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# When Safeguarding becomes Stigmatising

A report on the impact of FGM-safeguarding procedures on people with a Somali heritage living in Bristol



Saffron Karlsen, Natasha Carver  
Magda Mogilnicka & Christina Pantazis

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Saffron Karlsen

Natasha Carver

Magda Mogilnicka

Christina Pantazis

*“We don’t have the power – they have the power.  
I hope something will come of your research and  
they will hear how the community are feeling.  
This is something unacceptable.  
We are hopeful that something will change.  
And we will be proud of that if it is done.”*

6 March 2019

# Acknowledgements

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# Executive Summary

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Female Genital Mutilation (FGM) is considered by the UN to be a 'global concern'. International organisations routinely claim a 98% prevalence rate among the Somali population (UNICEF 2013). As a consequence, Somalis living in the UK have attracted particular attention from FGM-safeguarding policy.

This research presents the perspectives of Somali families living in Bristol with experience of FGM-safeguarding services. The evidence was collected during six focus groups conducted in the summer of 2018. In total, we spoke to 30 mothers, fathers and young adults about their experiences.

Somalis in our study are committed to eradicating FGM and many have already invested time and energy in this endeavour. However, some have been seriously affected by statutory approaches to FGM-safeguarding. This report highlights valuable opportunities for policy-makers and other professionals to improve specific approaches to FGM-safeguarding in schools, health care settings, and by social services and the police. There is considerable work to be done by local and national authorities to undo this damage and prevent further traumatisation and victimisation of both individual Somali families and the community as a whole. FGM-safeguarding has undermined the positive efforts of some individual professionals and many community activists and anti-FGM campaigners and engendering a truly integrated society.

## Key findings

A sense of the abuse of a disempowered community pervaded discussions of FGM-safeguarding. Safeguarding authorities were seen to put pressure on families to comply with demands which were stigmatising, unjustified and contrary to their rights as British citizens. They were considered indifferent to whether this engagement was traumatising, offensive, confusing or inaccurate, both in terms of the specific information on FGM they circulated and the specific FGM risk within particular families.

## Health Care Providers

Women in our focus groups experienced FGM-safeguarding repeatedly in routine health care settings with midwives, GPs and health visitors. They believed medical staff prioritised extracting the information required for Government statistics over and above their health needs and without consideration of their trauma in connection with their past experiences of FGM. Participants said that health professionals repeatedly "put salt on the wound" caused by FGM through relentless and insensitive questioning, and "fixated" on FGM to the detriment of the patient in front of them. As a result, they reported avoiding medical care and/or approaching appointments with hostility and fear.

## Schools

FGM-safeguarding in schools typically occurred when parents asked to take their children on holiday during term time. Professional guidelines indicate that coming from an FGM-affected community, maternal

experience of FGM and planned travel to an FGM-affected country do not, in themselves, constitute a level of risk requiring referral to social services. However, participants believed that Somalis in Bristol were referred to social services as a matter of course, simply because they were going on holiday, regardless of destination or length of stay. Some mothers were asked by school teachers about their experience of FGM, directly contravening this guidance. Such encounters were reported as upsetting, invasive, and offensive. School staff stigmatised, traumatised and alienated Somalis and their children, damaging their relationship with and trust in schools.

## Home Visits

School referrals frequently led to unannounced home visits by social services and (sometimes uniformed) police. These visits received particular condemnation from participants and were seen to have an especially negative impact on children who were left scared and traumatised. Safeguarding officers were described as failing to respect people's rights to privacy and autonomy, using formal interrogative styles such as detailed and lengthy questioning, the physical searching of property and at times the separation of family members (including children) during interviews. Participants were required on these occasions to sign a 'travel form' – a declaration that they would not place their daughters at risk of FGM. Participants described being compelled to sign this form in the face of implicit and explicit threats including preventing travel and exposing children to medical examination on their return. Translation services were not provided and those whose English was less proficient were not given the opportunity to fully understand what they were being asked to sign.

## Courts and Borders

While experiences in court were less frequent than other forms of safeguarding, the experiences of others affected the entire Somali community. There was a particular concern about the lack of evidence associated with these cases.

Participants also experienced hostile encounters at airports and expressed concerns both about the implications of this for themselves and other passengers.

## A Suspect Community

Participants repeatedly stated that Somalis were treated like criminals during FGM-safeguarding. They felt distrusted, their intentions suspected, and their needs ignored. There was a sense that the whole Somali community was unfairly targeted and had become a 'suspect community' (Pantazis and Pemberton 2009): a group considered by the state to be suspicious despite there being no evidence of criminal activity. Participants described FGM-safeguarding policy as inherently racist and gave examples of how wider debates on FGM directly contributed to experiences of racist violence from the public.

Participants believed that Somalis were targeted due to a perception that FGM was still highly prevalent and accepted among the Somali population. They argued that while FGM had been part of their culture historically, it was not condoned among Bristol Somalis. Participants reported feeling alienated from their Britishness as a direct consequence of FGM-safeguarding. They also described the significant work which had been undertaken by local activists to reduce the incidence of FGM and voiced their concerns that this was being ignored in state-led approaches which fed into negative stereotypes about Somali culture. This

encouraged a sense of victimisation and social dislocation from service providers and wider society and a feeling that these efforts had been in vain.

FGM-safeguarding directly contributed to a dramatic loss of trust in key state institutions, particularly those involved in FGM-safeguarding. This produced disengagement, a reticence to seek care or support and additional stress when this became necessary.

Participants also described how experiences of FGM-safeguarding encouraged suspicion and damaged relationships within their families, and the wider Somali community. It also prevented them from parenting in the way they wished to. Their choices about whether and how to tell children about FGM were undermined. Parents felt obliged to police their children's behaviour to avoid scrutiny, with mundane aspects of everyday family life – holidays, secrets and surprises – taking on sinister dimensions under the gaze of safeguarding officials.

## Policy implications

- All organisations involved in FGM-safeguarding must acknowledge the ways in which these negative experiences reinforce a sense of Somalis as a 'suspect' and stigmatised community, and reduce service engagement and trust and the sense of inclusion of Bristol Somalis in wider British society.
- A Governmental review of statistical evidence underpinning FGM-safeguarding policies is urgently needed.
- Health-care professionals must address concerns regarding the re-traumatisation of FGM-victims and poorer care associated with FGM-safeguarding in medical settings.
- Schools and educational authorities must ensure that all approaches to FGM-safeguarding concur with existing guidance. The recent work undertaken by Bristol City Council to clarify this guidance will provide schools with valuable support towards achieving this.
- Social services and the police must ensure that home visits are only conducted once reasonable risk has been identified; they must also address the distressing, criminalising and coercive nature of such visits. The recent decision to discontinue use of the 'travel form' in Bristol is a significant step in the right direction.
- Social services should also ensure key documents are translated and that, where required, provision is made for translators in all safeguarding meetings with families.
- All statutory authorities must improve professional education regarding FGM and FGM-risk for staff involved in FGM-safeguarding.
- Statutory authorities must develop more collaborative approaches to FGM policy planning, development and implementation - which involve diverse sectors and affected communities - to improve its sensitivity and accessibility and minimise risk of stigma.
- Those providing training on FGM-safeguarding must amend and update their training materials and delivery in light of the findings of this report.
- FGM-safeguarding must prioritise community prevention work and services should ensure that they recruit employees from a broad range of ethnic minority backgrounds including those with a Somali heritage.



# 1 Introduction

---

Female Genital Mutilation (FGM)<sup>1</sup> is considered by the international community to be a ‘global concern’. In 2015, United Nations members agreed a target for its elimination by 2030 (UNICEF 2015). In the UK, specific legislation against FGM has been in place since the Prohibition of Female Circumcision Act 1985, which was updated and replaced by the Female Genital Mutilation Act 2003. The lack of prosecutions under either Act, however, was seen as indicative of a lacklustre approach by the state and its officials to the eradication of FGM.<sup>2</sup>

In 2014, *The Guardian* newspaper backed a campaign spearheaded by a Bristol-Somali schoolgirl and the Bristol charity, *Integrate*, which brought the topic to national prominence. The UK government, with the support of the Bristol Safeguarding Children Board (BSCB), developed a range of legislation and policies in response to the perceived risk (which fall under the umbrella term ‘FGM-safeguarding’), largely implemented through the Serious Crimes Act 2015. These included mandatory reporting to police by state professionals (e.g. school staff, health practitioners) of any identified cases involving girls under 18; FGM Protection Orders (FGMPOs) which enable the local authority or another relevant person to ask a judge to impose protective measures such as the withholding of the passports of those considered potential victims (Home Office 2016b); and the

introduction of the FGM Enhanced Dataset, which requires NHS practitioners to record detailed information about FGM within the patient population (NHS Digital SCCI2026).

The lack of prosecutions for FGM in the UK encouraged a particularly high level of local, national and international interest when, in February 2018, a Bristol-Somali father was prosecuted for allegedly allowing or enabling FGM to be undertaken on his daughter. The press benches and the public gallery remained full (mostly with local Somalis) throughout the week-long trial, with the hearing being moved to a bigger courtroom to accommodate the public.<sup>3</sup> However, after the prosecution had put their case, the judge ordered the jury to return a ‘not guilty’ verdict on the basis that the evidence presented was “deeply troubling” and “wholly inconclusive”. A Channel 4 documentary television programme of the police investigation was broadcast shortly after the trial (Newman 2018).

Following the trial and this programme, some parents formed an organisation called Somali Parents Against Stigmatisation (SPAS) to draw attention to the negative impact of approaches to FGM-safeguarding in Bristol on the local community. As part of this activity, they approached the University of Bristol with a request for independent research which could document their experiences.

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<sup>1</sup> The term ‘female genital mutilation’ (FGM) is contested due to its application to a wide range of procedures and its separation from other forms of non-consensual genital cutting, such as on boys. However, it is used widely in policy documents and amongst the Somali community in Bristol

<sup>2</sup> The first successful prosecution for the crime of FGM was of a Ugandan woman in early 2019.

<sup>3</sup> One of the authors of this report attended the trial as part of fieldwork undertaken for a research project funded by the Journal for Law and Society.

This report presents the perspectives of Somali families with experience of FGM-safeguarding in Bristol, gathered through six focus groups conducted in the summer of 2018. Participants were identified using the research team's existing contacts with a range of organisations run by and/or representing Somali people living in Bristol. All participants were aged 18 or over, but the groups were divided by age and gender, to reflect the potentially varying perspectives of those who were children at the time of safeguarding and those who were adults and a preference of participants for gender specific groups. Focus groups were conducted in the university and in community settings familiar to the participants. Translation was provided by local Somali people when required. A total of thirty participants (twenty-one women and nine men) were interviewed. The findings presented in this report draw on the main themes that emerged through our analysis using thematic analysis (Ritchie et al 2013). All names used in the report are pseudonyms.

Somalis are the largest ethnic minority group in the city of Bristol and have been a particular focus for national and local debates on FGM. This attention has been encouraged by international statistics, including those from the World Health Organisation and UNICEF, which routinely state a 98% prevalence rate among the Somali population (UNICEF 2013). In response, UK politicians and media sources have repeatedly claimed that tens of thousands of girls are at risk in the UK and that ethnic Somalis make up the bulk of these (House of Commons 2016; Guardian 2014, 2016, 2017). In their speeches at the Girl

Summit in 2014, PM David Cameron and (then) Home Secretary Theresa May both claimed that 60,000 girls were at risk of FGM in the UK.

Bristol-Somali residents most commonly encountered FGM-safeguarding through state institutions which were prominent in their everyday lives, particularly schools and health services. Some then went on to experience FGM-safeguarding in encounters with social services and police, and some in the courts or at the national border, e.g. at airports or ports. This report recounts the experiences of participants with FGM-safeguarding in these specific contexts, along with recommendations for policy change.

This research identifies a number of valuable opportunities for policy-makers to improve their approaches to FGM-safeguarding.<sup>4</sup> In particular, there is evidence that schools in Bristol are not routinely following BSCB guidance on FGM-safeguarding, and that this risks traumatising families and undermining the important relationships between families and schools. The demand for data-gathering associated with the FGM Enhanced Dataset has, in some cases, affected the health care provided to Somali families, and led to FGM-victims being re-traumatised. Participants were particularly distressed by home visits undertaken by social services and police, which were felt to be unnecessarily criminalising and coercive, despite their supposedly voluntary and educational nature. They were perceived as particularly traumatising for children. Participants also described the broader impacts of these experiences, in terms of engagement with specific services, relationships within particular families and with the wider Somali

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<sup>4</sup> There have been some changes to FGM-safeguarding procedure in Bristol since the fieldwork for this report was conducted, which are described below.

population in Bristol, and the impact on their sense of social inclusion and levels of trust. Participants described the efforts they had made as individuals and as a community to integrate into British society, and their continued efforts to eradicate practices such as FGM. Current approaches to FGM-safeguarding were perceived to directly undermine these efforts.

Importantly, as well as describing the problems with existing approaches, participants made a series of recommendations to improve service provision, which are discussed at the end of the report. These generally suggest a much closer and more collaborative relationship between services providers and members of the Somali community.





## Section 1:

# Experiences of FGM-safeguarding

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## 2 FGM-safeguarding in health care

### *Aliyah's Experience with the Midwife*

Last year, when I was in early pregnancy and not feeling well, I had my first meeting with the midwife. I was hoping that she would ask me, "How are you feeling? What can I do for you?" But she had a form, and she just followed the form:

"First, I would like to talk to you, do you know anything about FGM?"

"Yeah, I know it," I said.

"Did you have the FGM?" she asked.

It was like an interview. I was quite shocked. I didn't answer her. Instead I said,

"Is that a problem?"

"You know you're in UK."

"Yeah," I said, "I've been in UK quite a while, 17, 18 years and I've had other kids, and this is a very private matter. You can't just ask me what it's like inside my legs."

"You are from Somalia, right?"

"Yes," I said.

"You have to answer this question," she told me. I told her that I didn't need a midwife like this, and she tried to calm the situation down by asking if my blood pressure had been taken. But then she came back to it:

"Did you have type 1, 2 or 3?" and then she asked me, "Why are you so serious? I see a lot of women they come in, they just answer first time."

"I will answer, but I don't want to hear it again," I told her. "I had it. It was a really bad experience. I love my mum, but it was culture. A hundred years ago, this country [the UK] had a different culture from today. Are the people still living in the same way? They modernised. So, in Somalia, we too modernised. So please from now on don't ask me again."

She said, "Ok," and she asked me other questions, but then at the end she asked me, "Did your mum have FGM?"

I stood up and told her, "If you have another question about my health, then I will answer, but this I will not answer."

She was desperate to fill in this form. I was uncomfortable. She kept coming back to it. I told her to look it up on her computer if she really wanted to know, but that I wasn't going to tell her. It frightened me really. If I tell her anything, she would start again. If you go to GP it's the same question.

FGM-safeguarding as delivered by health practitioners was predominantly experienced by women, often in routine appointments with midwives, GPs and health visitors. There were also notable examples of FGM-safeguarding experienced in Accident and Emergency (A&E) departments. Participants voiced mixed opinions regarding

whether FGM-safeguarding *should* occur in health settings. Some felt that medical practitioners were the most appropriate officials to undertake routine FGM-safeguarding. They argued that it was important and necessary for the prevention of FGM and that it could be done without causing offence.

*“The midwife, it’s ok, if she asks questions and tells you the rules. It’s fine.” (Woman FG1)*

*“[The nurse doing the vaccinations] said it was part of her job to tell us about it. The experience was ok.” (Woman FG1)*

*“She [the GP] wasn’t saying it in a kind of aggressive way, she was saying it as if it was a normal chat. She goes, “I know this is a really silly question to ask, but...,” She’s like “I’ve got to ask it.” She just said, “There isn’t a chance of you having FGM done [while you’re on holiday]?” I goes, “No, there isn’t.” She goes, “That’s fine, then,” and she just gave me my prescription.” (Young Woman FG6)*

Others, however, felt that FGM-safeguarding was inappropriate and unnecessary, and they expressed frustration and anger that they were asked about FGM at all. Sometimes this was related to the belief that the evidence underpinning these initiatives was incorrect and based on outdated data relating to the practice in Somalia, rather than the UK.

*“[The midwife said] “We’re just going to talk about FGM.” She said, “in Bristol, it’s highly practiced. Because it’s highly practiced, we need to make sure, because you were abused, we need to make sure that you don’t abuse your child.” Abuse? That was due to ignorance, that was 33 years ago, nothing that happens now.” (Woman FG2)*

Perhaps understandably, opinions on whether FGM-safeguarding was inherently problematic within a medical setting were often divided on the basis of personal experience: those who felt the health practitioner had asked safeguarding questions sensitively and appropriately felt less of an intrusion than those who experienced a clumsy or insensitive approach. Significantly however, this division appeared to be largely between those who

had not had FGM and those who had.

For Aliyah, and others who had been infibulated as children, the experience of being asked about FGM was frequently recounted as re-traumatising. Participants related their sense of offence at the priority given to FGM-safeguarding as well as the way it was undertaken. This sense of offence was compounded by the fact that these were often repeat encounters, seeking information already held by the NHS.

Approaches to FGM-safeguarding within the NHS mean that in practice, every time a female from an FGM-affected group engages with the health service, she is likely to be asked about her experiences of and beliefs regarding FGM. This is particularly so for those who are pregnant or have young children. One of the issues raised most often in the focus groups was the failure for health practitioners to acknowledge that FGM-safeguarding had already been undertaken. Women in the study joked about there being “a script” (Woman FG2) which they got to know very well:

*“Everywhere you go, you are told about it. You come to know it. You are like, I know what you are going to say next.” (Woman FG2)*

But the relentless and repetitive nature of these encounters also became aggravating. Ultimately, the trauma of FGM that many of the older cohort of female participants had experienced was one that they now wished to forget. This repetitiveness therefore became re-traumatising and resulted in many becoming cautious and defensive in their encounters with health professionals.

*“When I go to the GP, they ask me again and again, did you do that [FGM]? I told the GP, please write down on your computer, I don’t want to do that [FGM] and so please don’t ask me any more questions. I hate to hear these kinds of questions.” (Woman FG1)*

*“The parents who had it done they are traumatised. [...] To ask mothers who are traumatised over and over and over again. You’re putting salt on that wound, you’re making it fresh again. They didn’t have a choice when they were young.” (Woman FG1)*

The FGM-Safeguarding Guidance issued by BSCB states that “It is important that Professionals understand the trauma FGM can cause and the emotional impact and physical abuse the child will have experienced” (BSCB 2017:5). However, the evidence provided by participants in this study indicated that the potential for this trauma to still affect adults who had undergone FGM, typically as children, was not acknowledged by health professionals who instead aggravated the trauma by “*putting salt on the wound*”.

Participants also voiced strong concerns that their health was ignored, overlooked or de-prioritised by the health service and practitioners in their efforts to conduct FGM-safeguarding. Like Aliyah, who felt that her midwife was more intent on completing her safeguarding paperwork than attending to her needs as a pregnant woman, women in

the focus groups believed that data-gathering for the Enhanced Dataset was given greater attention than their own health needs.

*“[The Health Visitor] is asking all the time. [...] Before they cared about your health and how the child was feeling. Now it’s just FGM.” (Woman FG1)*

*“Instead of the nurse trying to figure out why I was in such pain or what – you know, the usual procedures, bloods, blood pressure, all of that – she [the A&E Nurse] skipped all those steps and directly, she was like to my mum, “Have you done FGM to your daughter?” (Young Woman FG6)*

As well as describing concerns regarding treatment delays, this Young Person also expressed concerns that health practitioners might “*misdiagnose*” a patient by “*fixating on FGM*”. As a consequence of their experiences, some participants described health visits invoking anxiety, hostility and loss of trust, resulting in some excluding themselves from services, something discussed in further detail below.



# 3 FGM-safeguarding in schools

## Halwa’s Experience with the Head Teacher

In 2016, myself and my sisters planned to go to Somalia to see family. We all have daughters at the same school. The Head Teacher called me in, and she read an agreement and she asked me,

“Did they make you do this thing?” [i.e. Did you have FGM?]

I hate that question. It’s personal. It hurts me a lot. Why do you need to know what’s happening on the inside of my legs?

She said, “It’s the law, you must answer, otherwise you cannot go, you cannot travel. If you don’t tell me, I won’t give you permission to take your child out of school.”

I told her. I said “Ok, yes, they did do that to me.”

She said “Ok, well that makes you high risk, you and your sisters as well. The Safeguarding Team will come. They can come at any time.”

I told the Head Teacher, “But I don’t want to tell my daughter about FGM yet, she’s too young.”

She said there was no choice. “It’s my job to refer you to safeguarding,” she said.

The most commonly described location for active (as opposed to informative) FGM-safeguarding was schools. In addition to mandatory reporting to police instances where the child states she has had FGM, school staff also have a broader safeguarding duty to report risk of FGM, typically to social services. To support this, BSCB produced an ‘FGM Referral Risk Assessment’<sup>5</sup> which outlines the referral procedure to be followed when there appears to be a potential risk of FGM. This divides risk into three levels, summarised in Table 1.

According to the FGM Referral Risk Assessment, the level of risk of each family should be determined by the school’s designated safeguarding person during an interview with the family, prior to deciding whether to refer them to social services. It is

expected that those considered low or medium risk experience no further action. According to these guidelines, no family simply requesting leave for extended holiday, even where there is evidence of maternal FGM and the planned trip is to an FGM-affected country, should require referral to social services unless some additional risk is identified. However, at the time our data were collected it appeared that many schools did not follow this guidance.<sup>6</sup>

Some families were interviewed by the Head Teacher and/or safeguarding officer, others were referred to social services without interview. Indeed, some were referred without being notified of the school’s intention to do so or were simply informed by a class teacher, either in person or by telephone.

<sup>5</sup> This tool is being updated, the one quoted here is from October 2018.

<sup>6</sup> Bristol City Council has taken steps to clarify this guidance since this research was conducted. There is

some evidence that this has led to a fall in referrals: <https://www.bbc.co.uk/news/uk-england-bristol-46301951>.

| Table 1: Indicators used for FGM Referral Risk Assessment |   |
|---|---|
| Low Risk  | coming from an affected community;<br>maternal FGM;<br>planned travel to the country of origin;<br>poor parental engagement with the school;<br>withdrawal of the child from PSHE.  |
| Medium Risk   | wider family members are pro-FGM;<br>inconsistency over travel plans;<br>only female children being taken on holiday;<br>changes in the girl's emotional behaviour;<br>parents not consenting for information to be shared.   |
| High Risk   | siblings and/or cousins have undergone FGM;<br>mother has had re-infibulation;<br>the girl is due to attend a special occasion just for girls;<br>talk around womanhood, rites of passage, etc.;<br>immediate family members are explicitly pro-FGM;<br>family members have been untruthful about concerns. |

Source: BSCB 2018

Participants believed that Somalis in Bristol were referred to social services as a matter of course, simply because they were going on holiday, regardless of destination or length of stay.

*“Everybody was asked where they were going for summer holidays. She [daughter] said we were going to Holland because my mother lives in Holland. At the end of the school day, they [school] called me, [and said] “we have to see you and talk to you.” [At the appointment] the safeguarding officer she said to me, “we meet up with everyone going away and send them to the police and social service as you have to sign a letter because you are from Africa, from Somalia.” “But,” I said, “I’m not going to Africa, I’m going to Europe.” She said, “We don’t care where you are going.” [...] [It made me] unhappy when someone said, ‘you can’t go without permission.’” (Woman FG1)*

*“The trust, honesty, with the school, I lost trust. I didn’t understand why they hadn’t alerted us beforehand. Why couldn’t the*

*head teacher tell us? I thought that safeguarding was when that child is in danger. But for us it was just because we were Somali.” (Woman FG2)*

Although the FGM Referral Risk Assessment explicitly states that people should not ask the mother whether she has had FGM “unless you are a medical professional and it is in accordance with your duties under the FGM Enhanced Dataset,” our research found evidence of school teachers doing just this. In addition, participants reported that schoolteachers routinely failed to appreciate the degree of sensitivity needed to raise the topic of FGM. Several participants grew visibly upset recalling the distress they experienced at being asked these questions by teachers: questions which were considered invasive and patronising. Participants believed that the majority of school teachers had a very basic knowledge of FGM and Somali cultural practice, which made their approaches to FGM-safeguarding clumsy and/or offensive.



*“[The head teacher said] “There is a very important issue that we need to discuss with you as well because you are going to Somalia and it is known for FGM.” They’ve been given a script and they’ve got to follow that script. It was nothing that he understood himself. It was adding insult to injury because I don’t know how he thinks he can educate me about FGM.” (Woman FG2)*

Teachers were also described as giving parents incorrect information about existing laws and policies, which at times exaggerated their authority to restrict families’ activities, including their journeys. This resulted in participants feeling angry and resentful, and losing trust in school staff.

While many Somalis in our study felt that the school was an inappropriate authority to investigate and assess risk of FGM, participants understood that schools had a

safeguarding responsibility. Some commented that they felt pleased that schools were looking out for children. However, the way in which this was achieved was considered to undermine effective safeguarding: instead stigmatising and traumatising Somalis and their children by using existing mechanisms designed to respond to evidence of child abuse, simply because a family was going on holiday.

Somali anti-FGM campaigners who participated in our study commented that the involvement of schools in the Bristol model of safeguarding was intended as part of a preventative, awareness-raising strategy, but had instead become a tool of stigmatisation. These findings strongly suggest that there are teachers in Bristol schools who lack a full understanding of the law, the guidance, and FGM itself.



## 4 FGM-safeguarding by social services and the police

### Fawzia's Experience with Social Services and Police

They came to my house. They asked me so many questions: "Where are you going? To a big city? To a village? Do you want to do this to her? Where is your ticket?"

The policewoman asked all the questions and the social worker didn't say anything, but she was looking at me with suspicion. My daughter, she was so scared, she said, "What is happening, Mummy?"

The social worker said she was going to tell my daughter about FGM. My daughter became so anxious. She was standing up, then sitting down, then standing up.

She said, "Are you going to do that to me Mummy?" Even she said to me, "I don't have a thing like boys, so how can you do that? How can you cut if there's nothing to cut?"

She was 10 years old. I was so upset, and scared too.

When the policewoman finished the questions, the social worker started. The police officer was polite, but the social worker was rude. She told me, "You must sign, otherwise you cannot fly." She said, "When you come back, we will contact you, we will check your daughter."

It was terrible – coming to my house like I was a criminal. I was frightened. I was so scared, upset, and angry. My daughter was frightened. The way the social services and police told her, it was like, "She's going to take you to Somalia, and they are going to do these things."

They made her scared of me.

Participants usually experienced encounters with social services and police after referrals from schools. As detailed above, schools appeared to make these referrals automatically and without due consideration of the guidelines. The reliance placed on the school's assessment of risk level is not known, but it would appear that social services and police also undertook their own risk evaluation, since some participants had home visits whilst others were requested to attend appointments at the police station.

It seems likely that the former are considered as 'medium' or 'high risk', while the latter are considered 'low risk'. Study participants, however, considered this distinction to be based on class and education, rather than any recognised indicators of risk. Their

experiences suggested that professionals, parent-governors or others working in positions of responsibility and those with stronger English language skills were more likely to be classified as low-risk and therefore not requiring a home visit.

*"They don't treat everyone the same. As soon as they know you are professional and what you do, it's suddenly very different [...]. Suddenly they didn't need to come to our house, the police didn't need to be involved. They said, 'You can come to us, or we can come to your work.'" (Woman FG2)*

One participant, who did receive a home visit experienced a similar change in attitude when discussing her profession:

*"She asked, "do you work?" I said "yes, but not at the moment." She said, "what do you*

*do?” I said, “I’m a nurse.” And the behaviour and their expression, it changed. They started to have a conversation like I was human.” (Woman FG1)*

Encounters in the police station were less intimidating than home visits, but participants still stated that they had felt obliged to attend and were frustrated by the time-consuming and stigmatising aspects of these approaches to safeguarding. Reports of home visits, by contrast, were universally negative.

Home visits from social services and the police were experienced by participants as state exercises in the overt display of control and power over a vulnerable migrant population, rather than activity undertaken out of a concern to prevent FGM. Participants described these visits as something akin to an interrogation following a well-founded allegation of child abuse. As such, home visits received particular condemnation from participants and were experienced as the most invasive and unjustified form of FGM-safeguarding.

Participants described how those making home visits frequently expected unreasonable access to people’s homes and lives, without prior arrangement, and failed to respect their rights to privacy and autonomy. Safeguarding officers generally arrived unannounced, with parents expected to “be ready” for a visit at “any time” (Woman FG1). Participants were left waiting nervously for many days, aware of the impending date of departure and fearful of the possibility of losing their air tickets and money. Indeed, some participants, such as the family travelling to Holland described earlier, were told by the school to expect the visit only for this never to occur.

Those who were not immediately available on the arrival of the safeguarding team were

treated particularly suspiciously:

*“I was in the middle of packing [when they knocked on the door], getting lunch ready for the kids when they came back from school, so everything was happening at once, so I decided not to open the door because I wasn’t expecting anyone. She [social worker] left a message, she said “we are outside, why are you not opening your door?” Which was a bit rude because she didn’t have an appointment with me. I called her back 10 or 15 minutes after. I said, “Well, you didn’t book an appointment.” She said, “We’re still outside.” They’d decided to wait outside for a good twenty minutes. So, I let them in, she had the audacity to say, “Why did you not open the door?” like I had something to hide. I said, “Why would I? I was in the middle of doing something, you didn’t have an appointment.” (Woman FG1)*

Officers expected to be able to observe people’s lives in ways which were considered intrusive and rude. People described feeling “harassed” (Young Woman FG6), exposed to “threatening” behaviour (Man FG5) and that they had “experienced badgering” (Young Woman FG6).

There were concerns about the general approaches taken in the conduct of home visits:

*“They sat down, very formal. [...] [They were] very official, paper and pen. When you go in to someone’s home, you need to remember they are human beings.” (Woman FG1)*

In particular, participants reported that social services and police took a formal interrogative style of questioning which started from an assumption of guilt. Participants also described being separated from their children, with interviews conducted in different rooms, having to provide extensive personal data about themselves and their family members, having

their time wasted through lengthy questioning, having to produce evidence of their travel plans, and even having their (already packed) luggage searched:

*“[Social services/police said] “We cannot talk to you all together. We talk to your children first. We must talk to you separately. Everyone must go to different room.” Like an [police] interview. Like someone who is criminal. They asked me so many questions. “Where are you going? Where is your ticket?” I said to her, “my ticket is inside my computer”, and she said, “you need to show me now”, and I opened the computer and she used my computer and she went to my inbox and she took a picture.” (Woman FG1)*

Social workers also presumed the right to have access to observing families more generally, for example while parents took their children to school “so that we can see the children in their own atmosphere” (Woman FG2). As such, participants felt social service/police visits to be a considerable invasion of privacy.

Participants also complained that their voices, experiences and opinions were not accepted. They felt patronised by non-Somali professionals explaining to them what FGM was and how it was practiced by Somalis:

*“I did say [to the safeguarding officers], “I’ve done a lot of work on FGM, I have worked with members of parliament.” They said, “Oh that’s great, but [...] you are a suspect because of where you come from. I’ve campaigned against it, in countries where they do practice it. But nobody really listened to that.” (Women FG2)*

*“The way I was spoken to [...] it was like they knew something in my culture better than me, [about] something that I can understand more than they can ever, because I have lived experience.” (Woman FG3)*

Participants described a sense of compulsion

to comply with the demands of safeguarding officers. Even when participants expressed concern, the responses of officers were to use tactics to elicit fear rather than to explain more clearly the justification for the safeguarding approaches adopted.

One aspect of the Bristol campaign which was widely adopted was to make available an ‘FGM health passport’ or ‘Statement opposing female genital mutilation’ (Home Office 2016). Anti-FGM study participants involved in developing this Statement – or ‘form’ as it was commonly referred to – for use in Bristol, indicated that it was intended as an empowering tool for families to use to ensure ease of travel but that it had been “changed, some of the service providers use it in a different way, they made something horrible to the community, they went after them” (Man FG5).

*“[The intention was that] everyone who signed the form will be able to travel and going on holiday will be easy. The problem is not with the form. It’s a very simple form, but the process [associated with the use of the form as undertaken by social services] is very frustrating and takes a long time.” (Man FG5)*

During these interviews, participants were frequently expected to sign this Statement confirming that they would not be subjecting their daughters to FGM or placing them at risk by their travel to Somalia or another country where FGM could be undertaken. The pressure to sign this form was described as overt and left families with little sense of choice. Across all of the focus groups, we were repeatedly informed that police, social workers and teachers had *told* people that they *had* to sign the form, or they risked certain consequences:

*“The form, it is compulsory. They said, we will take all the passports and we will not let your daughters fly. I asked, “What happens if I don’t sign?” They said, “Maybe you can fly,*

*but we will keep the passports of your children.” (Woman FG1)*

There was considerable confusion regarding the status of this ‘form’. Some participants, like the one above, believed its completion was compulsory, while others felt that *“it’s a voluntary form but it’s portrayed [presented to Somali families] as mandatory”* (Man FG5). It was also argued that families were not enabled to fully understand what they were being asked to sign. This manifested as a lack of accurate information regarding this process and a lack of time to digest that information effectively. Participants explained to us that families were already under pressure since they had sometimes saved for years to have the money to take the holiday, and might have purchased their tickets in advance. In addition, for some this was a once-in-a-lifetime experience for their children, and thus entailed a great deal of preparation and worry over packing, buying gifts for family, etc. These factors added pressure to sign the form despite the fact that they may not fully have understood it, in order to ensure there was no delay or cancellation. One participant told us that *“the families, especially mothers, just succumb to the pressure, just sign”* even though they did not have a true *“deep”* understanding of what they were signing (Man FG5).

Participants also expressed concerns regarding the tendency for interviews to be conducted only in English with no opportunity for access to documents in non-English languages, and no time to take away the documents and read them at their own pace or get assistance:

*“The way they put things across is not really understood by a mum or dad who doesn’t speak much English... you have one hour, two hours, they come and visit the family, they bring a pile of documents and then they go*

*through it and they ask them to sign on the spot.” (Man FG5)*

There was a concern that safeguarding teams did not make allowances for, and might even exploit, the English language difficulties experienced by families they interviewed. Indeed, one participant was suspicious that social services and the police purposefully did not bring interpreters with them *“to intimidate you”* (Woman FG2). People who felt unable to express themselves effectively felt less confident in asking questions or showing reluctance in participating in the process: *“you can’t say what you want to say [to explain your concerns], so you feel it’s better to do what they tell you”* (Woman FG2). As suggested earlier, for those whose English was less proficient, the sense of pressure and coercion produced by these encounters was exacerbated unnecessarily, while those parents with strong English proficiency felt patronised:

*“I think they were quite intimidated that I speak good English and they felt they could belittle me and undermine me further by saying “do you understand what we’re saying?” (Woman FG3)*

There was a belief that safeguarding officers could take advantage of the lack of education and legal understanding generally experienced by Somalis. Negative attitudes regarding the knowledge and skills of Somalis was felt to encourage their harsh treatment:

*“Sometimes they think, you come from Somalia, you are an African, maybe they think Somalis don’t understand the rule of law. For that reason, they use [the process] in a harsh way.” (Man FG5)*

This encouraged some young people to seek clarification regarding their legal position: *“I’ve started brushing up on my legal rights. I have to know. At some point I might be in a situation where I get targeted again.” (Young Woman FG6).*

Safeguarding professionals were described as using a variety of threats to enforce compliance and participants described a range of perceived eventualities arising from both signing and not signing the form. They described being told that if they did not sign the form they would not be permitted to travel, that their children's passports would be confiscated, and that their children would be subjected to medical examination on their return from holiday. Some participants believed that not signing the form could lead to lots of "hassle", particularly at airports, experiencing further "questioning" (Young Woman FG6) or having their holidays cancelled. Parents who had spent years saving for expensive flights for their children who were often undertaking their first visit 'back home' understandably capitulated in the face of such threats.

These discussions also provided further insight into the limited accurate information provided for families during these visits. For example, there was a strong sense among participants that not signing the form would lead to an escalation of "trouble" (Woman FG2), although the specific nature of this often remained undefined. Others felt that the information they provided would be kept on a register for "child protection forever, so social services are aware that you have travelled to those countries. They have all your details and they stay there" (Woman FG2). Participants described the ways in which "parents are told that if they don't agree to those terms and sign, that they might be prosecuted when they come back" (Man FG5). There was also a concern that people's children might be taken into care if they did not comply with these demands:

*"The problem is, you see a policeman with social services on your doorstep. That is very scary. Nobody wants to lose his children. Those mothers, those fathers, they are afraid. Whenever they see the police, they think they*

*want to take our children away from us. And they do whatever [they have to] to save their children. And [even] if they don't like the form, they just sign it, in order to protect their children."* (Man FG5)

The fear generated during these interactions stayed with families until and at times beyond their trip:

*"I was so scared. I forgot my letter when I went to the airport. I was so scared. I talked to my friends and asked them to go to my house and take a picture of the form. I was so scared until I sat down on the plane."* (Woman FG1)

Threats made during home visits that daughters would be examined on return from holiday produced a generalised fear which families experienced for indefinite periods. One participant believed that families were deciding to give up on their travel plans rather than expose their families to this negative treatment, resulting in a loss of liberty:

*"Parents [are] choosing to stay because they fear being targeted. No civil liberty. You cannot exercise your right to travel."* (Man FG4)

Only one participant (a young man without children) defended the practice of social services making home visits in the context of FGM-safeguarding, on the basis that whilst it may be stigmatising for the community as a whole, if one child was saved from having FGM this would make it worthwhile. However, he also felt that the police and social services did not have "good dialogue" and that their "approach" was wrong (Young Man FG5). Several male and female participants (FG2, FG3, FG4) believed that the heavy-handed approaches adopted under the remit of FGM-safeguarding actually increased the risk of FGM occurring, since it encouraged those considering or

planning to do FGM to become more secretive.

Participants who had been or were anti-FGM campaigners were deeply saddened by the way in which measures which were supposed to be protective had been usurped and mis-used by social services and the police:

*“[I ask myself] why have I been wasting my*

*time working with the community, doing all these awareness [raising activities] when the police knock on your door, and social services, when you haven't done anything? I know they are doing child protection, and if it is needed, yes, but if there is no evidence, then let the community work with the families [on prevention]. There is no need to knock their doors and scare them.” (Woman FG3)*



## 5 FGM-safeguarding in courts and at borders

### Yusuf's Experience at the Border and in the Court

I am the father of eight children. In 2015, my wife, one of my older daughters and my seven-year-old daughter were travelling to Kenya. I took them to Heathrow and saw them through the check-in, but on my way home my wife called me and told me they had been stopped from boarding the flight and please could I come back. My wife told me that the officials suspected FGM would be done on my daughter and therefore they could not fly, and they had taken their passports. They gave no reason why they suspected this.

Some months later, we were called to the court. The police said they had evidence, but they didn't produce any. Instead they asked the social services, but the social services said they didn't know anything about us or this case. We had to go to the court four times. I told them, "I am employed, you are wasting my time. If you have evidence, then show me." I told them, "Bring a doctor, I have other daughters who have been to Africa. You can check all my children, they never had anything." Eventually, the judge said to them, "You need evidence, if you don't bring evidence, then I will make my own decision."

It was such a waste of time, a waste of money. On the last time, I even threatened to go to the press. The police said to me, "We are sorry for the delay." I asked them, "Where can I find my money – for three people's tickets to Kenya?" And I said, "I want a letter to say I am innocent of the charge." The judge said, "I can give you that letter." And even then, the police asked to keep my child's passport for five years, but the judge told them to give it back straightaway.

The experiences of safeguarding described by participants predominantly focused on experiences at home, at school or with health services. But some participants did describe being questioned at airports, when beginning their holiday. These experiences were described as hostile and, as with home visits, might involve families being questioned separately:

*"[The Bristol airport attendant] took the girls in a corner and started to speak with them. I was thinking, "what is she doing?" [...] She said [to them], "what do you know about [FGM] and what will happen? Where are you going?" I was thinking, "Let them answer. They are old enough to answer her*

*questions," but I have my 7-year old daughter at the moment, my daughter wouldn't know, she is still young."* (Woman FG3)

One participant had expressed her concern that after being taken aside for questioning, the other passengers had become unduly nervous of their presence on the plane, worried, she thought, that the questions might have related to terrorism rather than FGM. Participants also expressed concern that questioning their treatment at the border would risk delays:

*"You can't speak up at that point [while being interrogated at the airport] because you're speaking to the Government, because you're speaking to authority and you don't want to*

*anger anyone to the point when they have to arrest you, where you're going to miss your flight." (Young Woman FG6)*

Shortly after the 2018 Bristol trial described at the start of the report, Channel 4 aired a television documentary which followed Avon and Somerset Police during the investigation which led to the prosecution (Newman 2018). This court case and associated documentary was raised by participants in most of the focus groups, and the shortcomings in the prosecution case and the attitudes presented by the police in the documentary that followed deeply affected many Bristol Somalis (BSF 2018), including our participants. The motivations of the personnel involved in the investigation were questioned:

*"If you watch the documentary which was aired by Channel 4 [...] you will [see] the prosecuting officer [when she got news that the second medical examination had found no sign of FGM] she became quite angry. She was expecting to put that guy, an innocent person, behind bars. [...] They are trying to get someone, convict someone [so that] their case will have a long life [i.e. For their own career enhancement]." (Man FG4)*

Participants also criticised the State in relation to specific aspects of the trial, in particular the fact that the first paediatrician who examined the girl had never seen a case of FGM.

There were also stories of Somalis experiencing FGM-safeguarding through the court system that are notably less discussed in the community and the press. These involve the Civil and Family Courts and the use of FGMPOs. These accounts described a perceived pressure from judges for families to avoid entering into court proceedings, even when there was a lack of evidence against them:

*"The judge said [to the mother], "I am on your side now, I've got the same perspective as you, but if we [proceed] to trial, I might change my perspective." And the mother got scared, in case he might give a harsher judgement. The police said they would reduce the time [for which they kept the family's passports if she didn't go to trial]. It was ridiculous! How can you put pressure on a victim who has done nothing wrong? I thought the Mum should have stuck with the trial because they couldn't prove anything. They will give her documents back. The judge can't punish you because you went to trial. But the mum got really frightened, she accepted the deal of the judge. See how unfair the whole system and the whole process is?" (Man FG4)*

Participants reported that FGMPOs were used regularly and that this apparent lack of evidence to support them, as shown in Yusuf's story and above, was not unusual.

## Section 2:

# Impact of FGM-safeguarding

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## 6 The impact of FGM-safeguarding: ‘Suspect communities’ and integration

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*“It’s the same as if you are a black person and you go into a shop because they suspect you of shoplifting because you are black. Do you know? They don’t believe you, even if you are an [anti-FGM] campaigner? They would say ‘somebody who is going to do it would also act like you, [so] we have to do this.’ Everybody is a suspect. You are guilty until you are proven innocent. Everybody in this room.” (Woman FG2)*

*“A lot of families have said that they feel that they’ve done something wrong when really and truly they haven’t done anything wrong. They feel that they’ve committed a crime. They feel that they’ve been targeted, stigmatised, racially profiled.” (Young Woman FG6)*

Participants repeatedly described feeling like they were treated like criminals by safeguarding professionals. People felt distrusted, their intentions were suspected, and their needs were ignored in safeguarding approaches and by professionals who were “fixated” on identifying criminal intent. Approaches to repeated questioning, presumably on the understanding that people would eventually be identified as being dishonest, were also considered problematic and disrespectful:

*“She (Nurse) kept going on and on and on and I think that the discussion with her and my mum went on about 10 minutes. If the person, the parent says ‘No, it’s not something that’s done in my family and we’re completely against it,’ then take their word for it.” (Young Woman FG6)*

Several aspects of the approaches to home visits also encouraged a sense of

criminalisation. The lack of pre-arranged appointments or respect for people’s rights to privacy encouraged a sense that the authorities felt families had illegal intentions: “Coming to my house [like] I was criminal. I was frightened” (Woman FG1). Approaches to safeguarding interviews, especially during home visits – demands to provide documentation and other evidence, answer questions and, particularly, interviewing family members (including children) separately – were viewed as “literally being interrogated” (Young Woman FG6). It is telling that participants described being “called in for questioning” to school, a phrase more commonly used for police interviews with criminal suspects.

Some felt that it was criminalising to be called to visit the police station. But the most significant issue encouraging the sense of criminalisation among participants, and the Somali community more generally, was the involvement of uniformed police officers who sometimes arrived at people’s home in marked cars:

*[The visit was] “a horrific horrific experience. [You] open the door and you see a policeman, [you’re] going to be shocked. I’d never been in contact with police. For the first time to be in contact with the police just by default, just based on where I’m from basically, I think it’s even worse than the stop and search policies. This is targeted at Somalis deliberately.” (Woman FG3)*

Such approaches had a particularly significant effect on children:

*“They [the police] invite the kids to come down(stairs) and the first thought in their*

*heads is what has Mummy done wrong, are they going to arrest you?" (Woman FG1)*

They also encouraged suspicion within the local Somali population, which some described as a *"whispering in the community"* (Man FG5), and undermined a sense of inclusion:

*"There is always suspicion in my house, my daughter cannot go to school, everyone's talking about, "oh but they're going there, they were doing...". Neighbours will look at you differently. It is very bad." (Man FG5)*

The 'suspect community' is a sociological term used to describe population sub-groups which are seen by state agents as suspect because their characteristics (e.g. ethnicity, race, culture) are deemed problematic (Pantazis and Pemberton, 2009). It departs from the criminal notion of 'suspicion' because it is not dependent on state agents (e.g. the police) having reasonable suspicion or actual evidence that an individual is involved in criminal wrong-doing. As such the term has been applied to understand the experiences of whole communities coming under state suspicion because of some shared characteristic or identity. This research identified clear evidence that Bristol-Somalis consider themselves as being treated like a 'suspect community' in relation to FGM-safeguarding, not only by the police, but also educators, health and social workers. Overwhelmingly, participants felt that the whole Somali community was unduly targeted by the Bristol FGM-safeguarding policy and identified as suspect by FGM-safeguarding professionals:

*"I thought safeguarding was when you think that child is in danger. But for us it was just because we were Somali." (Woman FG2)*

Even if participants had no direct involvement with professionals over safeguarding concerns, they knew of many

other local Somalis who did. This served to create a sense that the whole community was being targeted by Bristol's FGM-safeguarding policy. The impact was so significant that younger participants described worrying about potential negative interactions they would have with FGM-safeguarding services in the future as would-be parents:

*"The thought process is there. I feel like it's hanging over my shoulder. When I have children, am I going to be put in that predicament? Because I wouldn't be comfortable being questioned about something I'm clearly against. Am I going to feel as violated as every other person feels? Do I feel they have a right to question me?" (Young Woman FG6)*

Participants believed that Somalis were being singled out for attention because of a perception by Bristol safeguarding professionals that FGM was still highly prevalent in and culturally accepted by their community. They reported that families were perceived as continuing to import outdated cultural practices from Somalia or choosing instead to travel to Somalia or other countries so that their daughters could more easily undergo FGM. Participants acknowledged that FGM had been part of the cultural history of Somalis. But they argued that it was not a cultural practice condoned by Somalis living in Bristol today. Rather than being part of a separate and suspicious community, participants described themselves as being British, having British lifestyles, and the specific efforts they had made to integrate into Britain. They also described how experiences of FGM-safeguarding had directly undermined this.

*"Definitely my [British] identity was questioned. I didn't feel like a British Citizen. [...] I've got a British passport, but I'm not. You are treated differently. I felt like I didn't*

*belong here. All this time I've wasted thinking I fitted in – you question yourself, 'do I really fit in?'" (Woman FG2)*

Significantly, the frustration voiced by focus group participants was in part a response to the ways in which efforts to integrate were seen as being undermined by misplaced attitudes towards the prevalence of FGM in the Somali population:

*"They have nothing else to say about us as a community, that's [FGM's] the only thing. They keep bringing it back [focusing on FGM], keep refreshing it. And we are all sick and tired of it. We all want our kids to be like any other normal kid in the UK. Do well at school, be happy and healthy. We don't want them to keep being talked at like their parents are mental or they have some sort of problem. We just want it to stop." (Woman FG2)*

Instead, the current approach to FGM-safeguarding *"makes you feel different [like] you're somebody else from another place"* (Woman FG2). Participants also reflected that British citizenship should bring certain forms of *"civil liberty"* (Man FG4), but that these were undermined by approaches to FGM-safeguarding in Bristol:

*"It shouldn't be like that, you know, because as [with] everybody else in this country, when you are travelling, you should be able to travel without problems." (Man FG5)*

*"[My husband] said, 'ok I will sign [the form], but I'll tell you one thing, I've got a British passport, and you're not treating me like a British Citizen.'" (Woman FG2)*

Participants felt that their lack of capacity to respond to this poor treatment made them a *"soft target"* (Woman FG3) for exploitation and stigmatisation:

*"They know we lack educational background. They are taking advantage of our background and our history. They know that we don't know how to complain properly, we don't*

*know our rights properly, we are highly, highly marginalized." (Woman FG3)*

Participants described the ways in which approaches to FGM-safeguarding encouraged other negative attitudes regarding the capabilities of Somali people:

*"This whole stigmatising thinking that every single Somali parent that you come across is uneducated or cannot speak English needs to stop." (Young Woman FG6)*

Because of the association of FGM with Somali culture, participants argued, public discourses which condemn FGM as abhorrent and uncivilized also came to be associated with Somali culture. Parents described feeling shocked that anyone thought that *"I could do such a horrific act to my children"* (Woman FG3), a reaction which was felt particularly strongly by mothers who had undergone FGM themselves. There was a strong sense among participants that because of the discourses around FGM-safeguarding, Somali people were considered as less than *"human"* (Young Woman FG6), and this affected not only their encounters with professionals undertaking the safeguarding, but also with wider British society:

*"The Somali community are law-abiding, as far as I know. [But they are perceived to be] cannibals, inhuman, subhuman. These policies are stigmatising." (Man FG4)*

Participants gave examples of safeguarding officials drawing specific attention to a perceived inherent criminality among the Somali population, which appeared to blame Somali people for their own negative treatment:

*"The Head Teacher was like, 'The reason we're covering FGM is because it is done by your community. We have to read the rules and regulations.'" [When I said] "But there are other communities that do it", he said, "[it's]*

*mainly Somali communities we're targeting" [Then, the Head Teacher] turned around and said, "if a bomb goes off, you know we will withdraw the [permission to go on] holiday, so you won't be able to go on holiday." And I thought, "What?" So obviously they've been told they can say whatever they want, treat people like how they want, suddenly bombing comes into it." (Woman FG2)*

The perception that FGM was practiced by other cultures which were not exposed to similar surveillance, and that this focus encouraged negative attitudes about Somali culture, reinforced the sense of unfair treatment among participants:

*"It affects so many different cultures that it's kind of unfair to pinpoint it on just one and ignore the rest. There's a lot of Sudanese people in Bristol. I've never heard anyone say they need a consent form to go on holiday, which kind of speaks volumes." (Young Woman FG6)*

Some participants explicitly described the policies as racist, driven by *"very bad practice, humiliating and [involving a] micro-aggression of racism and discrimination, that left me really really upset. [...] a horrific horrific experience"* (Woman FG3). Participants also described the way that current FGM-safeguarding policy unfairly *"targeted"* Somalis, *"based on a stereotype, against Africans"* (Man FG4), which involved people feeling like they were being *"racially profiled"* (Young Woman FG6). Participants reported that the negative portrayal of Somalis as perpetrators of FGM had directly contributed to local incidents of racist abuse. One participant described witnessing this encounter at school drop-off:

*"The woman said to her [Somali woman], "Shut up. Because you are Somali you eat the things of your daughter. First you mutilate your daughters and then you eat [their private parts]. That's what you call Halal*

*meat'." (Woman FG1)*

There was a concern that the focus on Somalis in FGM debates in the national media, including the Channel 4 documentary, and elsewhere had encouraged negative attitudes towards and treatment of Somalis in Bristol:

*"Media news [presents] all these girls being done, [and people ask] 'why are they allowed to do this to children? This is a barbaric culture, they should be taken back to where they come from!' Nobody has been convicted of having it done here. But they are putting it out there like thousands of girls are being done. We get a lot of hatred from that." (Woman FG2)*

The descriptions clearly displayed the ways in which negative attitudes towards Somalis are galvanised and justified around publicity relating to FGM, and contributed to a sense of social exclusion, stigmatisation and victimisation among study participants.

Participants discussed the considerable progress made by the Somali community themselves, through community-led initiatives, to improve awareness of FGM and thereby reduce its incidence. They no longer felt that FGM was relevant to their own lives in Britain and had worked to develop a new identity which could incorporate both British and Somali culture, separate from FGM: *"We are trying to find our identity as British Somalis, and we don't want FGM to be part of that"* (Woman FG2). However, they felt that FGM-safeguarding undertaken by statutory authorities did not take account of the sea-change in attitudes.

*"Even though, as a community, we want to move away from this practice, [we are] slapped across the face with it- [...] Even if communities stop practicing it, they will still be stigmatised and labelled by it. It undermines the progress that we've made." (Woman FG3)*



Participants voiced a specific concern that approaches of state officials to FGM-safeguarding undermined the continuing work of community activists to address the issue among the Somali population: *“Do we understand that [FGM] is a crime? Yes, we do. Do we want it to stop? Yes, we do. But [this] way of going about this is not helpful.”* (Man FG4). This reinforced a sense of social dislocation, from service providers and wider society. In particular, Somali anti-FGM campaigners described their disappointment that the considerable energy and time invested by members of the Somali community, and their success reducing the prevalence of FGM, was being both discounted and undermined by statutory FGM-safeguarding services:

*“It makes me sad. It makes me feel like I have wasted my time. I know I’ve done a good job. There was a lot of families who didn’t know anything about the law in this country and FGM and they know now. But when they [social services] go behind you and they visit the family in this way- [...] We need to bring back the trust. How we are going to do this I don’t know.”* (Woman FG3)

*“It discredits everything you worked for. How*

*are we supposed to eradicate FGM if this is how it’s left communities to feel where there’s FGM prevalence? [...] If [campaigners] who work in this field for many years are left to feel ‘what’s the point?’, how are we ever going to move away from [this]? How are we going to progress? It damages the campaign.”* (Woman FG3)

There was also a concern that statutory approaches to FGM-safeguarding had *“divided the community. [There is now] So much tension. People who are campaigners, they have become like the enemy.”* (Woman FG3). It was argued that this could put Somali anti-FGM campaigners at personal risk of attack:

*“It’s heart-breaking. The parents will come back to you and they say, ‘Why are they [social services] coming to us?’ We are being blamed. We brought them [social services] to them [the parents]. ‘You’ve fed us to the lions! You fed us to the shark’s mouth!’ Which is why if you work in the field you deal with stigma but also the stick – the effect the services’ behaviour is having is going to get [you] stick from the community, you’re going to be blamed.”* (Woman FG3)



# 7 The impact of FGM-safeguarding on parenting and parent-child and other family relationships

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This research identified a number of ways in which people's preferred approaches to parenting were undermined by their experiences with FGM-safeguarding. This included parents insisting on particular forms of behaviour from their daughters, people being more cautious when seeking health care for their children, or telling their children about FGM before they would otherwise have chosen to.

Some parents wished their children never to know about FGM, on the understanding that it would not be something they would experience and would therefore traumatised them unnecessarily. Others planned to inform them at an age and in a way that they, as parents, considered appropriate. But knowledge of the likelihood of FGM-safeguarding forced some parents to do this before they felt their children were ready, in an inappropriately detailed way, and at times during or in response to the safeguarding home visit itself:

*"As a parent we [are the ones who should] tell our children about FGM. I didn't want to tell my daughter, but I had to because of social services, I had to. My daughter was frightened. [The social services and police told her] "she's going to take you to Somalia, and they are going to do these things." She was [made] scared of me." (Woman FG1)*

Certain approaches to FGM-safeguarding were argued to directly undermine parent-child relationships, such as suggesting to daughters that they were being put at risk of FGM by their parents and asking children

more generally about parental involvement in FGM-related activities: *"The police try to ask the child, does your father send the money to have the FGM?" (Man FG5).* Significantly, there was no evidence from the focus groups that disclosing such potentially-traumatising information to young children was considered problematic by safeguarding officers, even when these apparently contravened approaches to sex and relationship education in wider society:

*"[My] children [were] very young at the time so they didn't really understand a lot. But I felt very uncomfortable to be spoken to about a very intimate part of the body in front of my child [...] and she [young daughter] did pick up things. I was very shocked, shaken, upset and disturbed by what was happening and I did try and talk to my daughter about it afterwards and I think she was very confused. Even PSHE [Personal, Social and Health Education] isn't taught at that age so, it's quite scary for a child to go through horrific details of FGM and hear about it." (Woman FG3)*

Participants reported that learning about FGM during social services and police home visits dramatically enhanced the fear experienced by all children, regardless of gender, and damaged parent-daughter and other family relationships in untold ways. Sons, for example, were presented as losing trust in their mothers and believing that they had done something criminal.

*"The boys, they were sitting watching, and they were saying "Oh my god, what did you do?" (Woman FG1)*

There was a particular concern that all current statutory approaches to FGM education (including in schools) could make *“kids feel bad about themselves [...] [feel] they practice a bad culture [and] hate their community”* (Woman FG2). Adult participants also described the ways in which FGM-safeguarding could, perhaps intentionally, encourage distrust in their own mothers and relatives.

*“You don’t feel comfortable letting them stay with your own parents, your auntie. You want them to go and learn their culture, their language, and you are suddenly questioning things.”* (Woman FG2)

*“[The social services and police asked me] ‘What are you going to do if your mum did that to you?’ [i.e. How are you going to protect your children from your mother?] ‘What will you do if your mum, or grandma takes them to another house [to do FGM]?’ [...] It was uncomfortable to have that kind of experience. It made me worried.”* (Woman FG2)

Parents also felt a need to respond directly to the threats made by safeguarding officers by warning their daughters that they might be examined on return from holiday. This contributed both to the traumatisation of children, and put additional stress on parent-child relationships.

*“They say they going to check the children. So, we as parents have to prepare them. We have to say, when we come back from holiday, the GP might need to check your private parts. The girls they don’t understand. They say, ‘but Mum, you always told us that no one’s allowed to see your private parts, [...] so why do I have to show it?’ For us as a parent, to explain, it’s so hard. And the girls, they keep worrying about it, when they go to school - is it going to happen today? Tomorrow? And if you say, ‘you have to go to the doctor,’ they say, ‘Mum, is it for my*

*private parts?”* (Woman FG1)

Not knowing whether, when and by whom this threat might be carried out produced a generalised fear which families experienced for indefinite periods. In response to this perceived threat, some parents also felt the need to insist that their daughters did not draw attention to themselves, by always ‘being good’, particularly in school. Whether or not this level of paranoia was unfounded, some parents clearly believed that the threats issued by social services that their daughters might be medically examined would be realised if they gave them any opportunity to do so.

*“You feel as if you are not in a safe place. My daughters go to school. It worries us [that] if a child misbehaves in class, then... What has this got to do with the FGM?”* (Man FG4)

Parents reported instructing their daughters not to spend too long in the school toilet on the understanding that prolonged time spent in the bathroom, even for innocent reasons, could be misinterpreted as evidence of experience of FGM:

*“If you come back from holiday, you have to tell your daughters, if they go in the toilet for longer than 10 minutes, then. And some girls, they love to go to toilet, just for a chit chat. They go in there to chat, talk about holiday. But then the teacher [she feels she] needs to keep an eye out. If she sees a Somali girl walking out the room, she needs to put a time on her, which is again stigmatising, because a British girl, she might not [feel the need to] check the time. If they are staying more than 10 minutes, report her. So just let your girls know, wee and go back to the classroom.”* (Woman FG2)

Mundane aspects of everyday family life could therefore take on sinister dimensions:

*“As a parent, they feel their right to take their child on holiday is taken from them because*

*they get questioned about it and there's a whole palaver about – 'where you taking them?' 'why are you taking them?' I have to answer your question before going on holiday? You wouldn't ask me if I was a different race. You're asking me because of what I look like, where I'm from, where I'm going."* (Young Woman FG6)

This concern also affected planned treats and

surprises, because parents felt they could not tell their children *"to keep a secret because it turns into something else"* (Woman FG2). Experiences described in focus groups provided evidence of the ways in which such secrets – of surprise parties or special trips or events – could be misinterpreted as evidence of a risk of FGM, particularly by teachers and safeguarding officers in schools.



## 8 The impact of FGM-safeguarding: Loss of trust in statutory services

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*“You don’t want to travel. You don’t want to go and visit the doctors. If your child falls down you automatically think ‘my child’s going to have an examination.’ You don’t want your child to go through that.” (Woman FG3)*

FGM-safeguarding directly contributed to a dramatic loss of trust in key state institutions, including the NHS, schools, police, social services and the judiciary. This loss of trust developed from participants’ own personal experiences and was exacerbated with knowledge of the experiences of others in the wider community. There were particular horror stories that circulated with great impact.

Participants provided clear evidence of the ways in which FGM-safeguarding had directly contributed to a loss of *“confidence in the health service”* (Woman FG2). Participants described concerns that they would not receive appropriate or sensitive care due to a fixation with FGM generated by safeguarding policy, and that as a consequence they would again be exposed to interrogation:

*“We are just very worried now. I’ve got a daughter who is nearly 12, if anything should happen to her, to her privates, if she gets an infection, the first thing that comes in my mind is this situation [FGM-safeguarding]. [...] It’s very stressful, it keeps coming back. The first thing that comes in my mind is that the doctor will ask you this question.” (Woman FG1)*

*“Cases of thrush. The minute you say there is a problem, because [of] who you are, the first thing the GP will look at you, if you mention anything about that area, any health care*

*setting, they feel obliged to ask you [about FGM] because they don’t want to get in trouble.” (Woman FG2)*

Consequently, some participants chose to rely more heavily on unregulated or unorthodox medical and non-medical alternatives, while others described engaging with health services with more reluctance and, at times, hostility, and at a later stage: potentially risking their health and increasing the need for more intensive medical responses.

The role of schools in FGM-safeguarding undermined parents’ trust and *“confidence”* (Woman FG2) and created *“a bad relationship between parents and school”* (Man FG4). School referrals were especially damaging, particularly when they occurred without giving families prior warning:

*“The school is two-faced. They smile at you, and the next thing you know you’ve had a referral. In my case, I filled in the form for a holiday, [and] it was “Oh, no problem, yeah.” No-one even in the office said anything. Just nothing. And then social services visited. [...] It makes you feel so angry and upset. They are rude and two-faced, and it leaves you in conflict because you have to leave your child there. You have to leave your child with the same people, imagine, imagine. [...] My parents said [to me], “your teacher is your second mother or second father,” so imagine how [FGM-safeguarding] completely damages that trust and that relationship.” (Woman FG3)*

There was a strong sense of frustration and disappointment that schools did not take advantage of their relationships with parents

to provide a more open dialogue:

*“This is going too far, going too far. The school is misusing their power. They’re going straight away, to call [social services] without talking to the families. The school has good contact with the family. They can call the family, and say ‘guys, what is going on? Why have you booked two weeks earlier? Can you explain that?’ Then they can [work out] something then. But [they don’t], they call social services and they come with the police, and boom!” (Man FG5)*

Social services were understood as presenting a particular threat to the integrity of the family home, which led participants to comment that the “*relationship*” between families and state had “*broken down*” (Woman FG1). Indeed, FGM-safeguarding visits from social services and police negatively impacted on participants’ trust in all state institutions. The well-publicised court case also had significant detrimental effects: “*The trust between the communities and the local authorities and the police, now is lost. I don’t know how that can be revived*” (Man FG4).

*“It left me fearful to go to the doctors, hopeless, couldn’t go anywhere, couldn’t ask for school support, couldn’t even [ask] the police for support if something happened,*

*and something did happen [a racist incident which went unreported].” (Woman FG2)*

*“The police, we don’t trust them because of the things that happened. [...] It’s just intimidation, you just feel like, why are they constantly at me, I’ve never done anything wrong to my kids. [...] For us as a community, this is not helping because it’s just making us think, don’t work with the police, don’t work with social services, because the trust is not there.” (Woman FG1)*

Concerns were voiced regarding national legislation and policy as well as local implementation. Participants were distressed that the local authorities implementing these policies were not acknowledging these problems. This led to a concern that they were not interested in representing their needs and grievances:

*“Bristol City Council needs to accept and listen to the community concerns. [...] They don’t hear, they don’t listen. [...] We have no trust because the local authority they implemented this. [...] You [feel that you] are powerless. Your voice, no one will listen to you. No Mayor, no Bristol City Council, they never said any word [about the failed prosecution]. So, the community are quite really, they lost the trust. I don’t know how long it will last.” (Man FG4)*



## 9 Recommendations for policy and practice

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*“[FGM] Safeguarding is not fit for purpose. [It’s] Designed to harm specific communities rather than to help.” (Man FG4)*

None of the participants in our study claimed that they supported FGM and they all agreed that it was a practice that children should be protected from. Despite identifying problems with current provision, many of them were keen to support the authorities in providing accurate and appropriate FGM-safeguarding services and seemed positive about the potential for future initiatives.

However, the perceived unwillingness among local authorities to engage sufficiently with the wider Somali community led to skepticism regarding the motivation for these policies, which were considered to have had only negative consequences:

*“We have done two workshops with police and we were also trying to make a dialogue [between us and them], but we never get any attention from them, just they have their own agenda and they don’t respect the community.” (Man FG5)*

Some participants questioned the motives of the people leading FGM-safeguarding initiatives. The degree of skepticism was such that some participants even suggested that the service providers at both national and local levels were only interested in obtaining funding and *“making jobs for themselves”* (Man FG4), rather than eliminating FGM. There is therefore a clear need for service providers to introduce approaches which engage all members of the Somali population, and those from other FGM-affected groups, or clarify the ways in which existing initiative seek to do so.

Recommendations for improving services emphasised the need to involve the Somali community in the development and implementation of safeguarding services: through, for example, the employment of workers from Somali or other affected communities, and in the education of professionals and communities.

*“FGM-safeguarding is something that has to happen. It does exist in the Somali community and it is a problem, and in others. The main problem is how it’s done [the safeguarding process]. I think people have to take into consideration that there needs to be more opportunities for people from those ethnic groups to take part in the safeguarding process and communicate with families accused. It’s harder for someone who doesn’t speak the same language to relate to this person. [...] Miscommunication may happen.” (Man FG5)*

A more collaborative approach, involving service providers and members of FGM-affected groups, was seen to have increased potential to produce greater awareness amongst affected communities, more successful interventions within families and generational cultural changes that would eventually lead to the elimination of FGM. Most importantly: *“We need policies which we are part of”* (Man FG4).

There was a concern that Somalis and people from other FGM-affected groups were being excluded from decision-making processes that affected them. Participants emphasised the importance of input from local communities when planning safeguarding approaches:

*“The whole community is absent. We’re absent from decision-making platforms.” (Man FG5)*

*“If you want to put something on paper, and you say, this is what one community does, you have to have the numbers, you have to come and talk to [everyone in that community]. We have different perspectives. We’ve not had that done when decisions are being made.” (Woman FG2)*

It was felt strongly that the perspective and expertise of community members was necessary for the development of effective strategies to address FGM. There was therefore a need for service providers to be more open to the idea of working together with FGM-affected groups and respect the communities’ efforts to respond to this issue. Participants felt it was crucial that FGM-safeguarding emerged from a collaboration between communities and professionals and that an integrated approach would be more beneficial than the current measures which impacted on the Somali community so negatively.

*“Reflect on the way in which they [policy makers] deal with the community and then maybe change, and maybe have a roundtable discussion with those who are affected – service providers, maybe interpreters, people who work with schools, people who help affected parents – to come together to discuss and then maybe learn from each other. I think that would be a way forward.” (Man FG5)*

There was a concern that current approaches which only sought advice from anti-FGM organisations and charities were limited, as their funding and political stance meant that their position may be biased. It was felt that involvement of individuals from the wider community could provide a more balanced response:

*“It is crucial that there are teachers who are*

*from Somali background, there are social workers who are from Somali background, there are people in the community, or Mosque leaders [involved in anti-FGM policy development] who do not have a personal stake, or something they’re losing. They’re only there because they want to protect the interests of their community.” (Man FG5)*

Participants argued that there was a dire need to improve the education received by professionals involved in the provision of statutory FGM-safeguarding. This was in part to ensure both the provision of more sensitive and culturally appropriate engagement, but also in response to a concern that at present, FGM-safeguarding staff have very limited knowledge about FGM itself:

*“They had no idea what they were talking about. They were very unprofessional, very inexperienced and they needed more training, that was the way I saw it. I think they were very misinformed. They were very biased and that caused a lot of concern for me [...] They only named a few types of FGM [...] There are so many different forms of FGM, and to me, I don’t think they even explained it clearly and I just felt like it was wasted effort [...] So I felt like there wasn’t even safeguarding done really, because they didn’t explain things properly, they didn’t understand and they were very ignorant.” (Woman FG3)*

Participants described feeling both frustrated and patronised by the way that those people who were supposedly educating them about FGM knew less about the procedure than they did themselves:

*“It adds injury to insult because if somebody tries to educate you about something you’ve been through – ‘Look it didn’t happen to you, it happened to me, there’s no way I’m going to do it to my child. Who are you to tell me something you don’t know about?’” (Woman*

FG2)

There was also a frustration with the way in which supposed 'risk indicators' had been developed and were being used, particularly that with a "mum who has experienced FGM", there is an assumption that "100%, she will [do FGM on] her children" (Woman FG3). Our participants expressed that, by contrast, their own experiences of FGM had discouraged rather than encouraged them from performing FGM on their children, and more so than any statutory education or sense of its illegality. There was also confusion and distress relating to apparent discrepancies in the application of these indicators, for example where it flagged the daughters of women who had not had FGM:

*"It really came as a shock to me that I was asked to [sign the form], that I was put in the limelight, and that there was suspicion, and there was a risk indication [...] even though myself I haven't undergone FGM."* (Woman FG3)

As discussed above, this research has found evidence for the inappropriate application of safeguarding guidelines, in schools and elsewhere, and a lack of transparency in approaches which are both distressing and confusing for those families involved and the wider Somali community in Bristol. The recent work by Bristol City Council to clarify these guidelines and encourage greater dialogue between families and schools prior to referral has the potential to significantly improve this situation, although additional work is needed to repair the damage already done.

Participants identified a need for practitioners to have training in the application of these guidelines and to help them recognise and respond to evidence of FGM. Participants believed that those involved in FGM-safeguarding should

understand the historical context of FGM and the changing attitudes to FGM in Somalia/Somaliland. Moreover, participants argued that there was a need for the specific health concerns affecting women who had had FGM to be addressed:

*"50-60 years ago, you couldn't get married if you didn't have it [FGM]. But now it's died. It's completely dead. Now there is a fear she [the woman with FGM] will lose the child, she will have health problems, complications. People are now more aware of the health issue. How do we get our service providers here (in Bristol) to understand this? It's insulting. They don't know what they are talking about. It's insulting. You feel embarrassed and attacked."* (Man FG4)

Participants also described the need for those involved in safeguarding to have more general training in cultural competency to enable them to "be sensitive to that person's culture, no matter what that culture is. You need to be aware [of ethnic differences]" (Young Woman FG6). They argued that the nature of FGM made it imperative that conversations were conducted in culturally sensitive ways:

*"It's a relevant thing to ask [but] it's a very sensitive thing to ask, so the wording around it and how you actually approach a parent— it needs to be sorted out otherwise I feel like a lot of Somali parents are going to resent any organisation that tries to help or tries to prevent it because they're going to take it as an offence, instead of a general question."* (Young Woman FG6)

More sensitive approaches have the potential to engage families around FGM while minimising the harm associated with current practices, including the sense of fear, stigmatisation, criminalisation and (re)traumatisation which is evident in current approaches:

*"If I was approached in a correct manner, I*

*would obviously cooperate, but if I was approached in a manner where I felt targeted, harassed, I couldn't cooperate at all." (Young Woman FG6)*

Participants identified a need to respond directly to the distrust and assumptions of criminality inherent in current approaches. This requires families to be treated more sensitively, with more care being taken to establish the level of risk posed before initiating certain safeguarding interventions. Importantly, this suggestion is in line with current guidelines for the implementation of FGM-safeguarding. The recent initiatives by Bristol City Council which aim to clarify these guidelines and, consequently, reduce the number of referrals is therefore extremely important and timely. Broadening the cultural focus of existing policies to acknowledge other FGM-affected groups, and clarifying how this is being achieved, was also argued to be an important step towards restoring trust within the community.

There is a particular need to examine the ways in which 'the form' has been used, in light of the aims associated with its initial development by members of the Bristol Somali community and in consultation with FGM-affected groups. The views expressed in our study regarding how this might be changed were very diverse. Some participants felt that the form should be discontinued because it was deemed as racist and used to criminalise their community. Others, particularly those who had been involved in developing the form, suggested that it should be made available in the communities themselves, for their own use, rather than accessed only through social service or police visit. Irrespective, the recent decision by Bristol City Council to discontinue use of the form, with the aim of developing greater dialogue between families and statutory services, has the potential to be

very beneficial for those engaged in FGM-safeguarding in the future.

However, participants advocated a much more coordinated response to the practical aspects of safeguarding than is currently being proposed, where a range of services work together with the community to develop and implement more effective and appropriate policies. In particular, it was suggested that community workers from FGM-affected communities could assist safeguarding officers identify those particular individuals who were at risk, rather than targeting the entire community unnecessarily and problematically.

It was felt that community workers had a better knowledge and understanding of and a trusting relationship with local people and as such would be able to engage with them in a friendly, approachable and therefore more effective and sensitive way. As one woman explained, *"Let the community work with the family... The community will pass [on the info] if there is a serious situation"* (Woman FG3). It was felt that such an approach would help provide more transparency to the process, and help to provide *"a distinction between accusations and convictions because just because on hearsay one person has said X is doing FGM or Y is doing FGM, it doesn't mean that they are"* (Man FG5). Some participants appeared unaware of the extent of the work of community anti-FGM campaigners, particularly those organisations who have worked confidentially with individual families. Other participants were very aware or had participated in such activities. Both advocated that informative and preventative home visits currently undertaken by police and social services should be done by trained community workers.

Participants felt strongly that police involvement in FGM-safeguarding was extremely damaging:

*“when you involve [...] the police, it undermines everything. It makes [...] people think about crime. In order to win the hearts and minds of people, the school, the social services, with the community, they have to intervene together.” (Man FG5)*

If police were to be involved, it was felt that this should only be when there was evidence or strong suspicion that a child was in danger. A visit from police and social services to the family home was stigmatising in and of itself because it signalled criminality to the wider community, and as such, it was argued, such visits should not be undertaken as part of routine precautionary or advice work.

It was argued that involving Somali community workers in FGM-safeguarding implementation would also address the language issues identified with current approaches. Additionally, participants stressed the importance of having all written information available in the Somali language. There were a number of other opportunities identified to improve existing approaches, including ensuring the presence of interpreters, giving families sufficient time and capacity to familiarise themselves with documentation and not questioning children under 16 without parental consent in non-high-risk situations.

Participants also felt that current issues affecting anti-FGM initiatives related to the severe under-representation of ethnic minority professionals in statutory services, particularly in Bristol:

*“Social workers in London, they have far more intra-community skills. But the social workers in Bristol— There are only two social workers in Bristol from a Somali background and we’re talking about [many] Somalis living in Bristol. The police and social workers, sometimes they lack the right skilled approach to families and that is also affecting them. I’m quite sure that the person from*

*that background, he understands better [the issues affecting them].” (Man FG5)*

Employing staff which better reflected the cultural diversity of Bristol could therefore address the lack of cultural knowledge and sensitivity in approaching the issue and lead to more effective dialogue between statutory service providers and the community. As one man explained: *“Because if someone just barges into your home and Somali mother, some of them don’t speak English, they just hear gibberish, and they get panicked. Nothing’s going to get solved that way”* (Young Man FG5). It was argued that even if they were not Somali, having statutory service professionals from a broader range of ethnicities would make Somali people feel less stigmatised.

People argued strongly for safeguarding approaches which recognised that Somalis are not the only community where FGM may happen. One woman described an NHS FGM training film, which included people with a range of backgrounds and which was therefore considered less stigmatising:

*“It talks about FGM – different ethnicities and a priest and an imam [...] It was very good – It didn’t stigmatise, it didn’t make me feel uncomfortable. [It] shows that it’s not just one ethnic [group]. When you’re watching the film, you don’t just feel ‘all eyes on me’ kind of thing.” (Young Woman FG6)*

It was acknowledged, by some but not all, that there was a continuing need for the education of FGM-affected groups around this issue. However, it was argued that these educational opportunities would be more effective if they aimed to empower rather than indoctrinate and alienate people:

*“Sometimes when they do awareness in school, they tell the child, ‘your parents will hurt you’. [It] causes a problem between the children and the parents. We don’t want this.*

*Instead of that, do it in a proper way. Tell the parents how to help their children. Tell the parents how to stop FGM.” (Man FG5)*

Participants suggested preventative approaches for awareness-raising courses for parents and children in schools could be more fruitful than current procedure which stigmatised people. It was suggested that FGM education in schools should be incorporated into other PSHE training and provided by teachers who reflect on all groups affected, rather than treated as a separate issue which is often delivered by Somali trainers which then further reinforces the stereotype that this is an exclusively Somali problem.

Finally, many of our participants questioned the statistical evidence on which the policies and funding for organisations and services were based. These claim a large proportion of Somali women and girls to be at risk but participants argued that these estimates were out of date and did not include young people born in Western countries. As one man concluded: *“I have spent the last 25 years in Europe. I have never heard of someone who has done FGM. Think about that.”* (Man FG5). Including genital piercing and cosmetic surgeries under the definition of FGM was considered inappropriate and risked unhelpfully inflating these statistics. There is therefore an urgent need to review the nature and quality of these statistics,

particularly if they are used to justify the heavy-handed approaches identified here.

Indeed, some participants argued that rates of FGM in the UK were so low as to make current levels of financial investment in FGM-safeguarding unwarranted. It was suggested that funds would be much more effectively invested in tackling other social problems affecting the Somali community, such as issues of housing, employment and youth crime:

*“We’ve got a lot of issues with our boys, with our girls, a lot of our children are going in to guns. We’ve got issues with housing, employment for the women, and things to empower us, helps with the kids who are coming from prison, especially the boys, how can we help them. Those are the things we would like to discuss. FGM [safeguarding] is fantastic, but a lot of funding has gone into FGM and these issues that we are experiencing nobody is really looked at it. Boys coming from prison. Get them back to school and all that. So, we would like something similar to happen.”* (Woman FG2)

Instead of *“wasting tax payers’ money”* (Man FG5) on unsuccessful prosecutions which reinforced a sense of social exclusion, it was suggested that funding should be directed towards *“more fruitful”* approaches including *“educating the people”* at the *“grassroots level”* (Man FG5) which could more effectively empower the Somali population.

# 10 Conclusions

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We began this report with a quote from a participant regarding the perceived power imbalances which were seen to underpin the experiences of FGM-safeguarding of Bristol Somalis. These findings show in detail how this sense of the exploitation of inequalities in power pervaded participants' discussions of their experiences with FGM-safeguarding services in Bristol. There was an awareness that safeguarding authorities were putting pressure on families to comply with demands on them which were felt to be unfair and unjustified. There was also a perception that these inequalities enabled service providers to remain unconcerned about the extent to which their engagement with families might be considered offensive, confusing, intrusive or even inaccurate, both in terms of the specific information on FGM they circulated or whether particular family members might be reasonably considered at risk. An important way in which this power imbalance was enacted was through drawing attention

to, or failing to appropriately engage with, inequalities in socioeconomic position or class, and English language ability.

The Somalis in our study are committed to the eradication of FGM. Many have already invested considerable time and energy in this endeavour. They have made a number of recommendations to ensure the effective continuation of this work, and many are willing to work with statutory services to see this realised. However, some participants have been seriously affected by existing approaches to FGM-safeguarding in Bristol. This relates to both a problem with policy and also with the implementation of that policy. There is considerable work to be done by local and national authorities to repair this damage and prevent the further traumatisation and victimisation of both individual Somali families and the community as a whole.





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