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“The law against Female Genital Mutilation (FGM) can scare people from performing FGM, but it doesn’t change their attitudes”: Findings of a qualitative study on FGM in Leeds, United Kingdom.

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Abstract

The Female Genital Mutilation (FGM) Act was passed in 2003 as a measure to prevent FGM in the United Kingdom (UK); at the same time, other initiatives including Tackling FGM were set up. However, between 2016 and 2017, the National Health Service reported about 112 new cases of FGM, and in February 2019, a woman in the UK was prosecuted for performing FGM on her 3-year-old daughter. Our research therefore aimed to identify why

FGM persisted despite existing law and initiatives to prevent it in the country. We conducted in-depth qualitative interviews with 20 women aged 20 to 49 years from Somalia (n=9), Ethiopia (n=4) and Eritrea (n=7) living in Leeds, England. Only respondents with tertiary education understood the meaning of FGM and its interchangeability with female circumcision. Participants were unaware of ongoing FGM practice in Leeds but believed the law against FGM had not changed people's attitude.

Keywords Female Genital Mutilation, United Kingdom, perception, programs, law

Female Genital Mutilation (FGM) a.k.a. female circumcision is a surgical procedure whereby the external genitalia of a female are removed partially or totally for no medical purpose (World Health Organization [WHO], 2008). Dobbeleir et al. (2011) defines aesthetic female genital surgery performed in western countries including the United States and United Kingdom as any surgical procedure on a normal functioning female genital. FGM falls into this category except that it is performed on female minors ranging from one day old to around 16 years (Katsounari, 2015) or 18 years. This makes FGM a violation of children's right to privacy, right to protection by guardians and right to achieving good health as underpinned in the Convention on the Rights of Child (United Nations International Children's Emergency Fund [UNICEF], n.d).

In some instances, female genital mutilation contributes to both acute and chronic health sequelae an individual may suffer. For instance, Aziem-Abdallah-Ali et al. (2011) reported that a woman who had undergone female genital mutilation as a teenager and episiotomies during childbirths developed a cyst weighing 1.9 kg and measuring 11×10.6 cm in her vulva, which impaired her mobility. Although it is unclear if the cyst developed solely because of female genital mutilation or because of both procedures, it can be assumed that female genital mutilation could potentiate the development of a vulvar cyst. Furthermore,

Ismail et al. (2017) indicated that out of 197 genitally mutilated women and 197 unmutilated women in Egypt, about 84% of cut women compared to 65% of intact women had sexual dysfunction. This implies that FGM puts victims at higher risk of sexual dysfunction than the uncut. In addition, research conducted by Kaplan et al. (2011) indicated that out of 871 excised women in Gambia, 87% developed infections including urinary tract infection or inflammation of the vaginal mucus, 36% developed excessive bleeding in the genitalia and 38% were anaemic within 10 days of the procedure. WHO (2019a) also reported that female genital mutilation causes death due to body system shock, but we lack adequate literature to prove this observation. Given this evidence, female genital mutilation can be regarded as an act that violates the right of an individual to attain the highest standard and quality of health (WHO, 2008; Fisaha, 2016).

According to the World Health Organization (2008), varieties of female genital mutilation can be grouped into four categories including Type I (clitoridectomy), Type II (excision), Type III (infibulation) and Type IV (others). Puppo (2017) further elaborates on these procedures, explaining that clitoridectomy removes the clitoris (external genital or visible part of the organ) partially or totally. Excision amputates the visible clitoris with labia minora (inner skin fold around the vagina) or labia majora (outer skin fold around the vagina). In contrast, infibulation sometimes ablates the clitoris but sometimes doesn't; the aim, however, is to occlude the vaginal opening by positioning the labia majora and labia minora and stitching or otherwise making them adhere – using acacia thorns, for example, like staples (Puppo, 2017). Other styles of FGM include various harmful procedures done to the external genitalia including pricking (Puppo, 2017).

Why do girls submit to FGM? Why do parents subject daughters to it? Factors depend on the context but can be classified as ignorance, cultural belief, and gender inequality. In Nigeria, Kolawole and van de Kwaak (2010) reported that some tribes are ignorant of the

health damage labial ablation or clitoridectomy can cause. These tribes believe that during delivery, if the baby's head touches the clitoris, the infant will die. To prevent this, they perform Type 1 FGM -- clitoridectomy. In the same country, some ethnic groups believe that performing FGM -- the type is not indicated -- on adolescents initiates them into adulthood. Moreover, Shell-Duncan et al. (2018) report that women in Senegambia (The Gambia and Senegal) practice female genital mutilation to assure inclusion in the community and avoid ostracism by members and in-laws. In contrast to these motives, Fahmy et al. (2010) report that FGM is practiced in Egypt to reduce females' libido and ensure girls remain virgin until marriage.

Taking an in-depth look at female genital mutilation, it appears to be practiced globally although localised in specific regions and driven by similar factors in the communities where it prevails. The WHO (2019b) report shows that FGM is a social norm in many countries in West and East Africa including Nigeria, Ethiopia, Somalia, and Eritrea. It has also been reported in Asian nations. For instance, Ahmady (2016) in his book *In the Name of Tradition: Female Genital Mutilation in Iran* describes khatna in four Iranian provinces. In addition, the Asia Network to End Female Genital Mutilation/Circumcision [FGM/C] Consultation (2020) highlights Asian regions that excise girls' genitalia including Malaysia, Singapore, Sri Lanka, Brunei, Thailand, the Philippines, Maldives, India and Pakistan. The recent rise in migration, moreover, has shown that immigrants from FGM-practicing nations continue in their new homes (Ortensi et al., 2018). A report from the National Health Service [NHS] (2018a) in the UK indicates that 137,000 immigrant survivors of FGM reside in England and Wales. It was further elaborated that daughters born to FGM victims are at heightened risk of being cut themselves, thus totaling about 60,000 girls at risk in the UK (NHS, 2018a).

As a measure to end genital cutting in UK, the Female Genital Mutilation Act 2003 became law. It criminalizes perpetrators with up to 14 years imprisonment (The National Archive, n.d). Also, in 2014, health professionals were mandated to report any known FGM cases to the NHS (NHS, 2014). Yet these initiatives have not been shown to prevent excision even if they bring incidences to light mainly after the fact. This kind of situation was presented in a report from Debelle (2016), who showed that between January-November 2014, 118 cases of FGM could not be prevented but were rather reported after they had been performed.

Between 2010-2016, the Tackling Female Genital Mutilation Initiative (TFGMI) emerged (Brown and Porter, 2016) and campaigned to end the abuse. While the initiative aimed at raising awareness, the programme was short lived and reached only a few local authorities in London (Brown and Porter, 2016). Despite additional initiatives listed in an NHS report (2018b), 112 new cases of female genital mutilation were discovered between 2016-2017. In fact, a woman was prosecuted for performing female genital mutilation on her daughter in February 2019 (*The Guardian*, 2019).

No doubt we need to understand why female genital mutilation continues in the UK despite its illegality, but relatively little research asks why this is so. Yet understanding the rationale behind the custom's tenacity will contribute to appropriate interventions.

Our research, therefore, aims to identify facilitators and describe barriers to ending female genital mutilation in the UK from the perspective of affected groups. Our inquiry targets females from Somalia, Eritrea, and Ethiopia living in Leeds whose communities were chosen because, as the WHO (2019) report shows, they continue infibulation with religious fervor and tenacity, and we assume our interviewees' lived experiences can provide insight into the question, why does FGM continue? Research objectives were as follows:

- To explore target community perceptions of female genital mutilation and identify factors that influence the practice in Leeds.
- To understand awareness and knowledge levels of affected respondents in Leeds to programmes to end female genital mutilation.
- To explore how target communities in Leeds respond to approaches to ending FGM.
- To recommend appropriate interventions based on research findings.

2. Methods

We applied a constructivist epistemological stance that explains how knowledge of phenomena is dependent on people and their environment (Ültanır, 2012). We believe that our research aim can be met by questioning people directly affected by harmful traditions and learning how they explain their experience of female genital mutilation.

Additionally, data was acquired from participants through a qualitative approach to the target community's experience of the custom (Allen, 2017). Phenomenological methodology shaped our research process as the chosen method emphasizes capturing in-depth understanding from people who have undergone or arrange to perform FGM (Giorgi, 2012).

How did this work? Our researchers bracketed their perceptions and attitudes towards female genital mutilation and recorded how participants viewed the concept. This prevented prejudice in the process of data collection and analysis. In addition, the research process and reflections on each interview were recorded in a reflexive journal during fieldwork. This supported the quality of the findings, because they were critiqued using the reflexive journal to ensure the data analysis process was not subject to personal feelings.

2.1 Sampling

Purposive sampling was applied for it allows selecting participants whose characteristics accord with research objectives (Palinkas et al., 2015). We chose a snowballing approach

because it multiplies the number of participants with desired backgrounds identified through already-recruited participants (Naderifar et al., 2017). Initially, a gatekeeper from within the community who supports immigrants' integration into British society engaged interviewees.

The research did not aim to recruit survivors/victims of female genital mutilation because research ethics did not permit it. Rather, we accepted participants only from FGM-practicing communities, but differing groups were chosen to elicit data from varied sources. Inclusion criteria were age (23-50 years), length of stay in Leeds (3 years or more) and ability to communicate in the English language. The age range was chosen to exclude participants who might be vulnerable to some of the interview questions.

We set the length of stay in Leeds to find participants who had integrated into Leeds society. It was not feasible to employ an interpreter to communicate in all participants' languages within the short duration of the research. Therefore, we required ability in English and interviewed 20 individuals including 9 Somali (Muslim), 7 Eritrean (Christian) and 4 Ethiopian (Christian) females. Of the participants, 18 had attended high school while one Somali and one Ethiopian had tertiary education.

2.2 Data collection

A semi-structured interview using vignettes relating to research objectives was used to collect data. Vignettes were preferred because they initiate prompt responses in discussion of sensitive issues (Gourlay et al., 2014) such as female genital mutilation. We presented two fictional scenarios. First came the story of a family who infibulated their daughters. The second chronicled a girl protected from undergoing FGM. Based on their experience, participants could identify with or relate to each vignette; their responses to these stories were then elicited and recorded.

The interview process began by introducing the research question and informing each interviewee that participation is voluntary and withdrawal possible before the end of data

collection on June 28, 2019. Consent was sought from each recruit who was also assured confidentiality. The interview was audio-recorded, the duration ranging from 20-50 minutes; it ended with summaries of each response and confirmation of fidelity to the participants' views in the wording of synopses.

2.3 Data analysis

Phenomenological methodology guided the analysis we applied to this research (Whiting, n.d). Initially, the method prescribes transcribing the audio recorded interview to produce a text – transcript -- of the data. Transcripts were then read with intense attention to grasp the participant's mode of response. Again, each line of the typescript was re-examined to identify and isolate meaningful units -- excerpts -- that inform the inquiry's objectives. Themes appeared, and units that relate to a theme became sub-themes that in turn were merged to increase data manageability. We searched for the essence of these meaningful units by interrogating each one regarding its purpose vis-à-vis the research question. The chosen methodology defined this process as seeking revelatory themes. The reflexive journal was juxtaposed with the revelatory themes to ensure the analysis was not subjective but objective, that is, not swayed or distorted by personal judgements.

Ethics

An approval to perform this research was received from the University of Leeds research ethics committee.

3. Findings

Except for two participants from Ethiopia and Somalia with tertiary education, none of the women questioned understood the term female genital mutilation (FGM). After the meaning and procedure of female genital mutilation were explained to those for whom the concept was alien, they were able to relate it to female circumcision, and felt more comfortable responding to questions on female circumcision. Therefore, the term "female circumcision" was used

during data collection, but our research report maintains the use of FGM. Below are the findings for each theme (objectives) of the research.

3.1 Perceptions of FGM and Factors that Influence the Practice

All participants indicated that they are unaware of female genital mutilation occurring in Leeds, neither do they support its performance. Although united in their conviction that FGM is not good, they expressed various reactions to it. While some participants from Somalia and Eritrea showed their displeasure, some Ethiopian interviewees expressed reluctance to judge perpetrators because the practice had existed for so long and shaped behavior. A common voice shared by all from Somalia exposed universal performance of infibulation back in their home country decades ago, but all were certain that no Somalis practice FGM in Leeds.

Moreover, participants from Somalia and Eritrea were unanimous in highlighting FGM's huge burden on health. They explained that infibulation is painful. It makes a girl cry too much and lose too much blood. It hobbles her, for afterward she cannot walk properly. Additionally, they accused the procedure of potential interference with fertility: a sewn woman might prove unable to conceive or deliver 'normally'. Furthermore, the resulting pain in the external genitalia, they pointed out, vitiates desire for intercourse which in turn produces frustration and testiness in a wife unable to satisfy her husband's sexual needs. Important to interviewees were also the scars disfiguring external genitalia and the lasting memory of having suffered under the knife.

Participants emphasized, moreover, that factors such as culture, social networks and family, religion, and ignorance influence continuation of female genital mutilation. However, we deduced from their responses that they see the main underlying motive for ablating the vulva is to discourage a female from having sexual intercourse before marriage. As they saw it, the blades enable girls to control, that is, to suppress desire for intercourse until they

marry. As a result, the cut girl or young woman, possibly also sewn up, will be well-regarded and accepted for marriage by her future husband.

Culture

All participants cited culture as responsible for FGM, emphasizing the tendency of immigrants to import their home customs into the host country to show continued allegiance to the lives they'd left behind. In other words, they felt a need to prove they had not abandoned hoary traditions. Thus, they averred, one would suppose that FGM performed at home would carry over into the new locale.

Social network and family

According to some Somalis in our study, a girl left intact will be shamed by her peers and isolated from socializing with them. Contributing to this bullying, family members, including grandmother and great-grandmother, pressure their families even after immigration to conform to the cultural imperative by infibulating girls. But not only those still residing in East Africa demand obedience in this regard; a newcomer who wishes to integrate with, for example, the Somali community in exile will also be pressured to cut girls in exchange for approval. And once infibulated, the child or woman may then feel superior to the as yet uninitiated next arrival. A participant from Somalia offered an example of social network influence, explaining that when she delivered a girl in Belgium, some community members approached her, offering directions to meet an exciser. She was assumed to want to infibulate her daughter. Although she declined due to her private decision to keep her daughters intact, other women might have been victims of such influence.

Religion

A common theme among participants from Somalia and Eritrea was religion. However, they approached faith from different directions. All those from Somalia indicated that Islam does not support female genital mutilation, while some respondents from Eritrea, who

acknowledged religious influence on performance of FGM, were however unable to name the religion or the scriptural evidence.

Lack of knowledge

All participants felt FGM continued due to ignorance of its damage to health. They emphasized above all perpetrators' inadequate understanding of the harm they were inflicting, likely motivated by a desire to weaken the temptation to denigrate cutters and cutting cultures. They further pointed out how knowledge of the law is limited. Not everyone knows FGM is illegal in the UK.

3.2 Perceptions of program to end FGM

Efforts to end FGM identified by many participants include passage of laws and policies, support for NGOs, and information from hospitals.

Law

All participants were aware that the UK has outlawed female genital mutilation, but details of the legislation had not been conveyed. Some participants from Somalia approved of the jurisprudence but others, also from Somalia, expressed dismay because the law appeared not to persuade but rather to scare people away from cutting. Laws have not influenced attitudes, and thus support for FGM continues.

Regarding imprisonment of perpetrators, some Somalis approved but others disagreed. These contrarians opposed jailing cutters unless a girl dies. In other words, cutters hadn't (deliberately) committed murder, so jail sentences appeared incommensurate. In fact, circumcisers had only done what was right according to their lights. Nonetheless, many Somalis would call the police to report any incidence of female genital mutilation – despite hesitancy for certain reasons. A few would be reluctant to call the police for any reason, expressing fear that simply by being in touch they could cause trouble for themselves, though what kind of disturbance remained hidden. Moreover, contacting police might, they feared,

have negative consequences for their families although again the reason for fright went unstated. Should we hypothesize immigration issues? In any case, hesitancy to involve law enforcement despite the illegality of FGM in the UK seemed widespread.

Eritrean respondents, in contrast, disapproved of the law, contending that it didn't dissuade anyone from performing FGM. Ethiopians who didn't discountenance a legal ban put an interesting spin on the question, nonetheless. They didn't doubt obedience on UK soil but felt that perpetrators would likely continue cutting once back in Ethiopia. Additionally, a few Ethiopians observed that a child might be torn between obeying the law and snitching on her family. But conflicting loyalties when law enforcement and family are opposed might well cause confusion.

Support programs and information from hospitals

Few participants from Somalia had received information of any kind from campaigns concerning the health effects of FGM although, when delivering in hospitals, mothers from Eritrea and Somalia were asked if they had undergone female genital mutilation. None related their reactions to these inquiries.

3.3 Approaches to end female genital mutilation

Interviewees emphasized that information on female genital mutilation, community involvement, and implementing law against female genital mutilation are crucial to ending it.

Provision of information on female genital mutilation

Some Somali participants were emphatic about the need to inform affected communities that Islam does not support FGM. Additionally, they were convinced that warnings about adverse health effects and the law would dissuade perpetrators and possibly even change their attitudes. Interviewees reiterated: data should be easily accessible so that implicated communities can understand it.

Furthermore, a few Ethiopians addressed new immigrants' needs: they should be schooled concerning social norms in the host nation. Some Somalis also suggested that health effects of FGM can be illustrated through animation and disseminated in leaflets as well. Although the option was mentioned by a few, most Eritreans expressed skepticism at the suggestion to educate during women's gatherings like women's parties, but all agreed that high priority should be granted dissemination of data on health risks.

Community involvement

A few participants from Ethiopia thought that ending female genital mutilation was their community's responsibility, and that those directly affected should be raising awareness among their compatriots. But they recommended that communities be carried along in the movement to end FGM, with many interviewees gesturing toward the high esteem accorded to religious leaders who had the power to make change by expressing open opposition to the custom. Some Somalis also thought that once men are informed about FGM sequelae, they could advocate against subjecting their own daughters to it.

Law

According to some participants, a law against female genital mutilation is needed but the affected community should have been involved in drafting the legislation and, before implementation, communities ought to have been informed. A few Eritreans also pointed out that perpetrators can be fined, an additional deterrent.

4. Summary

Participants did not support female genital mutilation, but all acknowledged the role of culture and religion in influencing its tenacity. Some interviewees also doubted the sufficiency of law to change perpetrators' attitudes. Therefore, providing information on adverse health effects is of the utmost importance, and dissemination of such data should involve religious leaders and men in the movement to end FGM.

Discussion

This section discusses our findings. Of note is the fact that many participants did not understand the term female genital mutilation but instead referred to ablation of labia, clitoridectomy, and/or infibulation as female circumcision. Hence, a major barrier may have been uncovered when trying to pass information to them about female genital mutilation -- especially when using the term female genital mutilation in place of the term they know, female circumcision.

4.1 Perceptions of female genital mutilation

Section 3.1 records opposition to female genital mutilation even if known as circumcision. Gangoli et al. (2018) also found people -- immigrants from cutting cultures -- in the United Kingdom that do not support FGM. Their stance might have stemmed from personal experience with it -- or not. But no matter: an advantage to the movement lies in the opportunity to train this natural opposition to become advocates against the practice in their communities. Voices of non-supporters of excision and infibulation need a megaphone.

Moving on to our investigation of causality, findings in section 3.1 show that some parents ablate their daughter's organ believing the amputation will preserve her virginity until the wedding. This finding correlates with research by Gangoli et al. (2018) and Sakeah et al. (2019), who confirm perpetrators' belief in FGM as a guarantor of sexual innocence. Although there is no support for this widely disseminated myth, logical reasoning tells us a girl can choose to have premarital sexual relations even though she has had FGM. Hence, FGM clearly makes intercourse painful, but desire is another thing entirely. In other words, to effect the stated purpose, FGM doesn't work. This reasoning could be the basis for a movement in neighborhoods where premarital chastity is held in high esteem.

Although Muslim participants pointed out in section 3.1 that Islam does not support FGM, it remains unclear which religion other informants claimed disapproved of it. Gangoli et al.

(2018) contend that religion is indeed a factor that influences FGM, but which religion? Gangoli et al. did not say. Rashid and Iguchi (2019), however, emphasized Islam's non-support for the practice, just as El-Damanhoury (2013) found no Christian principle promoting it. It can only be assumed that many people are misinformed about the stance of religion toward female genital mutilation, and this points out that religious leaders also need to be informed so they can preach true religious principles to believers.

As indicated in section 3.1, El-Damanhoury (2013), Rashid and Iguchi (2019) confirm as well that social networks exacerbate by encouraging adherence to FGM. While this could be a barrier to ending the practice, non-supporters' advocacy against it within the same network can work to dissuade. Campaigners can use the same social networks to communicate the health damage, risks, and other disadvantages of excision and infibulation, and this implies that they SHOULD do so.

Section 3.1 highlights that the knowledge gap surrounding adverse health effects of FGM contributes to maintaining the practice. This might be true because if people are not provided with accurate information, they can neither understand a subject nor formulate an intelligent response (Laverack, 2017). Accurate and accessible intelligence on the adverse health effects of FGM is essential to transform erstwhile support into opposition.

4.2 Perception to programs to end FGM

In section 3.2, some participants spoke out against jail terms and fines for perpetrators of female genital mutilation. But the fact remains, the importance of legal sanction in this situation cannot be overemphasized. Legislation defines crime and prescribes the penalty. Nonetheless, a loophole remains. According to Article 7 of the Human Right Acts, a law is punishable only if people are well informed about the issue (Equality and Human Rights Commission, n.d.). In reference to section 3.2, practicing communities often know few details of the law including sanctions meted out to perpetrators in the UK. Thus, our interviewees

felt, cutters and parents should be punished only after provided with information about health risks and the minutiae of the law. To reiterate: FGM law may be applied to punish perpetrators under the Human Right Act only once vital information has been successfully disseminated.

In section 3.2, we learn that some programs to end female genital mutilation reach only mothers delivering infants in hospitals, thereby leaving out so many women not in the birthing category. Thus, we should upscale these programs to reach more people in affected communities, especially women of different age groups and literacy levels.

4.3 Approach to end FGM

Section 3.4 deals with the roles of men and religious leaders who are urged to advocate against female genital mutilation in their homes and places of worship. There are few studies of men's advocacy to end FGM in the UK, but Gangoli et al. (2018) confirmed that women in their studies recommended cultivating men and religious leaders, recruiting them into the abolition movement.

In addition, information about FGM that has been called for at length in our research should include convincing, descriptive details about adverse health effects and law on FGM to be provided through animation and leaflets. It may also be worthwhile to consider imposing fines for perpetrators rather than imprisonment because fear of jeopardizing the family may prevent potential victims from speaking out.

5. Recommendation

As mentioned in the previous section, affected communities must learn more about the damage to wellbeing wrought by female genital mutilation. This need could be met by providing information packages on the subject addressing health, law, and widespread erroneous beliefs such as FGM's faulty virginity assurance. If undertaken by Leeds City

Council in collaboration with the affected communities for the next 5 years, the data can be broadly disseminated from the population initially addressed to others in the community.

To increase the reach and coverage of abolition initiatives, already established projects like female genital mutilation support groups can be scaled up. For example, we suggest increasing human resource capacity so that more people can become involved and more in the affected communities can be reached. Funds must also support these groups, enabling recruitment and paying transportation fares. This can be done in collaboration with Leeds City Council, the support groups, and the affected communities for the next 5 years.

To encourage dissidents in affected communities to raise their voice, those who continue to approve of FGM should also be empowered by direct address and persuasion. We can encourage both groups to speak against it in their social networks, continuously equipping them with relevant information and supporting them financially to reach out. This can be done for the next 5 years in a coalition of abolitionists, the Leeds City Council, and the affected communities' leaders.

One promising strategy is to involve influencers of the faithful – often males -- and laymen in campaigns. First, they need information on harmful sequelae, the oppositional stance of religion, and the legal prohibition of female genital mutilation. This information can be provided by public health workers from Leeds City Council and can be accomplished over the next 3 years. Fortunately, men of faith and male lay persons already work with the Leeds City Council.

Conclusion

While participants do not support female genital mutilation, they also appear unaware of it being practiced in Leeds. Nonetheless, regarding factors responsible for the custom's longevity, interviewees listed culture, religion, and social networks. Our research also highlights the insufficiency of law alone to end female genital mutilation, but promising

would be a strategy supplying sufficient information to the affected communities about health damage and adverse effects with involvement of religious leaders and men to advocate against female genital mutilation.

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