University of Strathclyde Glasgow

FALLING BETWEEN THE CRACKS

Contradictions in approaches to protecting girls and women from Female Genital Mutilation (FGM) in Scotland

UKRI Economic and Social Research Council

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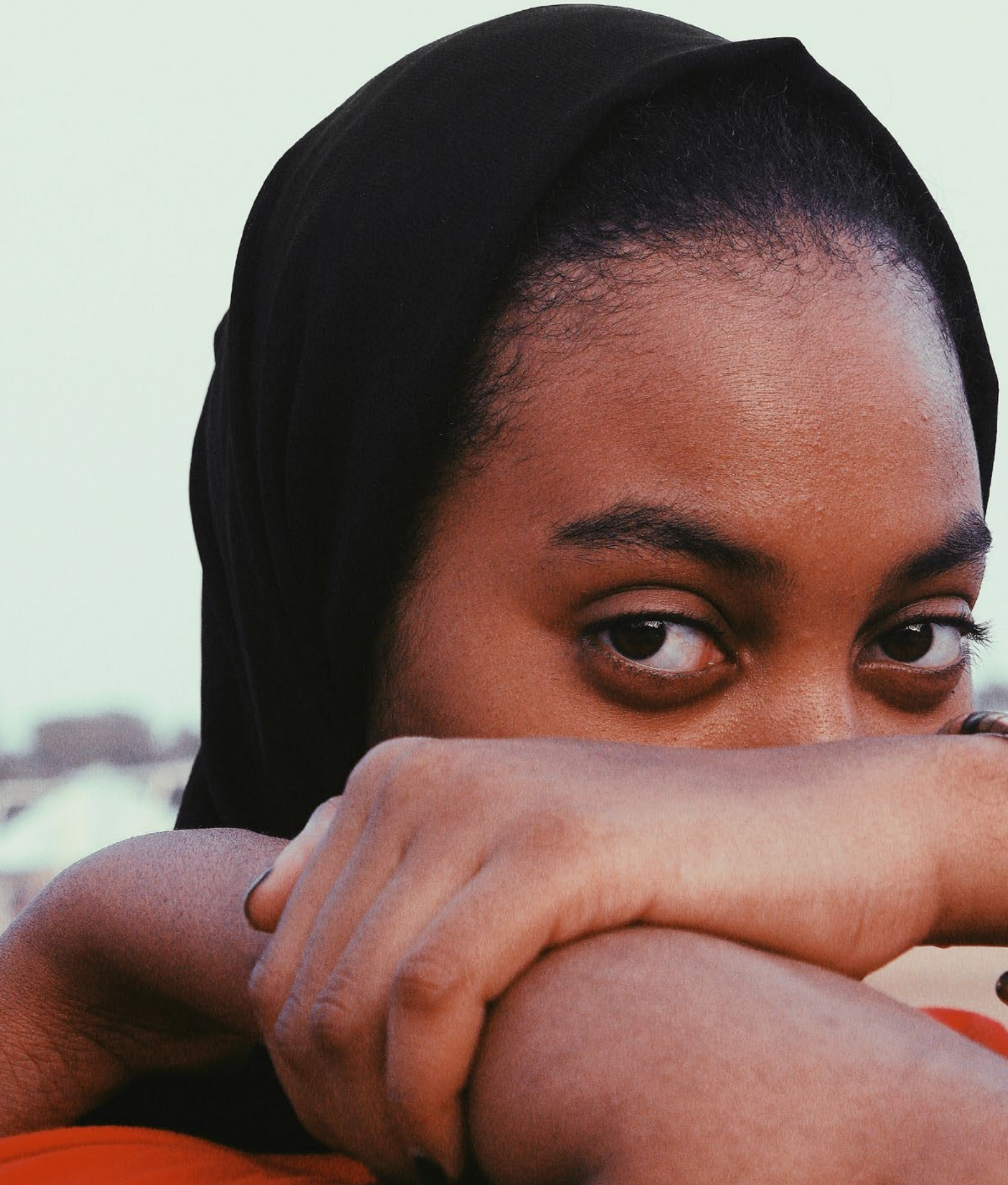
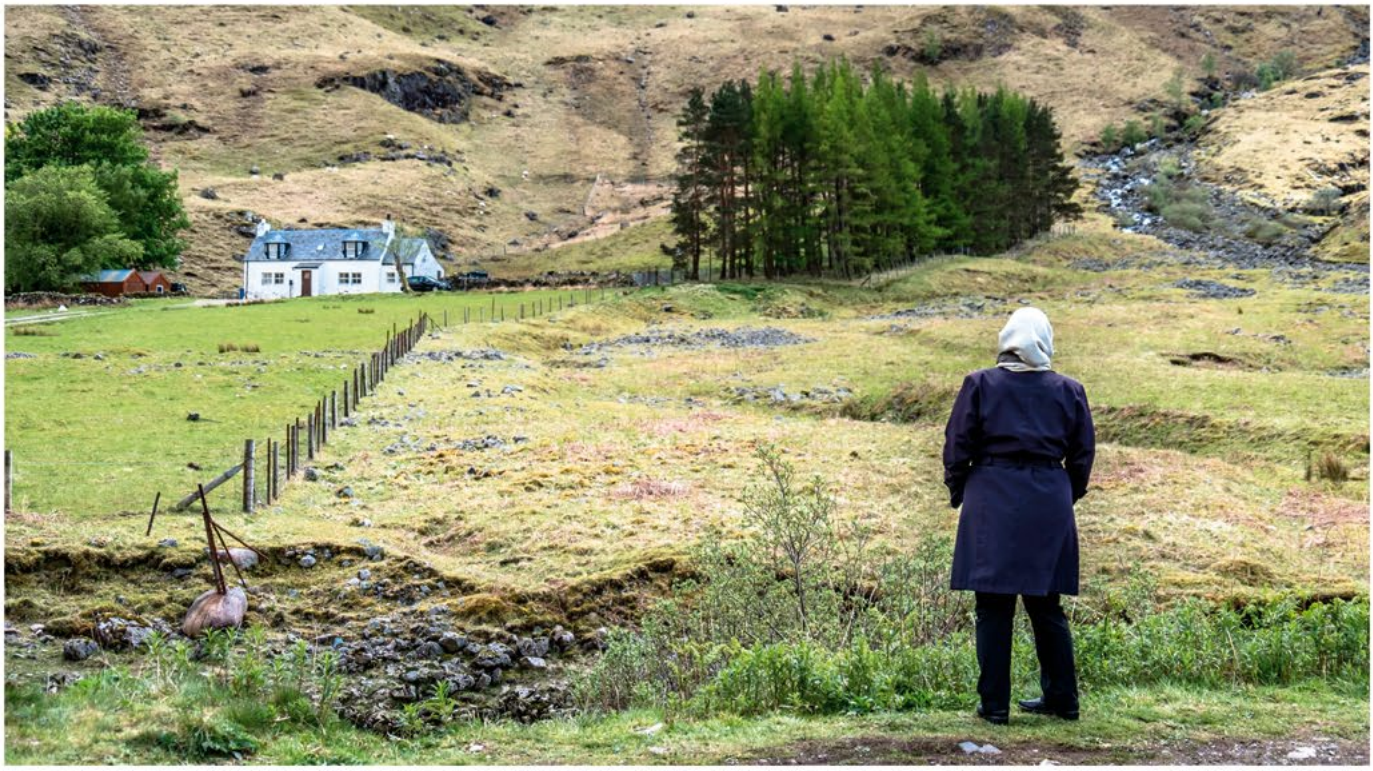


Contents



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One of the authors has chosen not to be named in this report.

Introduction

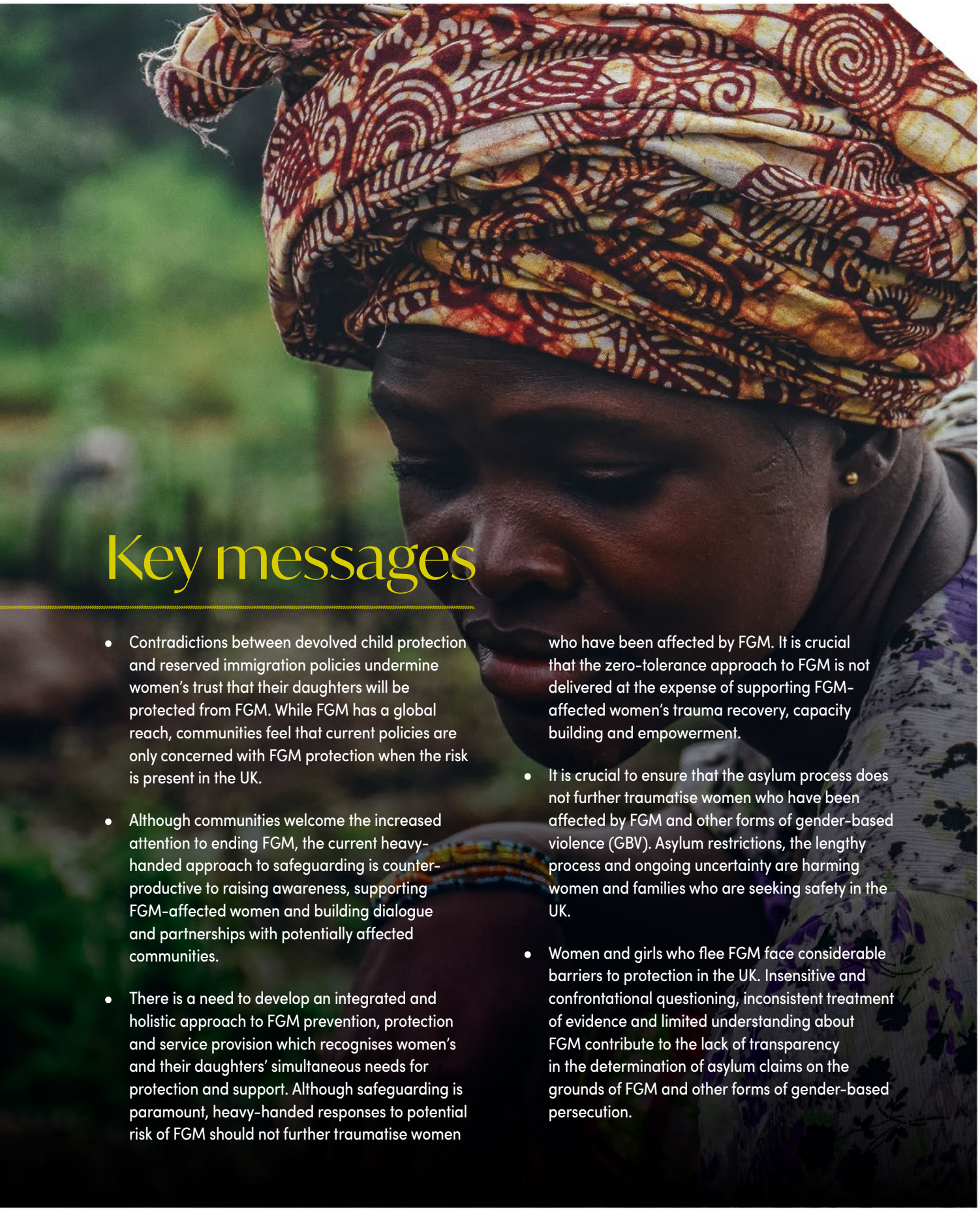
Over the last decade, ending female genital mutilation (FGM) has become a key policy priority in Scotland and across the UK. Although there has been a strong emphasis on community engagement in policy, we know little about FGM-affected women's views on the legislative changes and new measures which have been introduced to tackle FGM in Scotland.

This report is based on a participatory doctoral research conducted in collaboration with Glasgow Saheliya Champions for Change group between 2018 and 2021. The Champions have participated in the project as Community Advisers, contributing to refining the focus of the project, piloting the data collection methods and interpreting the findings. This collaborative partnership has been a key to ensuring the relevance of this project to FGM-affected women and communities.

The project has explored how cultural values, norms and practices are influenced by migration to Scotland. We have been interested in understanding how migration and resettlement influence identity, family relationships, gender roles and women's vulnerability to female genital mutilation (FGM). In gathering the views and experiences of FGM-affected women, community members and key informants, this project aims to support policymakers and services to address the needs of women and wider communities more effectively and sensitively.

This report specifically focuses on FGM-affected women's experiences of immigration control and child protection, an area which the women themselves have identified as a key issue affecting their lives. It has been five years since Scotland introduced the National Action Plan to End FGM which outlines actions to strengthen FGM prevention, protection and provision of support services for women and girls (Scottish Government, 2016). This report encourages decisionmakers and practitioners to reflect FGM-affected women's barriers to protection and engagement with immigration control and statutory services, including health, police and social work.

We believe that FGM-affected women's experiences and views should be placed at the heart of future developments in designing legislation, services and safeguarding procedures. With this report, we want to raise awareness about how women are falling between the cracks of different policies and professional practices which are intended to protect women and girls from FGM. At the end of this report, we outline key recommendations for policymakers and service providers to strengthen FGM prevention and engagement with FGM-affected women and communities.



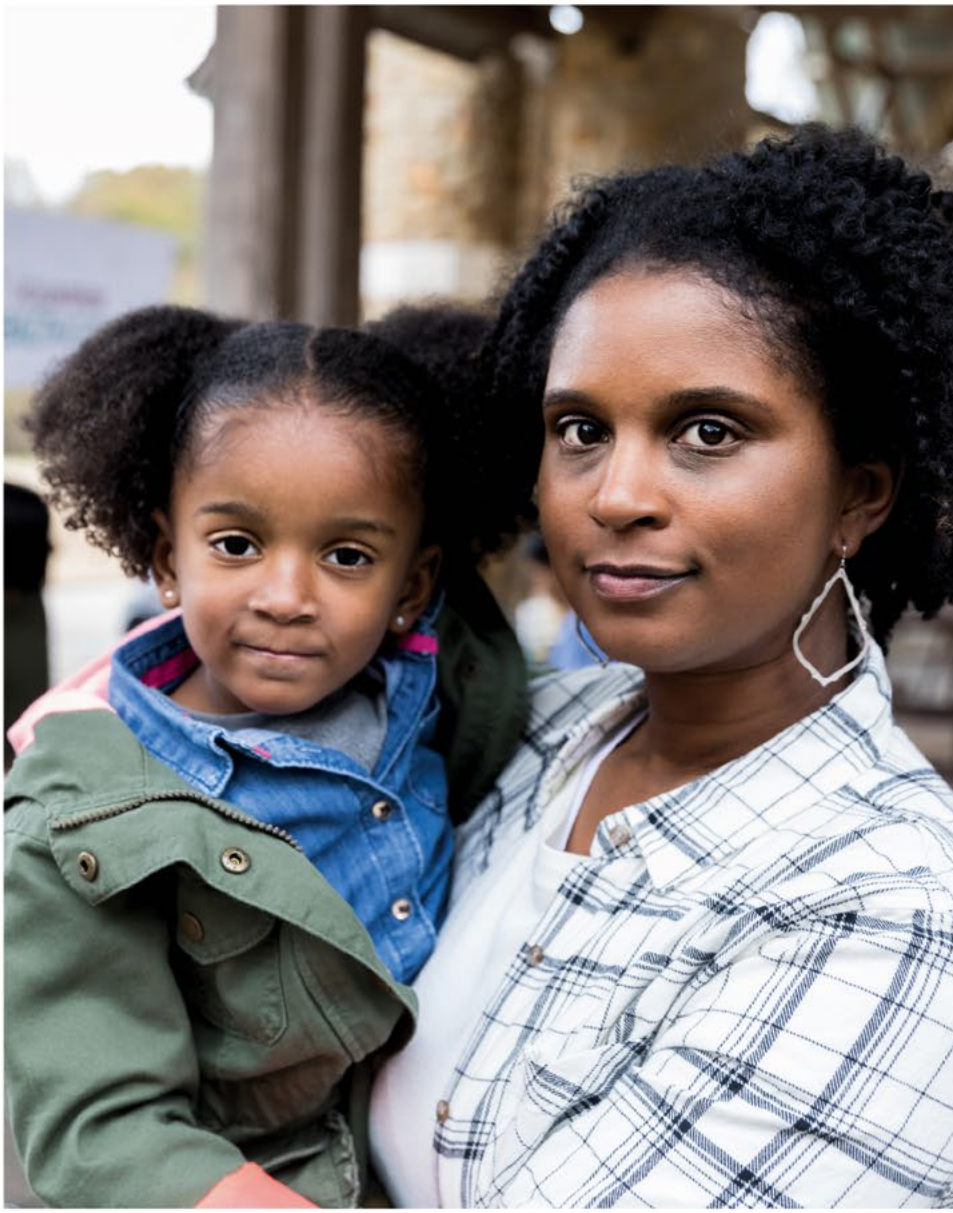
Key messages

- Contradictions between devolved child protection and reserved immigration policies undermine women's trust that their daughters will be protected from FGM. While FGM has a global reach, communities feel that current policies are only concerned with FGM protection when the risk is present in the UK.
- Although communities welcome the increased attention to ending FGM, the current heavy-handed approach to safeguarding is counter-productive to raising awareness, supporting FGM-affected women and building dialogue and partnerships with potentially affected communities.
- There is a need to develop an integrated and holistic approach to FGM prevention, protection and service provision which recognises women's and their daughters' simultaneous needs for protection and support. Although safeguarding is paramount, heavy-handed responses to potential risk of FGM should not further traumatise women who have been affected by FGM. It is crucial that the zero-tolerance approach to FGM is not delivered at the expense of supporting FGM-affected women's trauma recovery, capacity building and empowerment.
- It is crucial to ensure that the asylum process does not further traumatise women who have been affected by FGM and other forms of gender-based violence (GBV). Asylum restrictions, the lengthy process and ongoing uncertainty are harming women and families who are seeking safety in the UK.
- Women and girls who flee FGM face considerable barriers to protection in the UK. Insensitive and confrontational questioning, inconsistent treatment of evidence and limited understanding about FGM contribute to the lack of transparency in the determination of asylum claims on the grounds of FGM and other forms of gender-based persecution.

About the project

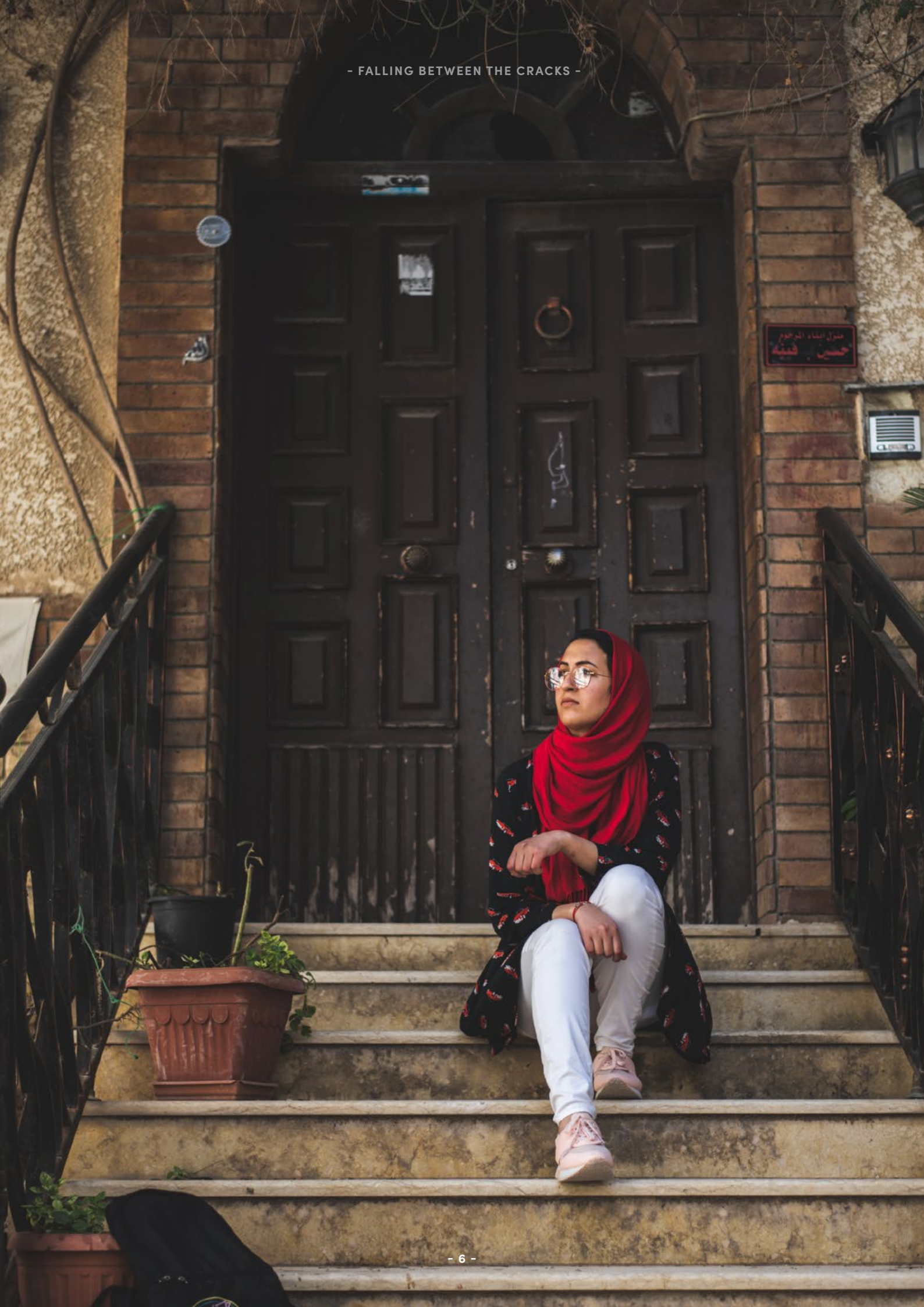
The project utilised in-depth interviews, focus groups and art-based methods to explore community perspectives and experiences of cultural change and vulnerability to FGM and other forms of GBV among migrant communities Scotland. The data was collected in Glasgow, Edinburgh and Dundee. In addition to one-off interviews and art workshops, the project conducted a series of focus groups with FGM-affected women to share their stories and views. While most of the data was collected in 2018 before the Covid-19 pandemic, discussions with well-connected Community Advisers suggest that the issues presented in this report remain key concerns for FGM-affected women.

The data for the project was collected from 11 key informants from community and third sector organisations, and 45 adult women and men who had moved to Scotland from 18 countries in the Middle East and Africa. This report focuses primarily on the experiences of 20 women from Uganda, Somalia, Malawi, Nigeria, The Gambia, Eritrea, Cameroon, Sierra Leone and Sudan who had claimed asylum in the UK. Although participation in the project did not require women to disclose experiences of FGM, many women shared their personal experiences of FGM with the project. Additionally, this report draws from the insights of key informants from women's support organisations who work with FGM-affected women in Scotland.



Women and girls who flee FGM face considerable barriers to protection in the UK.

In this report, we refer to FGM-affected women and communities. By this, we include both women who have experienced FGM, and community members whose lives are indirectly impacted by these practices. It is necessary to recognise that FGM does not always take place separately from other forms of GBV. Several women who took part in this project had also been victims to forced marriage, domestic violence, coercive control and rape. Although our findings and recommendations specifically address FGM, we consider that it is important that professionals across different sectors are cognisant of this interrelated relationship between different forms of GBV.

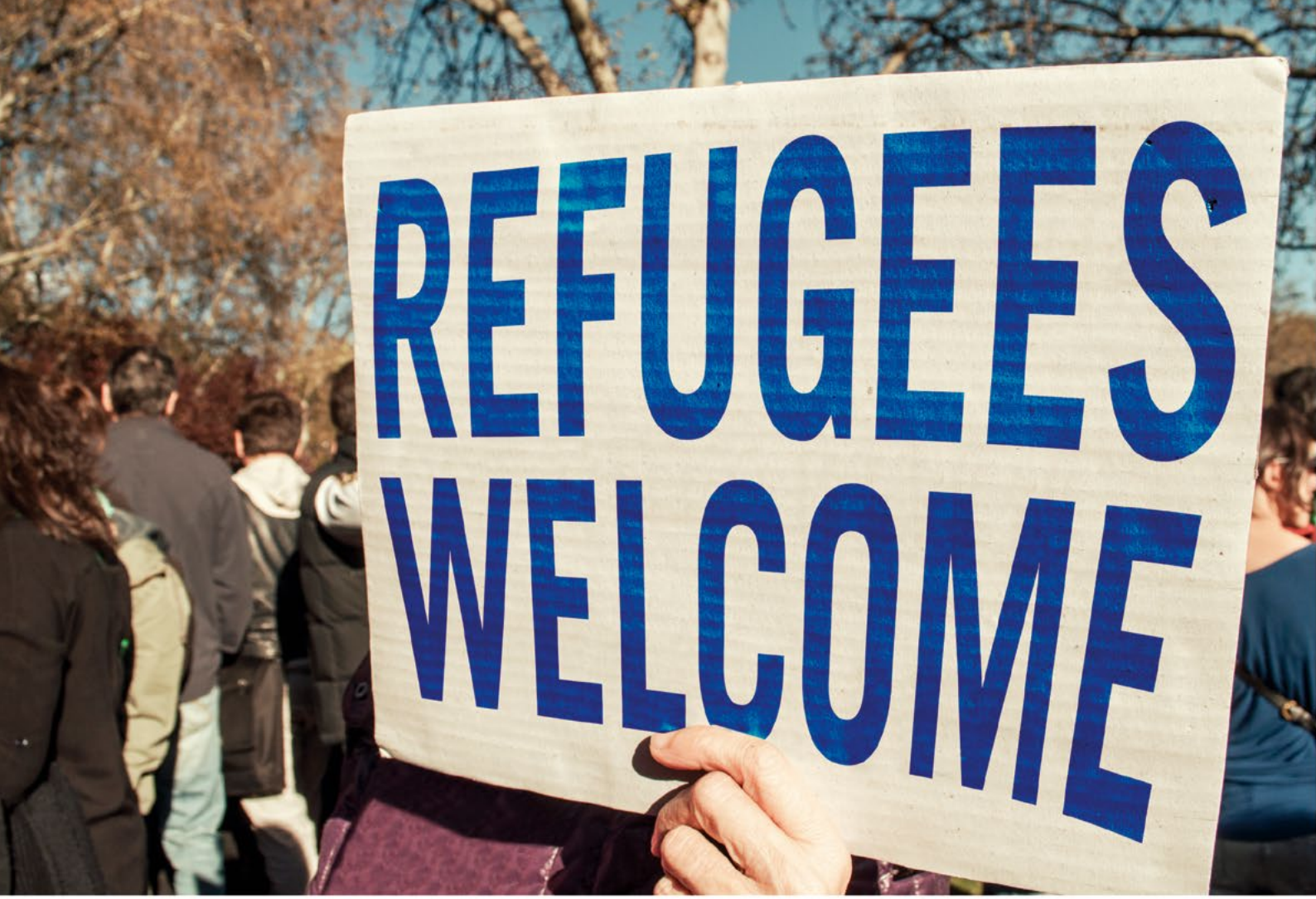


What is Female Genital Mutilation?

Female Genital Mutilation (also known as female genital cutting or circumcision) refers to a range of practices altering, injuring or removing parts of female genitalia for non-medical reasons (WHO, 2020). Throughout this report we use the term FGM in its widest sense to include practices involving different degrees of cutting, stretching of the labia and other medically unnecessary changes to female genitalia. FGM practices can lead to multiple short- and long-term health consequences and are internationally recognised as a violation of the human rights of women and children. FGM violates the rights to health and physical integrity, right to be free from torture, cruel, inhumane or degrading treatment and in the worst cases, the right to life.

It has been estimated that over 200 million girls and women continue to be affected by these practices worldwide (WHO, 2020). Although this report primarily draws from the experiences of African women, FGM is also practised in other areas. FGM practices cross national, ethnic, and religious boundaries, and can be found in both rural and urban communities. While there is a lack of reliable estimates about the prevalence of FGM in the UK, it has been estimated that 60,000 girls are potentially at risk (McFarlane and Dorkenoo, 2014). FGM is practised for multitude of reasons which include socio-cultural factors, religious beliefs and aesthetic and psycho-sexual justifications. How FGM is practised also varies greatly between communities, including the age when girls undergo FGM, and the traditions and rituals which accompany these practices.

FGM has been illegal in Scotland since 1985. Following the Prohibition of Female Genital Mutilation (Scotland) Act 2005, FGM has carried a maximum sentence of up to 14 years in prison. More recently, the Female Genital Mutilation (Protection and Guidance) (Scotland) Act 2020 introduced further measures in the form of Female Genital Mutilation Protection Orders. In addition to legislation, the Scottish Government has introduced a National Action Plan to Prevent and Eradicate FGM in 2016, multi-agency guidance for frontline staff in 2017 and dedicated funding for FGM-specific projects since 2015 (Scottish Government, 2016, 2017, 2019).



Key findings

Women's experiences of the asylum process

Although UK is among one of the top receiving countries for asylum seekers from FGM-practising countries (Novak-Irons, 2015), little is known how the asylum process impacts FGM-affected women and how FGM-related asylum claims are handled. The next sections will address these gaps by highlighting women's experiences of inequalities, unsafety and re-traumatisation during the asylum process.

Most of the project participants had claimed asylum in the UK. This included women who had claimed derivative asylum to protect their daughters from FGM, and FGM-affected women who had claimed asylum on the grounds of other forms of gender-based persecution. In many cases, women whose daughters were at risk of FGM were also themselves fleeing from other forms of violence. In disclosing their experiences of FGM and other forms of GBV, many women shared that they were still experiencing a multitude of physical and mental health complications, including depression, feelings of incompleteness and loss of trust in others.

The majority of these women had waited years in the asylum system, which they described as "exhausting", "frightening", "inhumane", and as "torture". Women reported experiencing symptoms of depression, anxiety, sleep problems, panic attacks, suicidal thoughts, and feelings of shame, unsafety and loneliness during the asylum process. These issues were exacerbated by discrimination and marginalisation which were frequently experienced by asylum seeking women. Most participants recounted experiences of everyday racism, islamophobia and labelling, which had led to heightened feelings of insecurity and social isolation. Participants' experiences of asylum were characterised by ongoing confusion and uncertainty. Women shared their fears of dawn raids, detention and deportation, which would expose them and their children to further violence:

"The system is making people more vulnerable, it's making people very broken."

"I'm on medication, I don't sleep, because I don't know what will happen next. I'm here, I should feel comfortable, but I don't know what the Home Office will decide. If they send me back home, am I going to go through what I went through again?"

"It is very difficult to recover from something if you don't know whether it's over. If you come here because you've got three daughters and you know that your family or your village is going to insist that they have FGM, or you have been raped in a conflict situation, or you're fleeing forced marriage, it's very difficult to overcome the trauma of what's happened to you if you think that you're going to go back to it. And the asylum process, it can easily take years and years. You are just trapped in limbo and you don't know how long the process is going to take, you don't know when you can start re-building your life."

Both FGM-affected women and key informants described the lengthy asylum process as a "limbo" which was putting women's lives on hold. Women did not understand why their skills were being wasted and why the asylum restrictions were forcing them to depend on the system:

"I had eight years of lost productivity. When I talk about that phase of my life, I say that it was like being put in a cold storage and then taken out when time was right for me to be taken out. But had I been given the opportunity, a person who was employable, a person that had the skills, when I still had all the energy and the motivation..."

The barriers faced by women to build their lives in Scotland during the asylum process had damaging consequences to women's mental well-being. FGM-affected women identified education and employment as crucial for enabling them to re-make their lives after experiences of violence. The ability to pursue one's aspirations and develop skills was described as a source of independence and self-respect, and as a way for women to create distance from their traumatic pasts. As described by one of the participants, asylum restrictions were re-traumatising women by stripping them of their individual autonomy to make decisions about their own lives:

"Having been through issue of domestic abuse, which was very terrible situation I went through, it really affected my overall wellbeing. This situation now makes it worse for me to do anything, except when I come out of this [asylum], that is when I can really move forward. When you tie the person's hands and legs and then you ask the person to jump and to walk, it's just impossible. Why would you accept a person being traumatised for this long?"

Women's experiences highlight how asylum restrictions work to erode women's confidence, sense of safety and hopes for future, perpetuating further trauma to the lives of already vulnerable women. Although women's first priority was to be protected from persecution, participants also highlighted the importance of challenging the stereotypes about all asylum seekers as uneducated and unskilled. Number of the women who took part in the project had degrees and careers prior to seeking asylum and were now being held back by the asylum restrictions. Women were prevented them from taking up employment and from being recognised as 'home' students to access student finance for Higher Education. These women shared their frustration over their inability to contribute to the life and economy in Scotland, which they now viewed as their home:

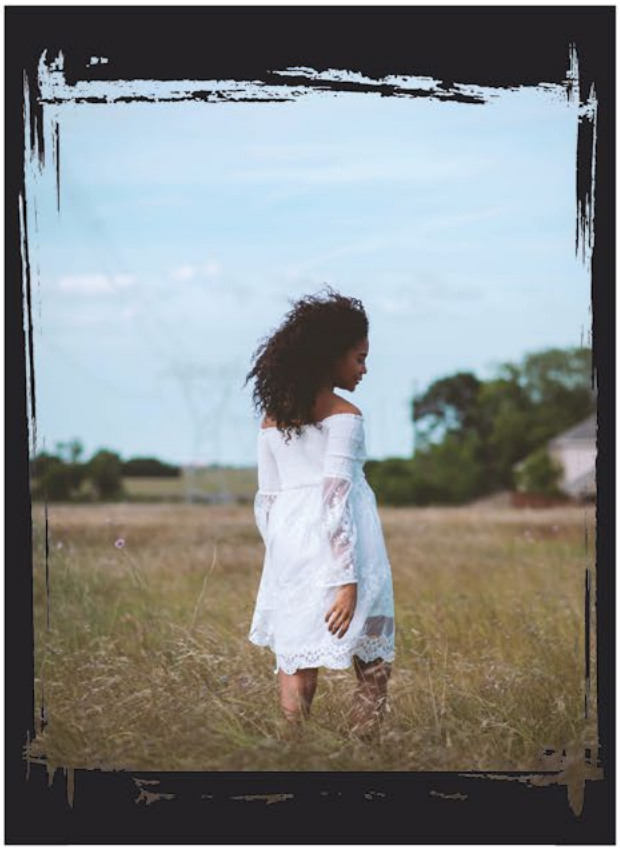
"Education is a devolved matter. I have wasted all those years [eight years in asylum] and they're telling me about inclusion, cohesion and fairness? You have to define these words for me, maybe I don't understand what they mean."

"As an asylum seeker you are vulnerable, but as a human being, you want to develop yourself".

Asylum restrictions were not only harming women, but also their children's mental health and development. Inequalities in accessing services, including the inability to access disability benefits and funding for Higher Education were a great concern for the mothers who took part in this project. Crucially, the participants felt that the devolved policies were saying one thing and doing another:

"My 16-year-old son couldn't access Education Maintenance Allowance because we're still seeking asylum. Asylum seeking children should be entitled the same opportunities that other children are entitled to... it's contradictory, because the policy statement says that we will make sure that all the children in Scotland have equal access to equal opportunities."

Women felt that their children were "robbed of opportunities" and "punished for the situations of their parents". Women said that their children often did not understand why they were being treated differently to their peers. These inequalities and women's daily struggles to provide for their children have a profound impact on the wellbeing of women and their families who are trying to rebuild their lives and achieve their full potential in Scotland.



Asylum interviews

All women who disclosed claiming asylum on the grounds of FGM and other forms of gender-based persecution had overwhelmingly negative experiences of asylum interviews. Women said that having to disclose past experiences and fears of further violence to often hostile strangers during the asylum interviews and tribunals had forced them to re-live their experiences of violence. The asylum process was described as "demining and demoralising". Most women had experienced accusations of lying, confrontational questioning and dismissive, insensitive and unsympathetic attitudes from asylum caseworkers. Many women said that they had been questioned for hours, which had felt like an interrogation. Participants felt that caseworkers lacked sympathy and understanding of women's situations:

> *"It is a scar in every woman who has gone through FGM, it's something you feel within yourself for the rest of your life... I cannot watch my child being caught going through this pain for so long. How can they [asylum caseworkers] say that I don't think they do FGM in Nigeria, how can they say that when I'm telling them what they did to me?"*

All women with FGM-related asylum claims had experienced considerable barriers in being recognised as refugees. In addition to cases where women apply derivative asylum to protect their daughters from FGM, FGM can also be a concern for women who come from FGM-practising communities, but who apply for asylum on other grounds. It is important that caseworkers understand the dynamics of FGM; as the age when FGM is perpetuated largely varies between practising communities, late disclosures of risk of FGM should not be immediately interpreted to go against the women's credibility. Some of the women who participated in the project had fled other forms of persecution, only to experience extended family pressure to practice FGM after their arrival to the UK. Marrying men from FGM-practising communities, giving birth to daughters or daughters reaching a certain age can give rise to a risk of FGM, which should be taken into account in the asylum decision-making.

In addition to questioning women's disclosures, participants said that caseworkers often overlooked the nature of FGM as a practice perpetuated by extended families and community members when making assessments about women's access to protection. Several women shared their fears that family members back in their countries of origin would take daughters to be cut without the parents' permission and despite their resistance. In these situations, community members were said to view themselves as doing the parents a favour, because FGM is a socio-cultural norm which contributes to girls' and

The nature of FGM as a normalised practice and as a taboo was also said to have fundamental implications to women's help-seeking.

women's higher social standing and marriageability within the practising communities. In addition to these family pressures to practice FGM, women said that the caseworkers lacked understanding of the gendered and age-based hierarchies which made younger women and new wives subordinate to other family members, thus limiting their capacity to resist FGM and other forms of GBV.

The nature of FGM as a normalised practice and as a taboo was also said to have fundamental implications to women's help-seeking. Women who spoke against FGM were often viewed to "let down" and "sell out" their culture, which could endanger women further:

> *"Once you learn more about gender-based violence including FGM, then you understand that actually, what happened to me was wrong. Once you start gaining consciousness and realising, challenging it, it can be a very hard situation from your community to understand. If you start questioning it, you become someone who is going against their family, and that puts you at risk."*

Women also said that caseworkers lacked understanding about the political and economic barriers women experienced in their countries of origin. Caseworkers were said to make simplified assumptions about how the existence of laws against FGM would guarantee that women and girls were protected in their countries of origin. These assumptions were said to overlook the ways police corruption, political instabilities and lack of multi-agency enforcement of FGM legislation perpetuated women's vulnerability to FGM and other forms of gender-based persecution:

> *"Because the police in my country are bribe-able, you can't call the police and say, oh my husband or my uncle or my family are going to cut me..."*

FGM is most often perpetuated by members of the extended family and often performed by elder women. Participants described how FGM was often not viewed as gender-based violence and a matter of child protection in their countries of origin, leaving women and girls without recourse to police protection. Most women also described how caseworkers had pushed them to internally relocate to protect themselves and their daughters from FGM. Women felt that the caseworkers did not understand the extent to which women relied on the family unit for survival in countries where women's participation in society was curbed by traditional gender roles, poverty and gendered labour marker inequalities.

In addition to barriers to internal relocation and state protection, caseworkers had also undermined the evidence which women had provided to support their cases. The treatment of medical evidence provides a concerning example of this:

> *"Sometimes they say that you are lying, but in this case there shouldn't be any way of feeling that I'm lying because everything is there...even the health visitor knows what I've been through. The doctor's certificate is there. Everything is there, but it's just the way they want to feel about this."*

> *"They said you need to go to the doctors and get checked, so I went and the doctor wrote stuff and said it is true, she has been cut...But they said that the way the doctor described it was like she was just listening to me. But she wrote what she saw down there!"*

Many of the FGM-affected women had been forced to undergo invasive genital examinations to provide medical reports, only to have their evidence undermined by caseworkers. Participants said that caseworkers frequently questioned the mother's FGM-status, which remains one of the key risk factors in assessing girls' vulnerability to FGM (Scottish Government, 2017). On the other hand, women who are unaffected by FGM may also struggle to evidence the risk facing their daughters if their husband comes from an FGM-practising community. This highlights another contradiction in the asylum process, whereby women who have not undergone FGM struggle to make their case for asylum if FGM is only practised by the husband's side of the family, but the fears of women who can prove their FGM-status are also dismissed by caseworkers. There is a need to carefully assess the use of genital examinations, which can have detrimental impact on women's mental health (Johnsdotter, 2019). Incorporating genital examinations as part of system which women already experience as harmful and unsafe can further traumatise women and erode their sense of bodily integrity.

Similar experiences about inconsistent treatment of evidence were also shared by women whose identity had been questioned by caseworkers. Even when the woman's country of origin had been confirmed by speakers of the same dialect, their case could still be rejected:

"In my case, they say that I'm lying, saying that I'm coming from somewhere else. But when they brought me a letter to say that I am liable to be detained and deported, the specifically said that they will return me to that country where they refuse to believe that I am from!"

Caseworkers had high expectations about women's ability to provide evidence for their claims. Women said that they had been pressed to acquire documentary evidence in a short space of time, even the community members they were trying to reach resided in rural areas with poor communications networks. Asylum seekers were expected to afford documents verified by lawyers in their countries of origin, while being restricted to the £39.63 weekly cash allowance. This limited allowance and restrictions on employment push asylum seekers to live below the relative poverty line (OHCHR, 2018). Women said that the asylum support was not sufficient for covering legal fees, let alone meeting their basic needs. This exemplifies how the asylum process is riddled with contradictions; while women were expected to have sufficient funds to acquire evidence through lawyers, they simultaneously needed to behave and look "vulnerable enough" to be recognised as genuine asylum seekers. Having a good level of English, qualifications, good appearance, tidy home and non-essential home items were treated with suspicion and seen to undermine women's need for protection:

"I think the Home Office just want to frustrate people. You've been in the system five, six, seven years claiming asylum to protect your girls, and all that they can come up with is 'oh, you speak good English, so you can protect your child'".

"They believe you should look a certain way, wearing dirty clothes, looking scruffy and not have any education."

There was a shared sense that women were penalised for integration, if they had succeeded in developing social networks and learning the language despite the asylum restrictions. Several women described how they had been interrogated about their belongings and purchases by housing officers who had walked in without forewarning: "They are questioning every move you make". This led women feeling stigmatised and "treated like criminals". This invasion into women's lives, and lack of safe spaces only furthered women's sense of unsafety and hopelessness during the asylum process.

Our findings highlight women's struggles to navigate the contradictory and complex asylum process. Women

had been frequently challenged over aspects of their claims even when these were supported by the Country of Origin Information (COI), which caseworkers use to inform the asylum decision-making. Caseworkers had also made contradictory statements, questioning in turn the prevalence of FGM in women's countries of origin, women's own experiences of FGM and their inability to protect their daughters from these practices. Although participants recognised that there are also cases where women's claims on the grounds of FGM have been addressed sensitively, many women had had to appeal their cases, leading to vicious cycle of repeated disclosures, submitting fresh claims and new evidence. Overall, there was a sense among the participants that the asylum decision-making lacked transparency and consistency, and that decisions were more strongly informed by statistics than the individual's need for protection. While women recognised the political context surrounding immigration and the need for rigorous assessment of asylum claims, they emphasised that these pressures should not take priority over the sensitive treatment of women's disclosures:

"Even if you don't believe what the person is saying, you don't need to say things that are mean or that will further traumatise that person. They should look for concrete and genuine reasons why they would not believe me."

Asylum seekers were expected to afford documents verified by lawyers in their countries of origin, while being restricted to the £39.63 weekly cash allowance

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Women's experiences suggest that there is a need to place further emphasis on culturally sensitive and proactive FGM support provision.

Experiences of safeguarding

The project found that FGM legislation, multi-agency safeguarding and women's ability to trust in the police are some of the key factors that support communities in abandoning FGM in Scotland. However, inconsistent, heavy-handed and insensitive approaches to safeguarding against FGM were also identified as pressing issues faced by FGM-affected women and communities.

Inconsistent approaches

The contradictions between immigration control and child protection policies and procedures emerged as a pressing finding during the project. Both key informants and FGM-affected women described how approaches to FGM protection varied depending on where the risk of FGM was present:

"Once you have a baby at the hospital, health visitors and social workers say you can't circumcise your child, if you do that you're going to go to jail. But they are not willing to write a letter to the Home Office to say if this child goes back to this country, she will undergo FGM. They say, it's not part of their job... it's is very difficult when other people who are influential are not backing you up."

"There's all this media about how FGM is horrendous child abuse, but say a Nigerian woman coming here with 3 daughters fleeing FGM, I would say that 99% of the time they'll just say to her, just go back to a different part of Nigeria. I've had conversations with women who have been quite angry because they say oh my doctor asked me about it, my midwife asked me about it, everybody is asking me what I am planning, the school has asked me about it. It makes people angry: 'How come I am a suspect all the time, but when the one thing that I am trying to do to guarantee my daughters' safety, then nobody can help me?'"

Participants described how these contradictions between professional approaches could alienate FGM-affected women and undermine their trust in statutory services. The lack of support from child protection in cases where girls would face the risk of FGM upon deportation impaired women's desperate efforts to protect their daughters. Although the participants recognised the different remits of social services and immigration control, women felt that the hypervigilant approach to FGM only when the risk was present in the UK was insincere and inadequate for protecting girls who were at risk.

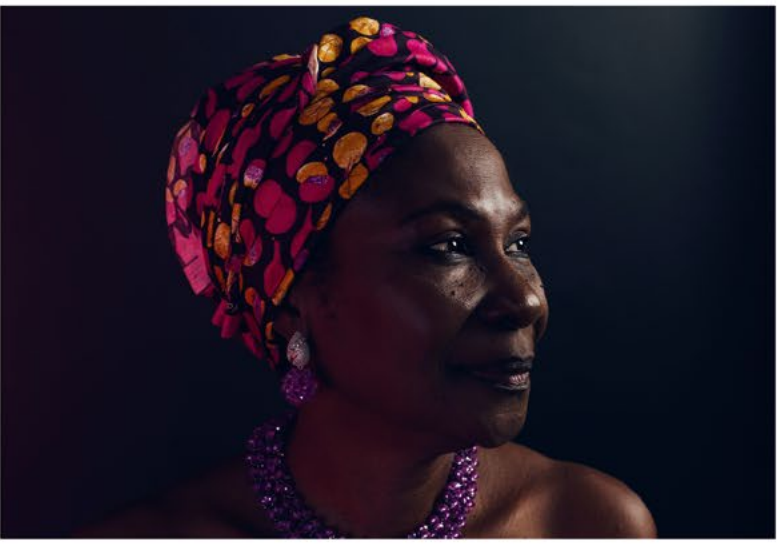
Several participants also discussed the heavy-handed approaches to FGM protection in the context of wider community fears over social work intervention and children being taken into care over physical punishment:

"What we are saying is that they cannot just choose when they want to help families. When FGM is a huge concern for you, they don't come to our rescue...Nobody is coming to my rescue when my child is about to be deported."

Differentiated approaches to risks to children's health and wellbeing were said to only further damage community trust in statutory services. In addition to addressing the contradictions in FGM protection, participants called for further proactive measures to support parents in understanding the role of social work and the laws in Scotland.

Importantly, women emphasised that the inconsistencies in approaches to FGM protection were not only a matter of practice but also policy. Participants sympathised with safeguarding practitioners who can find themselves in a difficult position to support families without Leave to Remain:

"The social workers do tend to step in to help, but they are also constrained, because there are two policies contradicting each other. There is a policy that says that a child should be protected if she's facing the threat of FGM, but at the same time the Home Office policy is saying that



if a family has not been recognised as refugees, they and their daughters can be deported. So, these two policies conflict each other, and the social workers to they find themselves in the middle of it, it's not that they don't want to help."

Our findings illustrate how FGM-affected women are falling between the cracks of devolved child protection and reserved immigration policies, which constrain the protective capacities of both social work professionals and FGM-affected women. While the participants supported implementing further legal measures to protect girls from FGM, the recently introduced FGM Protection Orders were not viewed sufficient for protecting girls from practices which are often perpetuated by extended families outside the UK borders. While the current legislation provides scope to prosecute extraterritorial offences, this reach does not extend to measures to protect all women and girls who are at risk of FGM outside of UK:

"The FGM Protection Act should protect all children, it should be equal. Immigration should not stop that, let the child be protected while the child is here. Let the parent know that this child cannot go anywhere, because we want to protect her."

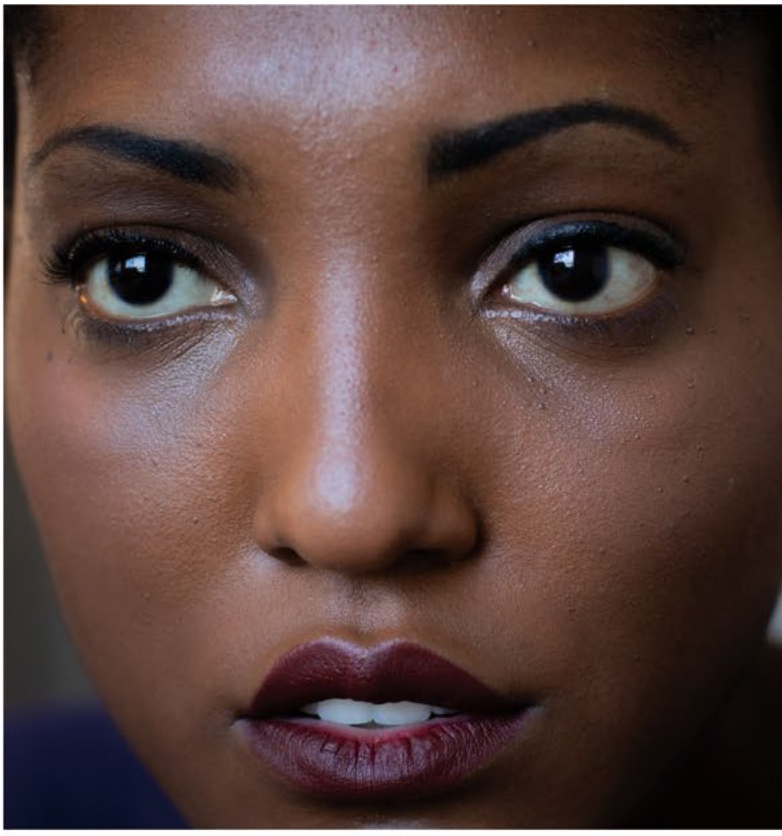
Insensitive approaches

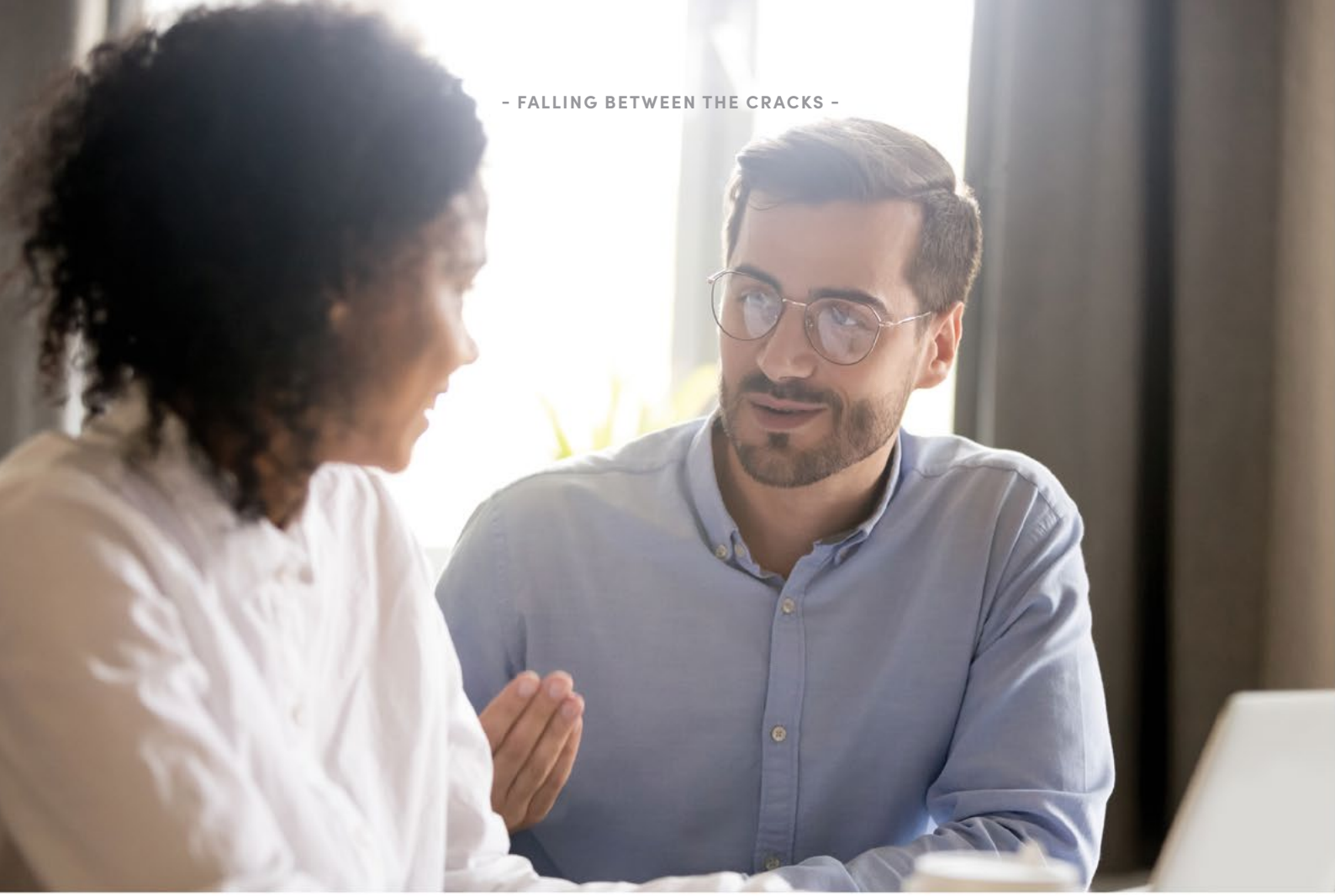
Both key informants and FGM-affected women identified the disconnection between FGM prevention, protection and support provision as a key issue. While only a minority of the women had negative experiences with healthcare providers, only one woman said they had accessed specialist support through statutory services:

"The issue of having closure from traumatic events is not well attended to at the moment... I think what has been missing really in this country is a culturally appropriate intervention to address those traumatic events in our lives. You know I've been sent to counselling, for example, and the counsellor says 'so, what happened?' and I find that is re-living the experience."

Women's experiences suggest that there is a need to place further emphasis on culturally sensitive and proactive FGM support provision. Although most of the women who had given birth to daughters in the UK had been asked to sign a declaration that they would not practice FGM, these women had not been signposted to further support offered by specialist FGM services within the NHS following childbirth. This was also the case when professionals had become aware of women's FGM-status during smear tests. While providers had generally recognised that women had been impacted by these practices, questions about women's country of origin hadn't been followed with a conversation about FGM. In the worst cases, health care professionals' shocked reactions to women's FGM-status during childbirth, gynaecological examinations and smear tests had left women feeling embarrassed and reluctant to engage further with health services. This highlights the importance of supporting professionals and equipping them with sufficient knowledge and training to sensitively address FGM with affected women.

In addition to lack of signposting, the findings suggest that there are also gaps in FGM prevention:





"A woman had just had a baby and the health worker raised the subject of FGM and the woman said that they'll probably arrange to get it done when she's older when they go back home, but she didn't know it was against the law. Her country did Type 1 when the girls were about 15-16. And so that became a child abuse investigation and the parents ended up feeling very hostile to health services, it was quite badly handled."

The above extract from a key informant illustrates how in the worst-case scenario, lack of an integrated approach to FGM prevention and protection can alienate FGM-affected women and communities. Key informants and FGM-affected women felt that the current approach prioritised punitive measures over community engagement to catch perpetrators in the act. Participants emphasised the need for further FGM prevention through awareness-raising, group work and one-to-one discussions with FGM-affected women earlier on in pregnancy to avoid situations where safeguarding measures need to be put in place after childbirth.

Hypervigilant safeguarding was also identified as pressing issue during the asylum process:

"When the Home Office asked me about the FGM, I was like, I wouldn't find anything wrong with it. A week later I was denied asylum, and then the following morning three policemen, a social worker and health visitor came into my house at nine o'clock in the morning, my children were still in their pyjamas. I have never been so terrified in my life, I just began to cry. The social worker had a copy of my Home Office letter and I thought I was going to be deported. It was very traumatic."

These issues were also highlighted by key informants, who described examples of women being frightened by heavy-handed responses from police and social work to potential risk of FGM disclosed during asylum interviews. This illustrates a missed opportunity for FGM prevention and support provision during the asylum interviews. Although asylum caseworkers have a clearly defined role in seeking to establish the facts of each individual case, their duty to safeguard children from FGM should be accompanied with a responsibility to inform new arrivals about the law on FGM in the UK. Although all the project participants were against FGM, new arrivals were still said to be often unaware of the laws on FGM and honour-based violence. The nature of FGM as a taboo, language barriers and barriers to accessing services and information about legislation were said to hinder migrants' ability to develop an understanding about their rights and responsibilities in Scotland. Migrants who came to the UK through other routes were also said to face barriers to information about FGM, because much of FGM support and prevention work was being provided by organisations that are funded to direct their services to asylum seekers and refugees.

All women viewed multi-agency safeguarding as a key factor in ending FGM in Scotland. As highlighted previously, FGM-affected women support further measures to equip professionals to support women to end FGM (Scottish Parliament Equalities and Human Rights Committee, 2019). However, our findings illustrate the adverse consequences of hypervigilant safeguarding practices on women and children who have been displaced to an entirely new cultural and legal context. Although our findings are limited to Scotland, recent research from England has reported similar negative experiences of heavy-handed safeguarding in suspected cases of FGM (Abdelshahid et al., 2021; Karlsen et al., 2019).

Unannounced home visits and multi-agency responses have a distressing impact on families who are already experiencing ongoing uncertainty, lack of control and fear of deportation during the asylum process. These issues are only exacerbated by the lack understanding about the role of social work within newly arrived communities. Further, women are often fearful of authorities due to previous experiences of police violence in their countries of origin. These fears were often compounded by experiences of hostile asylum interviews.

Engagement with FGM-affected women requires utmost sensitivity from statutory services and asylum caseworkers, who are often the first people to engage women in conversation about FGM. Crucially, while abandoning FGM ultimately benefits women, learning about FGM is not always experienced as an empowering process:

"Some people don't actually understand that they have been abused, because it's like you internalise it or you have been taught to grin and bear it. But when you start gaining consciousness of what has been happening to you, that can be too much for a person to take. And for them not to believe you, it's like double trauma now."

"A woman who had accepted it [FGM] as part of her religion, because her parents had genuinely believed it was part of their religion, so they had arranged for it. And then through some awareness work at one of the organisations, she found out it wasn't part of her religion and that traumatised her, I mean she was in a really bad way for quite a few days. And she had to overcome that, because she was just so angry. She didn't know who to be angry with."

Learning about FGM often has an unsettling impact on FGM-affected women. Many participants said that FGM had been a difficult experience which had forced them to reassess their identity, body image and feelings of belonging to their family and culture. Learning about FGM can unexpectedly confront women with trauma which they have experienced many years prior, especially when women come from cultural contexts where FGM is widely normalised. As emphasised by one of the key informants, FGM needs to challenged in a way that enables women to "re-evaluate what is normal, and to provide the space and the scope to evaluate what has been done to them". It is crucial that women are proactively supported when they first learn about FGM, and when these practices are addressed by service providers and immigration officials.

Building on good practice

Although our report has highlighted pressing issues in multi-agency responses to FGM, we also want to draw attention to examples of good practice and directions for future work. Despite the negative experiences of the asylum process, some women nevertheless said that they knew other community members who had been interviewed sensitively and respectfully. This suggests that there is scope to share good practice within the Home Office.

Although participants identified clear gaps in the provision of FGM services, they also highlighted examples of good practice that had enabled women to access trauma-informed support:

"From the place I am right now, I can really see the role of a social worker, I really see that she did she did a good job for me. She helped me because she was the one who referred me to Saheliya, and she followed up my case."

"We are still coming across women who have been in the country for 10 years, but because of where they've come from, they've experienced extreme trauma for different reasons. And what I really do want to acknowledge is, for many of them they have received quite good quality care from agencies that deal with victims of torture and all the rest of it."

Participants called for more partnerships between statutory services and third sector organisations to address community perceptions about safeguarding and social work. As the first extract highlights, social work and other services can play a key role in signposting women to specialist services and making women feel supported during the asylum process. Women emphasised the importance of supporting and training statutory providers about the dynamics of FGM and women's experiences of lifelong complications:

"The people that are supporting us, the social workers, the healthcare professionals, the people that are interviewing us, they need to know about these things. While we are raising awareness to communities, they also need to be trained, because if they don't understand FGM, what is the procedure, how it affects people's physical and mental health... If they don't understand that, there is no way these people are going to be any way human, or able to support us."

For most women, specialist third sector organisations had been main source of support for addressing their own experiences of FGM. Women generally favoured third sector organisations that had cultural knowledge and staff with lived experiences of FGM, and thus were in a strong position to provide culturally sensitive and survivor-centred support. Peer support groups had played a vital role in supporting the "learning, recovery and confidence building" of FGM-affected women. Ensuring that women are equipped to address their own trauma is a necessary first step to enable women to stand against FGM and other forms of GBV:

"I've learned the importance of protecting myself and my daughter... Before I wouldn't advice someone not to do it, but now I strongly would. When I'm with our people, I tell them, I say 'dear, don't even think of it, don't do FGM"'. It's the confidence I've acquired from here [Saheliya], it has groomed me to become so strong."

The key role that peer groups and third sector organisations play in supporting FGM-affected women's trauma recovery and empowerment highlights the importance of funding specialist services. Building collaborative partnerships between statutory and third sector organisations can provide a way forward for connecting practitioners and professionals with communities to increase awareness about survivor experiences and to improve the engagement with FGM-affected women and communities.

Recommendations

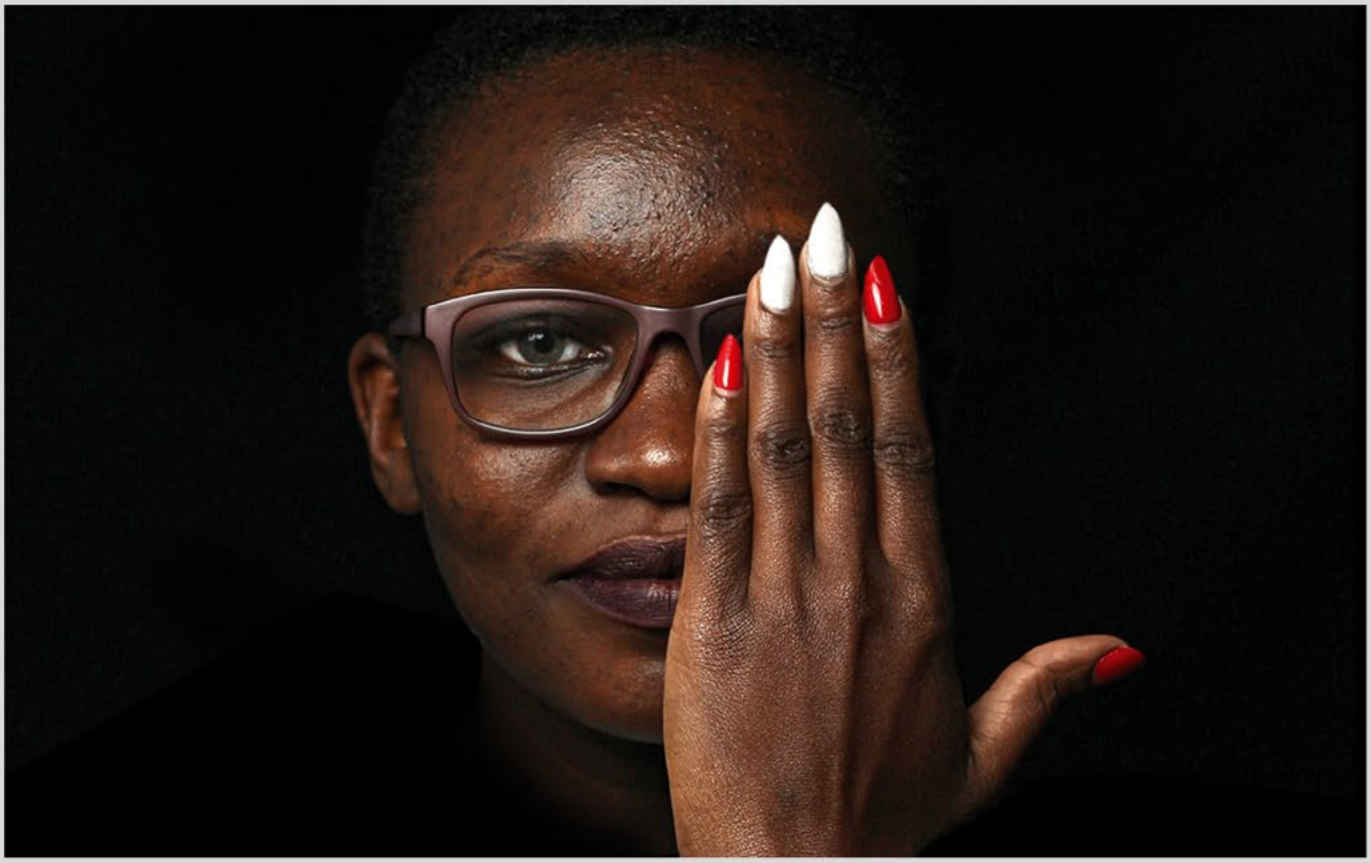
Based on our findings, we are making the following recommendations to service providers and policymakers who are engaging with FGM-affected women and communities. We hope that these recommendations can guide the development of survivor-informed and holistic approaches to ending FGM and supporting potentially affected communities in settling in the UK.

Immigration control

- Further training should be provided to increase asylum caseworkers' understanding about the dynamics of FGM and potential barriers to help-seeking and internal relocation. There is also a need for further training to increase caseworkers' knowledge about the cultural normalisation and life-long impacts of FGM to ensure that victims of violence are not further traumatised by insensitive questioning.
- There is a need to increase caseworkers' and housing officers' awareness about the diverse positions, skills and experiences that asylum seekers have to counter the influence of stereotyping during the asylum process.
- Asylum caseworkers and other officials should be adequately equipped and prepared to signpost women to further support and information, especially in situations where women are still unaware about the full impacts of FGM.
- A comprehensive review, and further monitoring is needed to ensure that FGM-related cases are handled in accordance to Home Office Guidance for assessing gender issues in asylum claims.
- The role of medical examinations and other evidence in the determination of FGM-related asylum cases should be reviewed and monitored to ensure just and due asylum determination process.
- Asylum tribunals should implement trauma-informed procedures to ensure safe spaces for women to disclose their experiences. This should include support mechanisms for women, sensitive questioning and minimising the number of people and times women have to disclose their experiences during this process.
- The Home Office should address the lengthy delays in asylum determinations to ensure that victims are not further traumatised by ongoing uncertainties and fears of deportation.

Policymaking

- There is a need to develop policy responses that recognise FGM-affected women's and their daughters' simultaneous needs for protection. This includes addressing the contradictory responses to FGM depending on whether the risk is present in the UK or in women's countries of origin.
- All asylum seekers, and especially children, should have access to appropriate provisions while their cases are being determined. Access to services, safe housing and adequate financial resources are essential preconditions for promoting the well-being of women who have experienced abuse, and who continue to face a heightened risk of further violence.
- More inclusive funding for community organisations is needed to reach diverse groups of people who need support and access to information about FGM and the Scottish legislation.



Service design and delivery

- Cross-cultural understanding and partnerships should be built between communities and statutory services to address communities' lack of knowledge and trust in statutory services.
- There is a need to support professionals in developing cultural knowledge to sensitively engage with FGM-affected communities. In addition to the need to develop an understanding about the cultural intricacies of FGM, professionals should be equipped to address communities' barriers to knowledge about the Scottish norms and legislation. These issues not only affect FGM safeguarding, but also need to be considered in cases involving physical chastisement and different cultural approaches to parenting.
- All agencies should place further emphasis on FGM prevention at early stages of engagement. Implementing one-to-one discussions between FGM-affected women, midwives and health visitors can help to ensure women are given the space and time to learn about FGM law and ask questions before there is a need to implement safeguarding measures against FGM.
- There is a need for further signposting and facilitating access to FGM service provision before and during safeguarding to ensure that women have access to support for their own experiences of trauma.
- Further service developments, especially support provision and approaches to engagement with FGM-affected women, should be closely informed by the lived experiences of FGM-affected women and their communities. This includes equipping service providers with cultural knowledge and an understanding about the confusion and concerns of women who have experienced violence, displacement and who are subject to immigration control.
- Further training and access to resources should be provided to support practitioners to signpost FGM-affected women to specialist services.

Community engagement

- We encourage providing further opportunities for social workers and health visitors to engage with FGM-affected women in community settings, for example through involvement in community parenting classes and peer groups.
- More awareness should be raised about FGM and other harmful cultural practices among young people in schools and community settings. It is important to develop ways to raise awareness about FGM and other cultural practices in a way that does not stigmatise potentially affected children and young people.
- More community organisations should be funded to incorporate FGM awareness-raising into their work with diverse communities across Scotland.
- Further measures are needed to support communities in understanding their rights and responsibilities in their new context. In addition to law on FGM, participants emphasised the need to increase community awareness about the law on honour-based violence and physical punishment.
- There is a need to develop further awareness-raising resources to inform new arrivals about the laws in Scotland. FGM resources should be made available more widely in public spaces including in community settings, libraries and health centres. Information about FGM also needs to be mainstreamed beyond refugee community organisations to also reach people who have arrived in the UK through other routes.
- Further opportunities should be created and funded to support FGM-affected women's engagement and capacity-building to lead future work to end FGM in Scotland.

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