research questions, and reinforces the contributions that this research makes to a range of debates. Finally, additional research areas are suggested based on my analysis and findings. The thesis will help provide a stronger base for further research into the impact of culture, gender and migration on FGM and changes that can be made to help reduce this practice in the future.

Chapter 2: Somali Migration, FGM and Gender

1. Introduction

Before discussing the theoretical underpinnings and conceptual framing of this research, it is important to provide some background information about Somalia, Somali migration and FGM practices. Given the importance of gender norms and expectations in shaping attitudes to FGM, the chapter also includes a brief discussion about gender norms in Somalia and among Somali migrant communities, particularly in the UK.

The chapter starts with an overview of key political events in Somalia since the 1990s, which have led to the displacement of large numbers of people both within Somalia and across its borders to neighbouring countries and further afield. It then discusses the international migration of Somalis, before focusing on FGM practices and wider gender norms in Somalia and among the diaspora.

2. Somalia and Somaliland

Somalia is located in the Horn of Africa, with a 2019 population of approximately 15.44 million (World Bank, 2020). It is not diverse ethnically which is a rarity in the African continent where many other countries are much more ethnically mixed and diverse (Takizawa, 2006). The vast majority (95%) of the population is Muslim, with 98% of these Sunni Muslims. Religion is strongly followed in the population's daily lives (Bird et al., 2017).

The government was led by Mohamed Siad Barre from 1969 until 1991, but the regime collapsed following a coup that year, leading to the outbreak of civil war. Following the start of the civil war there was a sustained period of no controlling government (Endo, 2010). As a result of this long period of instability, the domestic economy and social infrastructure were severely damaged and there were high levels of insecurity throughout the country. Moreover, the occurrence of several serious natural disasters, including droughts, combined with the levels of violence resulted in significant food insecurity and large numbers of refugees and internally displaced people (Bird, et al., 2017; Keating and Waldman, 2018).

The mainland of Somalia has been divided into three states since 1991; the Republic of Somaliland, the Puntland State of Somalia and the Federal Republic of Somalia (Hoehne. 2010). The Republic of Somaliland, which is located in the north-west, was a territory of British Somaliland and declared its independence in 1991; the Republic of Somaliland is however not recognised as an independent state by the international community. The Puntland State of Somalia is located in the north-eastern part of Somalia and it established its own autonomous government in 1998, and it was also not recognised by the international community. The Federal Republic of Somalia, which is located in the south of Somalia, established an official government in 2012; the situation however remains unstable, with ongoing threats from the Al-Shabaab militant group (Khayre, 2016; Keating and Waldman, 2018).

3. Somali migrants in the EU and the UK

The ongoing fighting and economic situation due the civil war in Somalia made it a very dangerous situation for civilians and led to many leaving Somalia for neighbouring countries such as Djibouti, Kenya and Ethiopia (Ssereo, 2003). Harris (2004) stated that by 1991, about 45% of the total population in Somalia had left the country and settled abroad due to the civil war. These people fled not only to neighbouring countries but also to EU countries and North America.

While the recent civil war prompted significant emigration from Somalia, international mobility is not new (Kleist, 2004). Part of Somalia (Somaliland) was originally a British colony, and as such there historically there has been a large number of migrants from Somalia in the UK (At Home in Europe, 2014). Communities of seafaring Somalis developed in the late 19th century (Farah, 2000), with the Somali community in Tower Hamlets, East London being one of the oldest Somali communities in the UK (Griffiths, 1997). These early communities were overwhelmingly male and were largely transient, with the migration of women and children only becoming significant in the post-independence period, particularly after the start of the civil war (Kleist, 2004; Griffiths, 1997).

According to the UK census, in 2011 approximately 100,000 people born in Somalia lived inside the UK (Liberatore, 2018), with an estimated 65,000 living in London (Office for National Statistics, 2016). However, these figures do not include the population who were born and raised in the UK, or came to the UK

having being born in another country outside Somalia. As such it is difficult to identify the size of the Somali/ Somali-British population living in the UK. A large number of Somalis arrived as refugees either directly from Somalia or having travelled through other countries, including other European countries such as Norway, Denmark and the Netherlands where they initially settled (Hemmings, 2010; Van Liempt, 2011). Due to the freedom of movement for EU citizens within the EU, large numbers of Somalis migrated as refugees into other European countries first then after receiving a European passport, moved into and settled in the UK (At Home in Europe, 2014).

Because most Somali migrants to the UK in recent decades arrived a refugees, they were provided accommodation where local authorities had housing. This has usually meant being concentrated in poor-quality accommodation (Easton, 2015). As communities have become settled, there has been some upwards social mobility, but Somali communities remain disadvantaged in socio-economic terms, with high levels of unemployment and relatively poor educational outcomes (Allport et al., 2019). However, Van Liempt (2011) highlights positive dimensions of living in urban districts with high numbers of Somalis. Her work on Somalis migrating from The Netherlands where the Somali community is numerically small to the UK with its much larger Somali population, reveals how many ‘Dutch Somalis’ appreciated residing with other Somalis due to shared language and culture, despite the poorer material living conditions. For younger Somalis, born in The Netherlands or the UK, the appeal of living in a district with a high number of Somalis was less appealing as they felt their behaviour was scrutinised by

neighbours and community members (Van Liempt, 2011).

Many first-generation Somali parents believe that the loss or weakening of the Somali language and their religion is damaging to maintaining their Somali culture, and lessens the connection with the mainland of Somalia, which many first-generation migrants still view as their “home”. A large number of second-generation Somalis largely use English outside of the home, leading to some second-generation Somali children losing their language ability, and indirectly resulting in a weakening of this group’s affinity with the culture of their country of heritage (Hopkins, 2010).

4. FGM in Somalia

Somalia has one of the highest FGM prevalence rates in the world at 97.9% (UNICEF, 2020a), with Type 3 FGM being the most common type of cutting practised (Macfarlane and Dorkenoo, 2015; Powell and Yussuf, 2018; 28 Too Many, 2019). Gathering accurate data on FGM in Somalia is challenging. Because Somalia's situation is unstable, it is difficult for international organisations and NGOs to conduct on-site research and surveys to gather data related to FGM (28 Too Many, 2019, p10). In addition, various problems other than FGM (poverty, for example) are often focused on, and research and surveys related to FGM are neglected. However, there are some sources of accurate data related to FGM.

According to Multiple Indicator Cluster Survey (MCIS) data, FGM prevalence in the 15-49 age group was 99.2% in South/ Central Somalia in 2006 and 98% in NE Somalia (Puntland) in 2011. In Somaliland the figures were 94.4% in 2006 and 99.1% in 2011, although this overall increase is queried by health and NGO workers on the ground (28 Too Many, 2019, p.12). Regardless of the exact figures, the continued widespread prevalence of FGM in Somalia/ Somaliland indicates the embedded nature of FGM as a social norm.

FGM remains widespread, but as in other countries with high prevalence levels, there is some evidence of a shift towards lighter forms of FGM in Somalia and Somaliland (see Chapter 3). For example, according to MICS data, in NE Somalia (Puntland) in 2006, more than 90% of women had experienced Type 3 FGM. This figure however dropped to about 85% in 2011 (28 Too Many, 2019, p.13). This small reduction of girls who were circumcised Type 3 had shifted into either Type 1 or Type 2, rather than not being cut at all. However, a Network Against FGM in Somaliland (NAFIS Network) survey among 2,000 women aged 15-49 in Somaliland found that 92.8% wanted Type 3 FGM for their daughters (28 Too May, 2019, p12).

FGM in Somalia is still mostly performed by traditional practitioners (28 Too Many, 2019). MICS data shows that in the period 2002-6, 4.4% of women who were circumcised had been cut by a health professional. This rate stayed at a similar level (4.7%) in 2006-2013. However, Newell-Jones (2016) reported that in Somaliland while 5% of women aged 15-49 had been cut by a health professional,

the figure was 14% for girls aged 12-14. In addition, in a Network Against FGM/C in Somaliland (NAFIS) survey, 75.6% of women who live in urban areas and 60.9% of women in rural areas responded that they would prefer health professionals to circumcise their daughters (NAFIS, 2014, p24).

Article 15(4) of the Constitution of Somalia prohibits the circumcision of girls and describes it as ‘tantamount to torture’, but despite this there is no national legislation which makes the practice illegal (28 Too Many, 2018, p.3). There have been ongoing gender equality campaigns in the mainland of Somalia over the last few decades, including campaigns against FGM (Denison et al., 2009; NAFIS Network, 2021), but it remains a widespread practice.

5. **FGM in Somali communities in the UK**

Korfker et al. (2012) suggested that the prevalence of FGM in European immigrant communities is roughly the same as the prevalence in their origin countries. However, there are significant problems with collecting accurate data (see Chapter 1), due to FGM being an illegal practice (Johnsdotter and Essen, 2016). Based on assumptions about prevalence rates in the UK being the same as country of origin, Macfarlane and Dorkenoo (2015) estimated that in England and Wales in 2011 the number of women who had been cut were 103,000 aged 15-49, 24,000 over 50 years of age and nearly 10,000 aged 0-14. These women are members of migrant communities including Kenyan, Somali, Sudanese, Sierra Leonean, Egyptian, Nigerian and Eritrean. Within the 15-49

age group, 42,000 women born in Somalia were estimated to have experienced FGM (Macfarlane and Dorkenoo, 2015, p.18).

In England and Wales an estimated 77,300 girls were born to women (not just Somalis) who had experienced FGM (Macfarlane and Dorkenoo, 2015, p.22). In the past, these figures have been used to try and quantify the number of girls at risk of FGM, but Macfarlane and Dorkenoo concluded that this is no longer appropriate given evidence of changing attitudes and practices due to migration in some contexts, while in other locations, FGM remains an important practice (this will be discussed in detail in Chapter 3). Instead, they stated that, '[r]isks to girls have to be assessed through contacts with individual mothers and families' (2015, p.22).

6. Gender norms and relations in Somalia

Gender relations in Somalia can generally be described as being rigidly patriarchal with a clear gendered hierarchy. This includes divisions of labour with men holding positions of power and influence in employment and politics, and women being primarily seen in terms of their domestic responsibilities as wives and caretakers (Ibrahim, 2004; Koshen, 2007; Gilmer, 2017). For example, in 2019 the labour force participation rate for people aged 15 and over was 73.6% for men and 21.8% for women (UNDP, 2020, p.364).

School enrolment levels are low across Somalia and Somaliland relative to most

other nations, but according to a UNICEF-administered Multiple Indicator Cluster Survey in 2006, 46.87% of girls had never been enrolled in school (formal or Koranic), while the figure was 28.59% for boys. Among rural nomadic communities nearly 70% of girls had never been enrolled, compared to nearly 50% of boys (Moyi, 2012, pp.165-6). The gender gap was even wider in higher education (Abdi, et al., 2009). Reasons given for the education gender gap relate to the focus placed on women's roles as wives and mothers. Learning about household roles and responsibilities, such as caring for family members, cooking and cleaning, may be seen as more important than formal education (Ochiltree and Toma, 2021). There is also the perceived value of virginity for girls in relation to marriage. Girls may be taken out of school in order to get married, or to avoid mobility outside the household that could be seen as exposing them to possible threats to their virginity which would harm their marriage prospects and bring dishonour to the family (Wafula and Mulongo, 2020). As of February 2021, 35.5% of women aged 20-24 were married or in a union before they were 18 (UN Women, 2021).

Marriage is seen as a religious duty and the only appropriate context for sexual relationships. As part of the marriage agreement, which traditionally would include the paying of a bride price to the bride's family, a husband is expected to provide for his wife and children, and a wife should obey her husband, including in sexual matters (Ahmed, 2004; Koshen, 2007; Gilmer, 2017). Violence against women may be seen as reasonable in the case of female disobedience. There are high levels of gender-based violence in Somalia, which has worsened due to civil war

(Wirtz et al., 2018).

The Quran emphasises the requirement for modesty between members of the opposite sex, with dress code playing an important role in this. Islam requires that men do not lustfully gaze at women other than their wives, and requires that women do not display their beauty. As such, a large number of Somali women wear a traditional veil when outside of the family home, and when in the presence of other adult males, to cover their hair (which is often considered sexual), part of their face and shoulders (Tsujimura, 2009). While this concept of religious modesty is referred to as “Hijab”, this is also the word that is often used for the traditional head-covering that Muslim women wear (Nakamura, 2011).

Long-standing expectations about gender roles and the gender division of labour were shifting before the civil war due to the growth of urban settlements and some moves away from pastoral livelihoods. The disruption and displacement of the civil war also unbalanced expectations of gender roles due to men’s absences leaving women to make more decisions. However, this seeming disequilibrium was often perceived in negative terms by men who feared losing their power and status, as well as women concerned about family stability (Koshen, 2007). Similar perspectives have been reported among Somali migrant communities elsewhere in the world.

7. Gender norms and relations within Somali communities in the UK

Research on gender roles and relations within the Somali community in the UK have highlighted how migrants have often sought to maintain the clear gender divisions of labour which had been so common in Somalia (Pessar and Mahler, 2003). The spatial distinction between women's position as homemaker within the domestic sphere, and men's roles in the public sphere of employment and community politics is reinforced by concerns about women's mobility outside the home, where there are worries about safety, but also about family honour in terms of appropriate behaviour (Van Liempt, 2011). Somali female migrants have fewer opportunities to learn English because they often stay at home and do not communicate with English speakers (Harris, 2004).

Migration to the UK can create significant tensions as expectations around gender equality, sexual freedom and the declining role of marriage in society, are at odds with the prevailing attitudes of Somali migrants. A commitment to maintaining cultural and traditional values in their new home may be difficult to achieve, especially in relation to children born in the UK, or elsewhere in the Global North (Liberatore, 2016). Somali migrants in the UK often expect their children to marry someone with a Somali background and this perspective is likely to be shared by relatives who live in the mainland of Somalia (Karlsen et al. 2020). Parents strictly monitor the behaviour of their children, particularly their daughters, prohibiting any sexual relationships before marriage given the ongoing importance of a girl's virginity for family honour (Ali, 2008). Throughout the Somali diaspora, there has been reported concern about the negative influences of

‘western culture’ (Koshen, 2007; Connor et al., 2016). Young Somalis interviewed in Leicester by Van Liempt (2011) commented on the surveillance they experienced in public, including the policing of headscarf wearing, as it was seen as shameful for both the individual and family for women to go out without a head covering.

8. Conclusion

This chapter has provided contextual material to inform the rest of the thesis. As well as explaining the factors behind the migration from Somalia to the UK, it has also given an overview of Somali and Somaliland communities in the UK. Given the focus of this thesis, the chapter has also discussed attitudes and practices of FGM in both Somalia and in the UK, as well as broader gender norms. The next chapter discusses the key themes emerging from the literature relevant for this thesis, as well as outlining the conceptual framework that will be used.

Chapter 3: Literature Review

1. Introduction

This chapter provides an overview of the theoretical debates and literatures which inform this thesis, and gaps in the current research which this thesis seeks to address. It begins with a discussion of the impacts of FGM, stressing the detrimental physical and mental health implications associated with the practice. This section also highlights other impacts of FGM which have received less attention from researchers, particularly around men's experiences, and women's relationships with family members and friends. The chapter then moves on to social norms theory and its role in explaining the potential mismatch between individual attitudes and behaviours around FGM. The chapter then builds on the overview data provided in Chapter 1 to describe and explain spatial patterns of FGM and changes in prevalence and type. The fifth section of this chapter addresses the small, but expanding research on migration and FGM, focusing particularly on migration to Europe and research which considers how practices of FGM are maintained, discarded or reshaped by migrants in their new homes, or by second-generation migrants. The chapter then explores approaches to eradicating FGM, including legislation, education and awareness-raising, and the growing engagement with social norms theory in interventions. A final section of the chapter introduces the conceptual framework that will be adopted in the thesis, bringing together debates around social norms, migration and transnationalism in relation to FGM.

2. Impacts of FGM

Campaigns, projects and legislation to eradicate FGM stress the damaging aspects of the practice. In this section, I lay out aspects of this harm for both women and girls who undergo the procedure, as well as on wider relationships. Despite the clear harm to individuals and relationships, the practice continues, as demonstrated by the figures in Chapter 1, indicating underlying reasons which I will discuss in Section 3 in relation to social norms.

2.1. Experiences of women who have undergone FGM

The identification of FGM as a harmful practice which 'is a violation of the human rights of girls and women' (WHO, 2020, no page) rightly focuses on the immediate and longer-term impacts of FGM on individuals. Campaigns to eradicate FGM have focused on the detrimental health impacts of the practice for individual women. It is important to acknowledge that these impacts are not experienced by all women (Shell-Duncan, 2001; Berg et al., 2014b), and may be particularly associated with certain forms of FGM (especially Type 3), or the skill or location of the practitioner. However, the fact that not all women experience these impacts does not undermine the argument that FGM is a significant human rights issue (Mackie, 2003). The possible health impacts include infection and the threat of death during the procedure, ongoing problems with urination and menstruation, painful sexual intercourse, and potential difficulties during childbirth (Reisel and Creighten, 2015). It is also important to acknowledge the potential psychological

impacts of FGM on women. Health impacts, education for medical practitioners, and medical support services dominate the research on FGM. This section provides an overview of this literature, but extends it by also considering the impact of FGM on men, and familial and friendship relationships.

The short term effects of FGM can be acute pain, post-operative shock, laceration of vaginal walls, haemorrhage and infection, all of which can prove fatal. Also there are long term effects, such as infertility from infection, chronic infections of the uterus and vagina (Adjetey, 2005; WHO 2018).

Given the procedure involves altering the genital area, having sex may cause pain particularly for women who experienced Type 3 FGM where the genitals are almost completely sewn up. For all women, regardless of the type of FGM they have experienced, sexual pleasure may be diminished because of the procedure (Berg and Denison, 2012).

FGM can also have impact on pregnancy and childbirth (Lundberg and Gerezgiher, 2008). Again, this is particularly the case with Type 3 FGM. Pregnancy, childbirth and the postpartum period are usually periods of increased risk of mortality and morbidity, but FGM could add extra risks for women's bodies (Berg et al, 2014a). In addition, Lundberg and Gerezgiher (2008) pointed out that women often feel strong fear and anxiety during pregnancy and childbirth if they have experienced FGM. This is because they are aware of maternal and infant deaths due to bleeding, difficulties with vaginal births and infection caused by

FGM.

There are also mental health issues associated with the practice and the pain and uncertainty that may go along with it. Mulongo et al. (2014) highlighted different dimensions of potential psychological impact, including Post Traumatic Stress Disorder (PTSD) and anxiety, but stressed that in the studies they reviewed, psychological impacts were very varied, and in some cases there were no differences between women who had been cut and women who had not been cut.

2.2. Impact on relationships

The research on the impacts of FGM has focused mostly on the immediate and longer-term effects of the procedure on the individual women who have been cut. There is much less research on the wider impacts of FGM on relationships with partners, family members and friends.

Several organisations have pointed out that where a mother or/and grandmother decides that her daughter and granddaughters should be cut, distrust can develop from the girl towards her mother or grandmother (Dorkenoo et al., 2007; FORWARD, 2007; BMA, 2011; Koukoui, et al., 2017). However, there has been very little research which explores the implications of FGM on family relationships in more depth. Additionally, the role of friendship in both supporting women who have been cut, but also the implications of different experiences of FGM on

friendship, has not been considered within the literature. This thesis seeks to address these gaps through an exploration of both inter-generational and intra-generational relationships in the context of FGM.

Gele et al. (2012) noted that sharing experiences of FGM with others who also experienced the procedure may have positive impacts on women's sense of self-esteem (see also Gough and Lynch, 2002). These activities are not only having a positive effect on the women impacted, but it is also helping women to communicate their experiences to the next generation of girls. These public discussions are vital if practices are to change (see later sections in this chapter).

In Chapter 1 I mentioned the case of a man who had come to the Orchid Project to find out how he could prevent his daughter from being cut. While FGM is often seen as 'women's business', men are entwined in FGM decisions, albeit not always directly. While there is some research which examines men's attitudes to FGM (see Section 3.2), there is very little on men's actual experiences of FGM. For men whose background is from a country where Type 3 FGM is commonly practised, they have a responsibility and role in opening their wife's genitals on their wedding night (Ali, 2008). There is however no research in relation to the experiences that men encounter on these occasions, or men's thoughts on their experiences. Including men in my research, will enable me to address this lack of information, greatly expanding understandings of men's roles in FGM and its future.

3. FGM as a social norm

3.1. Social norms theory

The continuation of cultural practices such as FGM, can be explained with reference to a range of factors such as tradition, religious adherence, and group identity. These justifications, along with others, are discussed later in this chapter. However, before going into those details, this section seeks to explore the explanations for the continuation of cultural practices, even when individuals involved do not support it. In the case of FGM, education and awareness-raising in communities where it is practised has often failed to change behaviour, even when individuals understand the health risks. Similarly, procuring or performing FGM can be made illegal, but it still continues.

Mackie (1996, 2000) compares the case of footbinding in China, which almost disappeared within a generation at the start of the twentieth century, with FGM today. For him, the key aspect is that considering individual attitudes does not capture the way in which individuals are embedded in networks of social relations, and that behaving according to the perceived social norms of the group to which you belong is vital for life chances. He drew on Schelling's use of game theory to discuss conventions and why it is in no individual's interests to change a particular practice by themselves.

In Mackie's explanation, footbinding was seen as important for a woman's marriage prospects. Remaining unmarried was seen as failing to fulfil a woman's

path in life, and would also bring shame and economic difficulties to her family. Footbinding was believed to be vital in securing marriage. Mackie argued that ‘marriageability’ lies behind the continued practice of FGM. This is because of women’s belief that men won’t marry uncut women, and men’s belief that women who are uncut are more likely to be unfaithful. There is what is seen in Schelling’s model as tacit coordination; nothing is explicitly discussed, but rather individual decisions are made based on what individuals think others are doing. Thus the ‘convention is self-enforcing’ (Mackie, 2000, p1007). This situation of interdependence means that it is too risky to change your behaviour individually, as you could face exclusion from marriage opportunities. Mackie also stated that, ‘[T]he public invisibility of FGM makes it harder for people to judge any change in the expectations of others’ (Mackie, 1996, p.1016). Drawing on the footbinding example, Mackie argued that change only happens when there is a collective public discussion and decision to change.

Mackie’s use of social conventions or social norms as the explanation for continuity or change in the practice of FGM has been adopted widely by researchers and organisations seeking to eradicate the practice (Mackie, 2000, Shell-Duncan et al., 2011; Shell-Duncan et al., 2018; Barrett et al., 2020). Mackie’s focus on marriageability has been challenged by research in some parts of the world. For example, Shell-Duncan et al. (2018) drew on research in Senegal and The Gambia and found that among some communities the practice of FGM is not linked directly to marriage prospects, but rather that uncut women are seen as being immoral and unhealthy. Unlike Mackie, Shell-Duncan et al.

(2018) also stressed that rather than FGM as a social norm being maintained without explicit sanctions, in their work, there was pressure to conform through the ostracism of uncut women, the public shaming of parents about uncut daughters, and stigmatisation of uncut women as lacking value. For Shell-Duncan et al. social norms are,

> ‘held in place by beliefs about acceptable and unacceptable courses of action that can, to varying degrees, shape and constrain the choices made by community members, and are produced, transmitted and often enforced through social interactions’ (Shell-Duncan et al, 2018, p.3).

The social nature of the norms, sets them apart from personal and legal norms (Mackie et al., 2015). It also stresses the interactions between personal, inter-personal and wider structural factors (Shell-Duncan et al., 2018). In this context personal relates to individual decisions and personal ambitions, while inter-personal can refer to intra-family or within-community relations. As will be discussed later, these inter-personal relations can be based on face-to-face interactions, or can be spread over significant distances due to migration. Finally, structural factors may include processes such as the operation of power around gender or age, economic inequalities, and legal systems.

In this thesis, the importance of relationships within families and social interactions within the wider community, are considered within the broader context of migration, law and anti-FGM campaigns. Social interactions and

relationships can vary in scale from within a household or residential neighbourhood, to transnationally, linking UK residents to families and friends in Somalia or Somaliland. While these relationships shape decisions about FGM, experiences of FGM also feed into these relationships, particularly intimate relationships between spouses, family members and friends.

3.2. Reasons given for FGM

A range of often overlapping reasons are given for the continued practice of FGM. As outlined above, Mackie (1996, 2000) argued that FGM is a requirement for marriage in some communities. FGM is seen as both a marker of women's virginity (particularly Type 3 FGM) and as a way of controlling women's sexuality and therefore faithfulness (Utsumi, 2003; Wright, 2013; Abdisa et al., 2017).

The perceived preference for men in some communities to marry women who have been cut, is an important tacit assumption in the replication of FGM as a social norm. Widely-held social expectations about men's attitudes and behaviours constitute what Connell (1998) has termed 'hegemonic masculinity', which stresses male dominance over women, but also involves the subordination of men who do not act in accordance with social norms about what makes a 'real man' in a particular context (Tan et al., 2013). Linked to this is the heteronormativity of hegemonic masculinity, with homosexual men seen as performing subordinated masculinities (Messner, 1997; Demetriou, 2001; Ozaki, 2018). As Connell and Messerschmidt (2005), in their review of the concept,

argued,

> ‘Hegemonic masculinity was understood as the pattern of practice (i.e., things done, not just a set of role expectations or an identity) that allowed men’s dominance over women to continue…. It embodied the currently most honored [sic] way of being a man, it required all other men to position themselves in relation to it, and it ideologically legitimated the global subordination of women to men’ (p.832).

A key part of their argument, and response to criticisms about its essentialist nature, is that hegemonic practices can be challenged, so can evolve and differ between locations.

In relation to FGM, there is some research which draws on expectations about male behaviour as underpinning the continued practice of FGM. This includes the prioritising of male sexual pleasure and control of women’s sexuality to guarantee faithfulness (Adjetey, 2005; Berg and Denison, 2012; Wright, 2013; Abdisa et al., 2017). Assumptions about men’s preference for cut women as marriage partners draws on particular ideas about hegemonic masculinity. However, there is currently limited data available on men’s attitudes towards the continued practice of FGM. This largely reflects the beliefs that FGM is a woman’s matter. This makes it difficult to undertake any field research or obtain any survey data relating to FGM targeting male attitudes (Almroth et al., 2001a). In a rare study considering Somali men’s attitudes to FGM in the USA,

Johnson-Agbakwu et al. (2014) found that among the refugees they interviewed, the men were largely opposed to FGM, but argued that matriarchal pressure was responsible for its continued practice. My research explicitly seeks to include men alongside women, to understand both their attitudes to FGM and their experiences relating to FGM.

Religion, particularly Islam, is sometimes used as a justification for FGM as some communities believe that the practice is part of being a good Muslim (Rahman and Toubia, 2005). This is despite the fact that there is no mention of the practice in the Quran (Adjetey, 2005; Beller and Kröger, 2018). Otsuka (2002) cited a study by El Dareer in Sudan. In this research about 23% of women and about 28% of men answered that religion was the main reason for practising FGM. In Alhassan et al.'s study among African migrants in Europe, Muslim migrants from Guinea-Bissau, Senegal and The Gambia, largely acknowledged that while FGM was not mentioned in the Quran, it made women clean and pure and therefore fit to perform certain rituals such as prayers and fasting (Alhassan et al., 2016). The use of religion as a reason for FGM is also found among Christians, Jews and followers of other religions (Rahman and Toubia, 2005).

The desire to be part of a group and gain social support from that group is also a key reason why FGM is practised. Shell-Duncan et al. (2018) in their research in Senegal and The Gambia stressed how communities use whether a woman has been cut or not as a mechanism to identify moral individuals who should be included. While other reasons such as health or religion may be used as

explanations, Shell-Duncan et al. argued that these are a form of post hoc rationalisation on what is a judgement on individuals' value. However, the research does point out an age difference; younger women have a preference to continue FGM for further generations due to a fear of being excluded from social support. Older women, in contrast, are more flexible. They commonly consider shifting social circumstances and whether and how traditions should be modified to keep their cultural values.

The decline in FGM prevalence in some communities could be seen partly as a response to increased education and awareness, as well as legislation which outlaws the practice. However, as will be discussed later in this chapter, legislation and awareness-raising are not enough to change behaviour as they do not necessarily address the social norms which shape beliefs around FGM.

4. Continuity and change in FGM practices

The concept of social norms stresses the contextual and contingent nature of attitudes and practices. While for some individuals or communities, FGM may be seen as an ever-present, unchanging tradition, it is clear that changes have happened in both the overall practice of FGM and specifics. This suggests that a tipping point has been reached whereby the social benefits of cutting have diminished.

4.1. Prevalence of FGM

Globally, the prevalence of FGM has been declining for a number of decades, but the overall reduction is spatially uneven (Batyra et al., 2020; Enselma et al., 2020). Batyra et al. (2020) and Enselma et al. (2020) used data from Demographic and Health Surveys (DHS) and UNICEF's Multiple Indicator Cluster Surveys (MICS) in 23 Africa countries to explore the prevalence of cutting among women born between 1940 and 2002. They found that at a national level, the largest declines were in Burkina Faso, Ethiopia, Kenya, Sierra Leone and Nigeria, whereas there was very little change in Guinea, Guinea-Bissau, Mali and Somalia. Details of the Somalia situation were provided in the previous chapter.

FGM was more entrenched in places where there was higher prevalence, providing support to the social norms theory outlined above. This was also the case within countries, with Azeze et al. (2020) using Ethiopian DHS data from 2000, 2006 and 2016. While there was a fall overall in the prevalence of FGM, this varied significantly between regions, with prevalence in the Somali region remaining high across all three surveys (98.7% in 2016 compared to 100% in 2000, while for the country as a whole prevalence fell from 79.9% to 65.2%).

4.2. Type of FGM

The type of FGM undertaken depends on the country, community or ethnic group. Types 1 and 2 are the most common types globally, with only about ten per cent being Type 3 in 2012 (Johnsdotter and Essen, 2016). As discussed in Chapter 2,

Type 3 remains the most common form of FGM in Somalia and Somaliland. An important trend in some countries, particularly those where Type 3 FGM was widely practised, is the growing practice of lighter types of FGM (Norman et al., 2016; Kimani and Kabiru, 2018, Powell and Yussuf, 2018; Powell, et al., 2020). However, in Somalia and Somaliland, while there has been some shift to lighter forms, this shift has been relatively slight (see Chapter 2).

Denison et al. (2009) pointed out that in some countries, such as Senegal and Ethiopia, there are concerted efforts to shift practices to different types of FGM, alongside the campaigns to eradicate FGM completely. However, the social norms around FGM, often include expectations around the type of FGM, particularly around Type 3 and the belief that this is proof of virginity (see section above). If the practice is embedded in these conventions, a shift to a different form of FGM would be challenging without collective agreement.

4.3. Medicalisation of FGM

As well as the prevalence and type of FGM changing, the location and practitioner have also shifted within many communities (Serour, 2013; Shell-Duncan et al., 2017). Traditionally, FGM is undertaken by a practitioner who does not have any medical training, and does not provide medical treatments or painkillers, such as anaesthetic before, during or after the practice. FGM is usually organised in groups, with several girls from the same family (sisters, cousins etc.) being cut at the same time with a traditional practitioner using their own tools (Utsumi, 2003).

Undertaking FGM on a group of girls at the same time, using the same tools (which are generally not properly disinfected), causes a significant risk of passing infections and diseases, including HIV, to other girls (Monjok et al., 2007). Similarly, the girls traditionally undergo FGM at someone's home, rather than in a medical facility, which not only brings about risks of hygiene, but can also result in it being difficult to manage any medical complications that could occur during the procedure, such as bleeding or pain; it is also not possible to have any suitable treatments after the procedure has been completed (Serour, 2013).

To reduce physical health complications, the medicalisation of FGM is an increasingly popular choice (Johansen et al., 2018; Kimani and Shell-Duncan, 2018). This refers to the practising of FGM by a health professional regardless of where the procedure takes place, so includes homes and other places, alongside medical facilities (UNFPA, 2018). Health professionals use surgical tools, anaesthetics, and antiseptics to minimise immediate physical complications.

Kimani and Shell-Duncan (2018) discussed the medicalisation of FGM in 25 countries using data from women who are aged 15 – 49 years old. The five countries with the highest levels of medicalisation were: Egypt (health professionals circumcised 38% of women), Sudan (67%), Guinea (15%), Kenya (15%) and Nigeria (13%). In the other 20 countries medicalisation of FGM is far less popular. Leye, et al. (2019) also highlighted the spatial differences in the move to medicalisation, not just between countries, but within countries, with medicalisation being more likely in urban than rural areas. This may reflect

differential access (in spatial and economic terms) to health facilities, but also variations in the acceptability of perceived non-traditional forms of the procedure (Shell-Duncan et al., 2018).

In December 2012, the United National General Assembly adopted a resolution to ban female genital mutilations worldwide, whether committed within or outside a medical institution (Kimani and Shell-Duncan, 2018). Moving the procedure to a health facility may reduce the risk of infection and involve pain control measures, but FGM regardless of where it is conducted is still a form of human rights abuse and leads to longer-term physical and psychological health problems (Schrijver et al., 2020).

5. Migration and FGM

The previous section examined how changes in FGM attitudes and practice can happen *in situ* as the reasons behind FGM as a social norm shift, and sufficient numbers of people in the community no longer see the practice as key to inclusion in the collective. Migration, both internally and internationally, can involve an uprooting from a social context where FGM is a social norm to locations where social norms are radically different, or alternatively where similar attitudes are held. Migration can disrupt social norms, shattering the forms of interdependence and tacit conventions which seemed so fixed in the pre-migration locations. New social, economic, legal and political contexts may also provide different opportunities for group identity. Berg and Denison (2013, p.848) argued that,

‘[m]igration presented individuals in exile exposure to other cultural models, models that oppose FGM/C, thereby allowing sharper scrutiny of the practice’. However, migration may just involve the transposition of existing practices and norms to a new location. In the case of international migration, this is because of ongoing processes of transnationalism, defined by Basch *et al.* (1994, p.6) in relation to migration as ‘the process by which transmigrants, through their daily activities, forge and sustain multi-stranded social, economic, and political relations that link together their societies of origin and settlement, and through which they create transnational social fields that cross national borders’.

Barrett et al. (2021) developed a ‘FGM-migration matrix’ as a framework to explore the impact of migration on FGM practices among migrant groups within the Arab League Region, including people who are displaced due to war and persecution, as well as economic migrants. This matrix combines FGM prevalence in origin and destination locations, classified as high, medium and low FGM prevalence to create a 3 x 3 matrix. The rigorous review of the literature highlights the role of social norms around FGM in the destination location, FGM legislation, issues of identity in a new society, and ongoing links to family in the place of origin. These themes will be picked up below in a more detailed discussion of existing research on migration from high FGM prevalence locations to places where there is low FGM prevalence i.e. one of the cells in Barrett et al.’s FGM-migration matrix. This focus is because of the communities that form the centre of my research; Somalia and Somaliland with high FGM prevalence and the UK with low prevalence.

Much of the research on FGM is on attitudes and practices within non-migrant communities within countries in the Global South which have long histories of the practice. There is much less attention paid to FGM in the Global North within countries where migration over recent decades has led to the growth of communities with FGM as part of their traditions (Alhassan et al., 2016; Barrett et al., 2020, 2021).

Gele et al. (2012) and Johansen (2019) noted a change in the social pressures faced between one's country of origin and a migrant's new adopted country. They noted that the practice of FGM in migrant communities, including Somali migrant communities, in Norway could be reducing, so lessening the number of girls who are at risk of FGM. The main driver for this is that following migration there is no longer the social pressure to perpetuate the practice. Morison et al. (2004) identified similar trends among Somalis in London. Farina and Ortensi (2014) also pointed out several reasons for the reduction in the number of girls who are at risk of FGM in African migrant communities in Italy; their first-generation parents are taught that FGM is an illegal practice, taught that it has negative health implications and importantly, Italian society is strongly against FGM so there is reduced social pressure for the continuation of FGM. Farina and Ortensi (2014) also argued that second-generation girls who were born and raised in Italy will be socialised into a different understanding and attitude towards FGM, and are likely to be against the practice.

However, it is vital to understand scale and social norms here. Johansen (2017) argued that even though FGM is not accepted by a host country's society, and even where there is no social pressure from the host country's society, there is still social pressure from within particular migrant communities of the host countries. Following social norms theory, social norms operate when there is interdependence within a particular community which is assumed to require particular practices to maintain cohesion and membership. Furthermore, key decision-makers in determining whether or not FGM will be practised on a young girls are typically either their mother or grandmother. While the mother has settled into her new adopted country, where there is less social pressure for young girls to be circumcised, other decision-makers, such as their grandmother, may still be living in their country of origin where there remains deeply-rooted social pressure for girls to be circumcised. There are, however, some existing arguments against this point of view. Some second-generation migrants may desire to continue the practice of FGM in order to maintain the culture and tradition of their parents' country of origin and their self-identity (Alhassan et al., 2016; Karlsen et al., 2020).

International migration rarely involves a complete break with a country of origin; family connections continue, maintained through phone and video calls, social media, and occasional visits (Al-Shamani, 2010). The ongoing transnational connections mean that while social norms in a new home country may be very different, individuals and families are still at least partly embedded in communities with contrasting social norms in their country of origin. Over 25% of women

interviewed in the three country study reported by Alhassan et al. (2016) said that they had received pressure from their mothers-in-law in their home countries (Eritrea, Ethiopia, Guinea Bissau, Senegal and The Gambia) regarding having their daughters circumcised. Gele et al. (2012) reported similar pressures from grandmothers on Somali migrants in Oslo. Additionally, new arrivals from the country of origin can also have an impact. Barrett et al. (2020) observed that people in Somali communities in the Netherlands who were heeding calls to end FGM, changed their minds after new migrants from Somalia supporting the continuation of FGM joined the community.

NAFIS Network (2014, pp30-31) sought to explore the opinions of people in Somaliland about family members in the diaspora. While many respondents were not sure about the FGM status of female relatives abroad, some, particularly younger respondents were aware that their relatives were not cut and that this was because their parents disapproved of the practice. Other respondents reported relatives being brought to Somaliland or Ethiopia to be cut, and also hoped that the practice would continue even for family members who were living outside Somaliland, as they saw it as an important tradition and part of Somali identity. Despite the importance of transnational links, there has been very little work on how these operate in relation to FGM. My research will address this through exploring how decisions are made about FGM among Somali migrant communities in the UK.

The importance of FGM for tradition and identity was discussed above.

International migration is often associated with a heightened awareness of identity and challenges to identity, particularly in a perceived hostile environment. This may lead to a reinforcement and maintenance, rather than a change in pre-migration cultural practices and social norms (Phinney et al., 2001; Okahisa, 2008). When many first-generation migrants relocate they are unable to carry many personal belongings and physical items, such as clothing and furniture to identify with their country of origin's cultural identity and ethnicity (Somerville, 2008). Religion, culture and lifestyle, however, are something that migrants can easily "carry" with them when they cross borders into new countries (Van Liempt, 2011) and feel that it forms the cornerstone of their being in their adopted country (Mayor of London, 2006). Strictly following their religion and culture also helps some first-generation migrants to continue to feel a part of their country of origin despite living in a different country (Van Liempt, 2011). As such, first generation migrants sometimes have a stronger desire to follow their original ways than they did when residing in their country of origin, and similarly, can follow their religion, culture and lifestyle more strictly than people living in their country of origin (Amara and Zappi, 2006).

For some migrants, living in a Western society brings up significant challenges when raising children, particularly daughters. There are fears about 'over-assimilation into Western culture' (Alhassan et al., 2016, p.34), particularly in relation to sexual relationships outside marriage given the perception of moral decadence in the West. As a result, some migrants may be particularly keen to have their daughters cut to control their sexuality.

Even though limited research is available about types of FGM in migrant communities, several researchers point out the shifting the type of FGM in migrant communities. McNelly and Jong (2016) for example explained that migrants to the USA have begun to believe that infibulation (Type 3 FGM) is not religious requirement, and this belief change leads them to shift to milder types of FGM. Of course, there is still strong cultural belief of girl's virginity, purity and family honour. As such large numbers of girls are still at the risk of FGM, as the social norms that underpin the practice remain.

As has been noted in countries with a long history of FGM (see above), medicalisation of FGM for girls who were born and raised in migrant communities has also been identified (Schrijver, et al., 2020). The most common way second-generation migrant girls have FGM practised on them is through their parents or other relatives taking them abroad, particularly to their country of origin, where a suitable practitioner can be found. This is often done during the school holidays, so the girls have adequate time to recover before starting school again, and more importantly, it is easier for the practice to be undertaken without anyone outside of the family and community suspecting anything untoward (Kaplan-Marcusán et al., 2010; Abdulcadira et al., 2011; Johansen, 2019). There is no detailed research available related to where girls born and raised in migrant communities were circumcised (McNelly and Jong, 2016; Ortensi et al., 2018).

6. Projects and policies to reduce FGM

The UN first considered FGM in the context of human rights in the 1950s, but the WHO did not take up the anti-FGM cause then because FGM was seen as a social and cultural issue, rather than a health one (Andro and Lesclingand, 2016). WHO held the first conference on FGM in 1979, and suggested that the practice of FGM needed to be eradicated (Barrett, 2014). This conference was part of the process whereby FGM began to be publicly acknowledged in parts of the world where FGM had not been a long-standing part of culture and tradition. As a result, campaigns and movements against FGM were established in many countries (Korfker et al., 2012). Attempts to eradicate FGM have focused on legislation, education and awareness-raising (Barrett et al., 2020). This has sometimes framed FGM as a health issue (Johansen, et al., 2018), but there is an increasing move to consider FGM as a children and women's rights issue (Berer, 2015) as part of an expanded consideration of violence against women (Shell-Duncan, 2001).

6.1. Legislation against FGM

Using the law to act as a deterrent against FGM has been one of the earliest and most common stages in the battle against FGM both in Europe and worldwide (Leye, et al. 2007; Berg, 2019). In September 2001, the European Parliament adopted a resolution on FGM, calling for the enactment of specific laws against FGM across all EU countries. This resolution called upon EU member states to collaborate to harmonise existing FGM legislation (Powell et al., 2004). The main reason for setting this movement up in the European Parliament was to ensure

parity (Kofou, et al., 2020).

All EU member countries' governments insist that the practice of FGM is not permitted inside their country (European Union, 2013). One of the main and most common starting points to reduce the number of girls at risk of FGM is to put in place specific legislation against the practice (Momoh, 2005; Berg and Denison, 2012; Alcarez et al., 2014; Williams-Breault, 2018). Powell et al. (2004) and Berer (2015) pointed out that this is the case in some European countries including Sweden (who enacted a specific law against FGM in 1982 amended in 1998), Switzerland (in 1982), the UK (in 1985 amended in 2003), Norway (in 1995), Belgium (in 2001) and Austria (in 2002). Other European countries do not however have specific legislation against FGM and, as such, FGM is covered by existing criminal laws, administrative laws, family laws, child protection laws, civil laws and migration laws (Poldermans, 2006; Mestre and Johnsdotter, 2019).

Even though many countries have adopted legislation against FGM, the number of girls that have undergone FGM in many of these countries continues to increase annually (Williams-Breault, 2018). Migrants that have settled in European countries however often take their daughters outside of their newly-adopted home, commonly to their country of origin, for FGM to take place (Mestre and Johnsdotter, 2015). This strongly suggests that expectations around FGM as a social norm within the migrant community, outweigh any legal norms and the fear of prosecution.

In addition to the lack of a deterrent, Bindel (2014) points out that there are several reasons why using laws to battle FGM is not having the desired positive effect on the situation in many European countries. She notes that it is difficult to identify when girls have had FGM as many girls do not report this practice. It is difficult to encourage FGM victims to report the practitioner as many girls who have experienced FGM are very young. It is also common for the practitioner and organiser of FGM to be related to the victim, so girls feel that they do not want to get their family or community members into trouble, or are afraid of the consequences from other family members should they report the crime (Dustin, 2010). The above factors have significantly affected the number of criminal court cases relating to the practice of FGM in European countries. Despite the illegality of FGM in European countries, if the European country and the country where FGM takes place do not have an extradition agreement it is difficult to arrest anyone involved in undertaking the practice abroad.

Increasing refugee and migrant populations from communities that practise FGM led to the British government recognising the issues this practice brings, and resulted in it being deemed a criminal offence in the UK under the “Female Circumcision” Act in 1985 (FORWARD, 2007). The main aim of publishing this law was to reduce the number of girls circumcised as a result of the legal repercussions to the FGM practitioner (Rahman and Toubia, 2005). To circumvent this legislation, members of migrant communities in the UK began to take their daughters overseas to be circumcised (The Royal College of Midwives,

2013). This was not punishable under the Female Circumcision Act as this law did not cover the practice of FGM being committed outside of the UK. To accommodate this change in the way FGM was practised, the government established a new law, the FGM Act 2003 (Home Office, 2016). The main difference between the 1985 and 2003 Acts is that the 2003 Act allows the government to prosecute parents who send their daughter overseas to be circumcised or cut (The Royal College of Midwives, 2013). The 2003 Act was amended in 2015, and it is currently a criminal offence for both UK nationals and permanent UK residents to be involved in any act of the process of FGM, including taking children abroad to procure or conduct FGM (Ministry of Justice and Home Office, 2015).

In 2014 the UK made the first charges against a doctor for practising FGM on girls (The Independent, 2015), but the doctor was acquitted. The first (and as of September 2021 only) successful prosecution in the UK was against a Ugandan woman in relation to her three year old daughter (BBC, 2019). Considering the number of girls that have had FGM practised on them and the number of girls at risk of the practice in each European country (see Chapter 1), the number of criminal court cases relating to FGM are surprisingly small.

Since the 1960s, some countries where there is a high prevalence of FGM have established laws against FGM, so criminalising the practice (Berer, 2015). This is currently the case in 31 countries, largely in Africa and the Middle East (WHO, 2020). Penalties if you are found guilty under these laws range from a minimum

of three months to a maximum of life in jail, and several countries impose monetary fines. There have been reported prosecutions or arrests involving FGM in several African countries, such as Burkina Faso, Egypt, Ghana, Senegal and Sierra Leone, but the number of cases are very few (Berer, 2015). Even when legislation does exist, it is often not strictly enforced, and locals are still widely and openly able to organise FGM for young girls (Leye and Sabbe, 2009; Mestre and Johnsdotter, 2015).

In 2014, a doctor was arrested in Egypt due to the death of a 13 year old girl due to an FGM procedure and he was jailed for two years, the maximum punishment under the law. In addition, the girl's father who arranged the daughter's FGM also faced prosecution, and he was put under house arrest for three months. This case publicly demonstrated the application of the law, encouraging people in Egypt to stop circumcising their daughters and granddaughters. At the same time, however, the government was also concerned that this case could push the procedure further underground and make it more difficult to uncover (Modrek and Sieverding, 2016).

6.2. Education and awareness-raising

Challenges in using legislation to reduce the number of girls who are cut has led to an expansion in awareness-raising and education (Wouango and Ostermann, 2020). The assumption behind such approaches is that individuals and communities need information to make informed and rational decisions about

having their daughters cut; once they are fully informed, then they will stop the practice.

The history of campaigns against FGM began in the 1920s in Egypt (UNICEF, 2013). The main activities undertaken by international organisations targeted at the reduction of FGM operated at a range of scales. Advocacy and policy development, often led by the WHO, involved structuring policies with other international organisations such as UNICEF and UNFPA. At national and sub-national levels, organisations held seminars in countries where FGM is part of the culture and traditions of at least part of the population, providing education about the negative health impacts of FGM. This also involves education to the groups of people who could be considered to be possible practitioners of FGM such as midwives and barbers, explaining how FGM harms girls and encouraging the abandonment of its practice.

NGOs also began to provide local-level approaches which targeted local people, such as parents, teachers, community leaders and religious leaders. Newell-Jones (2016) explained that discussing FGM with such people can have an impact on the parents' perception of FGM, affecting their decision of whether or not to arrange FGM for their daughters.

European countries, particularly EU member states, are providing support to women and girls that have already been cut, and are making further efforts to protect girls who are at risk of the practice (Powell et al., 2004). In particular, ten

European countries (Austria, Belgium, Denmark, France, Germany, Italy, the Netherlands, Spain, Sweden and the UK) have set-up both state and civil society organisations which focus on the eradication of FGM (European Union, 2013; Mäntynen, 2020). These ten countries have higher numbers of women and girls that have undergone FGM, and higher numbers of girls at risk of the practice compared with other European countries.

Despite significant efforts, many education and awareness-raising interventions often fail to change behaviour (Rahman and Toubia, 2005), or behaviour change involves a move towards medicalisation of FGM to address the health risks, rather than an end to the practice (Bedri et al., 2019). Such failures reflect a lack of understanding of the reasons behind FGM, and particularly the interdependence of community members and the role of FGM as a social norm. As Mackie (1996, 2000) and Shell-Duncan et al. (2018) argued, an individual may have information that leads them to oppose FGM, but publicly they still support it and they have their daughters and granddaughters cut as the implications for stepping outside the social expectations are too risky.

6.3. Interventions adopting a social norms approach

The limited success of approaches that rely on legislation or education has led to the design of interventions that directly address the importance of social norms in the continued practice of FGM. This requires both an engagement with the specific cultural contexts of the community (see Barrett et al., 2020 on

approaches within the EU), but also a project design which addresses the challenges of interdependence outlined by Mackie (1996). Individuals are unlikely to choose to end FGM by themselves, instead there needs to be a public and collective agreement about FGM.

In Senegal, a wide range of intervention strategies have been implemented with the goal of eradicating FGM. The most well-known and systematically implemented approach has been the community education program developed by the Senegal-based non-governmental organisation Tostan (Mackie, 2000; Shell-Duncan and Kandala, 2019). The Tostan program has had significant effects at the local level, and by 2010, more than 4000 communities in Senegal had participated in this programme and had reduced the significant amount of girls who experienced FGM. The programme includes education, but also training to support women's empowerment, and public agreement about the ending of FGM.

The REPLACE Approach (Barrett et al., 2020) also adopts a social norms approach in its design of interventions to reduce FGM among migrant communities in the EU. The REPLACE approach is a community-led participatory approach which seeks to understand the belief systems which underpin FGM practices, allows self-identified communities to assess how ready they are to change, and to design and evaluate appropriate interventions. The approach seeks to bring about individual behaviour change, by changing attitudes to FGM, but drawing on social norms theory acknowledges the wider socio-cultural

context within which individual behaviours occur. The community-led approach facilitates this sensitivity to context, but also allows the diversity of groups to be acknowledged. Within migrant communities there is also a need to recognise the dynamism of some communities where residence in a particular location is temporary; the transience of a population may make interventions particularly challenging.

The REPLACE Approach was developed and trialled in five EU countries, working with local organisations in collaboration with migrant communities; Eritreans and Ethiopians in Italy, communities from Guinea Bissau in Portugal, migrants and second-generation communities from Senegal and The Gambia in Spain, Somalis in The Netherlands and Somalis and Sengalese migrants in the UK. The approach has significant potential for behaviour change, although it requires significant input of time and other resources from communities (Barrett et al., 2020).

7. Conceptual framework

As outlined above, this thesis seeks to understand the role of migration in FGM experiences, attitudes and practices. To do this, it brings together social norms theory and research on the role of international migration and transnationalism on social norms. Shell-Duncan et al. (2018) highlighted the importance of personal, relational and structural dimensions of FGM decisions. To reflect these dimensions, the thesis highlights the importance of social networks at different

scales. At the centre of an FGM decision is an individual. This could be an individual FGM decision-maker, such as a mother or grandmother, or a girl or young woman who may be due to undergo FGM. However, that individual is part of a family, and their behaviour reflects not only on them, but on their family, with positive or negative outcomes as a result. Thus decisions made by, or in relation to an individual, need to be considered within the context of the wider community and its norms around gender and FGM. As outlined earlier, FGM as a social norm, may be unspoken and it maintained through tacit assumptions about its benefit, or through community surveillance and processes of exclusion.

In a non-migrant community this set of relationships will be located within the national context which includes legal norms and requirements, economic structures, NGO activity, religious institutions etc. The operation of power within these processes reflect the structural factors in Shell-Duncan et al.'s discussion.

International migration can result in settlement in contexts with different social norms. In such a context the individual/ family/ community relationships may continue (albeit with different community members), but in a different national context, including legislation and civil society organisations, ideas about gender equality, new economic and educational opportunities and forms of discrimination towards certain immigrant groups. However, as outlined above, in most cases international migrants (including Somali migrants) do not automatically abandon cultural norms and traditions as part of international migration; in fact they may seek to reaffirm their identity in their new location due to discrimination. Despite

being in a foreign country, their pre-migration identity remains. This is facilitated through ongoing transnational links meaning migrants are part of a wider co-national community and are exposed to influences beyond the national boundaries of their current country of settlement. Social networks and influences may be complicated by multi-staged migration journeys. For many migrants, including Somalis, their journey includes time in refugee camps outside their country of origin (Barrett et al., 2021), and/or original asylum status elsewhere in Europe (Van Liempt, 2011).

*8. **Conclusions***

This chapter has laid out the theoretical and empirical contexts for this research. The following three chapters draw on my interview data in London and Manchester to explore the experiences and impacts of FGM on both men and women, and the role of social norms in explaining changes or continuity in practice between migrant generations. Chapter 5 provides an overview of women's experiences of FGM, while Chapter 6 explores the operation of social norms in the practices of FGM, as well as community and family pressures which overtly seek to enforce these norms. Chapter 7 considers the often ignored dimensions of FGM relating to the impact of FGM on relationships between spouses, between mothers/ grandmothers and daughters, and within friendship groups.

Chapter 4: Methodology

1. Introduction

This chapter describes the research methodology adopted in this research. This includes practical information on how the communities and participants were chosen, the data collection and analysis methods. Given my role as an outsider in the research communities, and the sensitivities around FGM, the chapter pays particular attention to discussing research ethics and issues of positionality and reflexivity.

2. Methodology

This research seeks to put the experiences and attitudes of members of Somali communities in the UK at the heart of the discussion. This requires a methodology which provides opportunities for participants to discuss issues in depth, allowing them to raise perspectives and themes which were not pre-decided by the researcher. For this reason I adopted a grounded theory approach to collecting and analysing qualitative data.

Grounded theory approaches seek to develop hypotheses and theories based on data collected, rather than inserting data into pre-existing theoretical framings Green and Browne, 2011; Saiki-Craighill, 2014; Chun Tie et al., 2019). The concept of grounded theory was developed by Glaser and Strauss (1967) as a methodological approach which allows for the rigorous analysis of qualitative data

for theory development (Bryant and Charmaz, 2007). The techniques and procedures for developing theory come out of the systematic coding of data which has been collected in a non-directive way and theory development emerges iteratively through the data collection and analysis process (Strauss and Corbin, 1998).

Since the introduction of grounded theory methodologies in the 1960s, the approach has been widely used in social science research, including within FGM studies (e.g. Sakeah et al., 2019; Tarr-Attia et al., 2019). As Mills et al. (2014) stressed, since Glaser and Strauss' work in the 1960s, grounded theory has evolved, with the growing importance of a constructivist approach (Bryant and Charmaz, 2007) which acknowledges the role of the interactions between the researcher and participants in the research process (see discussion of positionality below).

I adopted a qualitative methodology because my research focuses on understanding experiences, feelings and attitudes. While information about these things can be assessed through quantitative data, a qualitative approach allows for much greater depth and nuance (Flick, 2009; Elliott, 2018). Rather than seeking to produce a large representative study of Somali communities in the UK through a more structured survey, my research questions were better suited to a smaller, more in-depth approach.

This research is also informed by feminist methodological debates, in particular

an explicit recognition of the importance of understanding gendered perspectives and the politics of research (Madge et al., 1997; Stanley and Wise, 2008). FGM is a highly sensitive topic, and as an outsider to the Somali community, the politics of this research were even more apparent. A commitment to understanding gendered perspectives on FGM informed my decision to interview both women and men, and my ethical approach to the research (see below) drew on debates around a feminist ethics of care. For Dixon and Marston (2011), this involves a sustained period of fieldwork, 'very much embedded within a feminist concern to engage with others, to work through ethical issues of trust, responsibility, empathy and compassion' (p.446).

3. Overall approach to the field research

Personal experiences of and perspectives on FGM are very sensitive subjects, not least because the experiences may include physical harm and painful memories. As such, there is always the possibility that participants will not want to share their experiences and thoughts about FGM, particularly with someone who is not of the same background or ethnic group (Devault, 1995). Undertaking field research around this sensitive topic requires a careful and flexible approach, and good relationships with participants, to enable the researcher to gather rich and reliable data (Dickson-Swift et al., 2009). Researchers need to take sufficient time to build strong relationships with participants to develop understanding before the start of the formal data collection (Dickson-Swift et al., 2009). Given this, I decided to work with the same

communities in London where I conducted my MSc fieldwork. I took time during the MSc fieldwork[1] process to get to know potential participants and the wider community members. Moreover, I also attended various events held by the communities and Somali university societies to introduce myself and raise my profile. Building a strong relationship with each of the communities took a long time, however I was aware that it was likely to be the most effective way for me to be able to gather appropriate, rich and reliable research data.

The mother language of all first-generation Somali background people is Somali, and some have very limited English language ability. To demonstrate my engagement with the communities and to help with communication, I learned some Somali language before the fieldwork started. The lessons were given by one of my research assistants, which also helped in developing our working relationship. While I was not able to build up enough Somali language ability to undertake any interviews in Somali, my efforts helped to develop trusting and strong relationships with the participants as I could exchange greetings and understand basic conversations.

4. Target population and sampling

As outlined in Chapter 1, Somalia has one of the highest rates of FGM worldwide, and despite some recent falls, FGM remains a prevalent practice. Within the UK

[1] I undertook the fieldwork in the same Somali communities in London for my MSc dissertation in 2014. My dissertation title was “Examining differences in attitude towards gender among different generations in Somali communities in the UK”

there are large clusters of people with a Somali background in large cities, such as London, Birmingham, Bristol and Manchester (Harris, 2004). The 2011 national census showed that the estimated figure of Somalis born in Somalia but currently living in London was 65,333 (At Home in Europe, 2014). Estimates of the Somali population in Manchester vary widely (Harris, 2004); it is however regularly quoted that there were approximately 30,000 people with a Somali background living in Manchester in 2006 (IOM, 2006). None of these figures include British-born Somalis as the categories and questions on the UK census do not identify ethnicity to that granular a level.

London was selected for my field research as it has the largest Somali population in the UK. Manchester was selected as it also has a large Somali population, but also as there is currently no available local- level research about FGM. As such, I was keen to undertake research in this area to better understand the practice and attitudes towards it. Logistically, I also had existing links with the London communities through my MSc research.

My initial aim was to focus only on participants with a background from Somalia. However, there was a rich mix of people with migrant histories from Somalia and Somaliland. To avoid giving the impression of discrimination against Somaliland, I decided to include participants with backgrounds from both regions (see Chapter 2 for further discussion).

Two Somali communities were selected for the focus of this research in London,

with a community and a university society also selected in Manchester. The communities were selected through discussions with community workers. As researchers often face unexpected problems during their fieldwork, it was important to have contingency plans for any unexpected issues (Flick, 2009). As such, I maintained contact with other potential communities in both London and Manchester, continuing to build my network and relationships with these community leaders and staff throughout my field research. This also helped expand my understanding of issues experienced by members of the Somali and Somaliland communities, particularly among first-generation migrants.

In selecting potential communities and societies in both cities, several factors were considered including community size (the larger the community the easier to find potential participants), whether similar numbers of both females and males regularly access the community centre and whether different age groups of members regularly access the community centre. Because of the use of the community centres as the main routes to access participants, the sample does not include people of Somali heritage who are less engaged with this social setting.

4.1. London

I made particularly strong relationships with two community centres in London, the West London Somaliland community located in West London and the Ocean Somali Community Association (OSCA) in the East. Both of these community

centres in London were founded with the aim of helping people who in the main had migrated from Somalia or Somaliland, including helping them with their language needs (such as document completion) and helping them settle into the UK. The West London Somaliland community has a café and English language classes take place in the community centre building. This helps local people to meet on a regular basis and communicate with each other. I initially contacted both communities in 2014 for my MSc field research, and after that between 2014 and 2016 I developed good relationships with both community workers and local people who regularly accessed the community centres.

I was able to meet with several first-generation members of the communities in the Somaliland community and OSCA. It was however difficult to meet with second-generation members of the communities as the centres' main function was to provide English language support, which is of course focussed on first-generation members of the communities. One first-generation community member introduced me to her daughter, who was studying at university in London. This second-generation female participant was then able to help me meet other second-generation community members. At the same time, I approached Somali student societies in some universities in the London area and through meeting with these expanded my network of second-generation Somali people in the London area.

4.2. Manchester

There is one main Somali community centre and one Somali university society in Manchester, I was able to make particularly strong relationships with both of these, the Somali Adult Social Care Agency (SASCA) and the Manchester University Somali Society. The SASCA was founded with the aim of helping people from the local area who came from different countries including Somalia, with their language needs (including filling in forms, for example), and helping adaptation to living in the UK. This community centre provides walk-in services to anyone who needs support – however, due to the profile of the local area, it is people with a Somali background who most regularly access this community centre.

The Manchester University Somali Society was founded to help students to meet people of a similar background and people who have an interest in Somalia and Somali cultures and traditions – this covers not only Manchester University, but also students at other universities in the area such as Manchester Metropolitan University and Salford University. The society has committee members and it often holds meetings (discussion nights for example) and charity parties. Finding potential second- generation Somali background participants mainly from this university society again would have provided some limitations on how diverse of a participant population I was able to gather. After mentioning this to a first-generation female participant she was kind enough to introduce me to the staff at an organisation called Focusing First On People (FFOP) which is accessed by a high number of people with a second-generation Somali background; the group accessing the organisation either worked at FFOP, or were accessing training to

develop new skills. Access to FFOP allowed me to meet a wider background of second-generation Somalis which added more diversity and depth to my research data.

5. Participants

In contrast to forms of international recognition, it was noticeable during my regular visits to the Somali communities in both London and Manchester, that people who originally came from the Republic of Somaliland often introduced themselves as a Somalilander rather than Somali. As Endo (2010) pointed out, while Somaliland is not internationally recognised, people who are currently living in Somaliland and people who originally migrated from Somaliland have a strong affinity towards the state and consider 'Somaliland' an independent nation. When I used Somalia or Somali during conversations, people often corrected me to use Somaliland or Somalilander. Indeed, one of the communities in which I undertook field research in London was the West Somaliland community. In the community, there was a large number of people who originally came from Somaliland; in order to show my respect towards those I met in the community, I decided to use "Somaliland" and "Somalilander" throughout the interviews even though is an unrecognised state in the international system. I did not, however, come across references to the Puntland State of Somalia during my research. To avoiding causing confusion through the interviews, I decided to not use this specific name of the state in both my field research and thesis write up.

In deciding how many participants to select for this research, I considered several key factors. My target groups for this research were both first- and second-generation and male and female participants in London and Manchester. The eight target groups needed to be compared as part of the analysis process, as such it was most appropriate to use the same number of participants from each category group (Marshall et al., 2013).

For qualitative research, the sample size depends on the research topic (Baker, 2012), but given the need for in-depth material, a large sample size is not necessarily the main focus (Simkiss et al, 2000). Given the length of the time available and the number of target groups, I decided to select eighty participants; ten participants from each of the eight groups. This would give a large enough sample to obtain conclusive results in the later analysis, but would not be so many as to limit the collection of sufficiently rich information from each of the participants.

Often, second-generation participants were worried about meeting me for the first time and were really nervous about being involved in my research. This was particularly the case with male participants who did not want to discuss sex-related subjects, including FGM. Additionally, some female participants had never talked about FGM with non-family members or friends, especially someone who wasn't of a Somali background.

After meeting with and interviewing several second-generation members of the

communities, these participants then told their friends about me and my research project. Through this word of mouth, I was then able to interview more participants through snowball sampling. Through these efforts, and the support of the local community members, I was able to find enough second-generation participants from each of the cities.

Even though I was able to find the required number and mix of participants, there were some issues that had to be resolved during and after the interview process. As noted, it was difficult to find second-generation male participants in the London area who were willing to discuss FGM with someone who did not have a Somali background. I felt that most second-generation males in London reacted quite awkwardly during initial discussions and indicated that would not want to discuss FGM during an interview as they did not have any experience of discussing FGM before and they had also never discussed any topic related to sex with women from a different ethnic group. I found it particularly challenging to access second-generation male participants except those who were either studying at university and/or members of Somali student societies. Because of this, there is probably less diversity within this group in my sample and this needs to be taken into account when analysing the research data.

During my field research, six participants contacted me after completing their interviews. They indicated that they were no longer willing for me to use their interview data for my thesis. There were different reasons for this. For example, one first-generation female participant was afraid that her daughters would find

out the details of her FGM experiences. Another participant told me that she was worried her mother in Somalia would find out that she shared her story of FGM with someone from a different ethnic group. Moreover, one first-generation male participant also explained that he did not want other local community members to find out that he had talked to me about men's experience of FGM. I had fully explained the research process including confidentiality before the individual interviews. When participants contacted me to withdraw from the study after the interview, the interview data was destroyed and suitable replacement participants were found.

6. Interviews

I chose interviews as the main data collection method as they allow the researcher to obtain information based on emotions, feelings or experiences (Dilshad and Latif, 2013). Because the research was focusing on personal and sensitive topics, using other methods of collecting qualitative data, such as focus groups (Kitzinger, 1995; Freitas et al., 1998; Onwuegbuzie et al., 2009) was ruled out (Flick, 2009).

I selected a semi-structured interview approach, which combined a set of pre-written questions, but with sufficient flexibility to adapt to the individual interviewee (Green and Browne, 2011). This is as I wanted my interviews to be in a conversational style, making the participants feel more comfortable, particularly at the beginning of each interview. At the same time, I also needed

to gather a good amount of rich information suitable for my research questions. In order to keep on track and gather suitable information for my research questions, I designed the interview questions in advance (Appendix 2). The interviews did, however, need to be flexible allowing me to expand on conversations during an interview or use different questions to prompt discussion.

Almost all individual interviews (76 out of 80 interviews) were recorded. The four interviews where the participants did not give me permission to record are indicated with an asterisk on the list of participants in Appendix 1. Using a voice recorder helped me to make exact and detailed transcripts of the interviews, and also allowed me to reflect on details of the interviews afterwards such as the tone of each participant's voice, their emotions and so on. This extra information was very helpful in trying to understand each participant's emotions and helped me to analyse data. For the four interviews which were not voice recorded, I got permission to make notes. This meant that I had a record of the main themes that came out of our conversations, but I could not get a verbatim transcript. To avoid misunderstanding what they said, I asked additional questions to make sure I understood what exactly they meant. I also tried to add notes about their emotions at different stages in the interview.

The interview venue is an important factor in determining how deep and rich a dataset the researcher can gather, particularly when highly sensitive data is being gathered (Parsons and Knight, 2015). Flick (2009) also added that the

venue should be selected carefully to make sure it will be sufficiently private and that all participants will be comfortable that confidentiality will be maintained so that they are happy to speak to the researcher.

I had planned to set up short meetings or introductions with all participants before their interviews to discuss the interviews, including what kinds of questions I wanted to ask, the purposes of the research and the venue. I also discussed the potential venues for the interviews with community centre staff. However, many participants were unable or unwilling to make the time to attend a short meeting before the interview. Because of this, I used different approaches to introduce myself and the research such as phone and Skype conversations.

The community centre staff kindly offered me the use of one of the rooms inside the community building for interviews in both communities in London. The Manchester community centre also kindly offered me the use of their whole community centre building on Friday as the centre was usually closed on this day. I was also able to use the other community centre building (the Women's Centre, see Plate 1), which is part of SASCA. This was founded with the aim of supporting female community members, particularly providing training to develop knowledge and skills for local female members of the community and helping women deal with issues including domestic violence and FGM. The Women's Centre is located a five-minute walk from SASCA and I used this building interviews for some interviews.

Plate 1: The Women's Centre

Source: Author

Undertaking interviews inside the community building meant that all participants were familiar with the building and knew how to access it, making them more comfortable undertaking interviews there. However, by conducting interviews in these spaces, other community members could easily recognise who was part of this field research.

The community centre buildings were mainly used for interviews with first-generation participants. Some first-generation participants asked to meet at different venues, such as a local café, as some participants did not want anyone in the local community centre to realise they were part of my research, or

preferred to meet somewhere near their workplace. When I had these requirements, I searched the areas they requested and found a suitable public café – not crowded, quiet and a good-sized café. I also went to several cafés in advance to make sure the venue was suitable for interviews.

I used different venues for interviewing second-generation participants both in London and Manchester. In considering suitable venues for these interviews, I commonly used university building meeting rooms such as Royal Holloway's Bedford Square building meeting rooms, meeting rooms in the University of Manchester's Student Union building and the University of Manchester Metropolitan's meeting rooms. I also used other venues where appropriate, such as private meeting rooms available for rent on an hourly basis, cafés and meeting rooms inside of the Manchester training centre. I tried to be as flexible as possible to meet participants' requirements so that they were comfortable to talk with me.

In selecting a venue, I not only considered the participant's comfort and safety, but I also had to be mindful of my own safety too (Connolly, 2003). To avoid any difficulties and ensure I did not put myself in an unsafe position, I did not use venues where I couldn't be sure of my safety, such as at a participant's house or in an area where there weren't many people around me that could help if needed.

7. Research assistants, language and translation

Early on in my research I decided that it would be important to employ research assistants as part of this project. This was for three main reasons. Firstly, to help me understand aspects of Somali culture or language that may come up in interviews that I was less familiar with. During my previous field research in Somali communities, I had experienced several cultural and traditional practices that I do not have in my own culture including Ramadan, wearing a hijab and females not being permitted to sit down inside of the main community cafeteria. Working with research assistants with a deep understanding of the participants' culture, tradition and religion would help me in showing the appropriate level of respect to all of the participants during my visit to the communities, as well as helping to place their interview responses in context (Dagron, 2010; Mohan et al., 2002).

Secondly, the English language ability, or language preference of participants might mean that they wanted to conduct the interview in the Somali language. Some first generation Somali migrants in the UK can speak a good level of English despite it not being their mother tongue; many, however, particularly women, often have a severely limited grasp of the English language, or in some cases, cannot speak English at all (Harris, 2004). On the other hand, second-generation British-Somali migrants speak English, and many of them can also speak Somali and/or Arabic.

Finally, having a research assistant from the Somali community could provide reassurance to participants if they were nervous about talking to a non-Somali about personal and sensitive matters.

Eight participants did not want me to be there for the interview. Reasons cited included some participants being uncomfortable talking about their experiences of FGM with someone who has no experience of FGM and is not from a Somali background, others because of language concerns, while some male participants were not comfortable discussing FGM with a female researcher. For some participants there were concerns around the length of time these interviews would take. I usually set up individual interviews with an expectation that each would last between thirty minutes to one hour. Some participants were concerned that the individual interview would take too long if it was led by me in English with a research assistant translating. I fully understood these requirements and concerns. As a result, the interviews for eight participants were undertaken by a research assistant by themselves (Indicated with a star on the list of participants in Appendix 1).

Before I started my interviews I met a large number of potential research assistants through attending university societies or visiting community centres. Firstly, I set up individual meetings over coffee with individuals who had expressed a particular interest in the research to find out more about them and to give them an opportunity to ask me questions about the research. After these meetings, there were four people that I got on with particularly well and felt could

be appropriate research assistants: two second-generation Somali background women in London and Manchester and two second-generation Somali background men in London and Manchester. At this point, I mentioned that I was looking for a research assistant for my research project and asked them whether they were interested in this role. All four of them kindly agreed to be my research assistants, although in the end one of the men was not able to participate. Fortunately, another male research assistant in Manchester was able to help me with my research in London as well as in Manchester. It was important to have both male and female research assistants to respect each participant's requirements and preferences for individual interviews.

All three of the research assistants were second-generation British Somali migrants, and could speak English, Somali and some Arabic; equally as important, they all had a deep understanding of Somali culture, tradition and religion. They also possessed the necessary skills to build a trusting relationship with the participants and were able to translate the views and opinions of the participants without inserting in their own personal views (Bujra, 2006). Having three research assistants also allowed some flexibility in the sense that I could ensure that the chosen assistant for a given interview was independent of the interviewee ensuring that this didn't act as a barrier in the interview discussion; if participants and the translator were related or friends, it may have been difficult to discuss honest experiences or opinions (Flick, 2009). None of the research assistants were part of the communities in which the field research was undertaken.

Before the field research started, I set up several meetings and training sessions with the three research assistants to discuss the research aims, how to process interviews (particularly the kinds of information I was planning to gather), how to deal with participants' confidential information, and importantly how to prepare and protect the researchers from any distressing situations during interviews. I also prepared documents explaining the research assistants' responsibilities and work details, including an agreement over daily/hourly payment and travel expenses (i.e. overground and underground travel ticket fees). All research assistants travelled between cities to support my field research if needed, and they usually travelled in advance (usually a day before individual interviews were undertaken). Fortunately, all of them had family members in both cities, and they were able to stay there. It meant I could minimise the travel costs, and built in more flexibility into the schedule.

Each research assistant undertook several individual practice interviews with me based on the semi-structured interview questions I prepared (Appendix 2) before they undertook interviews themselves. The purpose of these practice interviews was not only to help the assistants undertake interviews smoothly, but also to help them develop their interview style to make participants comfortable when discussing sensitive topics like FGM. At first some of the research assistants struggled to expand on the conversation allowing them to gather rich data. However, after practising several times, the assistants became stronger, more confident and more comfortable in discussing FGM. After all research assistants

were fully ready, they began to undertake individual interviews themselves, as well as accompanying me to other interviews.

For the eight interviews conducted by the research assistants by themselves, they provided me with voice recordings and translated transcripts in English (where the interviews were undertaken in Somali). After the research assistants completed the transcripts in English, I asked another research assistant to cross check the transcripts to make sure that details of the interviews were correctly translated from Somali to English. The process of peer reviewing between research assistants made them feel more responsible for their transcripts and ensured that quality and accuracy was maintained in the translations. I also set up regular face-to-face or Skype meetings to discuss interviews where I was not present and to get clarity about areas of the transcript that were not clear. This involved collecting extra information about how the interview went, including the behaviour and emotions of the interviewees. As Temple and Young (2004) suggest, regular and close communication between researcher and research assistant is vital. I believe that the quality and reliability of the information obtained in these interviews was enhanced due to the interviews being undertaken by the research assistants in line with the participants' requests, and this was also in line with an ethical approach to research (discussed later).

8. Researcher protection - legal and emotional aspects

8.1. Legislation on FGM

FGM has been a criminal offence in the UK since 1985, with laws since amended twice in 2003 and in 2015 as part of the Serious Crime Act. It is currently a criminal offence for both UK nationals and permanent UK residents to be involved in any act of the process of FGM, including taking children abroad to have FGM undertaken on them (Ministry of Justice and Home Office, 2015). It should be noted that section 74 of the Serious Crime Act 2015 was amended from the Female Genital Mutilation Act 2003 to include the legal duty for regulated health and social care professionals and teachers to make a report to the police if they are informed by a girl under the age of eighteen that she has been circumcised, or if they observe physical signs that a girl who is under eighteen may have experienced FGM (Home Office, 2016).

Given my position, there was a possibility that I may come across information in relation to people who are planning for their daughters to be circumcised, or in relation to girls who are at the risk of having FGM practised on them. As such, before undertaking the field research, I had to consider what actions I would be required to undertake should I come across any such information.

In relation to the UK's Serious Crime Act, a health or social care professional, or teacher, are the personnel that have a duty under the Act to make a report to the police if they notice or come across any relevant information in relation to FGM.

Even though I am not a social care professional or teacher, I had to consider whether to report if I came across any relevant information. Fortunately, I did not come across any such information during my fieldwork, and I did not need to take any necessary actions, such as making reports to third parties such as the police (GOV.UK, accessed 2020).

8.2. Emotional aspects of interviews

Before starting the field research, I expected to meet with females who had already experienced FGM; as such I considered that it may be emotionally challenging for me as a researcher to discuss FGM with these participants, particularly hearing about their personal experiences. As Dickson-Swift et al. (2006) noted, undertaking field research on a sensitive topic can often affect a researcher's emotions, and lead to the researcher struggling to continue their research. To avoid any negative emotional effects, Dickson-Swift et al. (2006) strongly recommended that the researcher prepares to protect themselves and adopts interview methods that minimise the emotional effects before the start of the field research. Given this, I considered accessing psychological support from local counselling services or University counselling services. I had, however, various experiences of talking with people about their experiences of FGM during my previous work at the Orchid Project. As such, I was confident enough to be able to undertake individual interviews with females who had experienced FGM.

After starting my field research, it did become difficult to hear some of the

personal stories of FGM from some of the second-generation female participants who had been cut. This was because a large number of second-generation female participants had not fully accepted or come to terms with their experience, and as such it was often very emotionally difficult for them to discuss their experiences during the interviews. Dealing with these situations affected me emotionally also. With hindsight, I was perhaps over-confident at the outset about how emotionally prepared I was to undertake these interviews and discuss these challenging experiences.

Researchers showing emotions during interviews is something which has been debated in the literature. For example, Dickson-Swift et al. (2006) argued that a researcher should not show their own emotions to participants during an interview. For Flick (2009), this is particularly the case when gathering sensitive data about experiences such as domestic violence. This is because participants could be offended by the researcher's reaction if they feel that the researcher had not had the same experiences. Hubbard et al. (2010) however contested this approach. They pointed out that showing emotion sometimes affect participants positively; for example, participants feel the researcher understands their feelings, and/or makes participants feel they would like to share personal feelings and experiences with researchers. I tried not to show my emotion during interviews, even though participants became emotional. However, I could not control my emotion several times, particularly when some second-generation female participants began to cry as they remembered their experiences and shared their experiences with me. When I could not hold my own emotion during the interview,

I started crying with one second-generation female participate in Manchester. After completing this interview, I expected to receive a negative response from her. Surprisingly, she was very positive, and this participant mentioned that if I did not empathise feeling with her and did not show my emotion, she could not share her personal story with me. Furthermore, this participant also mentioned to her friends before they met me for an individual interview that I empathised with them and tried to understand their feelings instead of being an outsider during the interview. Her comments seem likely to have encouraged several participants to talk with me more openly.

9. Field notes

During the field research phase, I decided to write field research notes. The purpose of these field notes was not only to provide supporting information on all participants for the creation of the transcripts, but also to provide a log of my feelings throughout the research process. Writing this field research diary was very helpful in remembering each interview clearly, particularly during the analysis of the transcripts. Moreover, as all details of the data collected were confidential, I was unable to share details with third persons (friends or family for example) to reduce and manage the emotional impact that the interviews had on me during the field research; the research diary acted as my way of managing my own feelings during the process.

I usually kept my field research diary at home. At times however I had to bring

it with me outside of my house, when traveling and staying in Manchester for interviews for example. During these occasions, I was extra careful to keep my field diary secure in the place I was staying rather than walk around with the diary on my person at all times and risk losing it. Finally, to minimise any information leakage risks, I decided to write the research diary in Japanese, and to not include any personal details, such as any participants' names, so that a third person would not be able to identify any sensitive information.

10. Positionality

This research required the participants interviewed to share intimate details of their personal background, experiences, life and opinions on sensitive matters. To successfully undertake this type of research, an interviewer must be open minded and should not show any strong personal opinion to the participants (Arai, 2005).

Due to the prevalence of FGM in Somalia, a high number of first-generation female participants have already experienced FGM before migrating to the UK. Moreover, some of the second-generation British Somali migrants could be at risk of having FGM practised on them or may have even already been cut. As I was expecting individual female participants to share their experiences of FGM and their opinions of the practice during the interviews, I had to take a neutral stance about the practice of FGM, and had to refrain from making a judgement about the practice.

Working cross-culturally also requires sensitivity to participants' backgrounds, including their religion, culture and race (Moser and McIlwaine, 1999). Most of the participants from the Somali communities were Muslim, and both first- and second-generation female participants tended to wear a hijab. From my previous field research experience I expected that both men and women, particularly first-generation Somali participants, would have a strong preference that visitors to their communities (including researchers) show respect for traditions, including dress. As such, I considered the clothes I wore during the fieldwork, usually wearing long-sleeved clothes to cover up as much of my skin as possible. Additionally, I decided to have a break during Ramadan (6 June to 5 July 2016) as the community centre workers advised me that people who usually access the community centres prefer to minimise their activities. I was however asked to undertake some interviews during Ramadan by a few participants because some of the male participants took holidays during Ramadan and as such found it easier for them to set up interviews at this time. At this time, I ensured that I refrained from eating and drinking while in the community centre / undertaking interviews to show respect to both the participants and other members of the community centre.

There is commonly a power relationship between the gatekeepers, researcher and participants (Chambers, 2002; Green and Browne, 2011). Flick (2009) mentioned that for some research topics the power relationship between participants and the researcher can be exacerbated if there is a difference in

gender between them. These power relationships can directly affect the results of the interviews. The impact of power relationships can be minimised if the researcher has a set of personal characteristics that makes participants more comfortable in the process. A researcher also needs to impart confidence in the participants and create an environment in which they want to openly contribute to the discussion (Clawson et al., 1995). I needed to show respect to participants and tried not to force a perceived position of power on them in a manner that could make me come across as a “teacher” which allowed the participants to develop an affinity with me.

During and after the field research, I received a high volume of positive feedback from both male and female participants. For example, they felt that it was easy to talk with me even when discussing sensitive topics like FGM or their sexual attitudes. This was because participants thought I had a deep understanding and respect for their background and religion, and was flexible in listening to each participant’s thoughts on FGM. Participants said that I made them feel really comfortable to talk with me (participants used words “good listener”, “girl’s/friend’s chat”). After I completed the interviews, some participants mentioned that they had previously held a negative image of academic researchers which made them scared to talk with researchers.

My personal position, in being a female non-English native who respected the culture and religion of the participants helped to reduce the impact of any power relationship, helped to put the participants at ease throughout the process and

helped me gain a rich and full data set through a successful interview process.

11. Ethical issues

Before I started my field research, I had to carefully consider how I would undertake an individual interview with various possible situations to protect participants, research assistants and myself from any possible difficulties. In terms of formal ethics processes I had to comply with the ethical research responsibility and procedure required by the College Ethics Committee in my university (see Royal Holloway Ethics Committee 2016) (see Appendix 3).

Formal ethical approval is, however, only a small part of an ethical research process. During my research, I came across confidential information and ensured that I maintained the individual's privacy and confidence during and after interviews. Given the sensitive nature of the information, before the interviews I explained in detail my research aims and methods so that the participants were fully aware of the intended use of the information that they would provide. It was also important that everyone invited to attend an interview signed a consent form allowing the data received to be used as part of the research analysis (Appendix 4). As the results of the analysis can be made available, the finalised data are anonymised in all forms in which it is presented. All participants were over eighteen years old and were not regarded as vulnerable so permission from other people was not required for them to participate in the research.

To avoid losing the source data, all voice recordings were archived on my personal laptop. My personal laptop is protected by passwords, and passwords were also used on the individual data recording files to ensure that the data was protected and could not be accessed. After archiving the original recordings on my laptop, all recordings were deleted from the voice recorder itself to reduce the risk of data leakage.

Where a research assistant was dealing with several interviews and making transcripts of these, I had to share voice recordings and transcripts with them. To avoid information leakage, I protected each voice recording and written transcripts using different passwords. Of course, as noted in the preparation and training for the research assistants (see above), I trained all research assistants in how to appropriately deal with confidential information. I also made sure that all research assistants who would deal with confidential information completely understood how to deal with this sensitive information before sharing it with them. The importance of maintaining confidentiality and protecting data was regularly discussed throughout the research process to reinforce this message and make the research assistants feel responsible.

As it was likely that the topics of conversation were very sensitive, there was a possibility that the participants may became emotional or could need external help and support after the interviews, such as psychological support. In case of this scenario, I created different documents with external sources of support included (Appendix 6). I liaised with the NHS and other organisations to obtain

appropriate phone numbers to include on the sheet.

There was also a risk that the research assistants needed support after helping to facilitate the sessions if some of the content or topics being discussed were distressing. During the initial meetings and discussions I ensured that the research assistants were fully aware of the types of conversations that would be taking place during the interviews, and that they were aware of the external support available to them if they did suffer any distress. Similarly, there was a risk that I could become distressed by the conversations in the interviews, and as such needed to retain access to the appropriate external support myself. To minimise the chance of any emotional distress to both myself and the research assistants the individual interviews were set up with adequate breaks in between them over the ten-month period that the fieldwork was undertaken. Fortunately, all of my research assistants were able to avoid being deeply and negatively impacted from an emotional perspective, and they were able to manage to deal with any negative emotions by sharing their thoughts and feelings with me on a regular base, both face-to-face and over the phone.

As already noted, I considered any emotional distress to myself during this field research. Many of the conversations with participants were emotionally challenging and difficult for both researcher and participant; more so than I expected. As all conversations with participants were confidential, I was only able to share my emotions fully with a limited group of people, mainly with my supervisor. With hindsight, I should have considered and prepared other

approaches to managing my emotional responses to the interviews throughout the research.

12. Data analysis

Completing eighty individual interviews allowed me to obtain a deep sample of data and findings. Before starting the data analysis, I needed to familiarise myself with the whole dataset, and organise the data so that it was easy to find the original sources for use in referencing. The first step of the data analysis was to make full transcripts of all individual interviews undertaken. Given the number of interviews undertaken, and the length of each individual interview, this was a time-consuming process – there were well over 100 hours of recordings. Given the volume of interviews I knew I would be undertaking, I commenced the process of making the transcripts at the same time as undertaking the individual interviews; this allowed me to minimise the gap between completing the individual interviews and commencing the analysis of the data.

Following some of the individual interviews undertaken, in which very personal and traumatic experiences were discussed in great detail, emotional fatigue meant that I had to take a few days break before undertaking the next interview and continuing with my field research. As such, I often used these non-field research interview days to make transcripts. Transcribing almost all individual interviews myself gave me an in-depth knowledge of the context of the interviews, and provided an opportunity to re-hear the emotion in each participant's voices;

something that I would have missed if I did not do the transcriptions myself. In addition, several interviews were undertaken in Somali language by research assistants. All of these were recorded, with the research assistants translating all into English. Having recordings of the interviews helped me to understand each participant's emotions while reading the English transcripts. Where first-generation participants requested that the interview be conducted in English either by myself or by a research assistant, I transcribed their interviews verbatim. I wanted to note whether some participants used Somali words during the interview, including "Gudniin" which means FGM in Somali, and I transcribed these words in Somali.

The transcripts were then semi-edited to remove unneeded sighs and sounds, such as phone rings and coughing, so that only the dialogue between the participant and I remained (Flick, 2009). Due to the sensitive nature of the research topic I often made "small talk" unrelated to the central topic of discussion in the interview to put the participants at ease and ensure that they were comfortable to talk with me, particularly at the beginning of the interviews. These initial discussions were a very important part of having participants open to up, however as these parts of the interviews did not relate to the research topic they were omitted from the final transcripts.

I commenced the data analysis phase of my research after completing all individual interviews in both London and Manchester. As outlined earlier in this chapter, a grounded theory approach was taken towards the analysis of the

interview transcripts. This involved a process of open coding, rather than starting with a pre-set code book (Green and Browne, 2011). The constructivist grounded theory approach (Mills et al. 2014) acknowledges that researchers approach coding with an awareness of existing research and theoretical frameworks (see also Kelle, 2007 for discussion of coding within grounded theory), but I sought to go through the transcripts carefully, reading each sentence and drawing out themes as they emerged.

For the main data analysis phase, after careful consideration, I decided to use a coding computer program, NVivo, given the data sample size was significantly large; this helped me to deal with all the collected information more easily. I imported all my transcripts into NVivo. Then I did first-level detailed coding seeing which themes emerged from the material, before grouping these into nodes. A code book was created (see Appendix 5) and this was used as a starting point for the analysis in Chapters 5, 6 and 7.

13. Conclusion

Given the very sensitive nature of my field research topic, I had to develop a clear methodology and give sufficient consideration to the various difficulties and issues that I would likely encounter during the research process; this was essential to ensure the fieldwork would run as smoothly as possible. Through this methodology and preparation I was able to successfully gather rich and reliable data, despite the challenging nature of the research topic

Chapter 5: Women's Experiences of FGM: Continuities and Changes Between Somalia and the UK

1. Introduction

This chapter focuses on women's experiences of FGM, with particular attention paid to the differences between the experiences of first-generation migrants and those of women born in the UK to Somali migrant parents. The chapter considers not just whether women had been cut or not, but the type of FGM experienced, where and by whom the procedure was undertaken, and who were the decision-makers. As outlined in Chapter 3, migration to Europe can be associated with changes in FGM practices among communities where FGM is prevalent. This chapter explores the patterns of FGM practice, and women's descriptions of their experiences. The reasons behind these patterns will be discussed in more detail in Chapter 6.

2. Changes in FGM type between generations

2.1. Type of FGM experienced by first-generation females

FGM is still practised by a large number of people in the world, with the type of FGM each girl faces deeply rooted in the cultures and traditions of individual countries, communities or ethnic groups. As such, the type of FGM that someone may have inflicted on them is largely dependent upon one's background. First-generation migrants usually have FGM practised on them before they migrate to their adopted countries, as such they usually experience the type

which is most common to their country of origin (Mesplé-Somps, 2016). Type 3 FGM is the most common type of FGM in Somalia, and a key reason that people in Somalia practise this type was that it is seen as being a clear way to prove a girl's virginity when they get married, which is of the upmost importance for family honour (Utsumi, 2003; Devers, 2010; Abathun et al. 2016: Johnsdotter and Essen, 2016).

Before undertaking my field research, I thought that older first-generation female participants may have experienced Type 3, however younger participants may have either not undergone FGM at all, or may have experienced a lighter version of FGM such as Type 1 or 2. This is because even though the prevalence of FGM in the mainland of Somalia and Somaliland is still high, the illegality of FGM in the UK and the potential changing social norms following migration may have changed attitudes and behaviours relating to FGM among Somali migrants in relation to their daughters.

Among my twenty first-generation female participants, most (eighteen out of twenty) had been cut, and a large number had experienced Type 3 FGM (see Table 1). Four participants had experienced a less severe type of FGM which is not the usual type for Somalis, particularly of their generation. More surprisingly, two first-generation female participants responded that they had not been circumcised at all.

Table 1: Type of FGM experienced by first-generation female participants

	Age group	Type 1	Type 2	Type 3
London	Under 30	2	0	0
	Between 30-39	0	0	1
	Between 40-49	0	1	4
	Over 50	0	0	1
	Total	**2**	**1**	**6**
Manchester	Under 30	0	0	1
	Between 30-39	1	0	3
	Between 40-49	0	0	3
	Over 50	0	0	1
	Total	**1**	**0**	**8**

Created by author

Amina's experience was typical of the narratives presented by first-generation women:

> *Amina: Type, I'm not sure what type I was done. Do you know Sunna[2]? Which type Sunna? I know lady (practitioner) removed and stitched up.*
>
> *Mina: The practitioner stitched up the whole of your genitals?*
>
> *Amina: Yes she did, just left small hole for wee, otherwise yes she stitched up. All girls had same one. Mine is normal Type I believe.*

[2] Sunna is often used internationally to refer to Type 1 FGM (Johnsdotter and Essen, 2016, Elijah and Korir, 2019 for examples). A large number of participants, however, used 'Sunna' to refer to Type 3 FGM. None of them knew the reason why they used the term 'Sunna' for Type 3. Some people added the words 'infibulation' or 'pharaoh type' to explain their type of FGM. Infibulation and pharaonic circumcision are used for Type 3 FGM; as such for participants 'Sunna' meant Type 3. The widespread use of 'Sunna' in relation to Type 3 FGM was observed by NAFIS Network (2014) in Somaliland.

Mina: I think you experienced Type 3. Is it possible to talk about your experience more? The day you experienced and, if you remember, why you think you experienced FGM?

(Later in interview)

Amina: I think because social pressure, culture, tradition, for family. I can't say one reason. Everyone believes different reasons. Mum told me "you will be clean" "you will be a good girl". I think all mums say similar things to daughters. If I chose one main reason (explaining why girls experienced FGM), I would say easy to show "I'm good girl" to people in the village.

Mina: What does a "good girl" mean?

Amina: We shouldn't have any sexual relationship before marriage. Of course should keep and prove our virginity on the wedding night for husband. How I can show I'm virgin? If girls were stitched up, easy to prove. I think that's why I was cut and stitched up.

(Amina, first-generation, female, London)

Mina: So you were circumcised by Sunna?

Taifa: Yes, Sunna. Is it Type 3 you said?

Mina: Yes, that's Type 3 I believe. Do you know whether your mum asked the practitioner to do Type 3 or another type for you?

Taifa: I don't think mum knew different types of FGM. FGM was only one type, Sunna (Type 3) for us. She asked lady

(practitioner), please come and do my daughters, that's it. I don't think mum ordered which type (of FGM). We only do Sunna, not any other types.

(Tafifa, first-generation, female, Manchester)

Many first-generation female participants shared details of similar experiences to Amina and Taifa, in that there was no consideration given to the form of FGM, only Type 3 was practised. It is easy to imagine that this understanding was common at the time the first-generation females were children. This is possibly why a large number of first-generation female participants were circumcised by Type 3 FGM, and there was no choice and consideration given to less extreme forms of FGM. In both cases Amina and Taifa described how their mothers were the decision-makers, but their words suggest a lack of choice, including Amina's mention of 'social pressure' and Taifa stating 'I don't think mum knew different types'. The former case suggests FGM was perceived as the 'right thing to do' through explicit or implied social pressure, while a lack of awareness of alternative procedures implies a socialised 'taken-for-granted' situation. This will be discussed in more detail in Chapter 6.

Several first-generation female participants (three based in London and one in Manchester) responded that they had experienced Type1 or Type 2. All four participants, including Ayanna who is a first-generation female participant based in London, noted that Type 3 FGM was the most common type of FGM practised in the area of Somalia where she lived. She explained the reasons why she

believed she was able to avoid Type 3 FGM and instead undergo a less severe form of the practice. Her grandmother and mother had a strong preference that she, and her sisters, would be cut in the form of Type 3 to maintain their family honour. Ayanna's father, however, was strongly against FGM and did not want this to be practised on any of his daughters despite his wife and mother-in-law's wishes to the contrary. After difficult discussions between these members of the family, a compromise position was reached that all of the girls would have Type 2 FGM practised on them. It is very unusual for male members of the family to have any influence over the decision to practise FGM on daughters, and if so what type of FGM; this decision is typically left to the mother and grandmother (Johnson-Agbakwu et al., 2014).

Ayanna was not clear how this situation had come about:

> *Ayanna: I don't know why dad disagreed FGM, maybe he knows FGM makes girls pain. I really don't know. I never asked him why. But I know If dad didn't say anything to mum, I could be done usual one (Type 3). If mum and grand mum didn't listen what dad said, I know I had normal.*
>
> *(Later in interview)*
>
> *Of course I didn't want to be cut, but I know all girls had to do it that time. I think mum needed to show "my girl is clean" and "she is a good girl".*
>
> *Mina: To who?*
>
> *Ayanna: People in my village. She needed to show everyone in*

my village, that's why mum set up "the day" (Ayanna's FGM organised date). It's important everyone know, she told neighbours and friends when should be my day.

(Later in the interview)

I know how painful and difficult my life could be. I know lots of girls still have lots of pain. I'm lucky one, I know how lucky I am.

(Ayanna, first-generation, female, London)

In Ayanna's case the inter-personal power relationships in her family lay behind the choice of her FGM. While she could not avoid being cut as that would have meant shame on the family, she did avoid the likelihood of greater pain that would have come from the more extreme procedure. Similarly, Fatima (a first-generation female participant based in Manchester) also responded that she was able to avoid undergoing Type 3 FGM and instead had the less severe Type 1; she noted that the reason for this was that her mother was strongly against the practice of FGM. Fatima was cut when she was just two years old. At this time she was in Somalia, and her mother was very much against the practice of FGM on any of her daughters, including of course Fatima. Her mother did however feel huge pressure from her mother (Fatima's grandmother) and the wider community. In light of this, to maintain family honour, Fatima's mother decided to practise the lighter Type 1 FGM on her daughters, and to do this while her daughters were still at a very young age to minimise any psychological distress. Both Ayanna and Fatima were able to avoid Type 3 FGM as one family member objected to this practice being undertaken in that form; under other circumstances there would

likely have been a high possibility that they would have had Type 3 FGM given their age and backgrounds.

The civil war started in Somalia in 1988, and a large number of people in Somalia were displaced within the country, with some fleeing across international borders (Kibraeb, 1993). Research has highlighted several cases of circumcision inside the refugee camps in Kenya (Mitike and Deressa, 2009). There is however not much research focusing on the details of FGM during the civil war. WHO (2008) mentioned that some girls possibly avoided experiences of FGM due to the civil war period as parents could not find a practitioner or they could not raise enough money to organise their daughter's FGM. Two first-generation female participants in my research responded that they were not circumcised. They believe they were able to avoid being cut as they had to move into different villages and refugee camps on a regular basis, and their family did not have any opportunities to arrange for FGM. Both participants' responses possibly support the WHO's point of view.

2.2. Type of FGM experienced by second-generation females

Some researchers and organisations (Gele et al., 2013; The Royal College of Midwives, 2013, for example) have found that a high number of first-generation female migrants, who originally came from countries where FGM forms part of their culture and tradition, still have a strong preference for their daughters to be cut. This is even when their new country of residence does not have FGM as a

part of its cultures and traditions. Within the Somali community, the continuation of FGM through the generations despite migration is driven by a continuing importance, even to those in the UK, to prove one's virginity at marriage (Davis and McCafferty, 2005).

Under half of the second-generation female participants interviewed (nine out of twenty participants) had undergone FGM (see Table 2); a much smaller percentage than among first-generation participants. The form of FGM also differed greatly; the most common form of FGM that second generation female participants underwent was Type 1.

Table 2: Type of FGM experienced by second-generation participants

	Age group	Type 1	Type 2	Type 3
London	Between 18 to 24	3	0	0
	Over 25	1	0	0
	Total	**4**	**0**	**0**
Manchester	Between 18 to 24	2	0	0
	Over 25	2	0	1
	Total	**4**	**0**	**1**

Created by author

Only one second-generation female participant interviewed, Sucdi, who is based in Manchester, underwent Type 3 FGM. This was when she was twelve years old. She responded that she wanted to have the practice undertaken despite both her mother and grandmother disagreeing (see later discussion regarding claims that children made the decision to be cut themselves). She added that her close

friends and relatives who visited her family in the UK from Somalia had already undergone the procedure, and they talked about FGM to her. After spending time with them, she began to want to have it done and she thought it would help her fit in with the girls around her. This indicates that despite being born and growing up in the UK, young women like Sucdi are part of transnational family networks which mobilise ideas about normative behaviour which are not part of wider UK society. Sucdi also noted that despite her mother and grandmother objecting, she thought that her stepfather wanted her to undergo FGM for her family's honour. Given her mother and grandmother's objections, Sucdi recounted how her stepfather had to lead the arrangements and asked a friend's mother, who was arranging for FGM for her daughter, to hire the same practitioner to undertake the procedure on Sucdi. The type of FGM was not discussed; as her friend's mother had arranged for daughter to receive Type 3 FGM, Sucdi also experienced this. In the interview, Sucdi described her experience:

> *Sucdi: I was ignorant, I didn't know what exactly FGM was. I even didn't know it was something painful, removing part of a sensitive part of my body. I wish I listened to what my mum told me more carefully, maybe she'd have explained the details (of FGM).*
>
> *(Later in interview)*
>
> *I think my stepdad wanted me to undergo Type 3. I know why he wanted me to do FGM, to prove my virginity. He believed the easiest way to prove my virginity and to control my sexual behaviour was to do the traditional type of FGM.*
>
> *(Later in interview)*

I talked about FGM with friends, and I was surprised no one had done the same as me. Only a small cut, not like I had done, then I realised I am not same as others

(Sucdi, second-generation, female, Manchester)

Sucdi's interview suggested, as also implied by other respondents, that the most common type of FGM undergone by second-generation females is Type 1; Type 3 FGM is not a common type amongst this population. The main reason for first-generation females experiencing Type 3 FGM was as a requirement to prove their virginity. However, a shift away from Type 3 FGM suggests that there is also a change in the purpose of undergoing FGM between first- and second-generations. Sabrinah discussed the increasing flexibility and debate around FGM following migration:

Sabrinah: Of course FGM shouldn't happened to us, but in reality it's hard to avoid it. Because mum had a pressure from grand mum, auntie and people inside our community. Mum may didn't want put us (Sabrinah and her sisters) into this, but it was hard for her to go against family, against community.

(Later in interview)

At least mine is only small snip, not like mum's (her mother was circumcised Type 3 FGM). I know she struggled her life because of she was cut.

Mina: Do you think you have any difficulties because of FGM?

Sabrinah: Compared with mum, I think I'm fine. I know she has

lots of pain, she told me how much she still in pain. Imagine she had it done, not in the clinic, no anaesthesia, no medicine.

Mina: So do you think compared with your mum, yours is better?

Sabrinah: Yes definitely.

(Later in interview)

I had lots of arguments with mum, because just couldn't forgive her fully. But I know mine is better than hers. I always tried to consider "mine is better than mum's, because she wanted to protect me".

(Sabrinah, second-generation, female, London)

Sabrinah's responses suggest that the main reasons for second-generation female participants having the lighter form of FGM is due to compromise; despite mothers not wanting their daughters to undergo the practice, this satisfies the wider community who exert pressure on families to undertake this tradition. Comments in relation to this social pressure were widely shared by other second-generation female participants during their individual interviews also. This point will be discussed further in the next chapter.

Of course the milder type of FGM (either Type 1 or Type 2) still negatively affects women both physically and psychologically. Type 3 FGM, however, has a more negative impact on a female's physical and psychological wellbeing compared with other types of FGM (Almroth et al., 2001a; Gele et al., 2013).

3. Differences between Somalia and the UK as to where FGM takes place

As outlined in Chapter 3, FGM has traditionally be carried out by practitioners with no medical training, access to medicines or emergency treatment in the case of complications. Similarly, girls have traditionally been cut at someone's home, rather than a medical facility. There is evidence of some changes in both practices and locations, although there is diversity.

3.1. Location where first-generation female participants underwent FGM

> *Feynuus: Yes, lady (practitioner) came to my house, there were maybe four or five of us (girls). First girl was taken to different room and I could hear she screamed and cried, then I was so scared. We (her and other girls) sang songs and tried not listening her screaming voice, but my hand was shaking, I looked mum and she smiled me and said "you will be fine", "you can do it". Second girl was taken and we kept holding hands and sang songs. One girl was crying and she was taken somewhere to be calm.*
>
> *(Later in interview)*
>
> *Imagine, lady (practitioner) didn't give me anaesthesia, tools she was using were not disinfected for sure. Imagine you have an operation or something without anaesthesia, someone cut part of your body at home, someone who are not a doctor do something like that. That we go through. Pain we had, we got through such a crazy thing.*

(Feynuus, first-generation, female, London)

Nadifa: I have lots of pain whole my life so far. Going to the toilet is painful, period is painful, I never feel good in night time with husband (sex with husband), had complication at the time deliver my first and second kids. I know why I'm always in pain. I know, because FGM. FGM gave me pain, FGM took away lots of things from me. Do you know I mean? (She cried and was emotional).

(Nadifa, first-generation, female, London)

Sixteen first-generation female participants (seven in London and nine in Manchester) responded that they were circumcised at their home or a neighbour's home. This suggests that it was the norm for the practice to be undertaken in an unsanitary area, in addition to being undertaken by someone who was not a medical practitioner; this is likely to be a contributory factor to the long-term physical issues experienced by females who have undergone FGM not conducted by medical professionals. Furthermore, as Nadifa mentioned, a large number of first-generation females have long-term issues caused by FGM that in many cases must be dealt with for their entire lives. Much of the FGM literature focuses on the health impacts of the procedure (see Chapter 3) and what this means for health professionals in countries such as the UK where there is low FGM prevalence. Such research is, by its very nature, somewhat clinical and removed from the visceral experiences and emotions of the women involved. The quotes from Feynuus and Nadifa really express the horrendous and ongoing

physical and emotional pain of what happened. In both cases this was a number of decades ago; Feynuus was over 50 and Nadifa was in her 30s when I interviewed them.

Two first-generation female participants in London however responded that they were circumcised in a clinic in Somalia. For example, Ayanna explained,

> *Ayanna: Mum took me to the town in the morning. She didn't say much, but I knew what was going to happen to me.*
>
> *Mina: Where did your mum take you? Someone's house?*
>
> *Ayanna: No, mine was done in the clinic. The clinic was in the town.*
>
> *Mina: Oh OK, I believe a doctor circumcised you?*
>
> *Ayanna: Yes a surgeon did mine. I know lots of girls were taken to friends' houses or did it at their house, by a random lady who wasn't even a doctor or nurse.*
>
> *Mina: Do you know why yours was done at a clinic instead of at someone's home?*
>
> *Ayanna: Not sure why, but I'm sure someone told my mum, it's possible to do it (FGM) at the clinic. I'm glad mine was done at the clinic. Lots safer than doing it at home.*
>
> *(Later in interview)*
>
> *One girl I know, she had the same one done (Type 1 of FGM) that I had done. But hers was done at her house, so even though only a small cut she was always in pain, hers was a lot worse than*

mine.

(Ayanna, first-generation, female, London)

There are organisations, including international NGOs, and movements in countries where FGM is still widely practised such as Somalia, which provide clear information about FGM including the health issues caused by the practice and providing support to women who have experienced FGM (Toubia and Sharief, 2003). Furthermore, after learning more about the negative implications and consequences of FGM, some people also began to consider practising FGM in medical clinics and having the practice undertaken by medical professionals to minimise the risk of any complications, provide appropriate support during the procedure, and reduce the risk of the spreading of infections or disease (FORWARD, 2007; Lunde and Sagbakken, 2014; Powell and Yussuf, 2018).

As mentioned earlier, the former Somali regime openly supported various projects against FGM. In the late 1970s, the practice was banned in hospitals, and a total abandonment strategy was targeted in 1988 until the regime collapsed in 1991 (Gele et al., 2013). Medicalisation of FGM continues to rise in many countries, including Somalia, even though there is a legislation against FGM in the countries (Shell-Duncan et al. 2017). Shell-Duncan et al. (2017) noted that the circumcision of girls by medical staff and using medical equipment has also been growing in Somaliland. This movement towards medicalisation may have affected first generation females, including those two first-generation female participants who were circumcised at the clinic.

3.2. Location where second-generation female participants underwent FGM

The most common way second-generation migrant girls undergo FGM is through their parents or other relatives taking them abroad, particularly to their country of origin, where a suitable practitioner can be found. This is often done during the school holidays so the girls have adequate time to recover before starting school again, and more importantly, it is easier for the practice to be undertaken without anyone outside of the family and community suspecting anything untoward (Kaplan-Marcusán et al., 2010).

Eight second-generation female participants had undergone FGM in Somalia during their school holidays, and only one second-generation female participant in Manchester reported that she was cut inside of the UK. This pattern is unsurprising give the illegality of FGM within the UK (Hodes and Beale, 2016; Plugge et al., 2019).

Three second-generation female participants, one based in London and two in Manchester, told me that they were cut at someone's home and a practitioner came there to undertake the practice. All three participants believe that the practitioner was not a medical professional, but that the practitioner used something like an anaesthetic or painkiller during and after circumcision. In contrast, six second-generation female participants that had undergone FGM did so at a clinic in Somalia. For example, Nafira described her experience:

Nafira: Mine was done at a clinic in Mogadishu. I know mum wanted it to be done in the best conditions for us (her and her older sister). I'm still not happy with what happened to me, but I'm lucky mine was done in a clinic. Less pain and less complications like my mum had.

Mina: Was your practitioner a doctor?

Nafira: Yes, he was a medical doctor in Somalia, he used anaesthesia and everything was properly disinfected. Still not nice, but at least mine was done by a doctor. I could even take pain killers and other medicine after the FGM, I was treated properly.

(Nafira, second-generation, female, Manchester)

Nafira still disagreed with what happened to her and was concerned by her mother's and grandmother's decision. She however also commented on the conditions under which she underwent FGM. Having the practice undertaken by a medical professional seemed to make her feel less frustrated by what happened to her, and allayed some of the concerns she may have had about any longer-lasting physical issues. Moreover, she may even feel less anger or frustration towards the family members who made the decision to have her cut given the way in which the practice was undertaken. Leye et al. (2019) pointed out that one of the most important reasons people are shifting into medicalisation is that it reduces the health risks and pain. They strongly argued, however, that medicalisation only focuses on health risks and does not consider the mental

health implications due to traumatic experiences which may affect girls for the long term in their lives.

> *Muna: Mine was only a small cut, not the traditional type.*
>
> *(Later in interview)*
>
> *Mum was with me (inside of the room at the clinic), and she was looking and told the doctor that's it, it's enough, don't cut anymore. She just wanted to make sure the doctor didn't cut too much.*
>
> *(Later in interview)*
>
> *I know traditional FGM is sunna (Type 3), I'm lucky mine was not sunna, I'm lucky mine was done in the clinic. It's safer and better.*
>
> *(Muna, second-generation, female, London)*

> *Mina: I know you have children. Do you think your FGM gave you any extra pain or complications during child birth?*
>
> *Faduma: I didn't have any complications. I know my auntie had lots of complications when delivering my cousins, but I didn't have any. Maybe because I didn't have same one as my auntie (her auntie underwent Type 3 FGM), or because mine was done by a doctor maybe, I don't know.*
>
> *(Faduma, second-generation, female, Manchester)*

Muna and Faduma's responses suggest that having the practice undertaken at a clinic by a medical professional and experiencing a milder type possibly reduced

their anxiety around undergoing FGM and led them to think that their experiences were better than undergoing FGM by a traditional practitioner. Moreover, a large number of second-generation female participants, including Nafira, Muna and Faduma, mentioned that they believed that their life had not been significantly negatively impacted so far by having the practice undertaken on them as a medical doctor had conducted the procedure (see Shell-Duncan, 2001; Berg et al., 2014b for discussion of the diversity of impacts of FGM).

As large numbers of first-generation female participants noted, the most painful and difficult times for them in relation to the impact of FGM were their wedding night, both in terms of opening their genitals and having sex with their husband, and delivering their children. I would like to note that only two second-generation female participants that had experienced FGM were married and have children of their own, and the most common form of FGM is milder type (Type 1 and 2) for second-generation female participants. As such, there is only a small sample of data in relation to the physical impact of sex and childbirth among second-generation female participants. Based on this small sample size however, it would seem that FGM had a significantly smaller physical impact on second-generation participants compared with first-generation female participants, who experienced FGM at home undertaken by non-medical practitioners; this may again lead to first- and second-generation females thinking that undertaking Type1 FGM, being performed by a medical professional at an appropriate clinic, could be an acceptable approach to the practice.

4. The FGM decision-makers

The most common age for Somali background females to have FGM practised on them is between four and eleven years old (Ali, 2008). At this age, girls are typically unaware of what FGM is and are legally unable to decide whether or not to have FGM practised on them themselves. As such, the key decision-maker in whether or not FGM will be practised on a young girl is typically either the mother, grandmother or another female family member (Abathun et al., 2016).

Decision-makers are responsible for various type of decisions related to FGM, with the most crucial decision of course being whether or not to have FGM carried out at all. Other decisions include type of FGM, which practitioner, when and where will the procedure take place (Abathun et al. 2016: Johnsdotter and Essen, 2016 for examples).

While theoretically, the central question to ascertain whether a participant has experienced FGM was a very simple one, it is of course inappropriate to ask directly. The interviews were semi-structured and as such the question of whether or not the participant had experienced FGM or not was gently worked into the conversation. After identifying whether or not the female participants had undergone FGM, I gently asked further follow-up questions to gather more data on the topic including who made decisions about their FGM. Further details on the interview process, ethics and my positionality can be found in Chapter 4.

4.1. Decision-makers for first-generation female participants

Based on the existing literature (Ali, 2008; Abathun et al., 2016 for example) I expected that the decision-maker for all first-generation female participants would be their grandmother, mother or another female member of the family. While mothers or grandmothers were identified as the decision-maker in ten cases, in another eight cases, the participants identified someone else (see Table 3).

Table 3: FGM decision-maker among first-generation female participants

		Mother/grandmother	Own	Other
1st	London	4	3	2
	Manchester	6	3	0

Created by author

For Canab, it was her mother and grandmother who decided, and she described her experience as follows:

> *Canab: I was around 11, mum and grandma decided. I didn't know they asked lady (practitioner) to come to house. I didn't know who will cut mine, I didn't know when could be my day.*
> *One morning, mum told me "today is your special day". I know FGM will happen to all girls, I was not scared.*
> *She smiled me and stayed with me. She never sat down with me because we are big family, she was always busy cooking, walk to get water. Before lunchtime other girls (lived near her house) came (to her house) with their mum, and we sat together and ate*

food together.

(Later in interview)

Mina: Did you say "I don't want to do it" to your grandmother and mother?

Canab: No, everyone was ignorant, so no one knew any better to refuse it.

(Canab, first-generation, female, London)

Canab's case was common for other first-generation female participants who also responded that the decision to cut was made by their grandmother or mother. All of this group noted that they knew what FGM was despite no one in their family explaining any details of the practice to them. Even though these participants knew what FGM was, and had a high-level understanding of what the process involved and how it would impact them, including the removal of part of their body, they accepted the practice as part of their culture.

Six of the eighteen first-generation female participants in my research that had experienced FGM did, however, claim that it was their decision to have FGM practised on them. For example:

Mina: Who decided?

Khadra: I decided myself, I was seven. The reason I was asking was all the neighbours they had it, when children found it each other, and it's cool, they feel proud.

They said "I had FGM", "I'm a good girl" so I want to also be a good girl. I wanted to be part of that. I didn't know it (what exactly FGM is). Automatically I asked, I want to have it, I want to have it.

(Khadra, first-generation, female, Manchester)

Ayanna: We (herself and her friends) always dreamed our day (when they would undergo FGM).
We know our hair is pretty, do henna and treat me like princess. I wanted to be pretty hair, henna. It's special day for us.
Some girls done (FGM) before me, people (in her community) told me "she is good girl", "she is clean now". Everything they said about her were good. So we wanted to be a good girl. I wanted to be a clean good girl.
(Later in interview)
I asked mum "when I can do it?" "when is my turn?" Everyday. Mum said "sisters (her older sisters) first, not your turn". So I was waiting and waiting and waiting. I even cried and begged mum "I want to do it" "please".

(Ayanna, first-generation, female, London)

Feynuus: ……I know it (FGM), because I have been through it myself
Mina: Oh Ok.

Feynuus: So at a young age I was circumcised it, as my primary years (six years old). So I know.

Mina: Is it difficult for you to talk about what happened that day?

Feynuus: it's not difficult, because I talked about it so many times, so not too difficult for me now. But….I remember I was at school and then no I did not go to school that day…I'm not sure, but I been told that I am going to be doing it.

I didn't like, I used to really thinking, I was not really scared because everybody used to do it. A girls like me used to fun, "oh when I goanna do mine", "oh I'm too young" ***(excited tone of voice)****, and then a lady physically came, and then "oh my god". I can't run away. So I was so scared.*

(Feynuus, first-generation, female, London)

Ayanna and Feynuus's responses show the wider social context within which FGM took place and the importance that was placed on the practice, indicated by public celebrations where the girls were the centre of attention, with hair-styling and the application of henna. Young girls possibly perceived that the day of FGM was a special day and event for them and they looked forward to their day. All first-generation female participants who responded that they made the decision themselves seemed to either be affected by their friends around them and were even looking forward to experiencing FGM. Even though the participants claimed that they made the decision themselves, in reality this was not possible; an adult would have had to make the decision.

Idil: I had it (FGM) when I was twelve years old. I can remember that day like yesterday, It was hard to forget, scared, painful, many, many mixed feeling.

(later in interview)

Who decided? ***(little silence)*** *I say community. Whole community decided. Of course my grandma and mum wanted to, and asked neighbour "who would like to do together", pay money to lady (practitioner), decided when girls should be done.*

I say community decided and grandma and mum planned and organised, do you know the differences?

(Idil, first-generation, female, London)

Idil, is very clear in her view that while it was her grandmother and mother that organised the practice, the decision was likely made due to pressure from the wider community. Some participants who responded that their decision-makers were either their mother, grandmother or themselves also shared Idil's perspectives. They also mentioned that their decision-makers might be affected by the community either directly or indirectly. This community influence will be discussed with more details in the next chapter in the context of social norm theory.

4.2. Decision-makers for second-generation female participants

There is very limited research about who the decision-makers are in relation to

FGM among second-generation females in migrant communities in the UK. Only a few researchers (Norman et al., 2009; Alhassan et al. 2016 for example) have considered this, pointing out that the decision-maker for second-generation females is likely to be similar to that of mainland Somalia where this tends to be the mother, grandmother or another female family member. The data collected following the interviews with the second-generation participants suggests that for the group of nine that have had FGM practised on them, the decision-maker was generally the grandmother or mother (see Table 4).

Table 4: FGM decision-maker among second-generation female participants

	Mother/grandmother	Own	Other
London	4	0	0
Manchester	4	1	0

Created by author

For example, Sabrinah discussed her experience:

> *Sabrinah: Mum took me to Somalia during the summer holiday. She told me we were going to Somalia to see my grandma. I was excited to go, of course, to see my grandma but also I looked forward to the summer holiday. I was packing my stuff, but my brothers and sisters didn't. My mum told me that only me and you go to Somalia.*
>
> *(Later in interview)*
>
> *My grandma organised everything (her FGM). A few days after I arrived, the day came. I didn't know what was going to happen. I*

was confused, scared, worried.

(Later in interview)

I asked my mum why she did it to me, maybe five or six years ago. It was hard for me to talk about it with her, but I just wanted to know why. Why I needed to get it, what she thought and what she felt.

(Later in interview)

I believe (short pause) grandma decided, I know my mum couldn't go against my grandma. I know my grandma is ignorant. She believes FGM should happen to all girls and she still believes this. I told her a few years ago FGM shouldn't keep happening, It's wrong. It doesn't matter what I say, she never listens, she doesn't like any changes, anything even though it's wrong,

(Sabrinah, second-generation, female, London)

For the practice of FGM to be undertaken, Sabrinah also mentioned that both the grandmother and mother should be in agreement for the child to be circumcised, with the family agreeing on details of the practice including the type of FGM that will be undertaken, who the practitioner will be and where the practice will be carried out. However, it became apparent during the interviews undertaken that some first-generation participants disagreed with their mother over the practice of FGM on their daughter. Through individual interviews, all grandmothers of second-generation participants who were circumcised who live in Somalia do not disagree with FGM and it seems as if they strongly believed that FGM should be

continued for further generations.

Johansen (2017) pointed out that even though FGM is not accepted by a host country's society, and even where there is no social pressure from the host country's society, there is still social pressure from within the migrant communities of the host countries. Furthermore, key decision-makers in determining whether or not FGM will be practised on young girls are typically either their mother or grandmother. While the mother has settled into her new adopted country, where there is less social pressure for young girls to be circumcised, other decision-makers, such as their grandmother, may still be living in their country of origin where there remains deeply-rooted social pressure for girls to be circumcised. Hence the importance of ongoing transnational links. This point will be discussed more in the next chapter.

Several of the participants interviewed, from both the first and second generations, discussed the disagreements about FGM between their grandmother and mother to demonstrate this point.

> Seynab: *I took all my daughters to the clinic in Somaliland on the summer holiday. Everyone did it, my sister, my cousins. All took girls to same clinic... Gudniin (FGM in Somali language) is our tradition.*
>
> *Mina: Why did you decided to take your daughters?*
>
> Seynab: *Gudniin was normal. I needed to…mum said all girls should do no matter where we live. I didn't have choice, whatever*

mum said I couldn't say no.

(Seynab, first-generation, female, Manchester)

Seynab provides a good example of who the real decision-maker often is. She seemed to disagree with her mother over the decision to have her daughter cut, and appeared to have feelings of hesitation about FGM, which is often shared with other first-generation female participants whose daughters have been cut. However, as Rima (1999) noted, one important aspect of Somali culture is to respect the views and opinions of the elderly (such as parents and grandparents). This appears not only inside of Somali society, but also inside of the migrant communities. This cultural obligation to respect the views of the elderly could possibly lead to situations where second-generation females are circumcised even though the first-generation mother is against, or hesitant about, the practice of FGM. There is a strong tendency for the core decision in relation to whether or not to practise FGM on a second-generation female to be ultimately driven by the grandmother's views on the subject. The decision around the type of FGM to then be undertaken however seems to be a more collective decision following discussions between the grandmother and mother.

Ubax: Yes, it happened to me. I think I was six. My grandma wanted me to be done (FGM), but mum was against it. I know mum tried to talk with grandma to protect me, but grandma didn't change her mind. I think grandma organised my FGM with Sunna (Type 3), but mum told grandma "only the Islamic way", "only a

small snip".

It was kind of mum to try her best, but I still had it done, I was circumcised.

(Ubax, second-generation, female, London)

If the grandmother is satisfied that the first-generation mother is in agreement with the core decision for her second-generation daughter to undergo FGM, the grandmother may concede the type of FGM and be content with a lighter form of FGM. Second-generation participants' grandmothers are often still living in Somalia, and as such, may face wider social pressure from the community around the decision of whether or not her granddaughter should have FGM practised on her or not. As such, social pressure from the community could also be considered to contribute to the decision-making process.

All eleven second-generation female participants who did not experience FGM explained that they avoided being cut as their grandmother and mother were against the practice. All of them responded that they are not sure why their mother and/or grandmother decided that they would not be circumcised, but several reasons have been identified by researchers: A large number of first-generation females often receive negative information about FGM after settling into their host country, including the knowledge that FGM is an illegal practice in many countries and how FGM affects women's health (Powell and Yussuf, 2018). Furthermore, Gele et al. (2013) mentioned that there are some campaigns against FGM in the mainland of Somalia, and some women decided not to continue FGM for further

generations of girls. Receiving knowledge about FGM either after migration into the new country or inside of Somalia may be reasons why more than half of second-generation female participants did not experience FGM.

Through discussion with second-generation female participants who underwent FGM. Only one participant, Sucidi, a participant based in Manchester, responded that she made the decision for herself.

> *Sucidi: I have two older sisters, my second sister is my like hero. She is so popular and everyone likes her, she is kind and beautiful. I like her lots and I always want to do same as her, same clothes, same make up – I just want to be her (laughs)*
> *We are a big family, so she (her second sister) took care of me when I was little.*
> *(Later in interview)*
> *Both of my sisters (sisters older than participant) were circumcised. Somehow I found out my sister was going to Somalia with my mum during the school holidays. I kind of knew the purpose for her going to Somalia. I don't know why, but I remember I begged my mum to take me as well in the kitchen.*
>
> *(Sucidi, second-generation, female, Manchester)*

Sucidi was seven years old at the time she visited Somalia. At this time, it seemed that she already recognised FGM as part of Somali traditions, even though she was not fully aware of what the practice entailed. She explained that

the reason she decided to be circumcised was because of her strong feeling to be more like her older sister.

The area she was living in did not have a large Somali community, and she did not have close friends of a similar age in the area. As such, she spent most of her time with her older sisters, particularly the second oldest sister in the family. Sucidi's living environment and limited friendships may have led to her experience of FGM being very similar to that of first-generation female participants in that the reason for her making the decision to be circumcised was due to a strong desire to be same as her peers. Sucidi's case does however appear to be a very rare one when considered with the other second-generation participants; had she had similar aged friends in the area she was living she may not have asked her mother to take her to Somalia. Regardless of whether or not Sucidi made the trip to Somalia at a young age as she did, she would have been at risk of the practice of FGM; she may have made the trip at a later age for example and been cut at that point, and this could have been a decision taken by her, her grandmother or her mother. Even though it would seem that Sucidi didn't say which type of FGM she wanted to experience, she mentioned that she wanted to undergo the practice and have the same as her sister. While Sucidi implied that she made the decision to be cut, she did not really make the decision herself. The real decision-makers were the social context within which she was living and the adults who took her to Somalia and arranged the procedure.

5. Discussion

The chapter has used the words of my female participants to place their experiences of FGM at the heart of the discussion; as a human rights violation against women and girls, it is important to remember the individual experiences and long-term impacts that FGM can involve. As the conceptual framework outlined in Chapter 3 presented, while the individual is at the centre of the discussion, decisions about FGM are made not by them (despite some of my respondents claiming that they made the decision to be cut), but by family members in accordance with the perceived values of the community. For first-generation women, the decisions about their FGM, the type and location, was made in Somali/ Somaliland where Type FGM was seen as normal and expected as a key part of being Somali. The lack of legislation against FGM also provided the national context within which FGM decisions were made about the first-generation women in my sample.

The experiences of second-generation Somali women, usually born in the UK and certainly brought up in the UK from a very early age, demonstrate significant differences. Firstly, far fewer women had undergone FGM, and for those that had, they tended to have experienced a milder form of FGM and were more likely to have been cut by a medical professional in a clinic. The contrast from the first generation's experience can be attributed at one level to settlement in the UK, a country with legislation against FGM, so different structural factors to Somalia/ Somaliland, as well as different societal expectations regarding gender equality. However, the narratives in this chapter demonstrate how, despite living in the UK,

ongoing attachment to Somali culture and a strong Somali identity, as well as transnational relationships meant that for some women, FGM was still seen as desirable. However, in the overlap between the national space of the UK and the transnational space of Somali family and friends, a shift to milder forms of FGM under medical supervision, was the usual outcome. In the next chapter, I examine in more detail the reasons underpinning changes in FGM as a social norm between first- and second-generation migrants.

6. **Conclusion**

This chapter has considered how experiences of FGM change (or not) between generations, and also the diversity within generations. The number of women who were circumcised reduces between generations. Furthermore, it was also clear that the type of FGM being undertaken had changed between generations from Type 3 to Types 1 or 2.

The second finding from my analysis is in relation to where FGM was undertaken and who the practitioners were. My data suggests that the place where first- and second-generation female participants underwent FGM has been changing towards the use of safer options such as clinics. Given that younger generations are now undergoing less-damaging forms of FGM, and are having this done by medical practitioners in medical clinics the anxiety around the practice seems to have decreased amongst some second-generation migrants. As researchers (Shell-Duncan, et al., 2017; Leye et al., 2019, for example) insisted, my data also

shows FGM is now being medicalised in Somali migrant communities in the UK. This shifting to safer options of circumcision could have a damaging impact on the battle against the future eradication of the practice if this is now seen as a compromise, with the practice undertaken in this manner potentially becoming more accepted. Importantly, this milder type of FGM may be accepted by some second-generation female participants as it has a much smaller impact when compared to the more severe type of FGM that their mothers were underwent. There is still significant pressure from the Somali community towards some second-generation female participants, both directly and indirectly via their grandmother and mother, as such there remains the risk that some second-generation female participants may decide to continue the practice of FGM for further generations. Continuing to adopt milder types of FGM, such as that some second-generation female participants themselves underwent, may be seen as a way to dissipate the pressure.

The third finding from my analysis was in relation to the decision-makers of FGM for both generations. While the main decision-makers for second-generation female participants were their mother and/or grandmother, both the grandmother and mother should agree for the child to be circumcised. Despite decisions being supposedly made by individuals, these decisions are informed by social norms and sometimes overt pressure from family and community members. Having laid out the patterns of FGM in this chapter, Chapter 6 turns to explore in more detail the reasons behind continued, adapted or eradicated practices of FGM as part of the migration process.

Chapter 6: Social Norms, Attitudes and Experiences of FGM

1. Introduction

In Chapter 5, I showed the shifts to less severe types of FGM and overall lower prevalence rates of FGM between the generation born and brought up in Somalia/ Somaliland and the generation brought up in the UK. This chapter explores the factors lying behind these changes, drawing on social norms theory, and debates around how norms travel with migration, or are reshaped in a new home country. It considers how ongoing transnational links with family and friends in Somalia/ Somaliland contribute to the decisions about FGM in the UK.

2. FGM as a social norm in Somalia when first-generation women were circumcised

As discussed in the previous chapter almost all first-generation female participants in my study had been cut. In the interviews, once I had found out whether they had been cut or not, I tried to expand our conversation to the reasons they thought lay behind their situation. For example, Canab drew on notions of tradition:

> *Canab: Why? Why we were cut? Because FGM is our tradition. Something we all done. Everyone, all girls were done. Can't tell you one reason. I think, I think many reasons. FGM is part of us. But I may tell you one reason. Needed to show how good girl I am to everyone (other community members).*

Mina: Good girl? What is a good girl?

Canab: We must be clean, good girl. Must show I'm pure. Pure is an indicator for men to find wife. We have to be chosen by them.

Mina: If you are not pure, what happen?

Canab: Means family are damaged, crashed, we all be in a trouble.

(Canab, first-generation, female, London)

As a first step in considering reasons why first-generation female participants had experienced FGM, all of the first-generation female participants who were cut said that the practice of FGM was seen as a normal and expected life event for girls in Somalia. As Canab said 'FGM is part of us'. The prevalence of FGM was very high in the mainland of Somalia, especially at the time the first-generation women were children. For many women the normality of the practice meant that they found it difficult to go beyond claims that the reason for FGM was tradition. When I tried to extend conversations, they also mentioned other themes as in the conversation with Canab; being a good girl, having to be pure and having to protect the family honour.

Through conversation with Canab being a good girl emerged as a significantly important concept for the family. Canab's response was shared with other first-generation female participants, and they also mentioned the concept of the good girl or good Somali. This concept of being a good girl or good Somali is an

example of how women's behaviour, such as being a virgin until their marriage, is an important indicator of family honour. FGM, particularly Type 3, was seen as definitive proof of virginity as Nawaal explained:

Nawaal: Traditional FGM (Type 3) is the popular, normal way we were done. Because mine (her genitals) was closed, easy to tell I'm clean, I'm a good girl.

(Later in the interview)

Everyone (all her friends) talk together, when we can be a good girl. When is our day to be celebrate we (herself and her friends) were at the parties (her older sister's celebration for FGM), we all had a dream to be celebrated. All girls felt the same I believe.

(Nawaal, first-generation, female, Manchester)

We all done Pharaoh one (Type 3 FGM). Not any other way, we didn't have any choice to select, only Pharaoh. Girls have to be virgin and I had to show it the time I married. If I couldn't show I'm a good girl, my husband didn't marry I believe. If I wasn't a virgin, my parents were in trouble, big big trouble.

(Sagal, first-generation, female, Manchester)

Awo: Yes, family honour is something we need to protect, we can't lose.

Mina: What is family honour? Why do you need to protect it?

Awo: Family honour is I think recognition how good daughters

we have. Show people (in the community) how good girls my daughters are. We probably need to advertise them into whole community our girls are good girls, good Somalis and they will be a good wife.

(Awo, first-generation, female, Manchester)

Proving a daughter's virginity is seen as crucial for the whole family inside of their community, in order not only for the daughters to enter into a good marriage, but also so that parents are recognised as good parents by other community members (Denison et al., 2009). The role of the physical appearance of Type 3 FGM is clear from the participants' responses. Having Type 3 FGM can be used '*to show it the time I married. If I couldn't show I'm a good girl, my husband didn't marry I believe'* (Sagal). For Nawaal, her FGM is a physical marker of her moral standing: '*Because mine (her genitals) was closed, easy to tell I'm clean, I'm a good girl'.*

To prove a daughter's virginity is deeply connected to the family's honour. A family's honour is often connected to its social standing within the wider community in some countries, including Somalia. It is seen by each family as very important to maintain its family honour and receive the associated respect from other families within the community. The concept of family honour is largely believed to be connected to the young female members of the family, with their actions and appearance scrutinised by the wider community, and with them being protected by the male members of the family (Dyer, 2015).

In the quotations above, the participants are very clear in stating that the decisions about whether they should be cut was made by family members, particularly mothers, in order to meet community expectations. Sagal outlines the implications for her family if she wasn't seen to be a virgin on her wedding day: '*If I wasn't a virgin, my parents were in trouble, big, big trouble'.* This trouble would be the shame of not being able to control a daughter's sexuality, and the longer-term implications of not being able to make a good marriage match. Awo's phrase *'advertise them* [cut daughters] *into whole community'*, really highlights the need for public recognition that girls have undergone FGM.

There are many things that are viewed as being damaging to a family's honour. Examples inside of Somalia are where one's daughter has a pre-marital sexual relationship or if it transpires that a bride is not a virgin on her wedding night. If one of the family members, usually a daughter, damages the family honour, other family members (usually male family members) have to act to recover their honour. In extreme cases this can include honour killings which typically take the form of either a girl being killed by family members or being forced to commit suicide to protect the family honour due to having had sex before marriage (Okahisa, 2008). Honour killing remains part of the culture and the tradition in some countries in the Middle East, North-East Africa and Asia, including Somalia (Grisham, 2020).

All male and female first-generation participants agreed how important the

concept of family honour was for them in the mainland of Somalia.

> *Taifa: Mum responsible all of our girls. What we do, where we go. And yes FGM. Mum had to make sure all of us were cut. Made sure all of us are a good girls.*
>
> *(Later on the interview)*
>
> *If any of daughter was not cut, people (around her mother) may say she is lazy mother. Not good person, not good parents. Maybe she felt pressure (from other people in her community), has to done all girls, have to be a good mother, all girls have to be a good girl.*
>
> *(Taifa, first-generation, female, London)*

In Taifa's interview the link between a daughter's body and community judgements about parental, particularly maternal, morals comes through. Her mother would have been seen as a *'lazy mother*' i.e. a mother who is not behaving in the correct way, and this would put her in the category of '*not good person*'. This resonates with Sagal's quote earlier about the trouble that her parents would have been in if she had not been cut.

Four first-generation female participants were however circumcised with the less severe type of FGM (either Type 1 or 2). As I explained in the previous chapter, all four participants explained that they avoided Type 3 FGM because of the dissenting views of a family member. However they do not know clear reasons why their family members disagreed. Fatima, a first-generation female participant

in Manchester did mention that her mother was talking about a campaign against FGM in the mainland of Somalia before and this campaign could have affected her mother's decision about Fatima's FGM.

Campaigns against FGM have been going on for about fifty years in Somalia with some variations over time. Beginning in the 1970s, the former Somali regime openly opposed FGM and they supported various campaigns against FGM (Gele et al., 2013). The primary goals of the campaigns were shifting the form of FGM (from traditional Type 3 to a less drastic type, particularly Type 1). These awareness campaigns against FGM started in the early 1980s but ended due to the regime's collapse in 1991. These various campaigns may have affected first-generation female's decision makers.

I was interested in how other community members reacted when they found out these four first-generation female participants had experienced a less severe form of FGM. Given the social pressure and expectations about cutting at the time, the decision to go against these norms was unusual.

> *Mina: Did anyone ask you or your mum if you experienced FGM?*
>
> *Fatima: Yes people (in the community) asked.*
>
> *Mina: What did you response?*
>
> *Fatima: People didn't ask me. They asked to mum. Then she told...she said my girls were done. They were clean, they were circumcised. That's it. She didn't tell we were not cut same type*

of others.

Mina: People didn't ask which type?

Fatima: I don't think they ask. They maybe (people in the community) cared we were cut or not. Maybe they think we were all done pharaoh type (Type 3).

(Fatima, first-generation, female, Manchester)

Other first-generation female participants who had experienced Type 1 or 2 FGM mentioned similar situations: it was important that community members knew participants were circumcised, but they did not ask for any further information including the type of FGM. This may have been because Type 3 was so widespread that it was assumed that if a girl had been cut it would be Type 3. Alternatively, it may have been that it was the act of cutting that was more important than the type. I asked Fatima if she had experienced any issues before she got married due not having Type 3 FGM. She explained that her husband did not care about which type of FGM she had. She believes, however, that her daily behaviour was the subject of scrutiny by her husband's family members, including questioning her neighbours. Asking her neighbours about her daily activities could help reassure her mother-in-law that she is a virgin even though she was not circumcised with Type 3 FGM. Public recognition of her acceptable social behaviour as a good Somali girl and not damaging her family honour inside of her community could be enough for her to marry her husband.

Powell and Yussuf (2018) pointed out that main decision-makers of FGM are

mothers or grandmothers, and this was the case in my study as outlined in the previous chapter. Six first-generation female participants responded that the decision to be cut was their own. All six of them, however, were circumcised at a young age (for example, Khadra was seven years old). Norman et al. (2009) explained that there are widely-whispered positive messages of FGM to girls inside of the community such as the claim that underdoing FGM is important for girls to be classified as 'good girls'.

Khadra's quotation in the previous chapter showed how much she was looking forward her day of circumcision; some interviewees discussed how, before it happened, the public celebrations and the positive discourses around FGM strongly influenced their desire to participate, even though it was an adult family member who would make the decision. On the day that they were cut, girls were the centre of attention wearing pretty clothes, having their hair styled and doing henna. Organising a celebration of FGM for girls and spreading the positive image of FGM, rather than providing details of the procedure itself, are parts of socialisation (Morgan, 2015). These practices not only helped young girls to accept circumcision, but in some cases made them look forward to the day and make claims that they wanted to participate.

Khadra, described the excitement she felt on the day her sister was cut because of the party that was held to celebrate the occasion:

Khadra: I can't remember when I knew FGM first time. Somehow, I knew. Maybe someone talked about it. I talked

with friends when will be our day. We were all excited.

Mina; Why you were excited?

Khadra: I was at the celebration party for my sister (her older sister). There was good meal, everyone smiled, we sang a song, lots of fun.

Mina: Your sister also enjoyed?

Khadra: ***(little silence)*** *She was* ***(little silence)*** *she was there (in the room), she was smiling but lying down or sat down. I was just enjoyed the day and didn't think about her (her sister).*

(Later in interview)

All of us (her and her friends) were waiting our day. We were talking what colour of dress we want to wear. We were all waited our day.

(Khadra, first-generation, female, Manchester)

When asked about who had made the decision about circumcision, Khadra responded that she had decided herself. Her description of the excitement around her sister's party, the clothing, the food and the change from the usual daily life, really expresses why a young girl would want to do this. Six of the first-generation female participants said that they had made the decision themselves, but in all cases, while they may have looked forward to the day, as they were all children, the decision would have actually been made by an adult family member. The public displays of what FGM involves also hides the physical pain and potential

psychological impacts. These are hinted at in Khadra's acknowledgement of her sister's behaviour at the party, and also expressed in Feynuus' discussion. She is a first-generation female in London who responded that she decided to be circumcised herself.

> *Feynuus: I run away and climbed onto the tree. I was not scared the day (her day to be circumcised). Everyone got through, all my sisters, friends have done. That's why I was not scared at all. But lady (the practitioner) came and I started shaking. I knew what she would do, I know what will happen to me. Automatically I thought I have to hide, and I run away. Of course mum found me quickly, she told me "come back here", "why you are on the tree". But I didn't want to move. I don't know how long I was on the tree, I wished the lady was gone. Mum tried to calm me down. She told me nothing you need to worry, just come here I can hold you.*
>
> *(Feynuus, first-generation, female, London)*

Feynuus explained that she was looking forward to experiencing FGM due to sharing the experience with her friends around her and that her sisters had been cut; she wanted to be same as everyone else. Despite saying that she had made the decision to be cut, in reality, this was not the case. She may have looked forward to it, but as the moment came nearer she ran away and climbed a tree to avoid it. However, her mother intervened, calmed her down and she was cut. Feynuus's story shows that she did not have a choice about being circumcised;

her mother was adamant that it would take place to fit in with community expectations.

Idil, the first-generation female participant in London, explained her very clear view that the decision was made due to pressure from the wider community. Some participants who responded that their decision-makers were either mother, grandmother or themselves also shared this belief.

3. **Justification for FGM experienced by second-generation women**

As discussed in the previous chapter, nine second-generation female participants were circumcised (eight experienced Type 1 FGM, and one participant Type 3). This section will considered the factors lying behind the cutting of second-generation women. To expand the sample size for second-generation female's experiences of FGM, I asked all first-generation female participants whether their daughters were circumcised or not. If their daughters were cut, I also asked which types of FGM they had experienced.

Sixteen out of twenty first-generation female participants responded that at least one of their daughters was cut. The other four participants responded as follows; two of them responded that none of their daughters were cut, and the other two participants do not have a daughter. Fourteen out of sixteen first-generation female participants responded that all of their daughters were circumcised, while one participant explained that her younger daughters had not undergone FGM,

and the other one responded that her younger daughters were circumcised with a less severe type of FGM (her older daughters was circumcised Type 2 FGM).

The ongoing link to the norms in the parental home community is very clearly demonstrated by Nafira's account of her experience of FGM:

> *Nafira:… I understood she (her mother) didn't have any other choices. It's normal in Somalia, It's normal where she came from.*
>
> *(Later in interview)*
>
> *Everyone (her mother and people around her) were ignorant, hard to say no, she (her mother) couldn't against the whole community, the whole family.*
>
> *(later in interview)*
>
> *They (her parents) want to be Somali, don't want to lose their soul. Religion, culture, life, memories, everything remind them Somalia, FGM is the part of it, they don't want to lose.*
>
> *(Nafira, second-generation, female, Manchester)*

FGM was considered as a normal practice for Nafira's mother, especially at the time she was circumcised. Almost all second-generation female participants who were circumcised shared this point of view, and they often used phrases such as "they were ignorant" to explain the reason why they were circumcised, implicitly contrasting the attitudes of their parents and grandparents in Somalia, with their own 'enlightened' views about FGM and the context of the UK. Their responses

may show that organising FGM for second-generation daughters was an expected and normal event for some first-generation mothers, just as their own circumcision had been in Somalia. Nafira's family felt a strong preference to keep their Somali ways after migration into the UK, and she believed that FGM is an important dimension of Somali practices and traditions which feed into maintaining their Somali identity.

Straus et al. (2009) argued that first-generation migrants often have a strong preference for their children to maintain the traditions, language, religion and lifestyle of the parental country of origin even though they were born and raised in Europe. This could include a preference for the continued practice of FGM among future generations. As the decision-maker about FGM for the second-generation females is often their mother, who is first generation, the influence of social norms framed by the country of origin is very important in the decisions regarding FGM among girls born in the UK.

Maintenance of pre-migration norms may be a result of feelings of segregation. Kuijpers (2016) said that first-generation migrants often feel that they are not accepted by locals in their adopted country, and as a result often stick to communities formed of people from the same ethnic group as their country of origin (see Chapter 2 for discussion of Somali migration to the UK). This commonly leads to first-generation migrants having a strong desire to keep their country of origin's lifestyle, culture and traditions instead of adapting their lifestyle and thoughts to be more in fitting with the country they have settled into (Phinney

et al., 2001; Okahisa, 2008).

The vast majority (32 of the 40) first-generation participants interviewed identified themselves as being Somali, with the remaining eight considering themselves Somali British. During individual interviews with first generation participants, I got the impression that all 32 first-generation participants were making an effort in their daily lives to retain their Somali identity through, for example, language, dress, food and expected behaviour.

Korfa, a first-generation male participant based in London, was very passionate about his feelings towards Somalia. He did however make an interesting comment in suggesting that Somali migrants' identity, and their affinity with Somalia, can reduce after living abroad (in the UK in this instance) for a sustained period:

> *Korfa: All my life, I'm always Somali, no matter where I've lived. Since all my friends were always Somali. So, you didn't lose any part of your Somali culture.*
>
> *(Later in interview)*
>
> *All my friends were only ever Somali. You can only lose your language or culture if you begin making friends of other cultures.*
>
> *(Korfa, first-generation, male, London)*

Korfa very much gave the impression that building and maintaining friendships only with others of a Somali background has, in his view, a positive impact on his

daily life and helps him to retain his Somali identity. Conversely, making friends with people of a non-Somali background could have a negative impact on his own Somali culture and language, which may lead to him to losing his Somali identity. Interestingly, all 32 first-generation participants who identified themselves as being Somali spend time inside of the Somali community areas with others of a Somali background every day. During my visit to the community centres, I would regularly see these participants socialising with their friends of a Somali background throughout the day. It may be that a large number of first-generation participants who I met through my field research only spend time inside of the local community areas, and socialise only with others of a Somali background.

There are opportunities for them to meet with people of a different background in their local areas if they wished to, for example meeting with people of other ethnic backgrounds through their children, making friends with neighbours etc. A large number of this population, however, do not actively communicate with people of a different ethnic background; some, it would seem, even minimise or avoid these opportunities to meet and build relationships with people of a different background in their daily lives. This attitude of first-generation participants may be because they have a strong desire to not lose their Somali identities by communicating with people of a non-Somali background.

I also would like to mentioned conversation with Balqis, a first-generation female participant in Manchester. During the interview she said:

Balqis: I took all my girls to Somalia on the summer vacation. All were done in the clinic, not at home we used to do. It's safer, I wanted to do the best for them all.

(Later in interview)

Balqis: Why I done it to girls (she stopped talking) I took them (her daughters) because they are Somali. All of us done, FGM is from ancient Egypt, it's part of us, always. I'm not in Somalia, but I'm Somali. I have to do everything local Somali do. I responsible for girls to be Somali, not treat them like local English girls.

(Balqis, first-generation, female, Manchester)

Balqis' discussion clearly demonstrates how FGM is seen as a fundamental part of being Somali; '*it's part of us always'*. Despite no longer being in Somalia, and her daughters being born outside the country, the distance does not reduce this fundamental identity in her mind: '*I'm not in Somalia, but I'm Somali. I have to do everything local Somali do. I responsible for girls to be Somali, not treat them like local English girls.* Hence the decision to have her daughters cut. This both contributes to their Somali identity and continues what she sees are core traditions. This feeling is possibly shared with other first-generation females, explaining why FGM was practised on some second-generation women.

Gele et al. (2012) noted a change in the social pressures faced between one's country of origin and a migrant's new adopted country. They noted that the

practice of FGM in migrant communities, including Somali migrant communities, in Norway could be reducing, so lessening the number of girls who are at risk of FGM. The main driver for this is that in Norway there is no longer the social pressure that perpetuated the practice. However, while the pressure and expectations from family and community members within the host country were different from those in Somalia, the continuance of social relationships, including family relationships, between the UK and Somalia, complicated the idea of a simple break with previous practices after migration. This transnational social pressure was discussed by Sagal:

Mina: So you organised FGM to all of your daughters?

Sagal: (Silence) Yes, I took all to the clinic.

Mina: Girls were done at the clinic? Is it in Somalia?

Sagal: Now we can do (FGM) at the clinic. Doctors do. It's safer, clean and less pain. Old lady (traditional practitioner) cut mine. It was lots of pain. I am happy girls could do at the clinics.

(Later in the interview)

Sagal: All girls (her daughters) were cut, long time ago. Last one was cut maybe over ten -fifteen years ago. Every girls were done. One day mum called me and asked me when. I told this summer. That's all I said. She (her mother in mainland of Somalia) set up all. I flew to home with my girls, that all I had done. I didn't say anything. No, I said should do at the clinic, and not same of mine (she was circumcised Type 3 FGM). She (her mother) said OK.

(Later in the interview)

Mina: You never think you don't want your daughters are circumcised?

Sagal: No. I may thought differently, if sister says something, she won't do her girls, maybe. But I didn't have choice, everyone done. It was normal our tradition.

(Sagal, first-generation, female, Manchester)

From the conversation with Sagal, it shows that there was an assumption that her daughters would be cut; in other words, there was no discussion either with the circumcised daughter or between the mother who is in the UK and grandmother who is in the mainland of Somalia. Even though Sagal did not explicitly mention any pressure she felt from her mother to circumcise her daughters, the phrase '*I didn't have choice, everyone done. It was normal our tradition*' clearly expresses her feelings of hopelessness in challenging the decision. She did, however, choose where and with what type her daughters were circumcised.

The concept of the real main decision-maker and pressure from a grandmother who is living in the mainland of Somalia could be supported by a conversation with Nadifa, a first generation female participant in London.

Nadifa: I just didn't have choice. FGM was normal for us, my mum was told by her mum, I was told by my mum. It was normal thing for us.

Mina: So you didn't know that FGM was illegal in the UK at that time?

Nadifa: I kinds of know, not too sure but I knew British doesn't do it. I called mum about it, but she said you are not British, we are Somali. Your daughters are also Somali. We should do it to them. I just didn't have choice, I couldn't against mum.

(Nadifa, first-generation, female, London)

Nadifa seemed to know that FGM is an illegal practice in the UK. However, her mother did not give her the choice of not circumcising her daughter. Both the actual practice of FGM and the act of organising the practice of FGM are now illegal in the UK (see Chapter 3 for more details). As such, some researchers (Berg and Denison, 2012; Alcarez et al., 2014 for example) insisted that this legislation against FGM could have an impact on the decision some migrants take in relation to their daughter's circumcision. Migrants that have settled in the UK however often take their daughters outside of their newly-adopted home, commonly to their country of origin, for FGM to be undertaken (Powell et al., 2004). Despite the illegality of FGM in the UK, if there is no extradition agreement between the UK and the location where FGM takes place, it is difficult to arrest anyone involved in undertaking the practice abroad. The conversation with Nadifa is an excellent example that legislation against FGM is not a deterrent for some people; the importance of meeting social conventions and therefore upholding tradition and identity, and maintaining family relationships overrides any legal position.

Mesplé-Somps (2016) pointed out that girls who came from abroad to be

circumcised joined the celebration parties or events organised by the community in the mainland of Somalia. Attending these events is because the family have to show which girls are now perceived as clean, ready to be adult and ready to marry. It means the whole community can recognise which girls are circumcised. Second-generation females however do not have these kinds of celebration events. As such, I questioned participants on how people in the community recognise which girls are circumcised or not in Somali communities in the UK. I considered that if there were no recognition by other community members, girls might not need to be cut.

Awo, outlined how this kind of information may be inferred by community members from particular actions:

> *Awo: We kind of know which girls are cut and which girls are not cut.*
>
> *Mina: How do you know? You mentioned never talk with other community members, only your mother, sisters and auntie.*
>
> *Awo: We don't talk (about FGM) but we talk who are going to Somalia. Someone goes to Somalia with daughters, we think she may go to Somalia for, well, FGM. Maybe I'm wrong, but we kind of think. They go to holiday maybe but we think differently, difficult to tell you but we kind of we can find it out.*
>
> *(Later in interview)*
>
> *Awo: Pressure? No, I didn't (feel pressure from community members). I just wanted to do (her daughter are circumcised)*

for her good. I didn't say nothing but I know everyone (in the community) find out anyway.

(Awo, first-generation, female, Manchester)

Awo pointed out that people in the community do not openly talk about which girls will be circumcised, and she did not feel any pressure from other community members regarding her daughter's circumcision. She however still preferred to organise FGM for her daughters – "*for her good*". This is because she strongly knows that other community members eventually find out her daughters were circumcised, and this fact will be positively recognised by other members of the community. She perceived that for the good of her daughter's future – not mentioned, but probably marriage – she decided to have her cut. Awo's response was shared by other first-generation female participants.

4. Changes in FGM type between generations

From the previous chapter, it was clear that the type of FGM being undertaken had changed between generations from the most common type, Type 3, to less severe type (either Type 1 or 2). This section will explore why second-generation participants were circumcised with a less severe type of FGM, and why more than half of second-generation female participants were not cut at all.

As mentioned earlier, there had been ongoing campaigns against the practice of FGM in the mainland of Somalia which were led by international organisations

spreading messages about the negative short- and long-term impacts for women's health. These campaigns possibly affected people in the mainland of Somalia, including first-generation Somali migrants' mothers, and they started to accept FGM of a less severe type, or the ending of FGM completely. For example, my conversation with Taifa revealed changes in practices in Somalia, even among women like Taifa's mother who was committed to traditions:

> *Mina: Were your daughters circumcised with the same type as you had?*
>
> *Taifa: No no no no. Small cut, only small cut they had. Not the same of mine.*
>
> *Mina: Did you ask the practitioner, I believe a doctor, which type you would like your daughter will be circumcised?*
>
> *Taifa: I didn't say nothing. Mum did. My girls will be cut same of mine I thought. Surprised actually.*
>
> *Mina: Did you expect that your daughters are circumcised same type (Type 3)? But they were circumcised small cut (Type 1)?*
>
> *Taifa: Yah, I know small cut (less severe type) is getting popular in Somalia but I know FGM is something keep mum as Somali lady, mum proud to set up (organise FGM) for girls (her daughters). That's why surprised what she changed.*
>
> *(Taifa, first-generation, female, London)*

Taifa was surprised that her mother had arranged for her granddaughters to be cut, but with Type 1, rather than the previously ubiquitous Type 3. Thus, why she

was still committed to the importance of FGM, her insistence on Type 3 had changed, possibly because of the influence of FGM campaigns (Abathun et al., 2016). I asked further questions about why Taifa's mother accepted less severe types of FGM. Taifa was not sure of the exact reasons, but she believed that other people around her started to accept less severe types of FGM for further generations, so demonstrating how individual attitudes and behaviours are affected by what you think other members of the community believe.

Literature suggests that many Somali men still prefer to marry women who have experienced Type 3 FGM. As discussed earlier, this is because it is believed to indicate "good" sexual behaviour so far in her life (Wright, 2013). In addition, a large number of men in Somalia also believe that a woman who has been cut will be a more loyal partner (Utsumi, 2003), and some men have a strong preference for girls to be circumcised by Type 3 FGM for their own sexual enjoyment as they believe that Type 3 FGM makes women's genitals tighter, and as such it can lead to more enjoyable sex for the man (Berg and Denison, 2012).

A large number of second-generation male participants in my study, however, responded that FGM should not continue in future generations. Rather surprisingly, many also believed that FGM has already been eradicated amongst their generation, and that none of their second-generation female counterparts have experienced the practice. For example,

> *Tomi: FGM is continuing in the mainland of Somalia, but not here (the UK). It's illegal here, so we don't do it anymore.*

Mina: But it's a possibility that you'll get married to someone who has experienced FGM? You never know!

Tomi: I'm sure I won't! I have never met anyone that had it. I have lots of close female friends. They never mentioned it.

(Tomi, second-generation, male, London)

It is easy to imagine that even in situations where a man has close female friends or relatives that have experienced FGM, there will be a reluctance to share personal details of these experiences with them. FGM is of course a significantly sensitive topic, and it is not an easy topic to discuss with men, even close friends or family. This misunderstanding of the extent to which FGM is practised today may inadvertently cause additional psychological distress for second-generation females who have experienced it.

Sadiiq: No Somali girls are circumcised in the UK. Maybe it's still happening in Somalia, but not here. I have never heard of FGM happening here, I've never met anyone that has been circumcised.

(Later in interview)

Sadiiq: It's too early for me to get married, maybe in a few years. But I will probably get married with someone like me, who was born here but is Somali or Muslim. It's easy for me and my family. It's easy to understand each other's religion and culture, so personally I prefer.

(Later in interview)

Sadiiq: I don't think the person I will marry will have been circumcised. It's over, it doesn't happen here anymore. I won't ask whether they've been circumcised before getting married, but I guess I will find out whether she has had it done.

Mina: If the girl who you marry has had FGM practised on her, how will you react?

Sadiiq: I don't know how I will react, I'm sure I will be surprised and maybe ask what happened and why, but I know no one does it anymore here.

(Sadiiq, second-generation, male, London)

Sadiiq's assertions that FGM does not happen anymore and has been eradicated in the UK – "*it's over*"' was a widely-held view of second-generation men, but my research suggests that many second-generation women in their communities have been cut, although generally with less severe forms than Type 3. While this is a small sample size and may not necessarily be representative of the wider community, there is a strong possibility that Sadiiq may marry a woman of a Somali background who has been cut; in this case, this will likely result in surprise given his strong belief that FGM is no longer practised in the UK. As a result, subsequent discussions and questioning may cause his wife emotional and psychological pain even though there is no malice.

While one of the reasons given for FGM was to ensure a good marriage for a

daughter (see above), second-generation men seemed not to care whether their future wife was circumcised or not. During my individual interview with Iman, a second-generation male participant based in London, he mentioned that he believes that his mother has a strong preference for him to marry with a woman from a Somali background. We discussed whether he intended to ask his future partner, whether or not she has been circumcised:

> *Iman: I won't ask, I don't care. I know it still happens for some girls, because of my sisters (his sisters experienced FGM). FGM is an old tradition and we don't need to do it anymore.*
>
> *(Later in interview)*
>
> *Mum might ask her (his future partner), I think she cares (about FGM). I can't stop my mum, I don't think she'd ask in front of me anyway.*
>
> *(Later in interview)*
>
> *I don't know if mum will like her if she's not circumcised. Don't know how strong a preference she has. I have never asked her.*
>
> *(Iman, second-generation, male, London)*

His sisters were circumcised when they were young in the mainland of Somalia, so he believes that his mother has a strong preference for her female family members, including his future wife, to have been circumcised. Interestingly, even though Iman does not have a preference for his future wife to be circumcised, I got a strong impression that his mother had a preference, and that if his mother

desired a circumcised woman for his wife, he would not resist his mother's wishes. Just as FGM is seen as something that is done to an individual but in relation to family honour and community expectations, so decisions about marriage within the Somali community are often made by parents, rather than the couple alone. Based on my conversation with Iman, I considered the possibility of second-generation female participants who have not been circumcised, being required by their future in-laws to be circumcised before marriage. This could lead to the continuation of the practice between the generations.

4.1. Campaign against FGM

FGM has been practised in migrant societies in the UK for at least the last three to four decades (Karlsen et al., 2019; Ali et al, 2020). The practice was commonly undertaken in secret, and as such it was generally not known of in the wider British society outside of certain refugee and migrant communities. The practice became more visible to the wider British community from second generations of migrants who were raised in the UK and educated in the British education system. Some of these second-generation migrants began to raise their voices against FGM (Morison et al., 2007). Many first-generation women are becoming aware that FGM is not common practice in all countries leading them to think of FGM as a violent practice that affects their human rights (Dustin, 2010), and also they recognised FGM is an illegal practice.

One of the Somali communities in London where I undertook my field research,

the Ocean Somali Community Association, was actively running the Community against FGM project. They mainly organised the group sessions with young people, women and other members of the community. The group sessions for The Community against FGM project were raising awareness and overcoming the taboo nature of FGM. Further project aims were to increase the skills and capacity of the community groups dealing with FGM. These campaigns against FGM and organising group sessions to spread the message about FGM inside of the communities are slowly expanding social change into wider Somali communities across the UK (Roach and Momoh, 2016).

Some of the participants in my research discussed their involvement in the project:

> *Samira: I was part of the group (The Community against FGM project).*
>
> *Mina: When did you join?*
>
> *Samira: About two years.*
>
> *Mina: Any reasons why you joined the group?*
>
> *Samira: I saw the poster here (inside of the community centre). And staff (community centre staff) asked me, do you want to join, we need people to come. I said no for the beginning. I didn't want to talk FGM. We shouldn't, FGM is private thing. Not something we talk with people.*
>
> *(Later in interview)*
>
> *Samira: Some of us still think FGM is something we should do.*

We should cut daughters. We are in London but we are Somali. My girls are Somali, not local girls. But (She used a specific staff name of the FGM project) told us, we don't need to cut girls.

Mina: What did you talk in the sessions?

Samira: FGM is against the law here, not only here, many countries. FGM is not part of Islam. We can be a good girl, good wife and good mum without the cut.

(Samira, first-generation, female, London)

Samira has four daughters, and all of her daughters were circumcised with either Type 1 or 2. She joined the Community against FGM project in the Ocean Somali Community Association after all of her daughters were already circumcised. Samira mentioned that if she had more daughters, she may consider not circumcising them now she has received the message against FGM through the project. I could see that Samira began to gather information about FGM through the sessions, and she could judge that FGM was something she does not need to continue anymore. Her statement that not practising FGM would not be counter to her Muslim beliefs is something that she stressed. However she also mentioned that not all of the women who attended the Community against FGM project changed their minds. Some of them still preferred to circumcise their daughters, but she felt that it was more likely that people chose not to organise FGM. These behaviour changes for other women could also influence Samira's further behaviour in relation to FGM.

All second-generation female participants who had not been cut told me that they did not know the reasons why they were not circumcised. Some of them got interested in asking their mother when they went home after the individual interviews. However, in most cases, it was clear that they had never really thought about why they avoided FGM; it was just the way that it was. This suggests a real shift in social norms around the expectations regarding FGM.

4.2. Social norms around women's behaviour

Shifting to practise a less severe type of FGM or no cutting at all seems increasingly prevalent in the Somali community in the UK. However, gendered norms around appropriate behaviour and family honour are still widespread as Samira's discussion demonstrates:

> *Samira: Night, after the meal maybe, mum took me to the outside. She started talking lots, how is my life here (in the UK), money support, school, community.. lots anyway. It was lovely talking with her not online chat. You know nice to touch her, see her not on the mobile. I was happy and wanted to be with her more.*
>
> *(Later in interview)*
>
> *She (her mother) suddenly be serious, I thought she got a sick like cancer or something. I was scared.*
>
> *Mina: Is your mum OK?*
>
> *Samira: (laugh) She is not sick, she is healthy, she just told me how to treat my kids, girls. Mum was worrying my girls*

will be in trouble because they were not closed (did not circumcise Type 3). She said I have to responsible, have to tell my daughters how to be a good girl.

(Samira, first-generation, female, London)

She discussed the time she visited Somalia when her daughters were circumcised, and the above quotation is the outline of a conversation with her mother when she was there. For her mother, FGM provided a clear sign of purity, and reduced the likelihood of young women behaving in an inappropriate way. She had alerted Samira to her concerns about the potential implications of not having her daughters cut with the traditional type of FGM (Type 3), and warned her to be vigilant about their behaviour. Seynab also highlighted how the shifts in FGM are not associated with changes in concerns about young women's behaviour, and in fact, can heighten them:

Seynab: I have to be careful what my daughters are doing outside. Where they go, who they meet. My daughters don't like I ask but I have to.

(Later in interview)

Girls should be virgin, if not virgin girl and whole family will be trouble. Girl's virgin is value for whole family. If my daughter is not virgin, people (in the community) think I'm not good mother, not good parents, not good Somali and not good Muslim do you know I mean? It's important for us. I could show my husband I'm virgin on my wedding day, Because mine was closed (she means she

was circumcised Type 3 FGM and her whole genitals were stitched up until her wedding day), easy to show. My girls don't (her daughters were circumcised Type 1).

(Seynab, first-generation, female, Manchester)

Seynab is concerned that her daughters were not circumcised by Type 3 FGM. The move away from Type 3, making it more difficult to prove a girl's virginity at marriage, could be a factor for first- generation parents wanting to monitor their daughters' behaviour, and ask daily questions about their lives.

During my regular visits to this community centre, I had lots of opportunities to see community members, mainly men, have daily communications. The topics being discussed were usually general topics, including their families and work. The conversations were very generic in nature, not referring to any specific or intimate details, with no gossip or judgement and seemingly with very little social pressure being placed on the participants. This may have been because the café was located in the community centre building, and the group was fairly large.

Some first-generation male participants in the West Somaliland community mentioned they have personal conversations including gossip or opinions on others at home or during the evening with other members of the community. This act is likely to exert social pressure on those related to the West Somaliland community.

Amina: Yes I hear what happening (gossip), usually from my sisters or husband. My sisters' husbands told them and we talk. This family done something not supposed to do, that family's daughter did this or that. These stories are so fast to be spread everyone here, whole community. If I done something wrong, I'm sure everyone (inside of her Somali community) know in few hours.

(Amina, first-generation, female, London)

Mina: You mentioned a "good Somali". What does a good Somali means?

Balqis: We are Somali but Muslim. Follow what Quran taught us is good Somali. How many time people pray per day, how long people spend time to learn Quran. We have to follow what Quran tell. Whoever follow Quran, they are good Muslim, good Somali.

(Later in interview)

We are now in here (England), not Muslim country. We need to teach kids what Quran teach us. We need to read it together. They need to know what they should do and what they shouldn't do.

(Later in interview)

Important what people (community members) think about us, especially what they think my daughters. People always see what they do. If they don't cover them, people think we (she and her husband) are not good parents, not good Somali, not good Muslim

because daughters don't follow what Quran tells us. Not only that, people think my daughters are not good Somali, not good Muslim girl. That's why we have to be careful. What my girls do are my responsibility.

(Balqis, first-generation, female, Manchester)

All first-generation participants who discussed gossip mentioned that people inside of their community only really pay attention to females, particularly second-generation females. The behaviour of a family's young women reflects on the whole family, particularly the parents. As Balgis says, "I*mportant what people (community members) think about us, especially what they think my daughters. People always see what they do. If they don't cover them, people think we (she and her husband) are not good parents, not good Somali, not good Muslim."*

Balqis's response provided some details in relation to what, at least in her opinion, the concepts of "*good Somali*" and "*good Muslim girl*" meant to people of a Somali background. One's behaviour and activities seem to be an important indicator of whether or not one is recognised to be a good Somali or good Muslim girl in public among people of a Somali background, particularly aspects that can easily be seen in the public space. Three key examples of these easily-observable social attributes are one's dress (particularly for girls), whether or not one has any pre-marital relationships, and the nature of socialising outside of the household.

Large numbers of first-generation male participants interviewed (nine in London and seven in Manchester) responded that they care more about their daughters' daily lives than their sons'. These responses from first-generation participants emphasise the importance of the social attitude and standing of their daughters in the community and the importance of them being recognised as a "good girl" by the rest of the community, with their daughters' daily behaviour directly affecting each family's honour. As such, each family, particularly parents, may have a strong feeling of responsibility for their daughters' daily behaviour outside of the household; at the same time however they also monitor other families' daughters' daily behaviour. By monitoring other families' daughters within the community, there may be a belief that they can ensure girls' behaviour is kept appropriate.

Second-generation members of the Somali community have a different attitude towards socialising. Second-generation female members of the community, in contrast to their first-generation counterparts, socialise and go out with their friends on a regular basis. Throughout my research I would often meet with second-generation female participants at city centre cafés outside of the Somali community area. However, in contrast to this, the reluctance of first-generation female participants to meet outside of the Somali community surroundings meant that I only met one first-generation female participant outside of the community buildings in a city centre café; I met with all other first-generation female participants inside of the community centre buildings. Ayanna discussed the forms of surveillance that she experiences as part of her family's commitment to

ensure she behaves appropriately:

Ayanna: I'm going to the cinema with friends tonight.

Mina: Nice! Are you OK to go out at night time? Will your parents say something to you?

Ayanna: I have to tell them (her parents) where I go and who I go with. If I tell them, they don't mind, because my brothers will come with us.

Mina: Oh OK, your brothers would like to watch the same film then.

Ayanna: (She laugh) My brothers will come because it's easier for me to go out in the evening. I know it's strange, but it's common that someone's brothers or cousins (male) will come out with us. When me and my friends (girls) go for a meal at night, either my brothers will join us or they will come to the restaurant at the end of the meal.

Mina: What do your brothers do?

Ayanna: "Protect us", but I think mum and dad want to know what we do outside, especially at night. Make sure we don't meet up with boys, walk around only as girls, don't do anything we're not supposed to do. Like drink alcohol, go to night clubs, bars, meet boys. Lots of things.

(Ayanna, second-generation, female, London)

Cawad: Yes I go out with my sisters at night sometimes. I went

out with friends last night, then my sister [Instant Messaged] me, so I went to the restaurant to see her and her (girl) friends and we went home together.

Mina: Why did you do that?

Cawad: Dad told me to. He told me "protect your sisters", they (girls) shouldn't go out at night by themselves, maybe someone will attack them. It sounds strange for you maybe, but this is what we normally do.

(Cawad, second-generation, male, Manchester)

Second-generation female participants seemed to have significantly more freedom to go out and socialise with friends, both during the day and at night, when compared with their first-generation female counterparts. This attitude difference towards socialising outside of the household perhaps shows that second-generation female participants could have a more diverse range of experiences, and be exposed to more diverse perspectives, in which women do not have limitations around how they socialise outside of the household. Second-generation female participants however did still have common conditions around being able to socialise at night time, which both Ayanna and Cawad noted, such as being accompanied by a brother or male cousin to give their parents some reassurance over their daughter's social behaviour outside of the household.

Of course, first-generation parents feel pressure from other community members

to make sure their daughters behave in ways which fit the socially-prescribed norms of being good Somali and Muslim girls. Amira seemed to show an acceptance of the situation in her life, and the importance of her role in upholding her family's honour within the Somali community. She seemed to be resigned to her parents monitoring her daily life, and that it would have been difficult for her to change or improve the situation. These remarks from parents to second-generation female participants however could possibly increase daily pressure and frustrations they experience, and could also limit or gradually reduce the freedom they experience in their daily lives.

Balqis: We need to put effort for girls (her daughters), make sure they are doing right. How we can show my girls are loyal, good Muslim and good

girls?

Mina: To show who?

Balqis: People in here (the area she lives). My girls probably marry with Somalis. Somalis are not only in Manchester, we have family in London, Bristol, Birmingham, also have in United States, Sweden, Holland, UAE, Somalia, Kenya, Ethiopia, lots of different cities and countries. What I have to do is everyone here need to know my girls are good girls, they need to know my girls are pure. Because you never know who related with who.

That's why we have to keep telling girls what they have to do.

(Balqis, first-generation, male, Manchester)

Where girls have not been circumcised by Type 3 FGM, girls have to show "good" social behaviour in public spaces to prove that they are virgins. Balqis's response supports the importance within the community to be recognised as a good girl from others of a Somali background, as this recognition could directly impact their futures. This echoes Van Liempt's work with young Somalis in Leicester, who were frustrated about the surveillance they experienced when in public in their local area which was predominantly Somali (Van Liempt, 2011). The local, national and international networks within which Somali migrants are embedded, also mean that girls' behaviour has potential impact far beyond the community and household level.

> *Fartuun: I always tell my daughters "don't wear that", "which friends will you go out with" and "where are you going"!*
> *Mina: Do you say this just to your daughters? What about your sons?*
> *Fartuun: Not for sons, only my girls. I need keep eye on them… I don't like their tight jeans (skinny jeans). Lots of girls here (the UK) wear it! I don't like it. Not sure what calls, but easy to see body line. My daughters wear sometimes! I always said "shouldn't wear it" "change clothes". They never listen to me, so I have to tell them "if you want to wear it, wear chador to cover"!*
> *Mina: I know girls are recommended not to show their skin in*

your religion. Do you think that skinny jeans cover your daughter's skin?

Fartuun: No! Not only skin, they shouldn't wear something easy to show their body line…..Our beauty and British beauty are different. British boys like girls show their skins and wear not cover clothes, but Somali boys like girls cover.

Mina: You mentioned that you don't tell your sons what they need to wear and don't ask your sons where they are going. Why don't you ask your sons?

Fartuun: Boys are not too important to be a good boy compared with girls, and nobody whisper me "your son is walking with girls" or "your son is wearing that".

Mina: You mean, people talk to you about your daughters?

Fartuun: Yes they does if they are not good girl.

(Fartuun, first-generation, female, London)

Ifrah: Yes I wear a chador every day. I want to wear only the head scarf, but my mum is never happy if I do.

Mina: If your mum didn't care, would you prefer to wear only your head scarf?

Ifrah: Maybe (smiled). I have had arguments with my mum about it (her outfit) before. I just wanted to wear nice colourful clothes like my friends wear…I like skinny jeans. Actually, I'm wearing skinny jeans now (she showed me her jeans). I can wear

whatever I want to, skinny jeans or anything now. I just wear a long hijab to cover up. Everyone is happy with what I wear (because she wears a long hijab), but I'm also happy I can wear anything I want under my hijab. My friends need to think about what they wear to go to work, but I don't need to think. It's easy for me in the morning! (both laugh)

*(*Ifrah, *second-generation, female, Manchester)*

Nimco: I am always careful with what I wear. Mum doesn't like my clothes. She always tells me "don't wear this", "wear that". She wants me to wear a long chador. Do you know what a chador and hijab is?

Mina: I know what a chador and a hijab is, but I have never seen you wear a chador!

Nimco: (laugh) Yeah, I don't like it. I never wear one. I wear this (pointed at her head which was covered). I like to wear jeans and nice colourful clothes, because I love fashion, and I love going shopping with friends. I keep telling my mum "I am covering my hair and skin!" But I know she isn't happy.

Mina: Why do you think your mum tells you what you should wear?

Nimco: She wants people around her to think I'm a good Somali Muslim girl.

Mina: By around her do you mean other members of the

community?

Nimco: Not only community members, maybe my dad, her friends and my grandma; anyone close to her. My mum doesn't like my skinny jeans (laughs). My friends (other non-Muslim friends) wear skinny jeans, so it's nice to wear popular clothes. My mum keeps telling me "your clothes makes it easy to see your bodyline" so we always argue.

(Nimco, second-generation, female, London)

Interestingly, all participants noted that the main driver for their interest in their daughters' appearance was religious reasons; it was however common to also imply that the way their daughters are perceived by the wider community was also a concern. Further to this, several first-generation participants, particularly women, felt that the wider community would judge them as parents based on their daughters' appearance. For some participants, such as Fartuun, there was clear distinction between "*British beauty"* and "*our [Somali or Muslim] beauty",* particularly around the amount of skin or hair on show, and the tightness of clothing.

All seven second-generation females who wear a chador daily talked about similar things as Ifrah. For example, five out of the seven women interviewed mentioned that they had argued with their mother about the clothes they wanted to wear when they were younger. They wear a chador on a daily basis, however they would have preferred to wear only a hijab if their family members and

community members had not put pressure them. Through these conversations, and seeing their daily clothes, I could see that they found a balance or compromise with both their own desire and their parents' expectations.

Furthermore, seven second-generation female participants in London and six second-generation female participants in Manchester who only wear a hijab to cover their hair or upper body also mentioned that their mother continually told them what they should be wearing. They may have also found a balance or compromise with both their own desires and their parents' expectation, with their view that wearing a hijab to cover their skin should be sufficient to be viewed as a "good Muslim girl" by their family members and the wider community; at the same time, in wearing only a hijab they felt they could enjoy fashion in the same way that their non-Muslim friends did.

Social pressure, particularly on females inside of Somali communities, is still significantly strong. The pressure and expectations around appearance may be changing between first- and second- generation females of a Somali background inside of the UK. Wearing a hijab and covering your skin however remains a minimum requirement and expectation from their religion, and is still considered the approach to follow the Somali way. As such, this is still applying pressure from the community to second-generation females to follow the Somali or Muslim way, which may make it difficult for further change among future generations.

5. Discussion

This chapter builds on the previous chapter to explore the reasons behind FGM as a social norm, or changes in attitudes to FGM within migrant communities. In the case of both first-generation and second-generation women, decisions about FGM were made by family members, but within particular community and national contexts. In Somalia/ Somaliland, the moral judgements around what a 'good girl' and therefore an honourable family and good parents consist of, underpinned Type 3 FGM as the norm. However, as the interview material reveals, the national context of Somalia/ Somaliland does not remain static. For most of the first-generation women, their experience of Type 3 FGM was the norm, however, for a few, they underwent a less extreme type of FGM, with some respondents suggesting that this reflected anti-FGM campaigns at the time i.e. a change in understanding and beliefs about the social importance of Type 3 FGM. The dynamic nature of the FGM situation in Somalia/ Somaliland was exemplified even more clearly by accounts from first-generation women of how their mothers in Somalia suggested Type 1 FGM for their granddaughters when they were brought from the UK to be cut.

For the women born and brought up in the UK, the national context where FGM is illegal, meant that it was less straightforward to arrange FGM. For some second-generation men and women, there was an understanding that FGM was not an issue for Somalis in the UK as it was a practice that was both temporally and spatially separate from the present-day UK. Some respondents talked about Somalia/ Somaliland as a place of 'tradition' and 'ignorance' around FGM. This

failed to understand that rather than being a bounded national space void of FGM, the UK, and in this case the Somali community, was part of transnational networks and family ties. In this context FGM was still a part of some people's experiences linked to strong ideas of what Somali identity involves, and the ability to travel to Somalia/ Somaliland for the procedure.

Finally, the chapter revealed the ongoing outcomes of living in the UK, but also within transnational Somali networks; the continuing importance of daughters behaving in an appropriate way to ensure no shame came to the family. While in the UK FGM as social norm is declining, the surveillance of women's behaviour and dress continues.

6. Conclusion

This chapter has analysed the data obtained in relation to the social pressures and social attitudes inside of communities in both the mainland of Somalia and Somali communities in the UK and considered the differences between generations.

For first-generation female participants, FGM in Somalia had been seen as normal and expected, and was continued through substantial social pressure both directly and indirectly from community members. The importance of being 'a good girl' was mentioned by many participants, but this concept had various meanings, such as proof of a girl's virginity, cleanliness and purity. Type 3 FGM

was seen as a very clear way of indicating virginity which was seen as important for a good marriage, but also to protect family honour, to receive respect and for their parents to be recognised as good parents by other community members.

Through interviews, there was clear that practising FGM was a social convention that included both positive sanctions from the community, such as celebrations and inclusion, and potential negative sanctions for non-compliance. Attending the celebration of FGM ceremonies often made the procedure seem exciting and hid the brutal reality of what was involved. All first-generation participants who were cut experienced FGM when they were young girls and thus unable to make independent decisions about whether to be cut or not. Parents, particularly mothers, saw FGM as a crucial practice to help their daughters in the future, as well as contributing to the status of their family.

Among second-generation participants, less severe types of FGM or remaining uncut are much more common. This reflects a shift in the underpinning need for FGM in the UK, helped, but not explained, by growing education about the harmfulness of the practice and its illegality. However, there are still gendered norms around appropriate behaviour, and family honour is still widespread. Thus, as with Alhassan et al. (2016)'s research in Spain, Italy and Portugal, Somali parents in Manchester and London are concerned about their daughters' behaviour and therefore reputation, particularly within what is seen as a wider permissive British society. In my research participants did not talk about using FGM as a way of controlling their daughters' sexuality, but other forms of control

and surveillance were adopted.

Chapter 7: FGM, Intra-Familial Relationships and Friendship

1. Introduction

The previous two chapters have highlighted the relational nature of FGM decisions in both Somalia and the UK, where decisions are not made by individuals in isolation, but as a response to particular social relationships and perceived expectations within families and communities. This chapter seeks to explore the inter-personal relationships associated with FGM, going beyond the usual focus on FGM decision-making. This chapter focuses on how FGM affects relationships such as those between husbands and wives, mothers and daughters, sisters, and friends. FGM is embedded within social relationships which can explicitly or implicitly encourage or discourage the practice. Additionally, FGM can affect how individuals interact with key people in their lives, most notably their spouses, parents, siblings and friends. These relationships are often ignored within the literature, or are only mentioned in relation to FGM decision-making. This chapter seeks to make these relationships more visible in the discussions of FGM.

2. Men's involvement in FGM

While FGM is often understood as a 'woman's issue' (see Chapter 3), men's opinions are often invoked as a reason to explain the continuation of the practice; men's desire to marry women who have been cut. However, in the previous chapter, it was clear that for many men, particularly those born and raised in the

UK, FGM was seen as something from the past or limited to other places, such as Somalia, and not desirable for modern generations. In this section I want to focus on the rarely-discussed experiences of men in relation to FGM. In the opening section of this thesis I mentioned the man who came to the Orchid Project as he wanted to prevent his daughter from undergoing FGM. He was doing this as a caring father. In this section I will explore the caring practices of Somali men in relation to their wives, and link to the idea of hegemonic masculinity discussed in Chapter 3.

2.1. The emotional impacts of FGM for men

> *Ali: I seen it (FGM), because my wife has circumcised. It's very difficult for her for the first day of our marriage, and giving birth, she had to be cut (open). It was suffer her lots…*
>
> *(Later in the interview)*
>
> *Ali: They (women) think man have to open it (on the first day of their marriage). It is really difficult process (for men)*
>
> *Mina: Did you open your wife?*
>
> *Ali: Yeah, took about 2 months. It was very difficult, I didn't want her in pain. I wanted to do as quickly as possible. It was really difficult process to be honest….*
>
> *(Ali, first-generation, male, Manchester)*

It was clear through the interview with Ali that Type 3 FGM causes not only

physical and psychological harm to the women who directly experience this practice, but there is also the potential for deep distress on the part of the husbands of these women. This is something that has not been previously identified in the literature.

During my field research, I had several discussions with first-generation male participants in both London and Manchester regarding their experiences on their wedding night. They provided details of their feelings during and after this difficult experience with their wives. At the beginning of the interviews, all first-generation male participants were hesitant to talk about FGM with me and frequently mentioned that men are never involved in FGM, that FGM is a women's issue and, as such, men never talk about it. Despite this initial hesitancy and reluctance to discuss the topic, many opened up during the interview allowing me to talk with them about their views of FGM and their family members' experiences of FGM.

After completing two-thirds of my interviews for first-generation male participants, I interviewed Ali, a first-generation male participant based in Manchester. Ali was able to share details around his very difficult experience of opening his wife's genitalia. He observed that this form of FGM, and the subsequent opening on their wedding night, is a very important part of a Somalian wedding night with this form of FGM being important to prove that his wife is a virgin.

At this time, I only had basic knowledge about the practice of men opening female

genitalia based on the existing literature (Ali, 2008; Barber, 2013). There is however no more specific research available that details the process and impact of opening genitalia, including the approach that men take, how long the process takes, men's feelings during and after this experience and the impact, if any, on the married couple's relationship. My experience of interviewing Ali and in hearing his story, something that hadn't come up in previous interviews and seemingly not covered by the existing research, encouraged me to try and gather information about others' similar experiences. As such, I decided, where possible, to meet again with other first-generation male participants that had already been interviewed to ask them additional questions relating to their personal experiences of opening their wife's genitalia on wedding night.

After having a general discussion, and when the opportunity was right, I talked about (on an anonymous basis) Ali's experiences and feelings during and after his wedding night. Many other first-generation male participants noted that they had similar experiences, with 12 out of the 20 first-generation male participants noting that they had to open their wife's genitalia on their wedding night.

Several participants noted that they could still clearly remember the experience and discussed how difficult an experience it was for them at that time. During these conversations, it was clear from the tone of most participants' voices that these were very difficult memories for them. This was in contrast to the discussions with first-generation female participants, who were generally calmer when discussing their personal experiences of FGM with me. This is perhaps

because while clearly an unpleasant experience for the women impacted by the practice, they had opportunities to talk about this with those around them, and access support; this is perhaps not the case with first-generation male participants that may have never previously shared their experiences with anyone and as such found discussing this experience with me particularly challenging.

Through these discussions in some of the interviews undertaken with first-generation male participants it was apparent that there was a distinct possibility that emotional difficulties from experiences connected to FGM were not just limited to females. The main consideration for support services relating to FGM is the victim of the practice; it is usual to consider that the woman is the only victim of the practice as it is only she that is physically harmed by the removal and / or stitching of a part of her body (FORWARD, 2007). It is only females that suffer physical pain during and after the practice of FGM; males do not have any physical harm inflicted on them which is perhaps the main reason why FGM is considered to be a female issue only (Leye et al., 2007).

As of 2019, there were eight special clinics which focused on FGM inside the UK, including clinics in London, Birmingham and Bristol (NHS, 2021, see Appendix 6). These clinics principally offer support with physical issues and difficulties resulting from FGM, but many also offer support in overcoming emotional distress. Specialised health care such as reversal surgery is also accessible in these clinics. In the UK, patients typically initially access healthcare by seeing a General Practitioner (GP) to discuss their issues, with GPs then referring their

patient to hospitals or specialist clinics if further specific treatment is needed. Women and girls that have undergone FGM are, however, allowed to visit specialist clinics without any referral from a GP. The healthcare provided by these clinics is also free of charge as the clinics are part of the UK government's National Health Service (NHS) (NHS England, 2017).

Women and girls that have undergone FGM often feel fear and embarrassment when discussing FGM with healthcare professionals (BMA, 2011). As such, all healthcare professionals and staff in these specialised clinics, including interpreters, are specially trained in dealing with women and girls that have undergone FGM. This training includes how to talk about this difficult subject, and the different cultures of communities that still practise FGM. The NHS also provides support and treatment directly to women affected by FGM. I contacted the NHS through their website to gather information for support and treatment in 2017, they responded that the NHS, including the specialist clinics, does not provide any support for males who have potential emotional distress related to their experience of opening their wife's genitalia.

Murphy (1998) notes a similar point in her research on miscarriages, where there were struggles in recruiting male participants to be a part of the research exploring experiences and feelings following a miscarriage. This is potentially due to most men thinking that they should not talk about these intimate experiences to protect their wife or partner's privacy, or perhaps due to thoughts that it would be inappropriate for them to discuss this as they were not physically

harmed or impacted by the experience.

It is difficult to judge what, if any, impact the experience of opening their wife's genitalia on their wedding night has had on males; experiences are also not likely to be consistent with some males potentially being impacted to a greater extent than others. Nine of the first-generation male participants I interviewed mentioned the difficulties they incurred in opening their wife's genitalia, and noted how difficult it was for them to see their wife's suffering during this process.

Murphy (1998) made several observations about men's experiences and feelings following a miscarriage in her field research. Generally, having a baby is considered to be a "couple's" event, however in heterosexual couples, experiences of miscarriage are considered to only impact the female partner. It was noted that concern was often expressed towards the female partner's wellbeing after a miscarriage, but little care or attention was directed towards the male partner from friends and family around them (Rinehart and Kiselica, 2010). The stage of pregnancy at which the miscarriage occurred was an important factor in determining the extent to which the male partner was emotionally affected. Murphy (1998) observed that while men do not experience any physical changes during a pregnancy, seeing baby scans and the changes to their wife's body can instil a feeling of impending fatherhood. As such, if a miscarriage occurs in the early stages of pregnancy, it may be difficult for a man to feel the same loss as their wife or partner. This lack of physical change for men during a pregnancy could mean that females feel a deeper sense of loss

than their male partner following a miscarriage (Lewis and Azar, 2015). However, men do, of course, feel strong feelings of sadness, loss and anger, and as such it would be unfair to conclude that males have less emotional distress compared to females following a miscarriage (Rinehart and Kiselica, 2010).

Society exerts pressure on men to hide their feelings and to recover from their miscarriage experience as soon as possible and support their female partner (Miscarriage Association, 2007). The Miscarriage Association in the UK is now providing information for men on how to deal with their emotions surrounding their partner's miscarriage and to explain how important it is to discuss their feelings of loss with their partner (Miscarriage Association, 2016); however the female is still considered as the "main" person in need of support.

Some male interviewees in my research mentioned that even though they heard and saw their wife's pain and suffering during the process of unstitching and opening genitalia affected by FGM, they felt that they should focus their efforts on supporting their wife with little or no consideration to their own feelings. This resonates with the constructions of desirable Somali masculinity as being a strong and reliable provider for a wife and children, rather than someone who shows emotional weakness and needs support from others (see Chapter 2). This form of hegemonic masculinity is common in many parts of the world where men are discouraged from showing emotions.

While there are eight specialist clinics in the UK which deal only with FGM, these

clinics do not provide support for men dealing with emotional distress. Similarly, there are various sources of physical and psychological support available for people who have experienced a miscarriage. There is however only limited support available for men whose partner has experienced a miscarriage, with even medical staff often expecting men to provide support to their female partner recovering from their difficult experience (Miscarriage Association, 2007, 2016). Due to this lack of support for men, most support for men following the experience of a miscarriage comes from their friends, family and their partner (Rinehart and Kiselica, 2010).

From men's perspective, cases of FGM may be similar to miscarriages in that there is no support network available for them. The following extract is from an interview with a first generation female participant in London who discussed her wedding night:

> *Warda: My husband did it (open her Type 3 FGM).*
>
> *Mina: On your wedding night?*
>
> *Warda: Yeah, his mum checked (her virginity) then he opens by… like scissors. Not really scissors, but yeah like that I think. I didn't look, but I think so.*
>
> *Mina: Is it possible you to explain bit more? How did he open or …something you can remember?*
>
> *(Later in the interview)*
>
> *Warda: He was so slow! So said "just do it" "quickly". It was really painful and blood. I just wanted to be finished. Man doesn't feel*

pain. Only girls feel pain.

(Warda, first-generation, female, London)

A significant number of female members of the community I spoke with throughout my research, in both formal interviews and in general conversations, noted that they did not believe that men have any emotional distress through the experience of opening their wife's genitalia. I suggested that men may have been upset and distress by seeing and hearing their wife's physical pain during the opening process, but my suggestion was typically rebutted; the general consensus was that as men are not physically impacted during the process they do not have any lasting distress. There is a view that men will soon forget this experience, and that it has no lasting physical impact on them, and that it is the woman who bore the physical pain of the process and can still bear the scars from the process, so they will not be able to forget the experience. This makes men's experience of distress invisible and possibly slows them in recognising their own distress, which may prevent them in accessing further support from surrounding people and organisations; men are being left behind in any consideration of the emotional impact of FGM, which may be leading them to a wider and bigger emotional distress in the future which could also have an impact on their relationship with their wife and may also impact their preference for their daughter's circumcision.

As noted, of the 12 first generation male participants that responded that they had opened their wife's genitals, ten strongly insisted that they did not have any

emotional distress and did not need to access any emotional support; this gave me the strong impression that they felt an element of guilt about their wife's experience. The need to present themselves as strong Somali men partly explains this, but there are also contradictions with what is expected through hegemonic constructions of Somali masculinity. The unintentional infliction of pain on their wives, clashes with ideas of masculinity as providing protection for your family, particular your wife and daughters.

Labban, a first-generation male participant in London, suggested through his experiences that pressure from the Somali community in his area, family members, and perhaps his own ideal to be a strong supportive husband, led to him not disclosing any emotional distress he may have experienced. He very much used the physical afflictions caused by the practice as a way of identifying the victim, his wife, and even felt an element of guilt that he may have made the pain worse by opening the genitalia before considering his own psychological afflictions. As he discussed:

> *Labban: I don't think I have any problems. I did it (open his wife's genitals), but I don't think I need to talk with doctors.*
>
> *(Later in interview)*
>
> *Women go to doctors sometimes, my wife went to NHS twice or three times. She had lots of pain. Not sure she is pain because of the FGM, maybe because I opened it. But she went to clinic. They (women) have pain on their body but we (men) don't have any problem on our bodies. So, I don't think I need to go to NHS.*

Mina: You never felt you would like to talk to about what you felt throughout your experience? I mean, talk about what you felt before, during and after your wedding night?

Labban: I talked with my friends before done it, how to do it. And I talked how I opened it. That's it. I know females talk about lots, but we don't.

It's not something we talk.

We don't need to share what we felt, because we are no pain. We should support girls from their pain and sick, we should be strong.

(Labban, first-generation, male, London)

During the individual interviews, none of the first-generation male participants who opened their wife's genitals, nor the first-generation female participants who had their genitals opened by their husband, considered themselves or their husband to be a perpetrator of sorts resulting in the physical pain experienced. Labban, however, considered that he himself was one of the contributory factors for the pain his wife felt, questioning whether the approach he took led to unnecessary pain, or whether a different method of opening would have achieved a less painful result. In considering themselves as a contributory factor in their wives' pain, men may put unnecessary pressure and guilt on themselves which could amplify the emotional distress experienced. Similarly, were females that have had their genitalia opened by their husband to question whether or not the role their husband took resulted in pain or complications, an element of distrust

may grow within the relationship causing broader issues for the family.

None of the 12 first-generation male participants who responded that they opened their wife's genitalia on their wedding night have any form of medical training; the knowledge that they had over the correct way to open the genitalia was obtained through discussions with their friends or family members who had previously had this experience themselves. As such, first-generation males are unlikely to be particularly confident about the process; this may result in many men questioning themselves and blaming themselves if the opening process has any complications or there are longer term implications following the procedure.

First-generation males of a Somali background may subconsciously feel guilty were they to air their emotional difficulties following the experience; furthermore they may be concerned that in doing so, their wife may begin to question whether the husband had a damaging role in the experience by causing her undue suffering. These additional factors may also result in men that have been emotionally impacted avoiding accessing appropriate healthcare services. Similarly, this may be resulting in males not openly acknowledging that they have had an unpleasant experience to the Somali community and their family.

This discussion of men's experiences of FGM reveals an aspect of the FGM narrative that is rarely discussed, either by the people involved, or by researchers. In contrast to constructions of ideal Somali masculinity of dominance, strength and the protection of family members, this discussion hints at potential

vulnerabilities and uncertainty on the part of men, and a sense of guilt at not performing their role as protector.

3. Relationships between females

In Chapters 5 and 6 I highlighted how decisions about FGM were usually made by mothers and/or grandmothers, albeit within a broader community context. In this section I am going to consider these female relationships in more depth, seeking to highlight the impacts of FGM decisions on the relationships i.e. going beyond the common focus on the impacts on the physical and psychological health of the woman who is cut. The section also considers other key female relationships, notably between sisters and between female friends.

3.1. Pattern of emotional distress faced by mothers and daughters

Mackie (1996) outlined how FGM as a social norm can continue even when individuals are opposed to it. He was keen to stress that people who choose to have their daughters cut are 'honourable' (2000, p.279) as they are doing what they think is in the best interests of their children. While parental intentions may be honourable, women may not view their experiences of FGM in the same way, and have negative feelings towards the person or people who made the decisions to have them cut. There is some research which suggests that FGM can create feelings of distrust between mothers and daughters (Dorkenoo et al., 2007; FORWARD, 2007; BMA, 2011; Koukoui et al., 2017).

Throughout many of the interviews with first-generation female participants who had undergone FGM, it became apparent that this distrust of their mother did not always exist. Rather than distrust, the feeling was often more one of understanding of their mother's situation; their mother did not have the knowledge and understanding about the damaging impact of FGM, along with support and laws against the practice, to aid them in taking a decision about the practice on their daughters. FGM was a deeply-rooted part of the first generation participants' mother's culture and tradition at that time, and it wasn't necessarily seen as a choice; it was simply the done thing. As Samira said:

> *It's shame I have lots of pain, even I have lots of pain now. I wish I wasn't circumcised it. But it was normal practice for us that time, everyone done it in Somalia. We didn't know what exactly FGM was, we thought FGM is good, FGM is important for us as culture and tradition. All of us thought FGM should continue. That's it. Nobody think FGM is bad, FGM should be stopped. Once white lady told me "you must be annoyed with your mum". Honestly, I don't annoy with mum, I know mum didn't have choice. Mum apologised me few times and I forgive her. I told mum it's OK, I forgive you. I know no one knew exactly what is FGM that time.*
>
> *(*Samira, *first-generation, female, London)*

Even though large numbers of first-generation female participants who have experienced FGM shared similar feelings as Samira, I cannot ignore Idil's case.

Idil is a first-generation female based in London who had a similar understanding of the circumstances around which her mother made the decision for her to be cut when she was a child. Despite this feeling of understanding, a strong sense of distrust towards her parents, particularly her mother, began to develop after she gave birth to her own daughter and her mother raised the question of FGM for Idil's daughter.

> *Idil: I cannot believe mum asked me when and how I would like to organise the day (practise FGM) for my daughter. I told her I don't do my daughter, really strong way. But mum still believed FGM is good for girls even though lots of voice against FGM that time in the UK and Somalia. Then, I start thinking "well, maybe mum just asked me forgiveness, but she didn't mean it". I was scared to leave my daughter with mum even though I went to toilet. I just don't trust her that time.*
>
> *(Later in interview)*
>
> *Idil: I didn't see mum for maybe 10 years after she told me my daughter's day (day her daughter will have FGM practised on her). I was scared mum take my daughter somewhere and cut her body without me. It was hard, my family asked me why you don't see mother, should meet her, should take care of her. But I'm a mother, I had to protect my daughters.*
>
> *(Idil, first-generation, female, London)*

While Idil's mother apologised and asked for forgiveness for allowing FGM to be

practised on Idil, leading to a long period where they had a healthy mother daughter relationship, the birth of Idil's daughter and her mother's suggestion her granddaughter be cut has resulted in a significant strain being put on their relationship and them not meeting for ten years.

Idil's case could be shared with other first-generation females who did not undertake individual interviews. Her case is proof that there are people who still have a strong preference to continue FGM for further generations, even though they have knowledge of the negative impact on women from FGM and that FGM is illegal in the UK. Idil's mother possibly asked Idil's forgiveness to have a smooth and easy relationship with her daughter for a while, but her view of FGM did not change. Idil's case was possibly rare, especially as she did not meet her mother for about ten years to protect her daughters. There is, however, the possibility that some first-generation females are struggling to have a relationship with their mother, due to the discussions and disagreement of second-generation daughter's FGM.

Second-generation female participants appear to have more of a difficult relationship with their mother, with strong feelings of frustration present towards their mother where the decision was taken to practise FGM on them as a child. However, a large number of second-generation female participants who have experienced FGM also told me that they had already forgiven their mother for the decision.

The first-generation females seemed to have had similar discussion with their mothers about forgiveness, which I mentioned earlier. Some, however, still have feelings of resentment towards their mother and continue to blame their mother for the decision to have them cut and the subsequent issues that arose from this.

> *NafiraI: I never talked about it with my mum for years and years and years. Only a few years ago, maybe recently, I'm not sure how long ago, I spoke to my mum about it. Mum said sorry, I could see she was sorry, she is genuinely sorry. But I don't know how easy it is to say sorry after what happened. I know she doesn't have any other option but to apologise, but I have a very difficult relationship with my mum. Traditional mothers have a strong view, and they are very similar. They are quite narrow minded. Me and my mum clash in lots of things we do, like lifestyle and a woman's role – my mum thinks this is to be a good housewife and take charge of the house, tidying and cleaning up and being very domestic which is fine to do, but I think women should also achieve something as well. The big thing is the view of marriage and view of FGM, because my mum is very traditional.*
>
> *(Nafira, second-generation, female, Manchester)*

> *Mina: Have you ever talked about it with your mum?*
>
> *Eiilo: In passing, so me and my sister said it. She doesn't know*

how I feel exactly. Mum it's awful what done to us. No one else done it, your sister didn't do it to daughters. I don't understand why you done it to us. She said, my sister accepted it, understood what came from, She didn't know nothing more than this, what mum's mum told her. What she assumes right, what her culture and her understanding

And it's normal. She assume it's normal where she is coming from.

I understand that part. But why you had to be part of your surrounding your sisters won't.

I feel like I know something unnatural has happened to me (FGM), and it's man-made, not natural. The effects on my body are done by someone's hand and the only hand I can blame is my mum's or my dad's. But I don't think it's my dad because I don't think my dad cares.

It's normal for a man to say that he wants his daughter to have that (FGM).

(Eiilo, second-generation, female, Manchester)

While it seems that Nafira and Eiilo have forgiven their mother's decision to have them circumcised, they still have a strong feeling of resentment towards their mother stemming from this, which is having a negative impact on their relationships and causing regular clashes. Perhaps the only way these individuals can manage their significantly complex feelings, including anger,

confusion and frustration, is to blame their mother and be in regular disagreement over their mother's opinions towards things, even though this attitude is putting a strain on their relationships. It was interesting to note that some participants were aware that their attitude towards their mother was damaging their relationship, but felt unable to change their behaviour such was the strong feeling of resentment.

Two first-generation female participants noted that their relationship with their daughters was very difficult. On several occasions their daughters had asked why they had taken the decision to have FGM them cut; these conversations were always very emotionally driven and they were aware that their daughters blamed them for experiencing the practice as a child. These participants did, however, feel that they did not have a real choice in the matter (see Chapter 6). They were themselves put under immense pressure from their own mothers to ensure that their daughters were cut.

> *Nadifa: I don't know how many years ago, but my daughters began to ask me why they had it done (FGM). I was hoping they won't ask me anything, but it was happened. They were not like want to know the reason. They blamed me, they said mum it's awful, I can't understand why you done it to us, it's your fault I'm pain. I could see they are upset, but I'm also upset. They cried, and I asked them forgiveness.*
>
> *(Later in interview)*
>
> *I just didn't have choice. FGM was normal for us, my mum was*

told by her mum, I was told by my mum. It was normal thing for us.

Mina: So you didn't know that FGM was illegal in the UK at that time?

Nadifa: I kinds of know, not too sure but I knew British doesn't do it. I called mum about it, but she said you are not British, we are Somali. Your daughters are also Somali. We should do it to them. I just didn't have choice, I couldn't against mum.

(Nadifa, first-generation, female, London)

These first-generation female mothers who made the decision for their daughters to experience FGM as children, and are now facing blame from their daughters for this decision and difficult relationships, appear to be facing their own emotional distress as a result of this experience. Indeed, this group of first-generation female participants appear to be developing their own feelings of blame towards their own mothers for the pressure that they exerted at the time the decision was taken to practise FGM on their daughters, and the negative repercussions they are facing from their daughters following that decision. As Nadifa said, "*I called mum about it, but she said you are not British, we are Somali. Your daughters are also Somali. We should do it to them. I just didn't have choice, I couldn't against mum.*"

These situations put a significant strain on the mother-daughter relationship between first- and second-generation females, and has a negative emotional

impact on both of these groups. There is currently no support available for managing this emotional distress, and in any case, it may be that these groups are not fully aware of the negative impact that this distress is having on their relationship (and vice-versa) and as such may not seek out support for this. Seeking out appropriate support (where available) could not only result in an improvement in emotional wellbeing, but could also repair mother-daughter relationships damaged by the decision for daughters to undergo FGM. Finally, in repairing the mother-daughter relationship, it is possible that a strengthening of this relationship could result in both mother and daughter supporting each other to deal with the long- lasting physical and emotional damage that can be caused by FGM.

Several first-generation female participants, such as Nadifa, who took the decision for FGM to be undertaken on their daughters often noted that they felt that they had to make this decision due to pressure from their own mother. Similarly, second-generation female participants who had undergone FGM commonly noted that while they forgave their mother for making the decision they did around FGM, there were still feelings of resentment towards her.

There is still a rigid hierarchical system inside of the family unit, with a strong recognition that elder family members' views are absolute, in the mainland of Somalia. This concept is carried on to families with a Somali background who migrated to the UK, and later generations of the Somali community born and raised in the UK (Boyle and Ali, 2010). This strong hierarchical system, and

attitude towards their elder family members, may lead to many people of a Somali background not being able to stand against their elders even where they have a difference of opinion. This was clear in the discussion of transnational links and influence on FGM decisions in Chapters 5 and 6. As Awo outlined:

> *I didn't want my daughter to be circumcised, Gudniin (FGM in the Somali language), but I just couldn't go against mum. I knew British doesn't do it, I knew we don't need to do it for my girls. I know how Gudniin will affect my girls' body, because I gone through. I know how hard my girls' life will be. But I just couldn't go against mum. Mum told me every Somali girls have to do it, if your girls won't be circumcised, you against me, against family, against community, against all Somali. How could I say No?*
>
> *(*Awo, *first-generation, female, Manchester)*

This strong feeling of respect towards the elderly is deeply rooted in Somali culture, particularly among first-generation participants like Awo who was born and raised on the mainland of Somalia, or Somaliland (Ali, 2008; Boyle and Ali, 2010). There is an implicit understanding among Somali households that you don't disagree with elder members of the family. Even though members of the first generation, like Awo, live outside their country of origin, they still have intense pressure and there are strong expectations to show respect towards the elderly. At the same time, Awo's mother may have known that it is difficult for younger generations to disagree with their elders, particularly family members. Awo's mother may have used this standing to exert her will inside the household, and

her desire for her granddaughter to be cut.

The relationship between second-generation female participants who have experienced FGM may share this power relationship with their mother. As Salma described:

> *Salma: I clash sometimes with my mum, especially when she says what I have to wear, what I can and I can't do, like I can't go out with boys. I have friends at Uni, I would like to wear skinny jeans and colourful clothes. My university friends ask me to go out*
>
> *Mum is maybe more understandable, and I can say something strong against her. If it's a small thing I can go against my mum, but I shouldn't go against her in general, I shouldn't disrespect mum and for whatever she has done to me, I have to forgive her because she has asked me for forgiveness. Maybe I can't fully forgive her, not from the bottom of my heart. But she asked for my forgiveness so I don't have a choice, I had to forgive her (crying).*
>
> *(Salma, second-generation, female, London)*

Even though Salma told her mother she had forgiven her, it would seem that this isn't entirely the case as she said she had not choice about forgiveness and she still harbours strong feelings of frustration and anger against her mother. This empty forgiveness from the daughter may lead to the mother feeling less

guilt about the decisions that were made regarding the practice of FGM on her daughters. Reluctantly granting this forgiveness may however lead to some second-generation daughters having more negative and complicated emotional feelings; for example reluctantly granting this forgiveness may make it difficult for the daughter to blame her mother for the inflictions caused by FGM and could lead to damage in the relationship with their mother.

4. Second-generation women

4.1. Pattern of emotional distress amongst sisters

Sisters, usually raised together in the same household and within the same environment, tend to have similar experiences and are raised in the same way. It is possible that one such common experience is in relation to FGM, with an expectation that siblings have very similar experiences of FGM including whether or not the practice is undertaken on them, if so what type of practice, at what age and where undertaken. Based on my interviews and discussions in the community for example, where one second-generation female had not been cut, their sisters were also uncut. Similarly, where a second-generation female participant had been cut in a clinic in Somalia, her sisters were also cut at the same clinic. There seemed to be a desire for sisters to be treated the same by parents with respect to the practice of FGM.

While sisters may share the same FGM experience, albeit typically at different times, the level of distress and impact that the practice has on their lives can be

different. The older sibling may for example feel a greater impact than the younger sibling because she goes through the experience first without a big sister to support her throughout the experience. Siraad and Faduma, second-generation female participants who are both older sisters in their respective families, seemed to feel an element of guilt and responsibility for their younger sisters having FGM practised on them. Both knew the practice was wrong and both tried, but to no avail, to stop the practice from taking place on their younger siblings. As they outlined:

> *Siraad: My little sister has done it as well. She is a lot younger than me. She is 20 now. She was older than me at the time she had it done. So she knew what happened. She was sent back home. That's the typical way other girls are done. Hers is not as bad as mine, but I was upset more because I couldn't protect her, and I think what hurt me most is how upset my sister is about it.*
>
> *(Siraad, second-generation, female, Manchester)*

> *Faduma: I begged my mum just please don't do it (to her younger sister). I wished now I could help her run off, or lay down in front of an airplane to stop the flight. But I thought it would disrespect my mum or be difficult. I never thought I should call the police or anything like that. That was never going to happen.*
>
> *(Faduma, second-generation, female, Manchester)*

Failure to protect their younger sister from the practice of FGM has negatively affected these older siblings, with both blaming themselves to an extent for the practice being undertaken.

This feeling does not appear among younger sisters, for example none blame their older sisters for their FGM experiences. The responsibility that older siblings place on themselves for their younger sisters' well-being may result in them experiencing distress for a longer period of time. It would seem however that both Siraad and Faduma's younger sisters, Eiilo and Nafira, have a different view of their older sisters and don't place the blame on their older siblings for what has happened to them.

> *Nafira: I know my sister (Faduma) told mum don't do it (FGM) to Nafira, don't take her to the clinic. I will do it, but don't do it to her. I knew there was no way my mum would change her mind. There was no hope. But my sister tried to protect me. I know how hard she said to mum. Of course I was upset about what happened to me, I still blame my mum for what she has done to me. But maybe what my sister tried to do made me feel, it's difficult to explain, but I feel I'm close to her and I trust her more than anyone.*
>
> *Mina: Did you tell your sister what you feel about what she tried to for you?*
>
> *Nafira: I haven't, but maybe I should tell her.*
>
> *(Nafira, second-generation, female, Manchester)*

Eiilo: My sister tried to protect me, she told my mum so many times, every day, during the day and night. I knew my mum will take me no matter what my sister and me said.

(Later in interview)

Eiilo: I always think I'm unlucky with what happened to me, being circumcised. Because my mum is ignorant, because I'm Somali. I blame everything around me. But one thing I'm lucky for is my sister. Because she is my sister, I can accept who I am. She is my supporter, she is what I want to be.

(Eiilo, second-generation, female, Manchester)

The outcome, undergoing FGM, is not the most important consideration for both Nafira and Eiilo; they feel that being circumcised was unavoidable and place significant importance of the efforts of their older siblings who tried to protect them. As such, in the younger siblings' eyes, their older sibling shoulders none of the blame and instead become more trusted.

Nafira noted during the interview that she has never told her older sister about the way she felt about being circumcised, and the closeness she felt as a result of her sister's efforts. Their discussions around this are more focused on the experience itself, including the physical and pain endured. This lack of wider communication between sisters may lead to the older sibling continuing to feel guilt; having more open communications around the circumstances surrounding

the decision to have FGM practised on them could reduce some of the guilt felt by the older sibling for failing to protect her younger sister. Furthermore, in doing so, the relation between the siblings could be strengthened and they may be able to better support each other and fight against feelings of frustration and anger connected to their experiences together in the future.

Siraad, a second-generation female participant in Manchester, has experienced emotional pressure as a result of her experiences connected to FGM. Siraad has already identified that she has a strong feeling of responsibility for her younger sister also being cut. The psychological distress however that Siraad has experienced in connection with FGM would seem to go beyond her feeling of failure to protect her sister, but also her feeling of failing to protect future generations in the UK from the practice. Siraad is the only participant that has been cut inside of the UK. She outlined what happened:

> *Siraad: A few days later, police came into the house, because I think they were investigating the man, he was under investigation, the man that did it to me. Around that time was the peak of when people in the public were realising what's going on. I think they caught him, and got his address book and the last client address was my uncle's address. So the police came. And I was the one, I think my parents, my family must have known something. Because my auntie hid and they tried to hide me. But I was running and I was the one that opened the door. And I remember my mother didn't tell me*

anything. The policewoman talked to me rather than my parents. She was asking me questions. I only realised now, she was asking me if I was hurt anywhere? Did anyone touch you anywhere, did you have anything special happen to you, I think I was five. No one told me I shouldn't say anything or anything like that. I just automatically said no, I'm fine, nothing, no. Really I knew, I must have known what happened to me was bad. Because the policewoman asked me about it. If I didn't know it's bad I would have told her. I remember very well doing a cartwheel, I just did a cartwheel to prove I wasn't in pain. I was in a little bit of pain, but I did a cartwheel to show her nothing had happened to me.

(Siraad, second-generation, female, Manchester)

It seemed that Siraad simply considered this to be an interesting experience for a long time, however after growing up and considering how many females have been negatively affected by FGM she began to suffer herself. She considered whether or not her younger sister could have avoided the practice had she raised her voice to the police officer that day, and whether in doing so she could have prevented the practice being undertaken on other young women too. This experience and subsequent self-reflection appears to be putting a significant amount of pressure on her, and at the same time she does not seem to know how she can resolve this distress and pressure going forward.

Not all second-generation female participants who are older sisters, however, consider themselves as responsible for their younger sisters experiencing FGM. Somali families are often large families, with the typical family having between five and eight people (if not more) living in the same household (Cole and Roinson, 2003, Gele et al., 2020), and it is common to have large age gaps between children. As a result of this, first-generation females can change their view of FGM, from being a supporter of its continued practice to being against it, or can develop knowledge about the practice impacting their attitudes towards it. The mother of Amira, a second-generation female participant in London, is an example of this case. Amira is a first child who has younger sisters, but there is a sizeable age gap between them. Due to this age gap, the severity of the type of FGM practised has reduced through the siblings, with the youngest sibling not having FGM practised on them at all.

> *Amira: Sometimes it's hard for me to talk with my sisters, they are lovely but it's difficult sometimes. Maybe it's because the youngest one could avoid having FGM. I remember she said "wow, disgusting!" about a TV programme we watched. It was about FGM, I know she was only little and didn't know the others had done it. But it still hurt me lots. After that I started being angry with my mum more about why she could do it to me.*
>
> *(Amira, second-generation, female, London)*

Due to Amira's explanation of how her youngest sister reacted, it seems as if the

sister did not experience FGM, and she may not have heard any stories of experiences of FGM around her. This is possible because her friends may be a limited number of girls who were experienced FGM, and she did not hear about FGM before.

The trend of FGM within families largely depends on the parents' attitude towards FGM. Where the attitude softens, there may be a weakening of the practice amongst daughters with younger siblings experiencing less extreme, or no, forms of FGM. This different pattern of FGM inside of the same family may also cause some friction amongst siblings due to the very different experiences, and the very different impacts that this has on their lives.

Where the parents' attitude is unchanging, it would seem that the experience of FGM is largely consistent with all siblings having similar forms of FGM at similar ages. While possible, I did not encounter experiences where the parents' attitude towards FGM gradually hardened over time with younger siblings experiencing more severe forms of FGM than their older sisters. This would seem counterintuitive as one would expect that where first generations move to countries like the UK, where FGM does not form part of that county's traditional practices and is illegal, the stance towards FGM would, if anything, soften.

Disparity in emotional impact experienced by older and younger siblings among the same family is not currently considered as an issue; this is a potential area of further research to identify the potential difference in impact and further

consideration should be given to this.

Family members, particularly siblings, sharing their similar experiences of FGM could be one of the more effective sources of support as the decision-maker is likely to be the same and there is a common understanding of each other's personal situations. There is however a lack of research available in relation to whether the experiences of siblings within the same families differ.

4.2. Importance of sharing experiences with friends

While the majority of first-generation female participants had been cut, significantly fewer second-generation female participants experienced the practice. As revealed in the analysis in Chapter 5, four London-based second-generation female participants and five Manchester-based second-generation female participants had experienced FGM; as such over half of the second-generation female participants interviewed had not experienced FGM. Through my field research, it appeared that the group of second-generation female participants that had been cut experienced additional emotional distress during their life.

During the individual interviews with second-generation female participants who had not experienced FGM, it appeared that many did not fully understand what FGM was until they became older. Most of this group of participants noted that the first time they heard about FGM was through the media, and that they learnt

more details around the practice after watching TV documentaries on the subject, or through discussing the topic with their family and friends. The following interview excerpts exemplify this:

Mina: So I believe you didn't' experience it (FGM)?

Idil: Oh no I've never experienced it. I think it is disgusting. Automatically I asked my mum is that really what happens back home? She said yeah, if you don't get it done people don't look at you like a normal person.

Mina: So you asked your mum?

Idil: I asked if that actually happens back home. I don't agree with that. Mum disagrees with that as well now. I'm glad it didn't happen to me, none of my friends have had it done.

(Idil, second-generation, female, Manchester)

Mina: So you haven't experienced it (FGM)?

Waris: No, I learned about it. Actually when I was on holiday in Syria, I met some family friends and my mum and her friends were talking about something. So I was like, "what are you guys talking about". The kids, the girls there had already had it done to them, so that's when I started asking what it was. I wasn't really told much about it.

Mina: How old were you?

Waris: I was 13 years old.

(Later in the interview)

Waris: We (she and her friends) watched documentaries (about FGM). They were really interesting documentaries, so we discussed it. I was shocked what Somalis did a long time ago, It's weird, awful and disgusting.

(Waris, second-generation, female, London)

All second-generation female participants who had not experienced FGM used very strong words against FGM when describing the practice, such as "*disgusting*". At the same time, a large number of this group also considered that FGM is a past tradition of the mainland of Somalia, not currently practised in Somali communities in the UK, and they also believed that their friends and sisters had not undergone FGM. Given this perception that those around them have not been impacted by the practice, it is easy to imagine that when discussing FGM with friends no thought is given to the possibility that their friends have actually experienced the practice. Given this, blunt, negative and unintentionally-inconsiderate language could be used by those that have not experienced the practice when discussing it. This could have, again unintentional, negative emotional repercussions towards those that have experienced the practice.

Muna, is a second-generation female participant based in London. While she has been cut, not many of her friends from a Somali background have direct experience of FGM. She explained what this means for their interactions:

Muna: I know many of my friends were not cut. I told some friends I was cut, but not many girls know. One day, we talked about a BBC documentary. It was about FGM, and the next day some of the girls asked me if I watched. One of my friends, she is Somali, and she didn't know I was cut said that she can't believe this happened in Somalia, that it's barbaric and that she couldn't believe it. After I heard what she said, I just didn't want to tell her what happened to me. There was no point for me to tell her what happened to me. Maybe I was scared she will ask me lots of things, like details. Maybe also that she will whisper about me to her other friends.

(Muna, second-generation, female, London)

Many second-generation Somali women do not always consider the circumstances and experiences of their friends and the people around them when discussing FGM. This can result in those that have experienced FGM not wanting to talk about their own experiences for fear of hearing negative comments from those around them. For Muna, the use of the term "*barbaric*" to describe what had happened to her made her feel unable to share her experiences with her friend. Having this kind of experience, and hearing negative comments in relation to the practice, may result in a negative emotional effect for the second-generation women that have experienced FGM. Bottling up their experiences in relation to FGM can make it more difficult to identify those in need of support and may make it difficult for those that need support to proactively go out and seek

the support they need.

It is important for those that have been cut to have friends and others around them that have also experienced the practice so that they do not feel isolated and alone in their experiences. This could help minimise the likelihood of long-lasting emotional distress and help with the recovery process.

None of the second-generation female participants that had undergone FGM access healthcare services to receive emotional support. This was as this group understood that the practice is illegal, and as such very rare, in the UK so healthcare workers may not fully understand the practice. There was a concern that through questioning and lack of understanding from healthcare workers, further issues could arise for those seeking support, rather than helping with their emotional recovery. I would like to add that a large number of female participants, particularly first-generation female participants know about the special FGM clinics in the UK. They mentioned, however, that they do not feel the need to access these clinics if they do not have any specific physical difficulties. Given this, sharing details of their personal experiences with friends and others around them who have had similar experiences is a significantly important step in the recovery process for those affected by FGM.

> *Nafira: I just came back to the UK, finished summer holidays. It's weird going to school because I just had a crazy summer. But I can't tell people. I thought I can't tell people because people will*

think I'm crazy. I didn't think oh mum will be in trouble, or anything like that. I didn't know it's a crime. I didn't know it's illegal. It just felt weird. I didn't think people in the UK had it done. But after I done it, I realised actually lots of girls in the UK have it done. It's a big thing. You might know. After I met lots of friends who have had it done, I did talk with them about what happened to me that day. I can't talk with friends that haven't had it done, but I have lots of friends who have had it done. We talked about our anger towards our mums lots, but now we joke with each other about FGM.

(Nafira, second-generation, female, Manchester)

It was initially difficult for this participant to discuss her experiences, however after she realised that her friends had also experienced FGM, she could start the process of healing her emotional distress through sharing experiences with those friends around her. As a first step, they vented their anger and frustration over their experiences of FGM; sharing their anger over their experiences did however lead them to accept what had happened to them, with them now even joking about this difficult experience.

Mina: Have you ever talked about your experience with your friends?

Sabrinah: Actually, yes I do talk about it with my girlfriends. I have a few close friends, you met them at the event, they also

had FGM. After it happened to me (was circumcised) it took me a long time to talk about what happened with my friends. I was not sure whether they had it done too or not. Eventually, I can't remember why, but I found out that they had FGM. We talked about how we were cut and where it happened. It was difficult for me to remember that day but talking about it with other girls, and hearing about what happened to them, was helpful. It was over ten years, so we joke about it now. Teasing the people that did this to us, how much money the family paid for it. Just makes us laugh. FGM is not funny memories for us, but making jokes with friends maybe helps us get over it.

(Sabrinah, second-generation, female, London)

This mindset was shared with other second-generation female participants in both cities. Making jokes about their personal experiences of FGM was done not because they considered FGM to be a funny experience, but they found that laughing and joking about their experiences of FGM helped them get over their experiences.

Consistent with expectations, neither Nafira nor her friends had accessed any psychological health care services or support to date, and none seemed to be considering accessing these services in the future either. However, sharing their experiences with friends who have been through similar difficulties in relation to FGM seemed to have had a positive effect on this group's emotional wellbeing.

Not all second-generation female participants who have been cut can share their personal experiences with friends to heal their emotional distress. A second-generation female who had experienced FGM may incur emotional distress if her friends have not had similar experiences. In the following quotation from a second-generation female participant based in Manchester, Siraad talks about herself and her younger sister; it is clear that there are differences in the emotional issues that they each face.

> *Siraad: She doesn't talk about it, how it happened to her, she just becomes very emotional. Also for her, none of her friends have had it done. She has no one to talk to about it. I talked to her, but she doesn't like to talk about it. She gets upset really quickly.*
> *I think it's easier for me to talk about it (FGM) because my friends have all had it done, so we talk about it, being older we joke, and laugh. But all her friends haven't had it done, so if she starts talking about it, maybe she is the odd one out. Or maybe they start asking her why your mum did it to you, because they were all born here, she doesn't want her friends to start saying bad things about her. I totally understand. She has more resentment than I had.*
>
> *(Siraad, second-generation, female, Manchester)*

> *Eiilo: My sister, she is obviously the older one. I have lots of girls, more girls my age in my family, a similar age, none of them have*

had it done.

Mina: Have you ever talked about FGM with other girls?

Eiilo: None of my friends know. My best friend of 10 years doesn't even know. You are the first person that is not my family member.

(Later in interview)

We have talked about the idea of it (FGM). But they are innocent and they say oh my god, yeah, I can't believe it, it's awful. The reaction I was getting from them made me feel uncomfortable to tell them that I have had it done or anything like that.

(Eiilo, second-generation, female, Manchester)

Even though Siraad and her younger sister (Eiilo) were both born and raised in the UK, and have had similar experiences in relation to FGM, their level of emotional distress appears to be completely different. Siraad had a large number of friends who had also had FGM practised on them and could share her experiences with this group. Her younger sister, Eiilo, however did not have any such friends to discuss this difficult experience with. Eiilo's case suggests that even though sisters can share their experiences of FGM, the healing impact and support that this provides is not the same as doing so with a support network of friends who have had similar experiences.

Similarly, one second-generation female participant based in London was also

unable to share her personal experiences in relation to FGM with her friends as they had not experienced the practice themselves. It is difficult to identify whether or not a second-generation female migrant has this support network of friends that they can call on to discuss their issues stemming from this practice, which aids with emotional wellbeing and recovery. The surrounding support network that second-generation females impacted by the practice of FGM has is currently not considered by external bodies, such as GP's and counsellors, when providing support to this group; this group is simply classified as a second-generation migrant when receiving support (Momoh et al., 2001). The individual circumstances in relation to support network, particularly from friends, of the second-generation migrant should be considered when support is provided by external support agents to ensure that the approach is tailored to suit their needs. If this is not done, the support received may actually result in additional emotional distress and may also lead to further difficulties such as depression and other symptoms which may affect their physical health.

5. Discussion

This chapter has focused on the inter-personal relationships within families and communities, and how decisions about FGM, experiences of FGM and different or shared knowledge about FGM are affected by the relationships and also have potential positive or negative impacts on them. The previous two chapters, along with this chapter, have shown that family and community are internally not homogenous, and there are inequalities of power within them.

Within families, the chapter highlights how FGM affects relationships between husbands and wives, between mothers and daughters, and between sisters. The discussion of siblings demonstrates, for example, how some older siblings tried to prevent the cutting of younger sisters, but were unsuccessful due to the greater power of their mothers or grandmothers who saw FGM as a desirable practice for the individual and the family honour. Within the wider community, the chapter highlights different levels of awareness and experience of FGM, particularly among second-generation men and women. While this suggests a move away from FGM as a social norm in the UK, it does mean that the smaller number of women of that generation who have been cut, can be left in emotionally vulnerable situations.

6. Conclusion

This chapter has analysed data obtained on FGM from participants in the same generation, examining differences from within the same generations, and the relationship between different generations of participants.

The first theme drawn from my analysis was one that has not yet been covered by the existing literature, the impact of the practice of FGM on the husbands of the women that have undergone the practice; much of the existing literature focuses on the direct impact on females. The data collected from men, particularly aspects of their personal experiences relating to unstitching their

wife's Type 3 FGM, suggests that FGM is also having negative repercussions on men. Almost all second-generation male participants interviewed however were not yet married, and as such it is not clear how further generations of males may be affected by the practice of FGM, specifically through the experience of unstitching their wife's genitalia.

Another theme in the data was the relationship between female family members, and how FGM appeared to have a significantly different impact on the relationship between siblings, and the mother-daughter relationship. The data suggests that FGM is having a negative impact on mother-daughter relationships and putting a strain on many daily lives, even where not directly related to FGM, but instead due to the lasting feelings of distrust, frustration and anger. Furthermore, the feeling of guilt from older siblings where younger sisters have been impacted by the practice is also having a negative emotional impact on sibling relationships. These subtle, indirect emotional impacts of the practice of FGM are difficult to identify, as it is difficult for people outside of the family to uncover; this is possibly why these themes have not yet been covered by the existing literature. Family members and dynamics are however among the most important influences on people's general daily lives, and as such these aspects need to be considered further.

Some of the younger generations of migrant communities, the second-generation for example, are having their attitude towards FGM changed by their surroundings and upbringing and as such there is a gap in knowledge and

experience of FGM between people in the same generations. These gaps are leading to careless remarks from some people within the same generations, which is adding additional emotional pressure to those that have had FGM practised on them. The gap in impact and attitude of second-generation females that have and have not had FGM practised on them is currently not considered in the existing literature. This gap could however expand among future generations and have a more negative effect for future generations.

Chapter 8: Conclusions

1. Introduction

The previous seven chapters have addressed the overall theme of this thesis of exploring migration and social norms around FGM among Somali communities in the UK. This chapter now summarises the findings of the research and the contributions it makes to wider understandings of FGM among migrant communities. The chapter also discusses possible imitations of this research and makes suggestions for future research that may be developed from this thesis.

2. Empirical findings

2.1. How the experience of FGM varies between first and second generations

Among my participants, the prevalence of FGM declined between the first-generation migrants and second-generation population; while almost all first-generation female participants were cut, over half of the second-generation female participants remained uncut. In addition, during individual interviews, some second-generation female participants pointed out that they were increasingly aware of the number of women and girls who had not experienced FGM.

Focussing on experiences of FGM itself, there are several key differences between the experiences faced by first- and second-generation women of a

Somali background; the type of FGM experienced, where the practice was undertaken and who the practitioner was. It was clear that the type of FGM being undertaken had changed from the most popular type of FGM in Somalia, which is Type 3, to less severe forms. Similarly, the place where first- and second-generation female participants underwent FGM has been changing towards the use of safer options such as clinics, with the practice being undertaken by a medical practitioner. As such, these gradual changes towards milder forms of FGM being undertaken in a safer environment may be accepted by some second-generation females, as the physical impact is considerably smaller than the more severe forms of FGM that their mothers underwent. These changes to experiences of FGM may, while making the practice safer, actually become a hindrance to the long term eradication of the practice; this safer from of the practice may be seen as an acceptable compromise to appease social and community pressure.

A particularly original element of this research was the inclusion of men's experiences of FGM. Somali men are expected to perform a form of masculinity in the roles of patriarch, the head of family, protecting members of the family and bringing in an income to provide support. Given the prevalence of Type 3 FGM among migrant women, many of the migrant men had the experience of opening their wife's genitals on their wedding night; an experience which inflicts pain on the woman, and as a result could be distressing to the man, not least as it conflicts with their socially-approved role as protector. Expectations about masculinity also meant that male participants were reluctant to discuss the potential distress that

they may have experienced through this process.

Only two out of the 20 second-generation men were married, so had not had the experience of a wedding night. However, in the interviews most second-generation men claimed that FGM was not practised anymore, at least not in the UK, as it was illegal and was a traditional practice which had been abandoned. None of the men born and raised in the UK said that they would prefer to marry a woman who had been cut, although some suggested that this may be what their mother favoured.

2.2. The social norms underpinning FGM practices, and how these are maintained or changed by migration and between generations

First-generation women outlined the reasons that they were cut when they were young girls in Somalia or Somaliland. The reasons reflect the deeply-embedded nature of FGM within the region, and FGM was described by the women as being normal and part of tradition and identity. Issues around purity and honour were also mentioned, linked both to statements of value around both the individual women, and their families. The sanctions for non-cutting were clear in many cases, echoing Shell-Duncan et al.'s (2018) discussions of how FGM was a route to inclusion and support in communities within The Gambia and Senegal.

For first-generation women and men, while many were clear in stating that they recognised that FGM was illegal in the UK, its perceived link to Somali identity

was strong. For migrant communities, often living in unwelcoming environments, asserting group identity through particular cultural practices can be very important as a form of coping with the new environment, and also gaining support from co-nationals or members of the same ethnic group. For some, this exemplifies the tensions outlined in Mackie's work on social norms (1996, 2000). They may not consider FGM as a desirable practice in itself, but its importance in reinforcing a sense of belonging to a wider community is key.

Shell-Duncan et al.'s (2016) discussions of sanctions for non-cutting in West Africa, can also be seen within the migrant communities in the UK. This is particularly important in relation to transnational links with family members, particularly grandmothers, in Somalia and Somaliland. First-generation migrant women in the UK sometimes discussed how they were not in favour of FGM, but that their mother or mother-in-law was pushing to have it done on their granddaughters. Here the challenges of living within different social contexts is brought to the fore. In the UK context, there may be far less social pressure for women to be cut, but within the broader Somali community, particularly within family groups, this pressure may continue. Expectations about respect for elders, may directly clash with the opposition to FGM.

My research did not suggest that there was strong community pressure within the UK for girls to be cut, and the reduction in the number of women cut between the first and second generation suggests that this is reflected in behaviour. While the desirability of FGM in a potential marriage partner was mentioned by some

second-generation men, this was in reference to what their parents (especially their mothers) would want, rather than what they wanted themselves. There therefore seems to have been a significant shift in social norms around FGM with migration and between the generations. However, women's behaviour as an indicator of both their morals and the honour of their family continued to be important, and involved daily oversight, with dress and socialising monitored carefully but family members in fear of gossip among the wider community.

2.3. The impact of FGM on intra-familial and friendship relationships

Through this research, it is clear that FGM can add complexities to existing relationships between family members, including siblings (especially sisters) and particularly the mother-daughter relationship. Disagreements in relation to a mother's decision for her daughter to be cut can result in lasting negative relationships. This can be disruptive to communications and relationships between mother and daughter, which at the same time can make it difficult for the daughter to manage her experiences in connection to FGM; her mother may be one of the more important pillars of support given that she will have gone through similar experiences herself.

Dorkenoo et al. (2007) pointed out that siblings have very similar experiences of FGM including whether or not the practice is undertaken on them, if so what type of practice, at what age and where undertaken. However my data shows that some siblings in the same families may actually have different experiences.

This result is possibly a reflection of shifting norms around FGM which have occurred in the past 10-15 years. For example, there were instances of older sisters being circumcised but younger sisters not experiencing the practice, or being cut with a less severe form of FGM. This experience gap also appears to be causing difficult relationships, particularly from the perspective of the older sister who may feel that this unequal treatment is unfair. Furthermore, as discussed in Chapter 7, older sisters can feel an element of guilt and responsibility for their younger sisters being cut. Failure to protect their younger sister from the practice of FGM has negatively affected these older siblings, with some blaming themselves to an extent for the practice being undertaken. Sisters who have similar experiences of FGM can be important in helping and supporting each other through the frustrations and difficult feelings from their experiences of FGM. Similar to difficult mother-daughter relationships, having difficult or troubled sibling relationships can also hinder the provision of support which could help mental health issues arising from FGM.

The existence of diverse FGM experiences between friends within the same generation can also complicate relationships. Most first-generation women generally had similar experiences of FGM, so were able to understand and support each other. The experience gap within the second generation where some of them experienced FGM, but others did not, led some second-generation women feeling alone, unsupported and excluded.

3. Theoretical contributions

The overall aim of this thesis was to understand the role of migration in FGM attitudes, experiences and practices, bringing together social norms theory with research on the impact of relocating across international borders, in this case from a region of high FGM prevalence to one of low FGM prevalence. The study also acknowledged the ongoing connections between migrant communities and later generations, and communities in the country of origin due to ongoing transnational practices.

This bringing together of literature alongside the empirical findings of my research has demonstrated how FGM decisions are located within specific social contexts, where perceived shared values are enacted through the decisions to cut/ not cut and what the form of FGM. FGM is linked to notions of family honour, but that honour is shaped by wider community perceptions of appropriate behaviour. In the context of Somalia, with its high FGM prevalence, FGM is reproduced as a social norm through expectations about morality, marriage and honour.

Moving to a country of low FGM prevalence (in the case of this research, the UK) does not bring great individual autonomy, individuals are still within family and community contexts, but the wider structures of the national space may challenge previously-held assumptions about the desirability of FGM for individual and family success. However, ongoing links to family and friends back in Somalia/ Somaliland, as well as strongly-held views about Somali identity and tradition in an unfamiliar and sometimes threatening environment, mean an overlap of

Somalia and the UK. The navigation of this complex environment can be affected by power relations within the family, FGM campaigns within the UK or Somalia, and changing values of later generations who are brought up and educated within the UK.

Thus in understanding FGM practices this thesis has demonstrated the importance of framing individual experiences within families and wider communities, as well as within national legal spaces and transnationally. This framework could also be used to consider other countries of origin or destination, perhaps with similar or divergent FGM prevalence rates, as outlined in Barrett et al.'s 'FGM-migration matrix' (Barrett et al., 2021). It could also be adapted to include additional countries or regions reflecting more complex migration journeys.

In addition to this overall framework, this thesis makes contributions in four main areas. Firstly, the research provides detailed insights into the experiences of FGM among a migrant community within the UK, and among second-generation migrants. While there has been some work on these themes within Europe (see, for example, Korfker et al., 2012; Alhassan et al., 2016), the research remains rather scant.

Secondly, the thesis addresses Alhassan et al.'s (2016) observation that little is known about the social beliefs that underpin FGM among migrant communities in Europe. The empirical findings from this research highlight the shifting nature

of social beliefs around FGM, but this does not mean that the practice is likely to be eradicated in the course of one generation (as Mackie, 1996, 2000 discusses in relation to foot-binding in China). For some people of Somali heritage in the UK, FGM is a fundamental part of being Somali, and despite being in a different country, that identity does not go away. This may be reinforced by pressures from family members who still live in Somalia or Somaliland, but are able to continue within the daily lives of people in the UK through phone and internet connections. In some cases where the social and family pressure to conduct FGM clashes within individual opposition to the practice, a compromise of a lighter form of FGM has been the outcome. Finally, even where FGM is no longer practised, social norms around the importance of pure and moral behaviour on the part of women, continues.

Thirdly, this research contributes to the neglected area of men's experiences of FGM. Previous research (Almroth et al., 2001b; Briggs, 2002) has included discussions of men's attitudes to FGM, important in understanding the social beliefs which explain its continuation or eradiation. However, there has been almost no consideration of men's experiences of FGM, particularly in relation to sexual relations. Through a sensitive approach to interviewing, this research has described the difficulties of the wedding night and men's responses to inflicting pain on their new wives as they open their genitals.

Finally, this research has brought attention to the impact of FGM on key relationships within women's lives. Social norms theory stresses the role of the

wider community on attitudes and behaviours around FGM, but there has been much less focus on particular family or friendships relationships. This is important in highlighting what support can be provided for people around FGM, but also shows how ideas about FGM can be transmitted or enforced through these relationships.

This research helps to understand the wider issues concerning FGM may prove beneficial in helping to reduce the practise of FGM regardless of who it was undertaken by. During field research, I had opportunities to present my projects to community members to show some findings through this project, and I was also interviewed about my project by a local newspaper in Manchester. Through these opportunities, I was able to have opportunities to not only share my findings but also to consider further actions with community members. My PhD and these opportunities will help provide a stronger base for further research into the impact of culture, gender and migration on FGM and changes that can be made to help reduce this practice in the future.

4. Methodological contributions

Researching a very sensitive topic, such as FGM, comes with significant challenges. These may be particularly acute if the researcher is not a member of the research participants' community. This was certainly the case for me, as a Japanese, non-Muslim, woman, interviewing Somali Muslim men and women about a topic that was rarely discussed within the community, let alone with perceived outsiders. This amount and depth of qualitative data presented in this

thesis, reflect the care, reflexivity, and sensitivity with which I approached this research, as well as the respectful relationships that I developed with my research assistants and participants.

Discussions of researcher positionality have moved on from simple assumptions about ‘insider’ or ‘outsider’ status, not least because of engagements with intersectionality and the dynamism of the research encounter (Mullings, 1999). As Zhao (2017) highlighted, ‘insiderness’ and ‘outsiderness’ can coexist, with many researchers finding themselves in an ‘in-between’ position. Rather than pre-judged and rigid notions of insider or outsider, Mullings discussed the idea of shared ‘positional space’, drawing on her research in data-processing companies in Jamaica. She defined ‘positional spaces’ as ‘areas where the situated knowledges of both parties in the interview encounter, engender a level of trust and co-operation’ (Mullings, 1999, p.340). For my research, what became very apparent during fieldwork was, how even though there seemed to be significant differences in the lives of myself and my participants, my identity as an immigrant to the UK, who did not have English as my mother tongue, was seen as a shared experience by many first-generation participants. Among second-generation participants, my experiences of living across cultures (UK and Japan) resonated with their own lives. Thus the ‘situated knowledges’ developed through experiences as migrants to the UK or as people living cross-culturally, greatly enhanced the research process.

My identity as a woman clearly facilitated engagements and discussions with

female participants, especially second-generation women. These women were relatively close to my age, and our discussions about family, fashion and relationships, as well as FGM, were frequently seen as being more like “girls’ chat” (to use one participant’s terms), than an interview. However, it is important not to assume that the nature of the interactions with female participants was simply a reflection of our shared gender identity. The material on first-generation men’s experiences of their wedding night, is an important finding in this thesis, and comes not from a shared gender, nationality or religious identity, but rather reflects the way that I approached the research.

Moser (2008) discussed the under-acknowledged importance of personality in research interactions, arguing that a focus on positionality based on markers of identity, failed to acknowledge why two researchers with seemingly the same positionality could have very different research experiences in the same context. She discussed her research in rural Indonesia highlighting the importance of particular social skills in interacting with villagers, where being shy and reserved was not viewed very positively. In my research, spending a long time getting to know community groups and then interacting with participants in an engaged, respectful and empathetic way was key to my research success.

5. Limitations

Given the sensitive nature of the material covered in this thesis, and the fact that practising or abetting FGM is illegal in the UK, some participants may have not

responded in depth to some of my queries. They may also have given me the 'correct' answer regarding attitudes to FGM. While these may be limitations, the nature of most responses and the very personal and sensitive information which participants shared with me, indicate a level of trust that enhances openness.

Another limitation for this research is in relation to the selection of participants. Participants for this research were selected through community centres and societies. As such, members of the community who do not access these were not included in the interview process. Furthermore, before undertaking the field research, I had regular visits with the community centres and societies to build relationships with locals of a Somali background, and approached them to become involved in my field research. This brings about a selection risk as only people who understood and had an interest in my research topic agreed to take part; people who were not comfortable discussing the research topic did not agree to participate in this field research.

6. Suggestions for future research

Several participants made comments in relation to the significance of technology, such as mobile phones, the internet and SMS. The speed of these developments is possibly affecting the social attitudes and decision-making of some of the population around FGM. In fact, all first- and second-generation participants had smartphones and it is one of the most important communication and information gathering tools in their daily lives.

Free international calls using applications like WhatsApp and Skype seemed to be widely used to communicate among people of a Somali background, including between those living on the mainland of Somalia and the UK. This development in technology has led to people being able to talk frequently between different countries. A large number of both first- and second-generation participants mentioned that they regularly contact their family members who are living in different countries and cities, communicating and exchanging information. Through this technology, it has become easier to obtain information from the mainland of Somalia; this may have an effect on the feelings of both first and second generations, making them feel a closer affinity to the mainland of Somalia and have an impact on their social attitude

As pointed out in the Chapter 3, the decision-maker in relation to FGM is commonly the grandmother or mother; the ease of communication between overseas countries and the mainland of Somalia may be resulting in an increase in pressure from grandmothers based on the mainland of Somalia to mothers to organise the practice of FGM for their second-generation daughters.

The impact of the development in technology on participants has not been considered in this thesis. It is easy enough to believe that technology will continue to develop in the future, and as such it is important to consider that this may have further impacts on social attitude, establishing identities, and of course the attitude towards FGM among future generations.

In Chapter 7, I focused the relationship between female family members, and how FGM appeared to have a significantly different impact on the relationship between siblings, and the mother-daughter relationship. The data suggests that FGM is having a negative impact on mother-daughter relationships and the feeling of guilt from older siblings where younger sisters have been impacted by the practice is also having a negative emotional impact on sibling relationships. Additional research could explore these processes in much greater depth.

I also focused on men's distress related to FGM in Chapter 7. Men's experiences related to FGM has not received attention, but it should not be ignored. There are specialised clinics in the UK that provide support for females, but there are no similar clinics that provide support for men who may have a distress from their experience of opening their wife's genitalia on their wedding night. Additionally, as also pointed out in Chapter 5, the type of FGM being practised on girls seems to be changing between first and second generations, from the more severe Type 3 to lighter forms of the practice. Even though the type of FGM is changing however, second-generation males may not face similar experiences that their first-generation counterparts did on their wedding night. Close family members' physical or psychological difficulties often deeply affect the feelings of other family members and can cause further distress. As currently no consideration is given to the male perspective of the distress caused by wives' experiences of FGM, this point also need to be considered further in additional research. It is my hope that this and further research in this area leads to these clinics to consider

additional support for women who are struggling with any relationship within the family, and men who are impacted by FGM.

FGM rates in East Africa have dropped dramatically (The Guardian, 2018), this is possibly because large number of organisations are putting in efforts to eradicate FGM in these countries. This movement could affect the situations of FGM in migrant communities in Western countries. The continued practice of FGM in the UK is becoming more and more complex through the generations. Attention needs to be paid at community or individual levels, to consider suitable forms of intervention to eradicate FGM for further generations in Somali migrant communities in the UK. Any successful approach, needs to be sensitive to the particular social and cultural context, and recognise that practices around FGM are driven by social beliefs, and not just individual attitudes. The REPLACE Approach (Barrett et al, 2020) has significant potential in this regard.

UNICEF (2020b) pointed out that COVID-19 pandemic may increase the risk of gender-based violence, including FGM. Care international (2020) shows the case in Kenya. Kenya has legislation against FGM, and police officers and community leaders are putting strong efforts into preventing circumcision. However, the ability to police activities are limited due to the pandemic, so it is feared that circumcision rates may increase. Furthermore, UNICEF (2020b) also mentioned that people who had lost jobs or income due to the COVID-19 situation may return or become an FGM practitioner to receive income. This may also lead to an increase in the number of girls who will be circumcised. Ongoing efforts the

eradication of FGM by international organisations, governments, local communities and activists have reduced the prevalence of FGM globally, and the number of girls at risk of FGM. However, it is important not to assume that this trend cannot be reversed in times of crisis, particularly within communities where FGM is still quite prevalent. We must flexibly respond to various unexpected situations and not stop the movement towards the complete eradication of FGM.

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Appendices

Appendix 1: List of participants

No.	City	Name	Generation	Gender	Age group
1	London	Abdi	1st	Male	Under 30
2		Abdikarim			Between40-49
3		Asad			Between40-49
4		Dalmar			Between40-49
5		Korfa			Between40-49
6		Labban			Over 50
7		Nadif			Over 50
8		Tadelesh			Over 50
9		Aden			Over 50
10		Muhammed★			Over 50
11	London	Amina	1st	Female	Under 30
12		Ayan			Under 30
13		Nadifa			Between 30-39
14		Ayanna			Between40-49
15		Samira			Between40-49
16		Taifa			Between40-49
17		Fartuun			Between40-49
18		Canab			Between40-49
19		Feynuus*			Over 50
20		Idil*			Over 50
21	Manchester	Abdullahi	1st	Male	Under 30
22		Ali			Between40-49
23		Jaamac★			Between40-49
24		Candi			Between40-49
25		Kaahin			Over 50
26		Inshaar			Over 50
27		Qalaad			Over 50
28		Ardo			Over 50
29		Barni			Over 50
30		Deggan★			Over 50
31	Manchester	Kaleafah	1st	Female	Under 30
32		Nawaal			Between 30-39
33		Balqis			Between 30-39
34		Fatima			Between 30-39
35		Najima			Between 30-39
36		Khadra			Between40-49
37		Awo			Between40-49
38		Seynab			Between40-49
39		Sagal			Over 50
40		Deka*			Over 50

No.	City	Name	Generation	Gender	
41	London	Saado	2nd	Male	Between 18-24
42		Sadiiq			Between 18-24
43		Suudi			Between 18-24
44		Libin			Between 18-24
45		Jinnow			Between 18-24
46		Koos★			Between 18-24
47		Busti*			Between 25-29
48		Khadan★			Between 25-29
49		Salugla			Between 25-29
50		Ugbad			Between 25-29
51	London	Amira	2nd	Female	Between 18-24
52		Muna			Between 18-24
53		Nadra			Between 18-24
54		Sabrinah			Between 18-24
55		Yusra			Between 18-24
56		Yaasmin			Between 18-24
57		Feynuus			Between 25-29
58		Ubax			Between 25-29
59		Nimco			Between 25-29
60		Qani			Between 25-29
61	Manchester	Mahad	2nd	Female	Between 18-24
62		Cawad			Between 18-24
63		Ebyan			Between 18-24
64		Saafi			Between 18-24
65		Sidciyo★			Between 18-24
66		Shamis			Between 18-24
67		Abyan			Between 18-24
68		Bile★			Between 18-24
69		Cartan			Between 25-29
70		Faras★			Between 25-29
71	Manchester	Salma	2nd	Male	Between 18-24
72		Sugaal			Between 18-24
73		Ifrah			Between 18-24
74		Waris			Between 18-24
75		Edina			Between 25-29
76		Faduma			Between 25-29
77		Nafira			Between 25-29
78		Eiilo			Between 25-29
79		Siraad			Between 25-29
80		Sucdi			Between 25-29

Appendix 2: Semi-structured interview questions

Before starting the interview:

- Introduce interviewer and research assistant (if needed)
- Explain the aim of my research
- Provide consent form to interviewee and request signature (if not able to provide in advance)
- Verify happy for interview to be recorded

Start the interview with a general, open-ended conversation

During conversations, the aim will be to find out the following:

- Place of birth
- Mother language
- When the interviewee moved to the UK

Background

- When first generation participants arrived in the UK
- Did they choose to settle in the UK? If so why?

Family

- Size of family / about family members
- Where does family live? In the UK, other country?
- What do you consider to be your household responsibilities?
- If you and your husband/wife disagree on something, how do you deal with the disagreement?

Education/School

- Did you go to school in the UK?
- Did you receive any English language training? (For first generation migrants)
- Were you involved in any school events?

Main part of the interview

The interview should be conversation based with the aim of finding out information on the points set out below. The structure of the interview should be flexible, if interviewees are comfortable to share their experiences or thoughts, the questions should be changed to be more open. However, if interviewees are not comfortable to share their experiences and thoughts I will stick to basic questions.

No questions should be asked directly; responses should be obtained through natural conversation.

The following topics will be discussed with the aim of obtaining information on:

- Do you know about FGM?
- What do you think about FGM?

All questions should be designed for each four participant groups:

Questions for first generation female

- Have you experienced FGM?

If response is yes:

- Could you explain the details? Including age, where practised
- Who decided for the practice to be inflicted on you?
- Do you know who practised FGM on you?
- Have you ever discussed your experiences with someone (family, friends)?
- Did/do you have any difficulties in your daily lives caused by FGM?
- Do you access any support?
- Did or will your daughter have FGM practised on them? – why?
- Do you think FGM needs to be continued in your family?
- Do you think FGM is an important factor for getting married?
- Do you think FGM is an important part of your origin culture?

If response is no:

- Do you know if your mum and grandmother experienced FGM or not?
- Why do you think you did not experience FGM?
- Do you talk about FGM with your family?
- Did or will you consider practicing FGM on your daughter? – why?
- Do you think FGM needs to continue?
- Do you think FGM is an important factor for getting married?
- Do you think FGM is an important part of your origin culture?

Second generation female participants:

- Have you experienced FGM?

If response is yes:

- Who decided for the practice to be inflicted on you?
- Do you know who practised FGM on you?
- Have you ever discussed your experiences with someone (family, friends)?
- Did/do you have any difficulties in your daily lives caused by FGM?
- Do you access any support?
- Do you think FGM is an important part of your origin culture?

If response is no:

- Do you know if your mum and grandmother experienced FGM or not?
- Why do you think you did not experience FGM?
- Do you talk about FGM with your family?
- Do you talk about FGM with your friends?
- Did anyone explain about FGM to you? – eg teachers
- If you have a daughter, would you consider practicing FGM on her? – why?
- Do you think FGM is an important factor for getting married?
- Do you think FGM is an important part of your origin culture?

Questions for male participants:

First generation

- Do you have a daughter?
- Do you know if your wife and daughter experienced FGM or not?
- If participants have a daughter: were you involved in a decision to practice FGM on your daughter or not? – explain details

- What do you think about FGM?
- Did you consider getting married with women who have had FGM practised on them? – why?
- Do you talk about FGM with your family?
- Do you talk about FGM with your friends?

Second generation male:

- Do you have any sisters?
- Are you married?
- Do you know if your mother, sisters or wife have experienced FGM or not?
- What do you think about women who have or have not experienced FGM?
- Do you talk about FGM with your family members?
- Do you think FGM should continue?
- Did / will you consider to get married with women who have had FGM practised on them? – why?
- Do you talk about FGM with friends?
- Do you think you will consider to practise FGM on your daughter if you have one?

Appendix 3: Ethics Review Details

You have chosen to self certify your project.	
Name:	Nakai, Mina (2013)
Email:	MAFA005@live.rhul.ac.uk
Title of research project or grant:	An investigation into the generational identity gap and geographical differences that lead to the spread of Female Genital Mutilation (FGM) into new generations of Somali communities in the UK
Project type:	Royal Holloway postgraduate research project/grant
Department:	Geography
Academic supervisor:	Professor Katie Willis
Email address of Academic Supervisor:	Katie.Willis@rhul.ac.uk
Funding Body Category:	No external funder
Funding Body:	
Start date:	18/01/2016
End date:	30/09/2016

Appendix 4: Consent form for participants

Consent Form for participants

Consent Form for participants

Please tick the appropriate boxes

- I have read and understood the project information sheet dated DD/MM/YYYY ☐
- I have been given the opportunity to ask questions about the project ☐
- I have explained the external support available if needed ☐
- I agree to take part in the project, including participating in a recorded interview ☐
- I understand that my taking part is voluntary; I can withdraw from the study at any time and do not have to give any reason for no longer wishing to take part ☐
- The information I provide will only be used on this project ☐
- I understand my personal details, such as phone number and address, will not be made available to anyone outside the project ☐
- I understand that I may be quoted in publications, reports, web pages, and other research outputs on an anonymised basis ☐

_____ _____ _____

Name of participant [printed] Signature Date

Mina Nakai

_____ _____ _____

Researcher [printed] Signature Date

Appendix 5: Code list

COVER TERM	COVER TERM	INCLUDED TERM	INCLUDED TERM	INCLUDED TERM
The type of FGM	First generation female	"Normal" or "usual"type (type 3)	N/A	
		Type 2	Father strongly against FGM	Campaigns against FGM
		Type 1	Mother against FGM	
		Not practised	No opportunities for FGM due to move into different villages and refugee camps	
	Second generation female	Type 3	N/A	N/A
		Type 1		
		Not practised		

COVER TERM	COVER TERM	INCLUDED TERM	INCLUDED TERM
Who were the decision makers	First generation female	Grandmother	Appearance of disagreement between grandmother and mother
		Mother	
		Female member of the family	
		Father	
		Own	Peer pressure/community pressure
		Community	
	Second generation female	Own (Peer)	Stepfather supported /older sister
		Grandmother	
		Mother	
		Female member of the family	
When FGM was practised	First generation female	Before migrated	
	Second generation female	During school holidays	

COVER TERM	INCLUDED TERM	INCLUDED TERM
Related to FGM inside of communities	Celebrate (parties)	
	Advertise into whole community daughters are good girls	
	Aarents are recognised as good parents by other community members	Not lazy mother, good person
	Receive respect from other families within the community	
	People do not care which type girls had	

COVER TERM	COVER TERM	INCLUDED TERM
Reasons why FGM was practiced	First generation female	Culture
		Tradition
		Social pressure
		For family (Family honour)
		Prove a girl's virginity
		Be clean (pure)
		Show a good girl for the community
		Pressure from family members
		Indicator for men to find wife
		Be a good girl
	Second generation female	Preference by family members
		For family (Family honour)
		Prove a girl's virginity
		Control sexual behaviour
		Community
		Couldn't against mother
		Be a good girl
Where the procedure was undertake	First generation female	Own home in Somalia
		Neighbour's home in Somalia
		clinic in Somalia
	Second generation female	Somalia (someone's home)
		The UK (someone's home)
		clinic in Somalia
		clinic in Mogadishu (Somalia)
whom the procedure was undertak	First generation female	Traditional practitioner
		Surgeon
	Second generation female	Traditional practitioner
		Medical doctor
		Not a medical professional

COVER TERM	COVER TERM	INCLUDED TERM	INCLUDED TERM
Feeling/reaction by FGM (Before/During)	First generation female	Fear/Scared	
		Cry	
		Pain	
		ignorant	
		Cannot refuse	
		Exciting	
		Celebration	Nice meal, Colour dress, pretty hair
		Lots of fun	
		Run away	
		Normal/usual thing	
		Hide	
	Second generation female	Fear	
		Cry	
		Cannot refuse	
		Confused	
		Worried	
Feeling/reaction by FGM (After)	First generation female	Accepted	
		Pain	
	Second generation female	Accepted	
		Give up	
		Frustration	
		Anger	
		compromise	

COVER TERM	COVER TERM	INCLUDED TERM	INCLUDED TERM
Affected by FGM	First generation female	Pain - Opening genitals	
		Pain - Having sex	
		Pain - Delivering children	
Changes FGM by generations	Second generation female	Lighter type / Milder type	Less pain
		By medical professionals	Less complications
			smaller physical impact
			Less affect to phycologically
Feeling to mother related to FGM	Second generation female	Wanted to know why	
		What she (mother) felt	

COVER TERM	COVER TERM	INCLUDED TERM
Experience of FGM	First generation male	Difficult to remember
		Upset
		Regret how he opened
		Difficult to have sex with wife
		Difficult process to open wife's genital
		Didn't want to make wife pain
		Shouldn't share own experience with others
		Shouldn't tell/share own emotion with others
		Don't need any medication
		Women have more difficulities
		Normal things to do (open wife's genitl)
		Feel sorry for wife
		Don't think affected
		Men didn't have any pain
		Guilt
Experience of FGM with men	First generation female	Pain to be opened
		Difficult to have sex
		Scared th first night
		Men should open quickly

COVER TERM	INCLUDED TERM
Movement related to FGM	Campaign / projects against FGM in Somalia
	Campaign / projects against FGM in UK
	Community event in Somalia
	Community event in UK
	Illigal in Somalia
	Illigal in UK
	Shift to medicalisation
	Shift to lighter type of FGM
	Practise at the clinics
	Practise by medical professionals
	Raise voices by women who are affected by FGM
	Media covered

COVER TERM	INCLUDED TERM
Relatoionship between sisters	Regret (not able to protect younger sister)
	Happy (Older sister tried to protect)
	Difficult to have relationship - different experience of FGM
	Different type of FGM had between sisters
	Share experiences between sisters
	Ignorant
	Older sister is brave /Older sister is a hero

COVER TERM	INCLUDED TERM
Relationship between friends	Share experience
	Get over difficult experience together
	Different experiences
	Different types of FGM
	Cannot share experience
	Keep secret
	Upset what friends saids about FGM
	Less upset to share feeling with friends
	Make upset cannot tell friends about own experience of FGM
	Ignorant
	Joke each other about FGM - help to heal emotional distress

COVER TERM	COVER TERM	COVER TERM	INCLUDED TERM
Emotional distress	Mother to daughter	First to second	Forgive
			Upset
			Hope daughter never ask
			Apologised
			Difficult to have relationship with daughter
			Hope daughter understand
	Daughter to mother	First to mother	Understand
			Frustrated (Decision for grand daughters)
			Anger (decision for grand daughters)
			Accept
		Second to first	Forgive
			Want to know why mother did
			Anger
			Not happy
			Confused
			Frustrated
			Difficult to have relationship with mother
			Understand
			Accept
			Mother has to apologise

Appendix 6: List of FGM specialist health services in England

(Source: NHS UK, 2021)

North of England

Leeds – Oakwood Medical Practice (Blossom Clinic)

2 Amberton Terrace, Leeds LS8 3BZ

Midlands and East of England

Birmingham – Birmingham Clinic

Summerfield Health Centre, 13

Heath Street, Birmingham, B18 7AL

London

Brent – SMS Medical Practice (Hibiscus Clinic)

116 Chapin Road, Wembley, Middlesex HA0 4UZ

Croydon – Edridge Practice (Calabash Clinic)

Impact House, 2 Edridge Road, Croydon CR0 1FE

Hammersmith – Queen Charlotte's & Chelsea Hospital (Sunflower Clinic)

Queen Charlotte's Chelsea Hospital, Du Cane Road, London W12 0HS

Tower Hamlet – Sylvia Pankhurst (Primrose Cinic)

Mile End hospital, Bancroft Road, London E1 4DG

Waltham Forest – Chingway Medical Centre (The WAHA Clinic)

7 Ching Way, London E4 8YD

South of England

Bristol – Eastville Medical Practice (Rose Clinic)

East Trees Health Centre, 100a Fishponds Road, Bristol BS5 6SA