

MY Voice

A Participatory Action Research Project with Men, Women and Young People on Female Genital Mutilation (FGM) in Scotland

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1. Executive Summary

Introduction and scope of the study

MY Voice is an innovative participatory action research project with affected communities on Female Genital Mutilation (FGM) in Scotland. The project aims are to facilitate community engagement on FGM with women, men, young people and religious leaders, to enable their voices to be heard, and to contribute to the development of awareness-raising around FGM, as well as ensuring culturally appropriate services for Scotland. There have been multiple calls for greater community participation and leadership in the work on FGM in Scotland from those directly affected (see section 1.3). The findings from MY Voice can start to identify key issues and help determine ways in which community participation can be built in to the Scottish response to FGM more effectively.

The objectives of MY Voice are:

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

The research was set up by a partnership between the Dignity Alert & Research Forum (DARF) (<http://www.darf.org.uk/>) and Roshni (<http://www.roshni.org.uk/>). The Institute for Global Health and Development (IGHD) at Queen Margaret University (<http://www.qmu.ac.uk/iighd/>) carried out the research with technical support from Options Consultancy services (<http://www.options.co.uk/peer/>).

FGM is described by WHO (2014) as comprising all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. It is one of the most extreme manifestations of the disempowerment of and violence towards girls and women. It is a traditional practice carried out in 29 countries across Africa and the Middle East, as well as among diaspora communities, including in Scotland. FGM can be part of a traditional ritual that symbolises the transition from being a girl to being a woman. However, this is not always the case. It is important to understand that there is enormous variety of different practices and meanings that FGM has for those that practise it.

The population which is from FGM practising countries resident in Scotland is estimated by the Scottish Refugee Council to be 23,979 from 23 different African countries (Baillot et al. 2014). There is no way of knowing how many of these women or girls have had FGM carried out and there are many limitations to the data, but the figures demonstrate that this is clearly an issue in Scotland, with all the associated duties to respond to protect girls from this violation and to provide support and services to those directly affected.

The Scottish response to FGM is located within the Government's work to combat violence against women (VAW), with a clear focus on the links between FGM and VAW. In 2016 the Scottish Government produced Scotland's National Action Plan. Both the Scottish Refugee Council and the Scottish Government's National Action Plan call for greater engagement with FGM affected communities to ensure their voice is part of the Scottish response to FGM and they are empowered to contribute their experience and expertise to prevention, protection and provision.

This report presents findings from the pilot phase of MY Voice and is intended to be a platform for the voices of affected communities and used as a tool for dialogue and interaction for all those concerned about the issues of FGM in Scotland. In particular, it is intended to provide information which can be fed into the delivery of the Scottish Government's National Action Plan to prevent and eradicate Female Genital Mutilation (FGM) 2016-2020.

Methodology

The methodology for MY voice was based on Participatory Ethnographic Evaluation Research (PEER) with additional interviews and focus groups to complement the PEER research. PEER is based on ethnographic research principles, and allows rapid collection of data on how people view issues and consequent decision-making in their everyday lives, as well as engaging participants and empowering them to become more involved in the issues raised. Options Consultancy Services Limited provided technical support and advice for PEER projects in Scotland for MY Voice.

Seventy-one people (29 men and 42 women) living in the central belt of Scotland (Glasgow and Edinburgh) who had associations with 17 African countries where FGM is practised participated in the project, either as PEER researchers, PEER interviewees, through attending a participatory workshop, or were interviewed separately as religious leaders.

Findings

Life in Scotland

We asked participants about life in Scotland as the first theme of the research. For many participants, Scotland represented freedom and safety. People said they felt they had many opportunities in Scotland, although others talked about how hard it was to get work and how their language, accents and the fact that their work experience was not in Scotland all counted against them. Religious practice was important for all participants no matter their age, gender or religion. There was a strong difference between men and women in their perceptions; men felt that it was easier for women to adapt to life in Scotland, that they had more to gain because of their increased rights, while they felt men had more to lose, in particular their sense of identity as African men.

Attitudes and perceptions to FGM

Most participants did not support FGM, or certainly did not support the negative health impacts of FGM. However, most of them explained how important it was to cultural beliefs and in particular, how it reinforced gender norms. They told us that FGM was believed to make women pure or calm, and suitable for marriage. A number of participants talked about the pressure people are under to carry it out, either from older relatives or the wider community. Although religion was not specifically mentioned as a pressure, it was part of the traditional values which the interviewees mentioned as contributing to the pressure. They talked about women not being valued and being stigmatised through name calling and isolation if they had not had FGM. Men are also valued through their women having had FGM. Sexuality emerged as an important theme for all three groups of participants: women, men and young people, with young women worrying that FGM could negatively affect satisfaction in marriage and cause difficulties in relationships. Men talked about the impact FGM has on women's sexuality and this had a big or even shocking impact on some men. Some women were really suffering from the impact of FGM with great pain and ongoing difficulties caused by it during their life. Some of them felt that it had had a negative impact on their relationships causing marriages to end and are still struggling to get help for their problems.

What needs to happen to end FGM?

All participants felt that everyone needs to contribute towards doing something to end FGM. Most of them actively wanted to take part in this, particularly with awareness raising and

sharing of experiences. Many people were unaware that FGM was illegal and others who did know that it was illegal were unclear about the details. There was a lot of concern about criminalisation of the affected communities with people saying they were cautious about telling anyone if they thought there was a serious risk of FGM being carried out as they were unsure of the response. They would like some reassurance that responses would be culturally sensitive. On the other hand, most people felt strongly that the law needed to be enforced. There was little knowledge of FGM specific services or how to access them. Some people had used services and found them helpful but others talked about how little specialised provision there was and the need for more skilled workers in this area. There were very strong feelings that the community contribution needed to be stronger and there was frustration from the women in particular that this had not happened as much as they wanted it to. They felt they were consulted but not enabled to drive responses to the issue.

Recommendations

1. Delivering the Scottish National Action Plan to prevent and eradicate FGM

We recommend that:

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

2. Community engagement

We recommend that there is:

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

3. Service delivery

We recommend that:

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

4. Working with Young People

We recommend that young people are:

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

5. Working with women

We recommend that:

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

6. Working with men

We recommend that:

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

7. Engaging religious leaders

We recommend that:

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

Conclusion

It is important that the work started by MY Voice continues in order to harness the energy and enthusiasm which emerged during the project. Many of the voices heard in the report are ready to participate and be part of whatever new developments take place around FGM in the coming years to develop positive culturally appropriate responses in Scotland. As stated in the Scottish Refugee Council report, if this is not done we run the risk of further marginalising the community voices that are the most effective advocates for change (Baillot 2014:45).

2. Introduction

MY Voice is an innovative participatory action research project, with affected communities on Female Genital Mutilation (FGM) in Scotland. The project aims are to facilitate community engagement on FGM with women, men, young people and religious leaders to enable their voices to be heard and contribute to the development of awareness raising around FGM as well as ensuring culturally appropriate services for Scotland.

MY Voice responded to an identified need for more engagement with, and information about how, affected communities perceive the issues around FGM in order to develop culturally appropriate services. Participatory methodologies including PEER research were used. Seventy-one people (29 men and 42 women) living in the central belt of Scotland (Glasgow and Edinburgh) who had associations with 17 African countries where FGM is practised, participated in the project, either as PEER researchers, PEER interviewees, through attending a participatory workshop or were religious leaders who were interviewed separately. This report presents findings from the pilot phase of MY Voice and is intended to be a platform for the voices of affected communities and used as a tool for dialogue and interaction for all those concerned about the issues of FGM in Scotland. In particular, it is intended to provide information which can be fed into the delivery of the Scottish Government's National Action Plan to prevent and eradicate Female Genital Mutilation (FGM) 2016-2020, and to ensure that the voices of FGM affected communities are embedded in the Scottish response.

The objectives of MY Voice are:

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In this section, the introduction explores some of the key issues about FGM globally and in Scotland. In section 3, the methodology is described, including a discussion of PEER research and of the ethical issues relating to the research. The key findings are presented in the main body of the report in section 4, and the final section 5 presents conclusions and next steps.

2.1. FGM a global health issue

FGM is one of the most extreme manifestations of the disempowerment of and violence towards girls and women. It is a traditional practice carried out in 29 countries across Africa and the Middle East as well as among diaspora communities including in Scotland. There is no health benefit to FGM and it can cause excruciating pain and trauma, as well as risks of haemorrhage and infection, and can result in long lasting health problems and complications at childbirth. For most women it reduces female sexual pleasure. It is estimated by the World Health Organisation (WHO) that 100-140 million women and girls have undergone the practice and UNICEF estimate that 30 million girls globally are at risk of FGM in the next decade (UNICEF 2014). Although many of the countries where forms of FGM are traditionally carried out have reduced the practice (it is estimated that practice has reduced by around a

third globally) progress is slow and uneven. Also because of increasing population growth, current trends indicate that despite these reductions the actual number of girls and women undergoing FGM will continue to rise significantly in the next 15 years (UNICEF 2016).

Due to the sensitivity and secrecy surrounding the practice, data on FGM is notoriously hard to collect. UNICEF (2016) has written that from the data available from large scale household surveys, it is clear that FGM is highly concentrated in a swath of countries from the Atlantic coast to the Horn of Africa, in areas of the Middle East such as Iraq and Yemen and in some countries in Asia such as Indonesia. Global movements of people mean that FGM is in evidence in countries where diaspora populations have moved and in particular countries that are recipients of migration such as Scotland along with the rest of Europe, USA, Australia and other high income countries.

In UK Government Department for International Development (DFID) document *Towards Ending Female Genital Mutilation / Cutting in Africa and Beyond* (2013) they write about the way practising communities bring traditions with them as they migrate and may be more likely to hold on to customs which they perceive as part of their cultural identity. It is also thought that the practice of FGM within diaspora communities can take on a slightly different meaning which is more associated with maintaining cultural identity than with marriageability. It can be too simplistic to think that migrants leave behind their traditions when they move. The International Organization for Migration (IOM) has written that diaspora communities living away from their countries of origin often hold on to practices long after they have become less important within those countries. Because FGM is so strongly linked to culture and beliefs IOM have maintained that it can become an integration issue, in addition to being a health and human rights issue. In situations where integration is difficult, it often results in a withdrawal into the community and sometimes stricter application of cultural practices. In this case, the preservation of ethnic identity is used to mark a distinction from the host society, especially when migrants are resettling in a receiving culture where women have more freedom of choice and expression, including in their sexuality, as compared to their community of origin (IOM fact sheet, no date).

FGM is described by WHO (see WHO factsheet) as comprising all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons and have established a generally accepted classification into four main types:

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

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

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

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

Terminology

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

FGM The use of the initials FGM standing for **Female Genital Mutilation** are not considered appropriate by everyone. A number of people who have had FGM carried out resist the implication that they have been mutilated and prefer the use of other labels. Many communities find the term ‘circumcision’ more natural. However, campaigners would argue that circumcision is a much more neutral word that does not carry with it the associations of pain and long term impact that can occur through the procedures carried out to women. An alternative approach has been to talk about **Female Genital Cutting** (FGC) or the combined term FGM/C which is widely used in international development and academic literature. Cutting does describe more accurately what actually happens. In MY Voice we found that many participants did not know what FGM meant (see section 4.2.1). Most languages have a specific term to describe it and these terms were used by the PEER interviewers. However, it has become the convention in policy documents in Scotland to use the term FGM and therefore we will use this term throughout the report, but with reservations, and the awareness that this is not the term used by most people affected by the practice.

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

The rituals associated with FGM vary greatly between cultures and within cultures. It is quite possible to find very different methods of practice and symbolic associations in peoples living in close proximity to each other. In some places it is carried out as part of a large celebration and closely linked to the education of a girl in her transition to early womanhood. Girls might be isolated together during their physical recovery time and this is when they are taught about appropriate behaviour and ways of conducting themselves as a woman in society. We heard about such rituals from our Gambian participants in MY Voice. In other places such as Egypt, FGM has become highly medicalised and increasingly the experience is a very personal one with girls being taken to a doctor by their family on their own with no broader community involved (Refaat 2009). In nearly all the literature on the cultural association and symbolic meaning of the ritual, it is associated with strong gender norms and roles. Words such as ‘purity’, ‘cleanliness’, ‘calmness’, and ‘womanhood’ are regularly raised, and as such, FGM can be classed within those activities which seek to perceive women’s sexuality as dangerous, and as something which has to be controlled.

2.2. FGM and gender

Gender norms are deeply entrenched in all societies and partly explain why it is so hard to stop FGM. Kaplan and colleagues writing about FGM in Catalonia¹ in Spain has written ‘The

¹ Catalonia has been an early recipient of migration in Spain particularly from West Africa including countries which traditionally practice FGM.

social and cultural roots of these practices condition their perpetuation, despite important restrictive legal initiatives having been developed in some countries of origin and destination of the immigrants' (Kaplan et al. 2010). FGM is a deep-rooted social practice that is carried out because of strongly held beliefs that, without it, girls will not achieve proper 'womanhood'. It is believed to be in a girl's best interests: uncut girls cannot marry and can be condemned to a life of stigma and discrimination (DFID 2013). As can be seen in the section of this report on pressure to carry out FGM, (section 4.2.5) FGM is widely perceived to be necessary not only to control women's sexuality but also to control their power and strength.

Within the literature on gender, FGM is widely perceived as an abuse of rights and an act of violence against women. FGM differs from other forms of violence against women because traditionally it is also carried out by women² and carried out routinely on all girls. It is also something which is valued in the society. Similar to other forms of violence towards women, FGM remains hidden and secretive, and those who had it done to them as children often struggle to remember what happened to them or make sense of the impact it has had on them. It can lead to a deep sense of betrayal and anger towards beloved older female relatives (see the account given in section 4.2.6). The Scottish response to FGM is located within the Government's work to combat violence against women (VAW) with a clear focus on the links between FGM and VAW.

The Declaration on the Elimination of Violence against Women, adopted by the United Nations General Assembly in 1993, was one of the first international rights agreement to specifically mention FGM as a cultural practice that represents a form of harm to women. Other international, regional and national agreements have made specific reference to the rights based issues related to FGM; it impacts on the rights of the child, freedom from violence and torture, sexual rights and reproductive rights. Perceiving FGM as a violation of rights can lead to fears being expressed by some practising communities that their traditional beliefs are under attack. Work to raise awareness about the harmful impacts of FGM requires extremely sensitive approaches and a robust understanding of the cultural and gender sensitivities involved.

FGM has been perceived as an issue affecting women and is often credited with being for the benefit of men, and desired by men in a wife/partner. Although it is certainly the case that some men actively want to partner with a woman who has had FGM, there is evidence in published research literature, which is backed up from some of our findings in this report, that many men feel excluded from information about FGM, have little idea about what it involves or the impact it will have, and feel powerless to stop it happening to their daughters or sisters and have no knowledge about how to support women with it. Men say it is 'women's businesses, and women say it is 'done for men'. Kaplan writing about research carried out with men in Gambia has written that 'efforts aimed at the abandonment of FGM in the communities where it is deeply rooted have extensively considered and addressed women's perceptions on the issue, leaving those of men barely acknowledged' (Kaplan 2013). While there is growing awareness of the importance of including men, it is still a relatively new development, and yet it is clear that if violence against women is to cease, this is unlikely to occur without men's support and intervention. Although MY Voice worked with both women and men, we carried out activities separately with both groups. We are aware that many participants would not consider it suitable to discuss an issue such as FGM with members of the opposite sex, and in addition, many women from the communities we are working with, both younger unmarried women as well as older married women, would not be comfortable engaging in an activity with men who are not close relatives.

Sexuality and sexual pleasure were rarely talked about in relation to FGM until relatively

² This is changing with the increased medicalization of FGM in some settings.

recently. However, it is now seen as central to any discussion of FGM as is the topic of the availability and success of 'reversal' surgery. Baldeh's work on obstetric care for women with FGM in Scotland came up with some findings about sexuality with women talking about lack of sensation and pain during sexual intercourse (Baldeh 2012:30). Discussion around sexuality and sexual pleasure was not specifically asked about in MY Voice but did emerge in the workshops as well as the PEER interviews with all three groups, women, men and young people.

2.3. FGM: The Scottish Response

The Scottish Refugee Council (SRC) report *Tracking Female Genital Mutilation in Scotland, A Scottish Model of Intervention* presented findings on the first piece of research which aimed to identify the size of the populations which potentially practise FGM in Scotland (Baillot et al. 2014). The report cites the work of Simpson (2014) on the 2011 Scotland Census which shows the growth in ethnic diversity in Scotland since 2001. The numbers of people identifying as African grew from 5000 in 2001 to 30,000 in 2011. This growth is significant, not just for the sharp increase in numbers, but because of the very small numbers of Africans who were in Scotland at the start of that decade. The rapid rise is partly due to the UK government policy on the dispersal of asylum seekers to Glasgow, but also due to greater global mobility for Africans, many of whom came to Scotland to study or work. The small number of Africans living in Scotland in 2001 meant that many service providers were unaccustomed to some of the health and cultural issues faced by this population group. A number of publications have documented the way in which HIV services in Scotland had to adapt to a rapid rise of Africans coming into their services in the early 2000s (Cree 2008, Sinyemu and Baillie 2005, Hamani Souley and Grant 2011). The situation is similar for FGM, with a range of Scottish services having to develop responses to FGM in African communities in recent years due to growing awareness of the issue, partly due to diaspora communities drawing attention to it through campaigning (e.g. DARF and KWiSA), and partly as a result of issues which emerged in service provision (Kandirikirira and Fotheringham 2013, Mhoja et al. 2010).

Drawing on different data sources, the SRC research was able to estimate that 23,979 people who originated from FGM practising countries are living in Scotland³. It is not possible to say how many of the women in these populations have actually had FGM carried out but the research calculated that 2750 girls were born to mothers from an FGM practising country between 2001 and 2012 in Scotland. The research identified communities from 23 different FGM practising countries amongst the African identifying population. In the report the authors stated: 'we do not have information about the effect of migration on the practice of FGM, nor the ethnic and socio economic origins or values of these particular communities in Scotland' (Baillot et al. 2014:14). They go on to emphasise the need to complement the research by engaging and working with affected communities to 'ensure the policy-making and practice development is shaped by the experiences, needs and views of those affected by FGM' (Baillot et al. 2014:19).

FGM affects very specific communities living in Scotland, those from potentially FGM practising communities across Africa and the Middle East. People from these populations may be recent arrivals, asylum seekers, refugees, or first and second generation migrants. Many of them have experienced a range of problems related to racism and discrimination and some will have concern over their legal right to remain in Scotland. Recent arrivals may have left behind traumatic events and experienced great hardship and loss on their journey. People in these situations can experience extensive isolation. All of these issues can affect their ability

³ See Baillot et al (2014) for a discussion of how the data was collected.

to secure employment, to find safe affordable housing, to secure or maintain a relationship, as well as their ability to experience a sense of wellbeing and safety. FGM may not be a central concern in their lives when there are so many other pressing problems. We document some of this in our first findings section, life in Scotland, to give the contextual background to the lives of the people who participated in MY Voice.

Until relatively recently there was little awareness about FGM in Scotland. The first organisation to be established with the sole aim to campaign to end FGM was DARF which was established in 2007. The leading campaigning organisation against FGM in England, Forward, was established in 1983. It could be argued that this 24-year time difference is not surprising given the differences in the sizes of affected communities. Because of the taboos and secrecy surrounding it, there was virtually no visibility of the issue in Scotland. Baldeh's (2012) study of the experience of obstetric care for women with FGM in Scotland highlighted the lack of awareness from health professionals. One of the first issues that campaigners fought for in Scotland was to reform the 1985 prohibition of FGM Act (UK). The act was updated in England and Wales in 2003 and The Female Genital Mutilation (Scotland) Act 2005 updated it in Scotland with the additional extra territoriality clause (i.e. it included taking a child out of Scotland for the purposes of carrying out FGM) and an increase in the penalty for convictions. Since this time people in a range of organisations have worked together to try and raise awareness of the existence of FGM in Scotland.

Subsequently there have been a number of highly positive changes. The report from the Scottish Refugee Council has been an important contribution in demonstrating the scale of numbers of women and girls who could potentially be affected by FGM in Scotland (Baillot et al. 2014). Perhaps more importantly, the process of carrying out the research enabled a number of interested parties to come together to work on consultations and attend events. There has been production of Scotland-specific materials (see The Women's Support Project <http://www.womenssupportproject.co.uk/content/home/1/>), as well as training of front line professionals taking place across Scotland. FGM as an issue has been located within the violence against women strand of work in the Equalities Unit in the Scottish Government and is included in the Equally Safe, Scotland's Strategy to prevent and Eradicate Violence against Women and Girls. However, the gap that is still apparent is around engagement with affected communities. The SRC report makes references to this gap in a number of places, arguing for example about work with the Nigerian community: any subsequent interventions must be designed with – and not for – the community recognising and building on the world to tackle FGM in the Nigerian context (Baillot et al. 2014:19)

The authors say that this point was emphasised by many of the people they interviewed for the research, from both NGOs and Statutory services. However, the general perception is that the UK is lagging behind other European countries in this regard:

In the UK, efforts to reduce FGM have focused on punitive legislation without at the same time sufficiently empowering women in the communities concerned to engage in debate, change attitudes and create alternative ways of affirming their cultural identity. (Dustin 2010:19, cited in Baillot 2014:19).

In February 2016 the Scottish Government launched a National Action Plan to prevent and eradicate Female Genital Mutilation (FGM) 2016-2020. The activities of the plan are intended to deliver the objectives of 'Equally Safe', Scotland's strategy to prevent and eradicate violence to women and girls. There are some places where the plan specifies working with communities and third sector organisations (specifically objective 3, action 1 of prevention and objective 2, action 1 and 2 of protection). There is little specific reference to affected communities in the objectives on provision, but the introduction to recommended actions of

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

We also heard from participants that they were frustrated that their expertise was not being called upon more. Section 4.2.3 documents some of this frustration particularly from the women. They said they are asked to be part of consultations, to respond to policy developments that have already been decided, but have not been invited to be proactive or supported to become empowered and lead their own communities.

There is clearly a gap between the services that say they need to engage with affected communities and the communities themselves who are frustrated at not being able to do this. New African diasporas in Scotland are not always well established and need support to build up a strong organisational base. The findings from MY Voice and the engagement from the participants forms a base for starting to think about what kind of mechanisms and structures could fill this gap and ensure that the voice of people affected by FGM is firmly embedded within the Scottish response to FGM.

3. Methodology

The methodology for MY Voice was based on Participatory Ethnographic Evaluation Research (PEER) with additional interviews and focus groups to complement the PEER research.

There is now an extensive global literature on FGM with a growing body of evidence on the impact of FGM on the lives of those affected, the effectiveness of awareness raising and education interventions and a smaller but increasingly growing body of evidence of the effectiveness of medical care in obstetrics and reconstructive surgery. A literature and document search looked for relevant materials on FGM and included a search of databases at Queen Margaret University including EBSCO, Scopus and Medline. We have not included an extensive literature review in this report which is intended to present the findings of the data collection phase of MY Voice, but the literature helped guide our thinking and enabled us to search for comparative information to our findings.

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

3.1. Participatory Ethnographic Evaluation Research (PEER)

PEER has been widely used to research the attitudes, perceptions and experiences of people with FGM (Price and Hawkins 2002, Oguntoye et al. 2009, Hemmings 2011, and FORWARD 2016 among others). In *Tackling Female Genital Mutilation in Scotland*, the report by the Scottish Refugee Council (2014) a number of references are made to PEER as a potential method for conducting formative research to inform community engagement strategies in Scotland and to compliment the work that has been carried out to date to estimate the size of the population affected by FGM (Baillot et al. 2014, sections 3.3 and 4.2).

PEER is based on ethnographic research principles, and allows rapid collection of data on how people view issues and consequent decision-making in their everyday lives. The method trains people from a target group to conduct basic interviews within their own social networks where trust is pre-existing. PEER uses third person questions (asking "what do other people say or do about an issue") and as such, does not require personal disclosure of experience. This makes the method well placed to research 'sensitive' issues, where social taboos or shame may make traditional research paradigms difficult⁴.

Options Consultancy Services Limited is a social enterprise, providing high quality public health research across the UK and internationally. In the UK, they have conducted a number of PEER projects with people affected by FGM, including in London and Birmingham, and are currently the lead evaluator for the FGM Initiative which has funded community based prevention of FGM across the UK. They also implement 'The Girl Generation' (funded by DFID), which is an African-led campaign to end FGM. Options technically supported PEER projects in Scotland for MY Voice.

3.1.1. Ethical issues

Engaging people in discussions about FGM can lead to some people talking about it for the first time and can raise some very disturbing and difficult reactions, memories and flashbacks. This may relate to personal experience of FGM, or to the realisation that other members of the family having problems, or have even died as a result of FGM (see section

⁴ For more information on PEER, including research on FGM in the UK, please visit www.options.co.uk/peer

4.2.6). It is therefore important that there is no coercion to being part of MY Voice if it becomes too uncomfortable for anyone. We informed participants they could leave at any time and had names of agencies where we could refer participants for counselling if need be. FGM is also an illegal activity in Scotland and most countries in the world. Carrying out research in this area can therefore lead to uncovering information about illegal activity, or the risk of significant harm. The PEER methodology asks no direct questions and asks for no names, and therefore data is not attributable to a particular person. For this reason, we did not expect such disclosure to take place. Other PEER projects in sexual and reproductive health have found that the method works well ethically, with low to no risk of breaking anonymity. However, we do have a robust safeguarding procedure in place, and after advice from Police Scotland, we are confident that we would respond swiftly and appropriately to any disclosure of significant risk of harm. Consent is requested from all PEER researchers and they are trained to gain verbal consent from the people they interview and they are informed that they can leave the research process at any time they want without having to give a reason why.

3.1.2. Recruitment

We used a convenience sampling strategy, contacting people from affected communities through contacts in community-based organisations. PEER researchers (PRs) were selected according to the profile of the research:

- PEER researchers self-identify as coming from a community/ethnic group thought to be affected by FGM
- Young people under 25 years old
- Men over 25 years old
- Resident in Glasgow or Edinburgh

The research questions were developed in collaboration with the PRs. The research aims were discussed in detail. PRs then used participatory exercises to explore issues associated with FGM in their social network. Three themes were then developed with short prompts as questions.

For this research 28 young people (women and men aged under 25 years old) and men (over 25 years old) from both Glasgow and Edinburgh were recruited and selected to attend the PEER training workshops along with the lead researchers and the PEER technical lead from Options. Men and women were trained separately to talk to people of the same sex and age and community as themselves through a series of three conversational themed interviews developed by the PEER researchers themselves. The themes were:

Theme 1: Life in Scotland

Theme 2: Talking about FGM

Theme 3: Tackling FGM

Interview guides are listed in Appendix 1

Although the PEER training workshops went very well with enthusiastic participation from the 28 PRs, various delays resulted in a gap between training and carrying out interviews and we lost some of the PRs during that time. Some of the PRs that did continue with interviewing needed chasing up and support in order to complete this phase. Others struggled to find people from among their social networks to interview. However, a core group did carry out their interviews.

Data was collected shortly after each PR had interviewed on each theme. PRs were encouraged to take notes after the interview had taken place, so that the interviews

themselves are kept conversational in tone. PRs come to meet the PEER facilitator in a neutral location⁵ where they relate the content of the interview and are further interviewed themselves on meanings and behaviour within the data. This is entered straight into the laptop and constitutes the data itself. As such, both the PR and the interviewees are counted as part of the sample.

	Number of Participants		
	Men	Women	Total
PEER researchers trained	16	12	28
PEER researchers trained – under 25	5	12	17
PEER researchers who carried out interviews	6	4	10
PEER interviewees	11	9	20
Interviews carried out	48	30	78

PEER usually includes a final workshop to bring back all of the PEER researchers, discuss the finding and decide on the best strategy for moving forward. Owing to the time it took to carry out the debriefs and other constraints, this event did not take place during this scoping study, but instead will take place in the next stage of MY Voice and will be the first step in deciding the activities for a second phase of MY Voice.

3.2. Complementary interviews and data collection

In the research design we included additional interviews and focus groups to complement the PEER approach. These include interviews with religious leaders as well as an additional participatory workshop/focus group with women.

We had one religious leader as part of our Men's PEER training and in addition were able to recruit another one who subsequently interviewed two further religious leaders. All of these were Christian and were leaders in churches with large African populations.

3.2.1. Women's participatory workshop

As MY Voice was drawing to a close, we were successful in obtaining additional funding from the Scottish Government Equalities Fund to carry out some data collection with women over 25 years old. We had been aware that this important voice was missing from the MY Voice project. The timing of the funding meant that it was not possible to carry out another round of PEER research so we held a one-day participatory workshop/focus group. Twenty women came to the workshop which was held at Waverley Care in Edinburgh. As with the previous training workshops, the women really appreciated attending and having a chance to talk to each other about FGM. The workshop was lively and interactive and all of the participants put a huge amount of energy into the day, and worked very hard. The aims of the project were explained to the women who were asked to give their consent to participate and told they could leave at any time if they wanted to.

⁵ We met for most of the debriefs in rooms at the MRC/CSO Social and Public Health Sciences Unit, University of Glasgow. The unit is centrally located and was easy for the PRs to get to. We also used rooms at YWCA, DARF and QMU for convenience for some debriefs.

The day followed the three themes that had been generated in the PEER training; life in Scotland, talking about FGM, what we can do about FGM. Following the PEER rules, we asked no direct questions, and no names, but we did ask for stories. During the workshop we had two note takers and afterwards wrote the notes up as well as information contained in flip charts. This data has been analysed alongside the PEER data.

3.2.2. Total number of participants

MY Voice participants were associated with 17 different African countries:

Countries	Number of Participants in MY Voice		
	Men	Women	Subtotal
Cameroon	1	-	1
Cote D'Ivoire	-	3	3
Djibouti	-	1	1
Eritrea	9	-	9
Ethiopia	5	3	8
Gambia	-	9	9
Ghana	-	1	1
Guinea Bissau	3	1	4
Kenya	1	-	1
Nigeria	6	8	14
Senegal	-	1	1
Sierra Leone	-	2	2
Somalia	-	3	3
Sudan	2	4	6
Tanzania	1	1	2
Uganda	1	-	1
Zimbabwe	-	3	3
Unknown	-	3	3
Totals	29	43	72

Participants had also lived in other European countries including England, Ireland, Spain, France and Portugal.

Data throughout this report is drawn from the three sources, PEER research, and the interviews with religious leaders and the data collected at the women's participatory workshop.

	Number of Participants in MY Voice		
	Men	Women	Subtotal
PEER researchers trained*	16	12	28
Participatory workshop for women	n/a	20	20
PEER interviewees	11	9	20
Religious leaders	2	1	3
Totals	29	42	71

* included one religious leader

4. Findings

4.1. Life in Scotland

In the first part of the MY Voice project we explored with all the participants what it meant to them to be living in Scotland. Among the project participants we had some who were very recent arrivals and others who were born in Scotland, so as expected, experiences varied greatly. Throughout all the data collection was a sense of the 'other life' which they might be having if they or their parents had not left Africa and this led to a natural tendency to compare Scotland with the possibilities of how they could be living if that move had not taken place. Some of the themes that emerged were as follows.

4.1.1. Freedom

An important theme in many of the PEER interviews as well as in the workshops was a sense of freedom about being in Scotland. For some this was linked to the process of seeking asylum, or leaving an oppressive regime, one where maybe they were in the wrong political party, or unable to practice the profession they want to or live in the way they choose. One researcher reported an interviewee saying:

When he was in Ethiopia he didn't feel good – he was in danger. He couldn't do the work he wanted. Here he can feel safe and he can study here. In Ethiopia he had a problem with the government, political problems which meant he could not work or study. He is so pleased to be here.

For others it was about having a sense of personal freedom to be able to make their own decisions and knowing they had the right to put them into practice. A young Gambian woman said:

In Scotland you have a choice to dream big and achieve. Also you have the opportunity to be whatever you want to be because there is gender equality and young people like us are given the chance to live their dreams and there is no form of discrimination regarding gender compared to back home.

Freedom was also linked by many to a sense of safety even by those who were not recent arrivals. It emerged as a strong theme in the workshops when asking people about life in Scotland. Others who had left countries where there was conflict over religion appreciated the fact that in Scotland no one minds which religion you have, and that people can go to different churches and no one will judge you because of it. One man from Ethiopia said:

[In Scotland] ... you can practice your religion anywhere – you can meet there together from different countries and languages – And you can go to the Mosque. I thought there would be problems with that in Scotland.

Freedom was also associated with being able to distance themselves from traditional customs including FGM and choice of marriage partners. Some of the younger participants acknowledged that their parents had had to resist FGM for themselves or their siblings. One participant attributed moving to Scotland with her parent's decision not to carry out FGM on their daughters. Although she said 'even back home times are changing, the mentality has also changed' she did think that it was the move that finalized the decision. When she was asked at what point FGM had stopped in her family she said 'it stopped with me'.

Another young male PR did not think that the move away from Nigeria had necessarily been the factor that led to resistance to FGM, but was aware of his parents' struggle:

My parents fought strongly for my sister not to have FGM and have always been very anti it. I know they had to fight against their parents back in Africa about this but they were determined their daughters would not have it done and also educated me about it.

4.1.2. Education and Aspirations

For many people the sense of freedom was also linked to aspirations and the possibilities of gaining an education, a good job and having the freedom to make friends and have an independent life which many were acutely aware they would not have had in their country of origin. A focus on studying and the opportunities to study, particularly for young women, was seen as a key advantage to life in Scotland:

When it comes to equal opportunities, compared to back home, in Scotland both young and old and boys and girls have equal rights. And what she was trying to say was that young people like us – if you are in Gambia things are different – here in Scotland a girl can do any kind of course in college. In Gambia that is different – certain courses or jobs – if you are a female they won't let you study that or give you that job. In Gambia it's all about boys getting education, nothing about girls. In Scotland there is nothing like that – male or female everyone has the right to do any kind of course they want to engage in. In Gambia it's all about boys getting education, nothing about girls.

The young women placed great importance on freedom and aspirations in discussions in the PEER training workshop, and this theme emerged through many of the PEER interviews.

Life in Scotland makes me feel free and happy – I don't have any fear, I can move through the cities without any fear. It is different from being at home. Life in Scotland offers me education, participation in the community, health care and basic necessities, human needs – this is very good. Even now I am not on work programme – I am attending ESOL classes. I have no work but everything is facilitated which is a big opportunity for me.

Getting a job was seen as very challenging for many reasons. It was the main aspiration for all our participants, either to get work or to get better work than they had. The women spoke about how hard it was for women of African origin to get professional posts with responsibility even if they had excellent qualifications and experience in the past.

Jobs are great when you can get them. They are hard to get because people don't believe that we have qualifications and the language is an issue.

Some interviewees who had extensive work experience in Africa found that that didn't count in Scotland. A man from Ethiopia spoke about one of his interviewees saying:

He said going to English classes is good. It is easy to find the English in community or college but for further education it's not easy for asylum seeker. He is a refugee. To get jobs is difficult – he can't get a job as he has no experience in Scotland. He has 5 years experience working as a carpenter in Ethiopia but he cannot get any experience here. And without experience he cannot get a job.

A young woman at college described the contradiction between the availability of education but the lack of access to jobs.

There is good education which is free but there are no jobs. It's very hard to find a job especially with a headscarf. It's difficult enough finding a job as it is without having these extra things to worry about.

Another young woman echoed this by explaining the difficulty of finding suitable clothing for college placements:

It has been difficult for me, I was late going out to placements, because I couldn't wear trousers but we were not allowed to wear skirts. So in the end we agreed upon a uniform that suited us both, I wore a longer tunic and they allowed me to wear long sleeves underneath.

4.1.3. Community and Isolation

Despite the largely positive responses participants gave to questions about life in Scotland, some of them did miss a sense of neighbourliness and community, and emphasised how hard it was to integrate with locals. They talked about going round to a neighbour's house for coffee at any time, something that didn't seem to be possible in Scotland. This Eritrean man said:

... when I compare our culture to here – in our culture all the community participate and we care for each other. When we say we care for each other – the way we live is that our living standard is the same so neighbours have a good interaction. Whole communities live very closely. But here only one or two people are considered your neighbours in your flat. Neighbours close the door, they don't speak to you. In our country you knock at the door and you say to them to bring coffee. It can make us feel lonely, we are used to being able to go to the neighbour and the door will be open and we can just go in and have coffee together.

Many people identified the importance of being able to speak good English in order to get to know people and reduce isolation.

If I'm a good English speaker, I can get contacts and integrate with communities. I have 25 years experience in mechanics. I want to share my skills ... and to be useful in my community in Scotland

Wet weather also led to a sense of isolation for people who were not used to being outside if it rained. Some people told us how they would never go out in their home countries if it was raining, and if it started to rain they were used to running for shelter. Apparently this custom caused quite a reaction from the local population when shortly after their arrival a group of recently arrived men from the Horn of Africa ran as fast as they could through the streets of Glasgow seeking shelter from the rain! We were told that they soon learnt to stay calm and walk slowly when the rain came so that they would not scare anyone.

The women who attended the women's participatory workshop talked about how their lives were extremely busy and this did not give them time to socialise with their neighbours. They listed the multiple demands on their time from looking after children, working, sending money back home, and participating in cultural and religious activities. They said that life is busier in Scotland, you do not even know your neighbour and that a lack of high paying jobs meant that many of them had to work long hours or do shift work. Ten of the twenty women worked at night and 14 of them felt they did not have enough sleep. This left little leisure time left to socialise with Scottish women who seemed to them to have a great deal of leisure time. They said:

We cannot compare ourselves with Scottish women; we work and send money home to our families. So that is what we use our money for instead of holidays.

One thread that ran through all the different groups (women, men and young people) was the importance of religion and prayer to their daily lives. Prayer and attending religious services whether Christian or Muslim, was an integral part of their identity and community in Scotland.

Local churches and English as a Second Language Classes (ESOL) were identified as places where it was possible to get to know people. Interviewee told the researcher:

(In Scotland) most of the people don't believe in God – that separates him from them. His faith is very important to him – and he feels very different from the people who do not believe in God. He goes to church and can have his own place there. He is meeting Scottish people in the church and getting a lot of help from them.

Another said:

He said going to English classes is good. It is easy to find the English in community or college but for further education it's not easy for asylum seeker.

The newly arrived also felt that those who had been in Scotland longer and those with good English would be better integrated. For those who had been resident in Scotland longer, the main sense of 'not belonging' was around what they felt to be unwelcome comments to visible signs of their religion and this was particularly the case for Muslim women, particularly young women who have grown up in Scotland. They felt that their religion attracted negative comments, in particular if they wore a hijab (head scarf) or chador (full body cloak). An Ethiopian young woman explained this:

It's more difficult in the Muslim side. If you wear the hijab people have perceptions about you which makes it difficult for people like us coming from a certain community and integrating into Scotland. Definitely there is a huge cultural difference.

Another young man from Nigeria talked about the problems of finding the right places to socialise and encountering racism, with the implication that he was physically attacked, before he settled down and found a good group to socialise with.

Most of the places when he first arrived were really rough and there was a lot of racism – some places were good but others really rough – racist element really there. That made it hard.

When we asked people for stories about life in Scotland we heard a lot of stories about getting lost when they arrived. One man talked about believing he was in London and asking for Big Ben before someone explained to him he was in a city called Glasgow. Others talked about not being able to recognise their own house, because the houses are so similar. Many of them had stories about the help they received from Scottish people when they were lost. One man didn't get off the correct stop on the bus and the bus driver helped him where he was going. One young woman from Gambia said:

When my friend first moved here she got lost and she was looking around everywhere to find her way back home. Until she met a couple, who she asked for directions and the couple were Scottish people and they were really helpful. They even made phone calls to make sure they were giving the right directions. From that day she believed that the Scottish people are so friendly and helpful and that made her decide to stay longer in Scotland because of the peace, tranquillity and friendliness that she received from every person.

4.1.4. Gender and Age

When talking about integrating into Scottish life a number of people expressed the view that it was easier for younger people and also for women to integrate. Younger people were perceived as being more adaptable and resilient, as well as having fewer worries and more access to institutions which would assist with integration, particularly education.

Younger people have it easier than older people – it's harder to adapt when old. When they get here they just stay with their communities and stay closed away when things are too difficult. If you have to go to school or college, it is easier.

The young women also felt that older people have a harder time. A young Ethiopian woman spoke about this:

For example, our mothers find it difficult to interact with the general public because of the language, they find it difficult to learn the language. They already have other things on their minds, they find it difficult to concentrate on anything else. They already have their own social group so find it difficult or don't see the need to leave their own social group therefore don't find it necessary to learn another language

One Ethiopian man said:

He felt that it was much easier for younger people to get on with others – especially people under twenty as it is easier for them to learn languages. He didn't include himself in this as he is older than that. He also felt it is much easier for women – life is easier for them. They find it easy to integrate because they find it easier to communicate and are good with languages. But still language is a barrier for new people depending where they come from. Also they have fear of unknown – they create barriers for themselves, especially people in middle age.

It is not the same for everyone. It is better for girls and also for young people because they have more rights when compared to boys. When he compared with Ethiopia, women have more rights here. Women in our country they cannot do what they like. But here the person has the right to do what they want so it's a bigger change for women. It is a big change for the men to see the women have more rights – they can do what they want. And young people can learn the language more easily and go to school.

4.1.5. Masculinity and Identity

This sense that women had gained more from moving to Scotland was linked to the men feeling that they had lost part of their African masculine identity. In the men's workshop, where all the men were together, this was a strong point of conversation which ran through the whole two-day training event, and was expressed through some sophisticated and nuanced understanding of gender relations. It was articulated largely through the difference they noticed in family life between Scotland and what was referred to as back home, i.e. Africa. Some of the young men had hardly lived in Africa, or only as young men, but joined in with the conversation. 'Back home' women had to do as they were told, and they had to look after the family. One man said that back home there was always a hot meal waiting on the table for him when he got in. In Scotland that was not the case. This was accompanied by much enthusiastic agreement and laughter from the other men and the 'lack of a hot meal on the table' became synonymous with the changes to gender relations that were experienced upon moving to Scotland. After some discussion about how much they missed their 'real' African masculine identity, they talked about women's role, finally acknowledging how hard women work and how much they have to do. One man said 'I don't really know how they managed that back home, always having

a meal on the table, because it is not as if they don't go out to work as well, like here'. Another talked about the preparations 'back home' that had to be carried out by women early in the morning to get the food ready as well as go to work, and the use of thermos flasks to keep the food hot. When asked how food was prepared now they said they (the men) were expected to help in the house and to share the food preparation or even do it for the woman.

In the PEER training the men appeared to welcome the opportunity to spend time together with other men, discussing family life and aspects of their identity. The discussion about the loss of their masculine identity almost seemed to be cathartic to them and many of them said that they had never had the opportunity to talk about such things before with a group of men who shared their culture.

The women were also aware of these changes, as can be seen in some of the quotes above under the section on freedom and education. The women participants clearly understood they had greater protection for their rights in Scotland than they might have in Africa. In the women's workshop they said that in Scotland 'Women are not that oppressed here and they have a voice'. Another one said that the problem now is that 'men have lost control. We have a voice'. One of the young women interviewees said:

Social life feels a safer environment, women are not objectified and can do whatever they want and wear whatever they want and not be judged for it. In terms of freedom they feel safer because of the ways the laws are enforced.

However, despite a general welcoming of these greater freedoms, the women's workshop was focussed on how busy they are in Scotland and how little time they have. This topic was explored extensively and although the expectation that men would share in family obligations was expressed, the focus was more on the lack of help from the extended family.

One said 'In Africa we get support for the family, you can even pay someone to work with you and help with the domestic work'. Another added 'In Africa you will have help and not have to do everything by yourself'. Some of the women talked about having younger relatives, such as nieces or the daughters of friends, who would come to stay and help with looking after the children and the household. Men were not perceived as stepping into this role and women felt the burden of domestic care still remained on their shoulders.

4.2. Attitudes and perceptions to FGM

As set out in the introduction, the main focus of MY Voice was to examine attitudes, perceptions and experiences of FGM among affected communities in Scotland. The experiences of moving to and living in Scotland clearly interact with attitudes and perceptions of cultural norms including FGM and all that is associated with it. The migratory experience led to participant re-evaluating social norms including those towards FGM. Participants were not asked direct questions about their own experience of FGM, including, for the women, whether or not they had had it done to them, but some participants shared with us whether or not they had had it done or people close to them had.

4.2.1. Awareness of FGM

In some cases, there was clearly a lack of awareness about FGM particularly reported by male PEER researchers from their contacts. A young male PEER researcher talking about West African communities in Scotland said:

Young men in our communities don't say anything or talk about FGM as they have no idea at all about FGM. It is never spoken about and they don't know anything.

Others reported 'the main reason for FGM happening is the lack of knowledge which means the local community members have no real idea about whether FGM is good or bad' and 'he didn't have any idea about it'. Other research on men has also found that men have very little actual knowledge of what FGM really entails. In most societies it is perceived largely as women's business and because of the secrecy and the taboos that surround the practice it is hard to talk openly about it (Kaplan 2013).

None of the women expressed such a lack of knowledge and awareness but some of them did struggle with the terminology. The use of the initials FGM were a problem for many people with a number of them not knowing what FGM meant. Some of the PEER researchers didn't try to use the words FGM but went directly to their local word for it, even if the interview was being carried out in English. When asked how her interview went this PEER researcher (young women) from Sudan said:

It went fine. She didn't know what FGM meant so I used the Arabic word 'Tahoor' (meaning to purify) to explain it and she understood.

In the women's participatory workshop, it became clear that many women did not know what the initials FGM stand for and had to have it explained to them for recruitment purposes. The issues were also discussed in the workshops. Out of twenty participants seven said they did not know what FGM meant although the practice was familiar to them. However other participants reported growing awareness particularly in their countries of origin. It was clear that even in countries that are considered politically unstable, and chaotic, awareness work including extension health workers is reaching remote areas and raising awareness about FGM. An Eritrean man told us:

Nowadays all men and women have to discuss about FGM where I used to live [Eritrea]. They talk about what their child and their families should do and how to make decisions about it. It is not specifically about FGM. It is about a few things. But there is much more awareness about FGM. Awareness has been raised. There are outsiders coming to raise awareness – nowadays people talk to each other – people ask – 'are you doing it to your child?' Everyone comes together in a big group. And they will appoint someone as the person to be responsible if anyone carries out FGM, he will take them to court. This is a new thing in rural areas.

4.2.2. How FGM happens

FGM is performed in very different ways in different cultures. How FGM happens has been well documented in other literature (for example, Morrison et al. 2004) much of which is echoed here. We asked people if they knew how it happened in Scotland. There have been anecdotal reports that FGM does happen in Scotland that cutters are brought in and it is carried out on young girls. Participants were asked whether they thought FGM was carried out in Scotland but not for any specific details or names. During the MY Voice project (from 2015 to 2016) the possibility was also raised that other places in Europe or England, in particular Birmingham, were becoming locations where girls were taken to be cut. None of this emerged from our data. Some respondents reported that they didn't think it happened in Scotland or they had never heard of it. Others said they had heard that FGM was carried out in Scotland but no one gave specific instances of this occurring. One young woman PR from Ethiopia told us her interviewee had said:

She thought that it does happen in Scotland, there is speculation about this. People talk about it happening here, but mainly it happens because young girls are brought back to their country of origin, usually during school breaks.

One young women interviewee related how this happened to a friend of hers when she was living in Germany, and the impact it had on her, which is related in section 4.2.6.

People talked about the way FGM was traditionally carried out in their cultures, what the traditions were and the manner of doing it. An Ethiopian health worker described how it is carried out where he is from. He was a health professional working in a laboratory and was aware that FGM was carried out in the area where he worked. He also felt his profession made it easier for him to talk about those things than for other men.

In our country there is a procedure, the girl is held down by many people. Maybe 4 or 6 people hold the hands and the legs. The lady (the cutter) she brings scissors or razor blades and she does the cutting with that. It is done differently in different places. They cut in different way. It is done with no anaesthetic, no medicine at all, no pain relief. It is usually done to girls under 8 years old. There is screaming and screaming – it is very loud.

People from Gambia in particular spoke about the strong connection between the ritual and behaviour and the intense pressure from the community for all girls to go through the procedure. In Gambia, one of the reasons why FGM is performed is to train girls on how to behave as a 'woman', so after FGM is performed, girls are kept in a room for weeks and adults come and talk to them about behaviours and manners. One of the young women talked about the pressure she felt from girls her own age to have FGM even though she came from an ethnic group that did not traditionally practise it.

We are Wolof, we don't do FGM. It is the Fula who do that. But also the Serahule, I had friends who were Serahule, we used to study and play together. There was a family near me. They get married very early at 15 or 16. The elder sister of those friends had a new born baby and the lady was holding the baby, the baby was shaking. They just cut her, they said it is a good thing, it is very important and if you have it you will get married. Your husband will like it and you will have a baby. They tried to persuade me to have FGM. When the baby was cut they said – the woman is there – [the woman who does the cutting] out on the veranda – – if you want they can do a quick one, just for you. I nearly said yes. I didn't really understand. The family had two girls who were my friends. We played together a lot as children and they were always telling me that I needed to do it (i.e. FGM) to be clean and pure. That without it you are not a proper woman. I believed them and I nearly went along with them – they wanted me to do it – they often said they knew a woman who could do it and their mother could arrange it. Even though it is not part of my culture I wanted to be like them and thought I should do it. I am not quite sure why I didn't because at one point I really thought I should, that it would be a good thing to do.

This same young woman was very surprised to find out that she had narrowly escaped from having FGM carried out on her when she was a child. Once she got involved in MY Voice she was telling her aunt about the research and her aunt asked her if she knew that she was nearly cut as a young child of 4 years old.

She said to me, did you know you were nearly cut? I said I had no idea about that. You were about 4 years old she said. We lived in a street where there were families who cut their kids and they had got a cutter to come to the street. There was a big queue of girls waiting to be cut. You were playing at the house – suddenly at one point we couldn't see you we didn't know that you had run away because you saw your friends being part of the queue. The lady who was doing the cutting

was there. She had a mat spread out and you were next in the queue! One of your grandmother's friends saw you and she ran and snatched you and took you away, you were going to be next and she just snatched you away and took you back to your grandma.

These two stories illustrate how people who are not even from ethnic groups which traditionally practice FGM can be affected by it and are in danger of having it carried out on them.

One of the women who attended the women's workshop did not escape in a similar situation. Her story highlights the complexity of decision making about FGM as well as the particularly damaging and horrific way it was carried out on her which continues to cause her severe health problems. She lived with her mother after her parents separated, but then the family decided she should move to her father's home when she was 9 years old. She had not had FGM. One of the reasons she believes she was moved was an accusation that she had no manners as her maternal grandfather was perceived as 'spoiling her'. The other young people in her father's house, young sisters of her father and cousins and other young relatives were all older than her and had all had FGM carried out on them. One day when her grandmother and other relatives were out of the house, they decided she should have FGM carried out on her.

I was living in my dad's house at the age of 9 (around 1997). There were a lot of adults around but they were all away. My grandmother was away fetching firewood – all the adults were working. My father's younger sisters – they were teenagers, family members of my father's side – they took me to an old abandoned house. They heated up a metal rod on the fire and opened my legs and put it on my genitals. I think they were just kids and didn't know how it is done. I don't know why they did it; I think they thought they were doing the right thing for me. They thought I had no manners. I was crying and crying with the pain and my grandmother came in and saw it and was terrified and didn't know what to do. Everyone came from work they all said not to say anything because they didn't want my mum to know. I wasn't taken to hospital – they just used hot water and salt on the wound. Every time I walked it hurt, the wound opened up again. It was so painful. In the end a neighbour told my mum and she came and took me to hospital and I was there for about 3 or 4 weeks. The hospital wanted to file a police report and my mum did too but you know how it is in Africa, my dad and the elders of the family got involved to try to make her not do that and in the end she didn't.

This upsetting story demonstrates the strength of the feeling in people for conformity to the practice and the way in which people in the wider social group feel they have a right to carry it out even if parents or caregivers have not given permission. It is also another example of the connection between what is considered gender appropriate behaviour (good manners) and FGM. Unfortunately for this woman, despite this occurrence, she was then subjected to ceremonial FGM, but once more this was through being lured away by neighbours to participate in a neighbourhood ceremony against the explicit wishes of her father.

My dad was away again and they were carrying out the ceremony in the neighbourhood. The drums were pounding and it was a big ceremony. My dad wanted me to have FGM but not in the neighbourhood as he didn't trust the local neighbours and was worried about witchcraft. The neighbours came to my grandmother to ask about me going – the phrase they used was to ask my grandmother to 'go and eat bread'. They say that so the kids won't understand what is happening. But my grandmother said no I wasn't to go because my father didn't want it done in the neighbourhood. About three days after the ceremony one of the girls who it had been done to came and invited me to go to the market

with her. She told me to come with her but actually she took me to the room where all the girls were, we danced and then someone took me by the hand and took me to a dark room. They covered my eyes and I felt a sharp pain, they cut me there. Even though the ceremony had been finished three days previously, they got the cutter back for me. I bled and bled for three days. My grandmother was frantic looking for me; she didn't know where I was. And when my dad and my family found out they were furious but I had to stay there with the other girls for one month before the final ceremony, the programme. Most people have their clothes and food provided by their family while they are there but because my family were so cross about it they didn't bring me anything – the neighbours fed me I suppose. They were cross with me as well for going off with the girl. We just lay there. There was a lot of bleeding, we were on concrete. One small girl about 5 years old died while we were there. All this was the same year that my relatives had burnt me, it was before my tenth birthday.

Unsurprisingly this woman has continued to struggle with the physical and psychological impact of this story and in particular the choices adults made about her when she was a small vulnerable child.

4.2.3. Gender, Marriage and Sexuality – Women

Both men and women talked about the pressure for women to have FGM in order to make a good marriage. As is documented widely elsewhere and mentioned already in some of the quotes in this report, FGM is often perceived to ensure purity and therefore make a girl suitable for marriage. It is believed to ensure that women behave appropriately and in particular it controls their sexuality. It becomes an issue around marriage negotiations.

FGM is performed to suppress the sexual urge of women before and during marriage. There is confusion that it's religious, which it's not. Some parents believe there is a need for female circumcision as it will help to get a good husband and to be a good wife. It is also believed that it promotes fidelity. They also say the clitoris makes the woman always want sex and if it is cut off she will stay faithful to her husband.

Some of the men explained how men's status and position in the community is also measured by his wife's perceived cleanliness.

The older people support it especially old men because they think it is rude not to have it. They think it is clean. If a woman is not circumcised she could not get married in our community in our culture and no one will talk to her husband. People would judge her and look at her as if she is not good. They would not talk to her husband because of it. Everyone knows if a woman has not had it done.

Whether or not a woman has had FGM and is 'clean' also affects the bride price or dowry her family receive when she marries and this can affect the whole family. One interviewee told the PEER researcher:

He knows people who are not circumcised who are 20 or 25 and then they feel they need to be circumcised to get a man or else they won't get married. So they go to the traditional healers, the traditional leaders. The father might push her to do this as he will be stigmatized if she doesn't marry. The parents know the disadvantages of FGM so they might not do it but when the girls are older and the pressure is on to marry, then they do it. Because the man brings things like dowry, gold and animals and stuff like that. If she is not circumcised they won't get it.

A man from Ethiopia told a dramatic story about a girl he knew from his village in Ethiopia:

One girl had experienced FGM when she was young, her family made her have it done and she had no choice. But after she grew up her family wanted to carry on and do it on her baby sister. She started a campaign to stop FGM and stop FGM being carried out on her sister – she said ‘no more FGM on my sister’. She took her little sister and ran away with her. She left the village and ran away with her to the city and stayed there. She was old enough to work and support her sister. This is the problem – people migrate to the urban area from rural area – she was working as a housemaid in town. The family are angry, they cannot get the benefits they would get from her husband, the dowry, the animals and they are excluded from community. They experience a lot of stigma because of what happened. But she didn’t come back.

If a woman marries without having had FGM, she can be in danger of being returned to her family. This was mentioned by a couple of participants and one of them, who was talking about FGM 4, which in this case involved labia elongation, explained how this happened to someone she knew.

There was a girl at school, and she got married and she hadn’t had it done. And her husband’s family asked her husband if she was ‘sorted’ and she wasn’t, so she was escorted back home. They hadn’t paid the lobolla (dowry). She had to go home and get ‘sorted’. She did go back in the end after a month or two.

Much has been documented about the impact of FGM on women’s sexuality and sexual pleasure. Other PEER reports have written about this. There was some difference in the findings of MY Voice data, between the young women PEER researchers, the majority of whom were not married and had not had children, and the older women who came to the participatory workshop. The young women identified concerns about sexuality and marriage with regard to FGM during group work in the workshop. They said that they worried that FGM would cause problems in the future because of a lack of sexual pleasure, and this would cause damage or even the breakdown of marriages. This was echoed by one interviewee who listed problems resulting from FGM, and added ‘young women in our communities who undergo FGM also have difficulties in their relationships’.

Rather than talking about their fear of the future the older women talked more directly about experiences. They were all in marriages and relationships, and had children. While some women said that FGM had not had particularly negative effects on their marriage or sexuality, others gave graphic descriptions of problems they faced:

FGM makes women feel frigid. Some say they don’t know what orgasm feels like. It’s a big issue for a woman.

For me, when I go to bed with someone all I want is for the pain to be over. I was married before and my husband used to tell me he wouldn’t be surprised if I was a lesbian.

Others spoke about the experiences of close friends or relatives and the problems they were experiencing. It was also felt that it could be difficult in a relationship, when the couple were from two different traditions

What she was trying to say was that, for instance, if you are from a FGM practising community and you are a girl and you move here or any European country and you happen to be in a relationship with a white man, it is sometimes very difficult to tell that person that you have undergone FGM.

FGM can cause many problems around sex in marriage as epitomised by this story from one of the groups at the women's workshop:

There is a member of our group who had FGM and her clitoris was removed and she was left with a tiny hole for urination and menstruation. When she got married, her husband could not have sex with her. The family were waiting to see if she was a virgin but husband could not have sex with her. She was taken away by the women and cut open before she could have sex with her husband.

Some women attributed the problems they had with their sexuality and marriage/partnerships to being a cause of violence in their relationships. Those that did said they thought the problems around sexuality placed greater pressure on a marriage. One woman whose marriage broke down said 'FGM broke my home'.

4.2.4. Gender, Marriage and Sexuality – Men

The previous sections described how women's sexuality and behaviour is often the means through which men's status is recognised and validated. This goes some way to explaining the sense of loss of masculine identity described in section 4.1.5. However, some of the stories of men's sexual encounters with women who have had FGM clearly challenged their previous beliefs around the practice. A powerful PEER interview was with a man who explained how his opinion of FGM had been completely changed when he had a girlfriend who was from his home country who met in Scotland. She had had FGM carried out on her. He said he had never thought about the issue before. Back in his home country it was normal practice

...when they got to know each other he was completely shocked because this person was in such pain – from FGM. It completely changed his understanding. He had heard about it but never saw it as a topic for men, never thought it was anything to do with them. He thought it was only a woman's thing. He has heard about it – but never thought of how it might relate to men.

When asked if this pain was during sexual relations, the PEER researcher said that although the interviewee had not mentioned the word, he understood that yes, he was talking about pain during intimate relations.

He was told, the pain is very hard – it can last up to two hours, she shakes, she hates me. It is so bad. It means they cannot really carry on the relationship. They are still together, but they are not a couple. It is so bad, so shocking – we need to do awareness with the women.... He is shocked to the – how do you say, to his soul, to the inside of his being. He never imagined it could be this bad. She is in such pain and he can't bear to see this pain and especially to be the one who causes the pain if they are together.

The PEER researcher who carried out the interview emphasised the dramatic impact this had had on the man. The word shock was mentioned a number of times as well as the importance this man now placed on the need for change. From having been someone who never gave FGM much thought he was now keen to be a key player in raising awareness and changing attitudes. Another young man talked about being aware that his girlfriend had had FGM. Increased mobility and migration as well as different norms around sexual relationships mean that men now have relationships with women outside of traditionally expected arrangements within their ethnic group. They can compare experiences of physical relationships with women who have and have not had FGM and this differs from the past and possibly the experiences of older men in their community network.

He proceeded to tell the story of a girlfriend he had had. He said he realized she had had FGM but she had never mentioned it to him. He didn't know whether or not to say anything and at one point it did come up. She said that it wasn't an issue for her and had had no impact on her life but he knew that it had. He said that compared to other girlfriends he knew that she reacted differently and that it did have an impact on her.

Most men did not relate such personal stories but could still show an awareness of the issues.

The disadvantage is that there is a lot of pain during birth, and during sex. Women have no appetite for sex, she doesn't like her husband, and doesn't have an orgasm. That is bad for women and bad for everyone.

Some men talked about the pressure this puts on men on the wedding night, especially where there is a strong emphasis on virginity at marriage. The man is expected to have sex with his bride that night and there are no allowances for the couple to take their time over what can be a very painful process for the woman. A man's masculinity is also being tested on the wedding night and can be perceived as failing if they do not have sex. One interviewee said that in his society people felt that FGM (including infibulation) was a good thing because it ensured that the women were virgins when they married. He explained

It is a very bad culture for emphasising your wife is a virgin. No one cares about the pain. Some men say it is bad for the men – a man is not able to have proper sex with his wife – and if a man cannot have sex in that one night [i.e. the marriage night] it is looked on really badly. If he does not have sex with her that night he is not seen as a man-, if he does not do- how do you say it in your language? de- virgining – It can be bad for men.

4.2.5. Pressure to carry out FGM: gender norms

Most people who participated in MY Voice felt that pressure to carry out FGM came from the wider community, traditional or religious leaders and older people. Many of these pressures are related to beliefs about gender norms, i.e. about how women and men should behave, how they are valued and treated in society. Some people talked about the way in which FGM is hidden, not talked about. In some cultures, young girls look forward to the celebrations, presents and being praised for coming through the ordeal. In the women's workshop one woman said 'The ceremony is like a coming of age, and the girls look forward to it'. Attending the ceremony can cost money and this is sometimes given in the form of a present from an older relative, usually a female who is maybe an aunt or godmother or has some other special relationship with the girl. Sending a girl to the ceremony in most societies which practice FGM is believed to help them have a more successful life, make a good marriage with a husband who will be able to provide for them. Some of the participants explained how the reputation of the whole family is at stake.

In Scotland we are not pressured but back in Africa the reputation of the family is at stake if the girls have not been cut. Even your own peers will tell you to go through it.

In particular men's honour is validated by the purity of women in the family. This can have repercussion for their livelihoods as explained by one male interviewee from Ethiopia.

Our fathers they talk about FGM, because if they have a child it must be circumcised. If he doesn't do it for his child, then people or friends ignore him or discriminate against him. He will be stigmatized and ignored. Because of that the father wants to be equal with others and so he will do FGM on his own daughter. This is an

area where you plant seed and need friends to help you with the harvest. We grow wheat, and corn and have traditional seeds. We plant in the traditional way – we have a grain we call it Teff – a grain – like flour. If FGM has not been carried out men say – ‘we have done it to our daughters, why have you not done it to yours?’ and they won’t come and help with the harvest.

One interviewee highlighted some of the tensions and contradictions of changing attitudes.

If a woman doesn’t have it she’s considered ‘rude’. Her behaviour is bad. Or she didn’t follow the community policies. She is seen as a problem. Nowadays especially in the town, they don’t support it, they say they don’t support it, but when they get married they want to marry someone with FGM. Even the people who live in the city they still want to marry back in the rural areas and marry a girl with FGM. Younger people are changing their minds about it and don’t support it.

This implication that older people’s ideas have to be respected and they cannot be stood up to is echoed in a number of interviews. A young woman explained the kind of authority an older relative in Gambia can have:

They are not like relatives are here [in Scotland], I mean in Africa you cannot say to your mum’s sister ‘you’re not my mum’. If she tells you to do something, you have to do it.

A man also compared attitudes towards elders in his country of origin to those in Scotland.

The religious leaders and community leaders have more respect in my culture. They follow their leaders and their ways. Elder people are more respected – their order has to be obeyed.

Others explained some of the beliefs around FGM. As well as controlling women’s sexuality and making them pure as mentioned above it was also believed that women had additional power and strength, including the power to break utensils, and glass if FGM was not carried out. These quotes perfectly encapsulate the role of FGM as something which ‘breaks’ women’ and leaves them in a submissive relationship reinforcing men’s dominance.

The main reasons for carrying out FGM are culture and perceptions of different people and the religion. His father was a religious leader [a Christian one] and recommended people to do FGM. Because if a lady doesn’t have FGM maybe she becomes like a boss in a community not only in her household and her family. She won’t want to hear others’ ideas. The advantage of FGM is that if she is circumcised she can get married and she becomes calm. The disadvantages if it is not done are that she can’t get married and it is and it is not good for her boyfriends or partners. She becomes a boss over him.

Religion emerged in some interviews, with some people saying it played a role in the pressure to have FGM and others saying that it didn’t. This will also depend on religious affiliation and ethnicity. Participants made links between religion and culture as well as concepts such as purity and virtue that might have religious connotations’. Some of the women talked about this saying:

Religion does not force us to do FGM, it is not a sin if you do FGM and it is not a sin if you do not.

Religious leaders don’t support it because it’s a cultural issue and not a religious one.

She doesn’t think it’s a religious thing so doesn’t think the leaders would support it because it’s part of her religion. She doesn’t know how, but she knows it is not part of her religion.

Another added that 'in Christianity there is nothing in the bible to say we must do it' and similar remarks were made about the Koran.

One man was going through a change in his attitudes towards FGM and talked about trying to find out information about it from his religion. He told the PEER researcher:

The advantage [of FGM] is for Tahoor – cleanliness. But he wanted to find out a lot more from other Islamic friends and talk to them about it. Some Sudanese guys invited their Imam to talk about the topic, they challenged him on it. They asked if I have a daughter should I do FGM or not – just say yes or no... But the Imam was just going back to the old days. The man countered this by saying – the prophet did not say 'please practice FGM'

Many respondents had difficulty in separating religion for culture as expressed through the woman who said 'the problem is we mix culture and religion together and are unable to separate the two'.

One man talked about the physical strength women have that needs to be reduced through FGM.

Previously societies said they did this because they thought if girls are not circumcised she would be very active or more active, not only sexually but she would become like a man, she can cut anything she likes, beat anything she likes. If she is uncircumcised when she is a teenager she is going to break the utensils – because she has too much strength. If she is not circumcised she can't make good friendships with boys because she becomes the dominant partner. She will have problems with men. She will be too strong and too dominant.

Others related pressure from women in the community. A number of women talked about the way in which FGM is linked to perceived appropriate behaviour by women.

Being a Wolof, we do not perform FGM. Out of the nine tribes in the Gambia, Wolof and Serrer both don't perform FGM but the Djolas, Mandinkas, Serahules and Fulas do perform it and are champions in it. For instance, when I was a kid if I went to a Mandinka's house and play and when there is food put out and I touch a piece of meat or fish they will look at me and say "Amon Khula" because I am a Wolof. They believe that if a girl undergoes FGM she will have manners and know how to behave in public. They believe that they have to teach the girl how she should and should not behave in the time they have between the cutting and before the girl heals. After FGM, they believe that the girl is perfect and correct and if you are someone who hasn't had it done they believe that you don't know anything, you behave in any way you want and you speak to the elders in any way you want.

Although the actual practice of FGM varies greatly from one country to another, it is often linked to a rite of passage whereby girls are educated in a group about how to be a woman and what behaviour is considered appropriate within that culture as expressed by this young woman. Women carry out the ritual and many women are strongly disapproving of behaviours that do not fit gender norms.

If you haven't undergone FGM then you are not a fully grown woman and you do not fit in the society. Others say it minimises the risk of prostitution and waywardness because when you have FGM done you tend to have manners and fit in to the society.

Some of the Nigerian women participants mentioned fattening rooms, where women are encouraged to make the transition physically and in behaviour from a girl to a woman. They talked about the isolation that can occur from being different. 'Stigma is associated with not doing it, that is what makes a lot of people do it, otherwise you are isolated'. It is common in FGM practising societies that if you have not had FGM performed, that girls and women are called insulting names. The names can indicate bad behaviour as well as impurity. Gambian women talked about how the term solima is used in this way, and can be used even if someone has had FGM carried out on them if their behaviour is considered poor. One young Gambian woman related the kind of pressure this name calling puts on girls and young women to have FGM.

We have had a neighbour from a tribe who didn't practice FGM and people always used to pick on her and called names at her and her daughters. One of her daughters, who was my age mate, was so annoyed and fed up with name calling. So she begged her mum to help her get FGM done but her mum refused. So the next time a group were getting it done, she joined the group and got it done herself. Her mum was really angry but she couldn't do anything. So it was due to bullying, pressure and discrimination that lead her to embark on such an act.

4.2.6. The impact of FGM on women's lives

Some people talked in a very general way about how FGM impacted on women's lives, how it changed them. This was often described as making them 'calm' which also can be interpreted as submissive and from descriptions given here and in other literature, having the spirit taken out of them. A quiet submissive woman conforms to expected gendered behaviour in many cultures. One man talked about the effects he saw on women in his community.

There are a wide range of disadvantages of the effect of FGM on women is in the community – firstly always she is not active in her day to day life, and she looks at herself like a disabled woman. Most of the time she wants to be alone and prefers to be isolated. And she thinks no one respects her. Now people have some awareness about it, if she is affected by FGM, maybe she is very calm. She is quiet and stays at home.

Sometimes, however, it has the opposite effect, as recounted by this young woman PEER interviewee:

A girl I know, a friend, (older), she was 15 and living in Europe, in Germany. She went home for holidays in Africa with her mother for the first time and her grandparents performed FGM on her. When she came back her performances in school started to weaken although she was really smart before the incident occurred. But because it affected her she started dropping in school. Also she became very rebellious after the incident. She was always engaged in school fights and then later she dropped out of school. Moreover, the relationship with her mother changed drastically. She had always had a very good relationship with her mother. But after the incident she was always engaged with fights with her mum and at the back of her mind she always blamed her mum for what happened to her because her mum was the one who took her on holidays and she was the very one who planned it all out. That is what she thought. So in the end she had to move out of the house because of the anger she felt towards her mum but years later she talked to her mum about the whole FGM issue and found out that

it wasn't her mum's intention but the pressure from the grandparents. By then it was too late and the damage was already done. She had no idea her grandparents were involved, she blamed her mum for everything.

Young people echoed this:

The effects on young women are really sad, because it lowers self – esteem and their love life. It affects you emotionally, lowering their confidence. Physically, it can affect them health wise. Like they have abnormal menstrual cycle, infections etc. also young women in our communities who undergo FGM also have difficulties in their relationships.

While most of the women agreed that it caused psychological damage, one woman disagreed, arguing:

I don't agree that it causes psychological damage. It does not affect everyone. What you experience is different from what I experience.

Most participants felt that the impact of was a very sad one causing pain and suffering and health problems, particularly in childbirth. Baldeh (2012) documented many of the issues for people with FGM experiencing childbirth in Scotland. Her data found women extremely concerned about childbirth and unable to talk about it easily with health professionals. (Baldeh 2012: 25) One man from Ethiopia talked about the impact of FGM on childbirth in his home country:

When women are circumcised they are isolated – they are not happy. They don't feel happy, they are not active, they have a bad perspective, a negative perspective of men. If they practice in bad ways – it makes giving birth very difficult, even sometimes she couldn't give birth because of the impact of FGM. When they cut women, (i.e. to open her before giving birth) if they are not professionals, they cut even the sack where the baby is coming. He has heard about these things.

Some of the dramatic impacts of FGM on sexuality and health are narrated elsewhere in this report such as section 4.2.3. There was a lot of awareness of the potential problems in childbirth, something reported in earlier writings about FGM in Scotland by Baldeh (2012). One man talked about danger in childbirth as the 'worst scenario' but interestingly blamed the way the FGM was carried out rather than FGM itself for the problems.

He knows someone else affected by FGM – she gave birth she had some difficulties and was very sick, because she had a scar, she lost a lot of blood – she had very severe bleeding. She didn't die but it took a long time to recover and that was the very worst scenario – when that happened her family/her husband and her parents went to the person who had carried out the FGM – to ask how to get treatment for her, but no one could help them. They took her to a clinic which was far away. She recovered. She took the baby with her. But it was a very hard situation – the clinic was very far, it took about 6 hours walking. They were carrying the woman. They had to lay her on the bed, on a stretcher. Teams of men carried her, more than 8 men carrying her on a dirt road. They knew her because she was a neighbour. If FGM had been carried out by a doctor it would not have caused a problem.

One male interviewee realised by the time he got to the third round of interviews that FGM might have affected him in a much more direct way than he had ever previously considered. The PEER interviewer related that the man who was from Eritrea, got very upset when he spoke about this and had to be comforted.

My mother passed away when I was born because of maternal problems. Maybe one of the causes was FGM. At that time, it was common, maybe I lost my mother because of circumcision?

4.2.7. Who supports FGM?

All three groups of participants, women, men and young people agreed that it was older people and people who followed traditions who supported FGM. It was presented by most participants as a generational issue, which young people no longer think is good but older people were still attached to. Community and religious leaders were also mentioned as people who support it as well as people who did not understand all the implications or were ignorant and labelled 'uneducated'.

Older people like uncles support it. Girls are not allowed to say anything – they mustn't talk about it. Maybe the traditional FGM cutters/ceremonial people support it, maybe because of their lack of knowledge.

Previously people had FGM in the traditional cultural way and the people who do this are maybe living in the same areas and share the same cultural beliefs. If the religious leaders or community leaders order them to do this, then it is an obligation. They can't say no.

However, another person disagreed with that saying 'some parents have information but still support FGM'.

Despite many opinions expressed through the interviews or workshops that religious leaders supported FGM, the religious leaders we spoke to did not give that view. It is possible that this might have been a difficult view to express in the context of this research. One religious leader who was interviewed said 'it is culture, I do not think it is good'. Other interviewees mentioned religious leaders in their lives, for example one man whose father was a religious leader stated that his father felt FGM was very important to cultural life and to keep women pure. Another woman whose step-father is a well-known Imam (not in Scotland) said that her father did not promote FGM but neither was he actively against it. He made sure people knew that although it is mentioned, it was not prescribed in the Koran and therefore not an essential requirement of Islam, and then felt it was up to them to choose.

The majority of the participants who took part in MY Voice expressed their opinion that it was a bad thing or were strongly against it. One PEER researcher interviewed a man who was not against FGM. Although he was aware of many of the harms that can be caused by it but he felt that the issue was the way FGM was carried out, and so he argued that it was important to carry it out safely, but not to stop it.

It depends on people's ideas – some of them have to accept it and others not, but for me, in my personal perspectives it should be carried out by a professional, it is important and useful for women's day to day life.

Young people who participated in MY Voice, both men and women clearly distinguished themselves from views supporting FGM. They were very clear that they did not support it and thought it was something that was part of the values of a previous generation. Young women told us:

The elderly follow the tradition, they support it and those who don't support it is the majority of our generation. The pressure comes from everyone wanting to follow tradition, and the way the generation before did it and to follow them.

Young people feel more comfortable talking about it with friends especially with our generation; they're more open with each other talking about it. They don't talk about it with their parents.

This finding is in line with the FGM initiative that used PEER methodology to evaluate a range of FGM awareness raising activities across different cities in England and Wales. In their mid-term evaluation study they wrote:

Across the country, respondents drew a distinction between the views of older and younger people on the issue of FGM. Older generations were held almost universally responsible for ongoing support for FGM (Hemmings 2011:4).

Some of the young men were strongly against FGM. They felt men had an important role to play in the fight against it and were extremely enthusiastic about being involved as PEER researchers. They told us during the workshop 'without men, nothing is going to change'.

The women who attended the participatory workshop also expressed strong views against FGM. This is the group who had most direct experience of the harm FGM can do. They were very open about their experiences and had a number of ideas about how to stop FGM. These will be discussed in the next section.

4.3. What needs to happen to end FGM?

Participants in the MY Voice project had different ideas about what should happen about FGM. Nearly everyone said that something should be done to stop it. And there was a general consensus from all those who thought something should be done to stop FGM that everyone needed to pull together to try to change attitudes.

When asked who needed to do something, varying replies were given:

All members of society are responsible, not only the government and health centres but also the community – everyone. People need more awareness on it. Everyone needs to get awareness about these things – it is everywhere and anywhere.

Everyone, even the older generation. It is good to have people like our parents and those who are very culturally orientated. If an organisation presents some valid points to those people, then they might change their mind and agree to be a part of changing other people's minds.

Scottish Government, Health workers: doctors, lawyers, community health workers.

Some were more passionate in their responses:

To become aware and stand up for their rights and fight. We should become one powerful community and stand shoulder to shoulder to fight, not only community members and leaders but other general responsible bodies, all those who are responsible for the wellbeing of women.

Yes, they (young people) are leaders of tomorrow. If they can say no to FGM then it means hopefully this act will be eradicated in the generations to come. Because every problem should be tackled from the grassroots level. [...]. If we all come together we can tackle this issue.

Some of the specific issues that people thought could help was more information and awareness raising, better application of the law but also ensuring that affected communities are not criminalised through this, and access to appropriate services.

4.3.1. How to do it – awareness raising

Most people mentioned the importance of increasing awareness. The participants made it clear to us that they had never had an opportunity talk about FGM before they got involved in MY Voice, especially the men. They really welcomed this opportunity and the workshops were extremely animated and lively. Although MY Voice is a research project to assess attitudes perceptions and experiences a number of participants talked about how much they learnt about FGM from being part of the discussions in the workshops in particular. Simply getting people together to talk about FGM seems to bring about a lot of learning and awareness as well as increasing participant's confidence to talk about it.

Women said they learnt about what FGM stands for, experience from other countries and cultures and learnt that FGM puts the victim through emotional & psychological torture. They learnt awareness of FGM especially about the way it is carried out and that some people from practising countries don't even know about FGM or have not even heard of it. Some said they had broadened their knowledge about FGM and learnt about FGM in different parts of Africa as well as the importance of helping people, where to get help and information about FGM.

One young women PEER researcher reported gaining confidence throughout the project, and finding that she was therefore able to raise the issue more openly with others. She reported raising it at college, implying that she would not have done this previously.

Last week when in college, I was talking to my careers advisor and everybody asked what I was currently doing so I talked about the MY Voice project and was trying to explain it. He asked what FGM was. I told him it stands for Female Genital Mutilation. He was surprised and asked whether it happens here and that he was not aware of it. So I had to explain that, we are not sure if it happens here, but we are trying to raise awareness and eradicate it. He didn't know what FGM was and he was a grown man. It's a topic that's very sensitive. Even people affected by it, don't talk about it.

Other group events on FGM have been held in Scotland in particular around the FGM strategy group coordinated by the Women's Support Project and focus groups and events run by the Kenyan Women in Scotland Association (KWISA) and have reported similarly enthusiastic responses from participants. People seem to want to have the opportunity to get together at this time to talk about FGM and to share experiences and learn from each other as well as decide how to raise awareness of the issue in Scotland.

4.3.2. The law and criminalisation

Understanding of the law was mixed. Many people knew that FGM was illegal in Scotland but were unclear about the details. In the women's workshop 12 out of the 20 women said they did not know FGM was illegal. Suggestions were made for making the information clearer. One young woman said:

Even if the laws are there, people are not aware of it, and people are not being prosecuted. If the law is implemented, people won't do it. I think that will stop people from doing it because they won't have the audacity to do it secretly. Maybe in their home country, but not in Scotland. If they are taking their girl child to their home country, services should be provided so that the child is monitored

throughout their holiday. Or the child should be medically examined before travelling and also upon her return so that they will not dare to perform FGM because they will be punished.

There seemed to be little awareness that this is the procedure that should already be followed. In the women's participatory workshop, we asked who knew about the FGM passport (travel document) and not a single woman said she had heard of it or how it could be used. There was however support for using the law and in particular for making new arrivals aware of it.

People will come to the Scotland and practice it without realising it is illegal. People should be given the information when they go for visa interviews. The same way they tell you don't bring fish into the country, they should also inform you that that FGM is illegal in the UK.

Others felt that prosecution wouldn't be enough and said 'you cannot stop FGM through prosecution, go to the mosque, churches and communities and raise awareness of the issue'.

One of the biggest concerns that emerged from the Women's workshop was how the law had the potential to criminalise the FGM affected community. This is a very complex and sensitive issue which they discussed at length, and they shared many of the stories that have been passed around the community about bad experiences of criminalisation and how they wanted the Scottish government to support them in their fight against FGM not make them feel like criminals for having a daughter. They were also very concerned about what would happen if they reported someone, particularly a friend or relative, who they suspected of considering doing FGM on their children, and were looking for reassurances that the treatment would be culturally sensitive. They shared stories of how African women they knew were treated by social services and the police, after giving birth. One woman said:

The way Scotland handles FGM is almost criminalising Africans. Once a woman has it, it is assumed that her daughters will have it too.

A number of the objectives, actions and activities of the National Action Plan relate to reporting of FGM and it is extremely important that the police and other services continue to explore the opinions and concerns of FGM affected communities, working with them to support sharing of information. Women said they would 'like to know how to report if they suspect a family want to perform FGM without feeling bad'.

Just as with the travel document mentioned above, very few of the women at the participatory workshop had heard about the short animation called "Sarah's Story" which explains how the travel document can be used by families. These two Scotland specific resources are designed to support women who are trying to resist family pressure to have FGM carried out on their daughters or to commence a dialogue with families in the country of origin (see References for links to these resources).

Women have found some other ways of protecting girls. One woman related that she had built a house in her home country for her mother and her youngest sister. She has one sister younger than her who has had FGM carried out, and three who have not. She is trying to protect them from having it done, and in particular to the youngest, so the women in the family use that house to stay away from relatives who might want to carry it out.

During the MY Voice project it became apparent over Christmas that a number of families were travelling back to Africa for the festivities. As a result of awareness raising many of them decided (or were persuaded) or maybe through fear of the law, not to take their daughters with them realising that it would be extremely difficult to resist the pressure of families to carry out FGM. These little girls were left with family and friends who took them in in often difficult circumstances, lack of space and money, in order to protect them. This epitomises some of the difficult decisions people from FGM affected communities are making to ensure their girls are safe, both those who

make the heart rending decision not to spend Christmas with their daughters, and those who looked after them during an already busy time of the year, with no external help or support.

One story emerged from the data in relation to this which was an example of a woman who had been monitored when she returned to have a holiday with relatives in Africa when she was a child of nine years old. This story, shared very openly with the group, illustrates how the law can work very well to prevent FGM being carried out during visits to a country of origin.

The Law in Action: Being examined to see if FGM has been carried out on a 9-year-old girl

One of the women participants, now in her twenties, grew up in Catalonia in Spain. Her parents were from Gambia and when she 9 years old she went back to the Gambia and stayed with her grandmother for one year in 2004. While she was there other children started to call her names because she had not had FGM carried out. It made her very unhappy to be teased like that and her grandmother contacted her mother to suggest that she should have it done. However, her mother who was back in Spain knew about a new law which had made FGM illegal and told her grandmother that it absolutely must not happen or she, the mother would be put in prison. The reason the mother knew this was that a family friend had already been arrested and had to serve a prison sentence in Spain as a result of FGM being carried out on her daughter when they had returned to Gambia. After this the grandmother guarded her granddaughter very closely and protected her. FGM was not carried out on her. On return to Spain after the year was up the mother received a letter asking her to bring her daughter to the hospital to be examined to see if FGM had occurred. The daughter can remember this very vividly and her discomfort at such an intimate examination. Because FGM had not been carried out the family were free to return home. Despite the obvious ordeal of the examination, this woman is now very grateful that the legal processes prevented FGM being carried out on her. Other children in the family her age had had it carried out, although she said that on the whole it is disappearing in her family because many of them are living abroad.

4.3.3. Services

People mentioned a range of services they thought could help people affected by FGM if they needed them. However, answers tended to be vague and few people had used them or knew what they might be used for. One young male interviewee told the PEER researcher:

He thought there were some services available for women affected by FGM, for example the NHS. But then then he thought going to another random doctor after FGM had been carried out wouldn't necessarily help. He thought there were probably loads of places, for example, private therapists, counsellors and loads of other places that could offer help.

Other male interviewees said:

He thinks there are no services for FGM. There are lots of barriers to access – fear, shame, embarrassment, not trusting others.

Another girl spoke to him about FGM – she asked for info – she said 'listen I want to find out more about FGM'. She was a girl from Eritrea – people from Eritrea are always asking where can we get it undone. People that come forward like that believe there is some money given to

get it done...The PEER researcher thought it's a good sign – people are asking about it.

When people had used services or knew more about them, it was often in relation to pregnancy. Two young women said:

Personally I'm not aware about services available or not. From the little I heard, when you are pregnant in Scotland, and you are also from an FGM practising country, GP's can refer you to some units but apart from that, no services are offered that I know off.

She told me her aunt was pregnant and she had undergone FGM. When she was referred to the midwife, the midwife found out that about the FGM and she referred her to a doctor as she thought there would be complications when it was time for her to have a baby. Her GP then referred her to a specialised midwife who took care of her throughout the pregnancy. They were monitoring her and were taking good care of her until she delivered that baby. Apart from this she has not heard or seen any services offered to women from FGM practising countries.

The women's workshop had more participants who had used services. 15 women listed the following (the other five didn't know of any services they could go to):

- GPs
- Chalmers Sexual Health Centre, Edinburgh
- Police
- Social work
- NGOs (+NGO in the Gambia)
- Women's Aid
- United nation
- Citizens Advice Bureau
- Shakti Women's Aid (2 people used)
- Waverley Care
- Health visitor
- DARF
- Events such as those held by MY Voice

Although many people were able to list services for specific issues such as a need for counselling, health care, obstetric care or domestic abuse the opinion was expressed that there were no spaces just to go and talk about it 'like today has been'. Throughout the project a number of people told us that they would like the opportunity to talk with other people from Africa about FGM and learn from each other, even if they had no specific or pressing problems. This kind of service is not available currently in Scotland although a number of people mentioned the FGM service previously provided by DARF. This was an African led service solely for the purpose of providing advice, support and training for FGM. Diaspora groups are also in a good position to carry out this work. A number of people spoke about the importance of a specifically African voice from affected communities to be stronger.

I don't want someone else who does not know my experience to talk about our problem.

Africans need to be given funding to do this work.

I am fed up of Africans being marched on... am fed up.

The enthusiasm of the participants for more activities, desire for information and their focus on bringing everyone together to take action about FGM bodes well for the development of a strong community voice in Scotland.

One of the issues is that some of the women do not know what words to use if they go to services. They do not usually use the phrase FGM, and are unsure about how to explain it. Additionally, some women are not even fully aware of what happened to them as children. It is important that frontline services are aware of how little some women know about their own experience or how difficult it is for them to find the words to talk about it. These issues are illustrated by this account of trying to use services from the woman whose story was about having FGM carried out by young female relatives who burnt her and then had FGM carried out again within a year in section 4.2.2. Unsurprisingly she has had to live with a number of serious health problems. She ended up married in Scotland and her search for help through services is related here and the how important the good response from her GP has been to her.

I had a lot of pain, pain with menstruation and no interest in sex at all. That started a lot of problems with my husband. I went to my GP and was referred to specialists who examined me. I was given various medicines to deal with the pain. At the same time, I was trying to leave my husband who was very violent, but had a lot of problems because my immigration status meant I had no recourse to public funds, so even the women's refuges had problems housing me.

Eventually, after some really hard times, living in complete poverty so that my son and I could escape from my husband, I moved into a flat in Edinburgh. It wasn't until I moved there and went to a new GP, and she examined me, that I realised FGM was at the heart of my problems. After she examined me, she said 'excuse me I hope you don't mind me asking, but I know that in Africa they have a procedure they carry out on young girls, where they cut them. Did that ever happen to you?' As soon as she asked that, I felt a mountain lift from my head. I had never been able to say it. I didn't have the words to say it. I didn't think it was something anyone would take seriously. It has been such a help having such a good GP. I can talk to her. She has helped me, suggested creams and pain killers.

She referred me for counselling at Shakti. At first I found that so difficult – the counselling raised everything up for me and it was good while I was there – but afterwards I just cried and cried. Nothing can resolve the problems I have; I am still in pain a lot of the time. I stopped counselling, it was too upsetting, but now Shakti is helping me with other things and I like going there. Now I have a nice partner and he understands about FGM. He is from a culture that practices it. But we still have problems. He can't go on being understanding for ever.

5. Concluding recommendations and next steps

This report has presented a range of findings about attitudes, perceptions and experiences of FGM from affected communities in Scotland. It is intended as a platform for dialogue and interaction. This section will draw together some conclusions from the findings and outline some recommendations and proposed next steps. The aim of MY Voice is to work towards creating a much closer relationship between affected communities and those delivering services. Currently statutory and third sector services might not know how to ensure this happens, for example how to contact relevant communities and which voices to ensure are included.

1. Delivering the Scottish National Action Plan to prevent and eradicate FGM

The overarching recommendation of the report is that the findings from MY Voice is intended to be fed in to the objectives, actions and activities of the Scottish National Action Plan to Prevent and Eradicate FGM. This can be achieved through specialised training using techniques such as problem based learning to ensure that those responsible for delivering the plan are supported to listen to the voice of FGM affected communities. We recommend that:

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

2. Community engagement

The data collection methodology used in MY Voice was based on the PEER ethnographic method. One of the aims of MY Voice was to engage people from FGM affected communities in future activities to raise awareness about FGM. PEER has been shown to have a transformational effect on participants. FORWARD have documented how PEER researchers expressed interest in taking action in their community after taking part in PEER research on FGM and young girls in Sierra Leone (Forward 2016). They were given training in confidence building and working with girls and subsequently developed an action plan for working with their community. In MY Voice although we did not keep all of the PEER researchers 'with us' for the data collection, those that remained engaged in carrying out interviews show a real interest in further action such as awareness raising, campaigning or further research. They represent all of the three main population groups we were working with: young women, young men and men. Three of them have already presented some of their experience of taking part in PEER at the Scottish Parliament event on zero tolerance in February 2016. Similar to the work carried out by FORWARD they reported an increase in awareness about FGM and an increasing confidence in discussing the issue as a result of being PEER researchers.

We recommend that there is

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

3. Service delivery

A range of services exist to support people with FGM and are engaged in raising awareness and prevention. Some of these have developed extensive expertise in the area and are employing skilled workers to deliver the services. However, the people who participated in MY Voice were not aware of most of these services or the Scottish specific information that has been developed such as the travel document and Sarah's Story. Those that did know about them did not know how to gain access. The most commonly mentioned service that people said they would go to was their GP but to date not many GPs have had specific training on the issue. There was also great uncertainty and many concerns about going to authorities if they thought there was significant risk of FGM being carried out. They wanted assurances that there would be a sensitive reaction to this. A number of people wanted to engage in talking and sharing information about FGM with other people from FGM affected communities in a general way rather than only having services to respond to specific health or psychosocial problem.

We recommend that:

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

4. Working with young people

Young people from FGM affected communities (both young women and young men) saw themselves as the future. They felt their ideas and attitudes were the ones that needed to influence change. They were enthusiastic about the development of interventions to prevent FGM and talked about wanting to inform people at their schools, colleges and other social settings. They told us that older people might support FGM so it was up to the young (both young women and young men) to get out there and do something about it. This is in line with findings from other research such as the FGM initiative in London which has found that although older people's views which support FGM have not changed they do not have the same influence in their families as they once had and younger people are making their own minds up about FGM.

We recommend that young people are:

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

5. Working with women

It became clear from very early on in MY Voice that focussing on young people and men resulted in a big gap, with no representation from the group most affected by FGM, women over 25. Extra funding at the end of the project enabled women's voices to be heard in MY Voice but many women over 25 are frustrated that there are not more formal mechanisms for their involvement in FGM. Many of them have extensive expertise and knowledge and have been campaigning on the issue for some time now through diaspora organisations, or are experienced service providers in agencies that have women with FGM using their services.

They had particular concerns about criminalisation. Also some of the women directly affected are badly in need of better trained specialist support which is in short supply. The increase of awareness about FGM in Scotland leads to women realising, sometimes for the first time, what has happened to them or people close to them and this can cause traumatic reactions which sometimes go on for a long time as the understanding deepens and increases. Skilled support is required for this situation. Some excellent services are now well established which people are greatly appreciative of, but others had difficulty knowing how to access them or there wasn't enough provision for their needs.

We recommend that:

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

6. Working with men

Until now there has been very little work carried out with men and FGM in Scotland. The men in MY Voice responded enthusiastically to being invited to participate. Although FGM is perceived as 'women's business' the male PEER participants have shown very clearly the importance of involving them. FGM is embedded in gender inequality involving both women and men and any Scottish response to FGM will be much stronger for including men.

We recommend that:

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

7. Engaging religious leaders

Although we had a religious leader on the PEER training and had input from 4 religious leaders by the end of the project, we did not achieve a great deal of engagement with them in the time we had available. There was little overt data on the importance of religious leaders in either promoting or preventing FGM which emerged from the research. Religion was mentioned as one of the factors affecting the pressure to carry out or not carry out FGM or was linked to the ideas of 'tradition; and 'older people'.

We recommend that:

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

Conclusion

It is important that the work started by MY Voice continue in order to harness the energy and enthusiasm which emerged during the project. In addition, it became clear that there needs to be an FGM specific service which can act as a focal point for FGM. This service can be a conduit for engagement with affected communities and service providers and to examine the scope of existing services as well as identify gaps or areas where support and training is required. Many of the voices heard in the report are ready to participate and be part of whatever new developments take place around FGM in the coming years to develop positive culturally appropriate responses in Scotland. As stated in the Scottish Refugee Council report, if this is not done we run the risk of further marginalising the community voices that are the most effective advocates for change (Baillot 2014:45).

References

- Baillet H, Murray N, Connelly E and Howard N (2014) Tackling Female Genital Mutilation in Scotland: A Scottish Model of Intervention Scottish Refugee Council and London School of Hygiene and Tropical Medicine http://www.scottishrefugeecouncil.org.uk/news_and_events/news/2545_scottish_national_action_plan_needed_on_fgm
- Baldeh F (2012) *Obstetric Care in Scotland: Experience of women who have undergone Female Genital Mutilation (FGM)* Unpublished MSc Thesis, Queen Margaret University
- Cree V (2008) *It's Good to go for a Test Final : Report of the Evaluation of Waverley Care's HIV Awareness Campaign in African Communities in Glasgow.* <http://www.waverleycare.org/about-us/publications-and-literature/reports/>
- DFID (2013) *Towards Ending Female Genital Mutilation/Cutting in Africa and Beyond [GB-1-203024] Business Case and Summary 203024.* <https://devtracker.dfid.gov.uk/projects/GB-1-203024/documents>
- FORWARD (2016) *If you go into the Bondo Society, they will honour and respect you.* Research on Female Genital Mutilation in Freetown, Sierra Leone. Available from Forward <http://forwarduk.org.uk/information-hub/>
- Hamani Souley I and Grant L (2011) *Promoting Connections and Wellbeing: A Review of HIV Scotland's Links With Africans Living In Scotland HIV Scotland and the Global Health Academy,* University of Edinburgh. <http://www.hivscotland.com/about-hiv-1/data-and-research/research-library/view-document/promoting-connections-and-wellbeing/>
- Hemmings J (2011) *The FGM Initiative interim report,* Options UK. <http://www.trustforlondon.org.uk/wp-content/uploads/2013/09/FGM-Interim-Report1.pdf>
- IOM (International Organization for Migration) *Fact sheet on FGM* (no date) Accessed 25.5.16. http://www.iom.int/jahia/webdav/shared/shared/mainsite/projects/documents/fgm_infosheet.pdf
- Kandirikirira N and Fotheringham J (2013) *FGM in Scotland Scottish Justice Matters,* Volume 1:1, http://www.womenssupportproject.co.uk/userfiles/file/SJM0613_Kandirikirira_Fotheringham_FGMInScotland.pdf
- Kaplan-Marcusán A, Del Rio NF, Moreno-Navarro J, Castany-Fàbregas MJ, Nogueras MR, Muñoz-Ortiz L, Monguí-Avila E and Torán-Monserrat P (2010) *Female genital mutilation: perceptions of healthcare professionals and the perspective of the migrant families.* BMC Public Health, 10 04/13, pp.193-193.
- Kaplan A, Babucarr Cham Njie LA, Seixas A, Blanco S and Utzet M (2013) *Female Genital Mutilation/Cutting: The Secret World of Women as Seen by Men* in Obstetrics and Gynecology International Volume
- Mhoja MEM, Azong JA and Lawson AM (2010) *Baseline Survey in Glasgow and Edinburgh on the Beliefs, Views and Experiences of FGM.* Dignity Alert Research Forum, Edinburgh <http://www.darf.org.uk/page13.htm>
- Morison LA, Dirir A, Elmi A, Warsame J and Dirir S (2004) *How experiences and attitudes relating to female circumcision vary according to age on arrival in Britain: a study among young Somalis in London.* Ethnicity & Health, 9:1, 75-100
- Price N and Hawkins K (2002) *Researching sexual and reproductive behaviour: a peer ethnographic approach.* Social Science & Medicine 55 1325–1336

Oguntoye S, Otoo-Oyortey N, Hemmings J, Norman K and Hussein E (2009) *FGM is with us everyday: women and girls speak out about genital mutilation* (FORWARD and Options Consultancy Services Limited). International Scholarly and Scientific Research & Innovation 3(6)

Refaat A (2009) *Medicalization of female genital cutting in Egypt East.Mediterr.* Health Journal, 15, 6, 1379-1388

Scotland's National Action Plan to Prevent and Eradicate Female Genital Mutilation (FGM) 2016-2020 (2016) <http://www.gov.scot/Publications/2016/02/8232/downloads#res493752>

Simpson L (2014) *Dynamics of Diversity: Evidence from the 2011 Census. How has ethnic diversity changed in Scotland?* ESRC Centre on Dynamics of Ethnicity (CoDE) Manchester

Sinyemu E and Baillie M (2005) *HIV becomes my name: a report on the issues facing Africans living in Scotland who are HIV positive.* <http://www.waverleycare.org/wp-content/uploads/2015/03/HIV-becomes-your-name.pdf>

United Nations Children's Fund (2014), *Female Genital Mutilation/Cutting: What might the future hold?* UNICEF, New York. http://www.unicef.org/media/files/FGM-C_Report_7_15_Final_LR.pdf

United Nations Children's Fund (2016) *Female Genital Mutilation/Cutting: A global concern.* UNICEF, New York, http://www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD.pdf

WHO *FGM factsheet* (updated Feb 2016) <http://www.who.int/mediacentre/factsheets/fs241/en/>

Appendix 1: Interview Guides

PEER Questions Young Women

Theme 1: Life in Scotland

1. What do young women in our community say about life in Scotland?
Prompt: Good? Bad? (Tailored to interviewee)
2. Is it the same for everyone?
Prompt: Young? Old? Girls/boys? Newly arrived or settled? Easy? Difficult?
3. What do young women say about what life in Scotland offers?
Prompt: Education? Freedom? Jobs?
4. What do young women in our community say about integrating into Scotland?
Prompt: Religion? Culture?
5. What is your aspiration as a young woman in Scotland?
6. Please tell me a story.

Theme 2: Talking about FGM

1. What do young women in our communities think / or say about FGM?
Prompt: What it means to young women?
2. What are the main reasons for/against FGM?
3. Who supports / who doesn't support FGM in our communities?
Prompt: young women like us / Parents / Religious Leaders / Grandparents & extended family
4. How does it happen to young women like us?
Prompt: In Scotland? In country of origin?
5. How does pressure from our communities influence FGM?
Prompt: From whom? What type?
6. Who do young women in our communities who have had FGM talk to?
7. Please tell me a story.

Theme 3: Issues with tackling FGM?

1. What are the effects of FGM on young women in our communities?
2. What services are available for women affected by FGM?
Prompt: women at risk?
After FGM has been carried out?
3. What do young women in our communities understand about the law on FGM?
4. Should young women in our communities work to end FGM?
Prompt: Why?
(If yes?)
5. How should/could FGM be ended?
Prompt: who should be working to end it?
6. Please tell me a story.

PEER Questions Young Men and men

Theme 1: Life in Scotland

1. What do (young) men in our community think about life experience in Scotland?
Prompt: Good? Bad?
2. Is it the same for everyone?
Prompt: (Young? / Old?) (Boys? / Girls?) (Newly arrived / settled?) Immigrants?
3. What do (young) men feel about what life in Scotland offers?
Prompt: Education? Jobs? Health care?
4. What do (young) men in our community think about integrating into Scotland?
Prompt: Culture? Religion?
5. What do you think the aspirations of (young) men are in Scotland?
6. Please tell me a story.

Theme 2: Talking about FGM

1. What do you think (young) men in our communities think or say about FGM?
Prompt: What does it mean to young men? What does it mean to young women?
2. What are the main reasons for FGM?
What are the main reason against FGM?
Prompt: Advantages? Disadvantages?
3. Who do you think support FGM in our community?
Who do you think does not support FGM in our community?
Prompt: Men? Women? Parents? Grandparents? Religious leaders? Community leaders?
4. How does it happen to women in our community?
Prompt: In Scotland? In country of origin?
5. How does pressure from our community influence FGM?
Prompt: From whom?
6. Do men talk about FGM?
Prompt: Whom to? What about?
7. Please tell me a story.

Theme 3: Issues with tackling FGM?

1. What are the effects of FGM on women in our communities?
What are the effects of FGM on men in our communities?
Prompt: social? Psychological? Health?
2. What services are available for women affected by FGM?
Prompt: Women at risk? After FGM had been carried out? Barriers to access
3. What do men in our communities understand about the law on FGM?
4. Should young men in our communities work to support ending FGM?
Prompt: Why?
If yes:

5. How should / could FGM be ended?

Prompt: Who should be working to end it? Government? Communities? Faith communities? Health services?

6. What should men do?

7. Please tell me a story.

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