Written evidence from Dr Emmaleena Käkelä, University of Strathclyde [HBA0010]

Summary

- Research shows that communities are increasingly abandoning FGM, but international risks where FGM is perpetuated overseas by extended family members remain a key concern
- Despite changing attitudes to FGM, women continue to be vulnerable to other forms of "honour"-based violence due to insecure immigration status, lack of full access to services and fear of authorities, which form barriers to help-seeking
- FGM-affected women continue to face considerable barriers in accessing support services, including limited provision of culturally competent, trauma-informed and survivor-led support groups
- Insensitive responses to FGM during the asylum process and in encounters with health, social work and police traumatise affected women and communities

Introduction

This submission is based on an ESRC-funded study with African and Middle Eastern migrant communities in Scotland, completed in 2021[1]. The research was co-produced together with a Community Advisory Board made up of asylum seeking and refugee women with lived experiences of different types of Female Genital Mutilation (FGM) and other forms of "honour"-based violence. Our co-produced report can be read here.

The project collected data from 45 adult women and men from communities potentially affected by FGM living in Glasgow, Dundee and Edinburgh, and from 11 key informants from community and third sector organisations working with migrant women. Although the project had a principal focus on FGM, women also disclosed experiences of forced and child marriage, rape, breast flattening and domestic abuse which are also frequently motivated by "honour". Participants had migrated to Scotland from 18 different countries in Africa and Middle East. Several of the interviewed FGM affected women had also previously lived in England, sharing their experiences of engaging with health, social work, education and police there.

How prevalent is honour-based abuse? Is there available data/ or research on the prevalence of these practices?

Despite growing research, evidence on the continuation of FGM after migration to Europe remains limited. This can be explained by several factors, including: the nature of these practices as a private and taboo matter; community pressure; affected women's and communities' distrust towards authorities and/or research; the still-limited provision of survivor-led initiatives; and the difficulties in measuring the effect of migration on attitudes to FGM. FGM occurs among diverse communities and geographical locations and is justified by a range of beliefs and norms depending on the community. This was exemplified by our research which engaged with both Christian and Muslim survivors from different ethnic and national groups.

There have been some attempts to quantify the number of affected women and girls, and women and girls at risk. Estimates for England, Wales and Scotland have been based on country of birth reported

[1] The research was conducted by Dr Emmaleena Käkelä. After the completion of the study, she took on the role of Specialist Adviser for the Women and Equalities Committee Inquiry into Equality and the UK Asylum Process.

in the 2011 Census; these include estimated 137,000 women and girls with FGM living in England and Wales (MacFarlane & Dorkenoo, 2014) and 23, 979 members of *potentially affected* communities in Scotland (Baillot et al., 2014). These figures are not comparable as the Scottish estimate also includes men. While these figures can inform service developments, they should be taken with a degree of caution. Country of birth can be one indicator of risk, but prevalence rates of FGM commonly greatly vary between ethnic groups and geographical areas within these countries. Our findings also highlight that community pressure and the role of extended family in perpetuating FGM, and marriages between practising and non-practising communities mean mother's FGM-status is also not always a clear indicator of risk for daughters. Most notably, existing figures do not take into account the influence of migration in the continuation of FGM. Research from UK and elsewhere in Europe has shown that migration and related factors (such as length of stay, social integration, reduced social pressure, access to information…) are influential in changing attitudes towards FGM. In addition to the risk of over-estimating prevalence, our evidence also suggests this can be under-estimated; our research identified several women with FGM from a country not included in the Scottish, or international UNICEF and WHO estimates for global prevalence rates.

In addition to research, data recorded by authorities remains limited. 2019 Freedom of Information request found that the Scottish Government does not hold data on number of women protected, number of incidents prevented, number of women provided with support or number of arrests made since 2005[2]. NHS data shows that 745 women and girls with FGM were identified between April and June 2022 in England[3]. NHS data includes women with genital piercings[4]. In addition to limited data recording, figures are often poorly cited by media and politicians, with a frequent assumption that the number of affected women identified by authorities represents the number of women who have undergone FGM after migration to the UK, despite FGM most commonly taking place between the years of 0 and 15, and the increased international migration from countries where FGM is more prevalent.

What do we know about the background or characteristics of victims and perpetrators?

Our research further confirms previously established patterns in characteristics of survivors and perpetrators. While FGM is a form of gendered violence, it stands apart from many other forms of GBV because women (mothers, extended family or older women from the community) are often the organisers, champions and perpetrators of these practices. FGM, while child abuse, also stands apart from many other forms of violence against children as it is not conventionally practised to harm, but to enable girls' and women's survival in communities where not undergoing FGM can lead to bullying, harassment and exclusion from vital social and economic assets and opportunities to marry. This has implications on how FGM should be tackled to protect women and girls.

Our research found that prior to migration to the UK, young girls themselves can also sometimes exert pressure to practice labia elongation[5] because these practices can symbolise maturity and belonging to a community. Women who had experienced cutting also said they would have not previously associated themselves with un-cut women because these women are considered dirty, uncivilised or lacking maturity. These forms of exclusion and pressure, informed by cultural norms and notions of "honour", contribute to the continuation of FGM. While men are not often directly involved in the acts of FGM, men and the wider community participate in upholding the harmful restrictive gender

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[2] Female genital mutilation (FGM) questions and funding: FOI release
[3] Female Genital Mutilation, April 2022-June 2022
[4] Genital piercings are included in the definition of FGM, but women from non-FGM practising backgrounds can also have them.
[5] There remains an ongoing international debate whether labia elongation is a form of FGM. All participants in our research who had experienced this identified themselves as survivors of FGM.

roles and norms which justify these practices (women as subservient caregivers, woman as their husband's property, perceiving uncut women as promiscuous or as unsuitable wives...) as well as in the celebration of these practices in communities where that does occur. It is vital that community engagement work also reaches men.

While FGM can occur separately, many affected women have also experienced other forms of violence, either connected or separate from FGM. Our participants included a woman who had experienced FGM after forced marriage at the age of 14, several women who had experienced domestic violence in the UK or in their countries of origin, and several women who had experienced other culturally justified forms of violence and abuse.

How prevalent is honour-based abuse?

All our research participants said that communities were increasingly abandoning FGM in Scotland, saying most people had stopped practising FGM after migration. While FGM remains a taboo and is rarely discussed openly among communities, some participants had however come across women asking for advice online for practising FGM. Additionally, some people were said to view FGM positively despite stopping the practice out of fear of legal repercussions. These accounts highlight the need for further community engagement.

Ending FGM is a difficult process for (often-displaced) communities. This involves encountering completely opposing norms and challenging deeply seated beliefs and the cultural pride previously associated with FGM. It is important to recognise that many people are simultaneously navigating new systems, laws and norms after migration which adds to the confusion and uncertainty experienced during the process of cultural change. This experience is particularly difficult for affected women whose sense of womanhood, cultural identity and relationships are abruptly challenged.

> *Before I came here, I saw myself as a goddess, because of FGM, that's what I thought… [Now I know] that the practice is a determinant of failed living aliens, because you are no longer a complete human… It numbs your very being, your very existence.*

While it is important to send a clear message to end FGM, many women had felt embarrassed and ashamed in first learning about FGM as violence. This could traumatise women who encounter FGM education without signposting to support services. For many of the women, the shock caused by this was further compounded by uncertainties experienced during the asylum process, loss of social networks, limited English language proficiency and lack of understanding about the different cultural and legal context in the UK.

It is vital that services and policies do not stigmatise communities through assuming that ending FGM is a simple choice, but facilitate it through providing opportunities for dialogue, reflection and unlearning of cultural values. All our participants emphasised the importance of funding more *survivor-led* education and awareness-raising initiatives, peer-support and genuine opportunities for women to lead campaigning and service developments to end FGM in the UK. Communities should be supported to uphold other parts of their cultures which can empower and provide meaning and sense of belonging after migration to a new context.

None of the affected women considered their daughters to be at risk of FGM in Scotland. However, international risks remain; several women had experienced pressure from extended family back in their countries of origin to travel to bring their daughters over to undergo FGM. Many migrant women retain very close and meaningful relationships with family and friends in their countries of origin, and it is vital to work with women to support them in resisting these pressures. Additionally, some women's daughters continued to be at risk of FGM due to barriers to family reunion, whereby

daughters would remain with FGM-practising communities. These risks were sustained by lack of information and support for family reunion, or the prolonged asylum process, as discussed below.

Despite reduced risk of FGM, many women continued to face an ongoing risk of other forms of gender-based violence. Evidence included women not reporting physical abuse due to insecure immigration status and reports of prostitution and rape of women following destitution after rejection of asylum claims. Services and professionals need further training to recognise women fleeing other forms of gender-based violence may also be survivors of FGM in order for this to be addressed sensitively and effectively. Additionally, the UK Government's commitment to ending FGM is seriously undermined by the hostile approach to asylum provision which sustains women's vulnerability to gender-based violence.

What are the challenges or barriers faced by victims of honours-based abuse in seeking support or protection?

While participants did not consider FGM to be a widespread practice in Scotland, many women did not feel safe. Number of factors increase women's risks of experiencing other forms of "honour"-based violence, including: asylum poverty and insecure immigration status; lack of full access to services and the labour market to become financially independent as a precondition for leaving abusive relationships; fear of authorities due to previous experiences of police violence, or lack of familiarity with social work; and the imbalance between the need and provision of culturally sensitive support and peer-led support groups. In 2020, it was reported that funding for FGM services has been cut by 76 percent[6].

Most of the affected women who had applied derivative asylum to protect their daughters from FGM had waited for years in the asylum system, longest for over eight years. In many cases women themselves were also fleeing other forms of "honour"-based violence. Women experienced the lengthy process even when their claims had been supported by medical evidence on mother's FGM-status, Country Policy and Information Reports or documentary evidence such as letters from the family evidencing the continued treat of FGM or forced marriage. Women were frequently challenged to internally relocate, despite lack of police protection and their financial dependency in the family unit. Some women had undergone invasive medical examinations, only to have their experiences of FGM undermined during asylum interviews. All women, along with interviewed men and key informants, described widespread culture of disbelief during asylum interviews:

> *When I said, if you send me home, my daughter is going to go through FGM and my husband is going to do this [domestic abuse], they [the interviewer] were like, "Does your husband know you are here?" I said I don't know, but I never told him. Even my kids don't know that I'm here. But if I go home, I would want to see my kids. And they asked: "Why would you want to see your kids?"*

Many women's wellbeing was seriously undermined by hostile questioning and dismissive attitudes towards disclosures of trauma. Women described asylum 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. The asylum system acts as a barrier to information and support services. The ongoing limbo and asylum poverty many of the women continued to be in severely undermined their trust in others, self-confidence and independence, and their capacity to make sense of their own experiences of FGM to move on with their lives.

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[6] Funding to stop female genital mutilation reduced by 76 per cent despite hundreds of new cases each month, The Independent, 20 July 2020

At the same time, participants recounted women's feelings of being constantly under suspicion from statutory services:

> *My doctor asked me about it [FGM], 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?*
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> *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 very difficult when other people who are influential are not backing you up.*

Although all women valued the clear stance against FGM by the UK authorities, the contrastingly different responses from immigration control and statutory services undermine women's feelings of safety and their agency to protect their daughters. It is important to develop a coordinated approach to protecting girls and women from practices that are often perpetuated by extended family members outside the UK borders. Additionally, there is lack of proactive community engagement and awareness-raising about the role of social work and multi-agency child protection, which has led to pervasive levels of distrust and suspicion among potentially communities in the UK. This should not be taken as a criticism against frontline social work professionals; social work in the UK is under enormous pressure due to insufficient funding and capacity, which leaves social workers with limited scope to engage in preventative community engagement work or specialised training on cultural competence[7].

What are the challenges for services supporting victims of honour-based abuse? How could those challenges be mitigated or overcome?

Our findings suggest there is an ongoing disconnection between FGM prevention, protection and support provision. Lack of proactive information about UK legislation, women's rights and the workings of child protection, and the underfunding of support services undermines efforts to end FGM other forms of "honour"-based violence in the UK. Most women's normalised understandings of FGM had first been challenged when giving birth in the UK or during asylum interviews (if women were not claiming asylum on the grounds of FGM), without them being actively signposted to support services or being given an opportunity to ask questions about FGM.

In addition to the barriers to protection faced by mothers who claim asylum to protect children from FGM, there are clear failures in the delivery of FGM protection. Not all FGM affected women claim asylum on these grounds but may instead be fleeing other forms of gender-based persecution. Our findings show that women are not only often inadequately informed about the UK legislation, but can also be re-traumatised by disproportionate measures to investigate indicated risks:

> *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 removed [from the UK]. It was very traumatic.*

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[7] Narratives of power and powerlessness: Cultural competence in social work with asylum seekers and refugees https://www.tandfonline.com/doi/pdf/10.1080/13691457.2019.1693337?casa_token=GrGuphUsSyIAAAAA:ErZsJzHXYz9lSQpBRFwgwX5Mq8yLZ2ULFsBlxj1ixrkUy6Ng0q5wNYB3suFiY-9lBDXu7C03L8TK

Several similar examples were recounted during the research. There is an urgent need to increase professionals' understanding about the often-normalised nature of FGM within affected communities and many asylum-seeking women's previous experiences of police violence to improve frontline responses to FGM. While protecting girls and women is paramount, this should be done in a way that does not further traumatise already vulnerable survivors.
There is a need to place further emphasis on culturally sensitive and proactive FGM support provision. Some great examples of specialist NHS provision exist in the UK, but these are often not accessible for women due to lack of awareness and signposting by other statutory professionals. In mainstream provision, further training is needed; in the worst cases recounted by our participants, professionals' shocked reactions and inappropriate responses to women's FGM-status had left women feeling embarrassed, shocked and reluctant to engage further. Additionally, we found that many women feel reluctant to engage with counselling provided by Western practitioners and in accordance with Western understandings about the disclosure of trauma. Instead, all women we engaged with had hugely benefitted from support provided by Black women's organisations and particularly peer-support groups and programmes ran by FGM survivors themselves. Unfortunately, these are often organisations that have to compete for very limited available funding with mainstream GBV services or other third sector organisations.

Although all women valued the UK commitment to ending FGM, survivors and communities face ongoing barriers to lead these actions themselves. Participatory and community-led action has been extremely successful in FGM practising contexts[8]. The taboo nature, women's experiences of long-lasting trauma and the cultural specificities of FGM mean that conversations to challenge cultural norms are best facilitated by people with lived experience. FGM prevention solely championed by statutory providers can not only face cultural resistance, but also misses the opportunity in providing a peer support space for survivors seeking to make sense of their own experiences:

> *I've been to a workshop that was organised by white people, but it was about the issues affecting ethnic minorities. And it has reached the point where people feel infuriated, they were angry, because we keep repeating the same things. They were talking about "thinking about the ways we can work with you or what we can do to in order to support or to help you". So, we said that you really need* is *to let ethnic minorities take charge of their own issues. Why is it that you can't build the capacity in us? If it's because of the language, why can you not teach us? We have women from Africa who were midwives back home, they were teachers back home, they were nurses back home… But when they come here, they are just sitting on the back bench.*

> *We need more awareness, more community meetings… there are a lot of people out here who have gone through FGM who have really big scars. Maybe with help it would be easier for those people to come out and talk about it. Because the people who talk about FGM, they don't go through it. The survivors are down there, they don't talk about it. If you are talking about it, everyone will just sit and nobody will talk, they will just let you explain until you finish and then the meeting is over and you all go away. But it has not been solved, because it's just the lecturer talking about it, who thinks they know more than the people who go through it, they think they know more than we do.*

Participants who had been supported by third sector organisations to make sense of their own experiences of violence had become powerful advocates for change. These women have a voice and need platforms to encourage others to listen. Future funding should prioritise opportunities for survivors to lead awareness-raising and campaign efforts, build new peer support spaces and open up dialogue within communities about the best ways to end all forms of "honour"-based violence. Some women had experienced bullying and harassment in challenging FGM within communities. It is vital that women and survivor-led organisations receive further resources and recognition to challenge the resistance to ending FGM.

[8] See for instance the work done by Tostan https://tostan.org/

Is the current law in relation to honour-based abuse adequate to protect victims? If not, what should change?

Women's experiences of ongoing risk of gender-based violence particularly during the asylum process are a clear indication that the current legislation, including the Domestic Abuse Act 2021 and the Government decision to reserve article 59 of the Istanbul Convention, fail to protect women with insecure immigration status. The lengthy asylum system and financial dependency forced by this continues to serve abusers who use women's insecure immigration status as a tool for control. Lack of full access to statutory services, women's shelters and full integration including facilitated access to information, labour market and connections to services continue to undermine women's safety. Additionally, our research found that the ability to build social networks and fulfil one's aspirations through education and employment are of central importance to women seeking to move on with their lives after "honour"-based violence. "Honour"-based violence support and prevention should be seen as a matter of holistic integration, beyond the current focus on promoting attitudinal change alone.

While women value the increased focus on tackling FGM in the UK through strengthened legislation, their experiences about the contradictions between immigration control and child protection indicate more needs to be done. The separation between FGM Protection Orders and asylum claims feels arbitrary to women and girls who face risks of "honour"-based violence with a transnational dimension:

> *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.*

Until we have an asylum system that creates safe spaces for women's claims on the grounds of "honour"-based violence to be made and heard, women will not feel reassured by other legal measures to protect girls and women from FGM. At the same time, we need a better balance between punitive, preventative and supportive measures. Tackling FGM in ways that traumatise survivors and alienates communities is counter-productive to facilitating long-term attitudinal change. While legislation can give powers to act to prevent FGM, such powers lack empowering potential if survivors and communities are not meaningfully involved in informing trauma-sensitive and culturally competent service designs and delivery.

Recommendations

- Further training should be provided to increase immigration officials' understanding about the dynamics of FGM, cultural normalisation, life-long impacts of FGM and potential barriers to help-seeking and internal relocation.

- All professionals across the immigration system, health, policing, education and social work should be adequately equipped and prepared to signpost women to further support and information.

- Asylum interviews and tribunals should implement trauma-informed procedures to ensure safe spaces for women to disclose their experiences.

- 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.

- Survivors and their 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.

- 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.

- Service developments and further policy and legislation should be closely informed by the lived experiences of FGM-affected women and their communities. Funding should prioritise survivor-led initiatives for FGM prevention and support provision.

The author would be honoured to be invited to expand and explain further any of the above summarised evidence.

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